Request for Proposals

RFP #C042625

Actuarial Rate Certification Services and Support

Issued: January 15, 2026

PERMISSIBLE SUBJECT MATTER CONTACT:

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

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DESIGNATED CONTACT:

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

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1.0 CALENDAR OF EVENTS

RFP #C042625 – ACTUARIAL RATE CERTIFICATION SERVICES AND SUPPORT	
EVENT	**DATE**
Issuance of Request for Proposals	January 15, 2026
Deadline for Submission of Written Questions	February 3, 2026 **4:00 p.m. ET**
Responses to Written Questions Posted by DOH	**On or About** February 24, 2026
Deadline for Submission of Proposals	Proposals Due On Or Before March 20, 2026 **4:00 p.m. ET**
Anticipated Contract Start Date	February 27, 2027

2.0 OVERVIEW

Through this Request for Proposals ("RFP"), the New York State Department of Health (the "Department") is seeking competitive proposals from qualified bidders to provide actuarial consulting services and other related services as detailed in Section 4.0 (Scope of Work). It is the Department's intent to award one (1), five (5) year contract from this procurement.

2.1 Introductory Background

A. INTRODUCTION

This RFP is to secure actuarial services and support for Medicaid, including Medicaid Managed Care and other State health-related programs administered by the Department in collaboration with other state agencies as described below. The Contractor selected as a result of this RFP will provide actuarial services for the range of public health insurance programs administered by the Department. These programs currently include Mainstream Medicaid Managed Care (MMC), HIV/Special Need Plans (HIV SNP), Health and Recovery Plans (HARP), Managed Long Term Care Partial Capitation (MLTCP), Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus (MAP), Essential Plan (EP), and Child Health Plus (CHPlus).

The Contractor selected as a result of this RFP will serve as the Department's independent actuary responsible for certifying that managed care premium rates developed by the Department for existing and new Managed Care ("MC") programs are actuarially sound in accordance with the appropriate sections of 42 CFR § 438, including but not limited to, 42 CFR § 438.4, CMS rate setting checklist guidance and any subsequent CMS-issued rate setting guidance and also meet requirements of the Balanced Budget Act (BBA) of 1997. Additionally, the scope of work includes certification that service-based payment rates comply with all State and Federal requirements and regulations including but not limited to the State Plan Amendment (SPA) approval process.

The Contractor will also provide fiscal management, consulting and technical assistance with other initiatives including but not limited to the following: rate development for service based payment programs; actuarial and fiscal analysis of budget initiatives; development and implementation of risk methods including risk adjustment, reinsurance (stop-loss) and risk corridors; actuarial and fiscal impact analysis of new or proposed federal or state

law, rule or guidance; analysis of financial terms of federal waivers including but not limited to budget neutrality for federal Section 1115 waivers; among others.

The Office of Health Insurance Programs (OHIP) is responsible for operating the State's Medicaid program, which provides coverage to over 8 million members and totals $111 billion annually. OHIP is also responsible for administering the Child Health Plus (CHPlus) program, the Elderly Pharmaceutical Insurance Coverage (EPIC) program and health care financing programs including the Disproportionate Share Hospital (DSH) program and the Health Care Reform Act (HCRA). NY State of Health, in coordination with OHIP, is responsible for administering the Essential Plan (EP).

OHIP is comprised of the following divisions led by its senior staff team:

- **Executive Team led by the Medicaid Director, Deputy Medicaid Director**
- **Medicaid Chief Operating Officer**
  - **Finance and Rate Setting:** This Division is responsible for all functions within OHIP related to rate setting, including managed care rates. This division has full oversight of the Medicaid budget and is the liaison with the Division of Budget and managing the Medicaid Global Spending Cap. This Division is also responsible for the administration of OHIP's operations.
  - **Health Plan Contracting and Oversight:** This Division is responsible for regulating the managed care industry and purchasing health insurance for the Medicaid program. This includes managed care contracting, oversight of health plan compliance with policies, monitoring of financial viability, mergers, acquisitions and transactions for both government and commercial health plans, provider and management contract review and approval, and the operation of the States Managed Care Complaint line.
  - **Operations and Systems:** This Division is responsible for the oversight of information systems that support the New York Medicaid Program and Department of Health initiatives including the Medicaid Management Information System (MMIS), Healthcare Exchange, and Medicaid Data Warehouse. The Division is also responsible for the prior approval for durable medical equipment, private duty nursing, hearing aids, vision care, dental, out-of-state nursing home placements, high tech radiology, and the Medical Indemnity Fund.
  - **Eligibility and Marketplace Integration:** This Division is responsible for eligibility and enrollment policy for Medicaid, the Child Health Plus (CHPlus), Essential Plan, and tax credits for qualified health plans. It is also responsible for disability determinations related to Medicaid eligibility and third-party coverage claims, liens and recoveries. The Division is also responsible for the operations of the CHIP program.
  - **Program Development and Management:** This Division is responsible for all policy and strategic planning including waiver and State Plan Amendments, and policy related to medical, dental, pharmacy (including EPIC), behavioral health and transportation management. This division is also responsible for performance management and quality improvement within the Medicaid program.
  - **Communications:** This Division is responsible for the development, coordination and management of OHIP and NY State of Health's Internal and External Communications strategies including public list serves, websites, social media platforms and consumer outreach and awareness campaigns.
  - **Data Services & Analytics:** This Division supports the infrastructure and function of OHIP by providing overall management of the availability, usability, integrity, and privacy of the data employed across the Medicaid Enterprise System and serves as the data and data privacy steward for all of OHIP. It is charged to develop, direct, and implement a comprehensive strategy to incorporate data analytics into the operations of the Medicaid program, resulting in improved efficiency and consistency of information used to develop policy and programmatic recommendations.
  - **Medicaid Payment Reform:** This Division oversees and manages OHIP's Medicaid Value Based Payment (VBP) Strategy and Roadmap, which is critical in supporting OHIP's goals under the 1115 Waiver Amendment.
  - **Medical and Dental Directors:** This Division provides medical and clinical leadership in advancing the goals of reforming service delivery and ensuring that we meet the needs of the over 6 million New

Yorkers who access services through Medicaid.

- **Strategic Operations and Planning** – This Division ensures the alignment of Medicaid initiatives with New York State's broader health policy goals. The division is dedicated to long-term planning, streamlined program implementation, stakeholder engagement, and performance-driven oversight to ensure that Medicaid evolves to meet the needs of all New Yorkers. This division is responsible for various project and waiver management under the New York Health Equity Reform (NYHER) 1115 Waiver Demonstration Amendment, including Social Care Networks (SCNs) and the Health Equity Regional Organization (HERO).

OHIP also routinely collaborates with the Department's NY State of Health and Office of Health Services Quality and Analytics as further described below:

- **NY State of Health:** NY State of Health, New York's official health plan Marketplace, is an organized marketplace designed to help people shop for and enroll in Medicaid, Child Health Plus, the Essential Plan, and Qualified Health Plans with and without premium tax credits. The NY State of Health marketplace is responsible for the policy, planning, and operations of the Essential Plan and Qualified Health Plan programs
- The Office of Health Services Quality and Analytics (OHSQA) encourages an information-based decision-making culture to improve health outcomes and value for all New Yorkers. OHSQA focuses on how to use health information to improve equitable health outcomes, efficiency, and value within the Department of Health and in the broader health community in New York State.

In addition, OHIP collaborates with other state agencies in the administration of Medicaid including policy development, program oversight, and rate setting. These agencies are as follows:

The Office of Mental Health (OMH) operates psychiatric centers across the State, and regulates, certifies and oversees more than 4,500 programs, which are operated by local governments and nonprofit agencies. These programs include various inpatient and outpatient services, community support, residential and family care plans. OMH collaborates with the Department on the development of Medicaid policy and coverage.

The Office of Addiction Services and Supports (OASAS) certifies a range of substance use disorder treatment programs and funds them through a mechanism referred to as net deficit financing. Once certified, programs submit a budget with projected third-party reimbursement revenue and projected costs. The program is approved by the agency field office for State aid to fund programs for the deficit between third party and other non-state revenues to the reasonable costs.

The Office for People with Developmental Disabilities (OPWDD) is responsible for the provision, regulation and oversight of services to New York citizens with developmental disabilities. Individuals served by OPWDD have a documented history of experiencing diagnoses which could include, but are not limited to, intellectual disabilities, cerebral palsy, epilepsy, neurological impairments, and autism spectrum disorders. The complexities of managing this vast system, even in a relatively static environment, are significant. Adding to these complexities, OPWDD is committed to transformational goals designed to make its outcomes, supports and services, business processes, administrative structure, and decision- making capabilities more person-centric and streamlined. These goals involve transforming the traditional service delivery model to a system with a heightened ability to offer more opportunities for self-direction including; self-directed living arrangements, allowing the individual and circle of support to make choices related to the types of interventions and services utilized, designing individualized and customized services, providing individuals opportunities to be part of and contribute to their community, and the provision of services that are community- integrated.

The Office of the Medicaid Inspector General (OMIG) is an independent entity created within the Department of Health to promote and protect the integrity of the Medicaid program in New York State. Health care fraud, waste, and abuse can involve physicians, pharmacists, beneficiaries, medical equipment companies, and transportation providers. In carrying out its mission, OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations.

The Division of the Budget (DOB) is responsible for advising the Governor in matters that affect the financial health of the state. In addition, this agency assists in formulating the Governor's budget proposal to the Legislature, offers policy recommendations on fiscal issues and oversees the implementation of the final Enacted Budget.

The Office of the State Comptroller (OSC) responsibilities include serving as sole trustee of the New York State Common Retirement Fund, administers the New York State and Local Retirement System for public employees, maintains the State's accounting system, reports on state finances, manages and issues state debt and audits state agencies (including contracts and payments).

B. PROGRAM BACKGROUND

1. Managed Care Programs

As noted above, the State operates several MC programs. Throughout this document, MC will generally be meant to include the following programs.

- Mainstream Medicaid Managed Care (MMC)
- HIV/Special Need Plans (HIV SNP)
- Health and Recovery Plans (HARP)
- Managed Long Term Care Partial Capitation (MLTCP)
- Program for All-Inclusive Care for the Elderly (PACE)
- Medicaid Advantage Plus (MAP)
- Essential Plan (EP)
- Child Health Plus (CHPlus)

Taken collectively, these MC programs provide needed health insurance coverage to over 8 million New Yorkers. Monthly managed care enrollment reports are available on the Department's website for some of the programs listed above at: http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/.

A brief description of each program is provided in Attachment C: Program Definitions.

2. Services Based Payment Programs

The State also operates the following service-based payment programs:

- OASAS
  - OASAS System of Care
  - Medically Managed Detoxification Service
  - Medically Supervised Withdrawal Service
  - Inpatient Rehabilitation
  - Opioid Treatment Program (OTP)
  - Outpatient Clinic Services
  - Intensive Outpatient
  - Outpatient Rehabilitation
  - Stabilization in a Residential Setting
  - Rehabilitation Services in a Residential Setting
  - Re-integration Services in a Residential Setting
- Foster Care
- OMH
- OPWDD
  - Individualized Residential Alternatives (IRA)
  - Intermediate Care Facilities (ICF)
  - Day Habilitation
  - Pre Vocational Services

A brief description of each program is provided in Attachment C: Program Definitions.

3. Other Initiatives

i. Budget Neutrality

NYS 1115 MRT Waiver was renewed on April 1, 2022 effective through March 31, 2027 with the expectation for an additional five-year renewal until March 31, 2032. Goals for the waiver are to:

- Improve access to health care for the Medicaid population;
- Improve the quality of health services delivered; and
- Expand coverage with resources generated through managed care efficiencies to additional low–income New Yorkers.

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serve Medicaid populations.

Demonstrations must also be "budget neutral" to the Federal government, which means that, during the course of the project, Federal Medicaid expenditures will not be more than Federal spending without the demonstration. Centers for Medicare and Medicaid Services (CMS) policy requires the demonstration's budget ceiling to be rebased using recent cost data and growth trends at every extension, and will also limit carry-forward of accumulated savings from one approval period to the next.

Special Terms and Conditions (STCs) outlines the basis of an agreement between NYS and CMS. STCs specify the NYS´s obligation to CMS during the life of the demonstration, including general and financial reporting requirements and the timetable of State deliverables.

- Quarterly and annual reports are required, and an Independent Evaluation is completed at the end of a Demonstration program.

Budget Neutrality must be demonstrated. Federal Medicaid Expenditures with the Waiver cannot be more than Federal expenditure without the waiver during the course of the Demonstration.

https://www.health.ny.gov/health_care/managed_care/appextension/docs/2024-01-09_ny_stc.pdf

ii. Cost Effectiveness

The Department currently operates three 1915c Waivers. These waivers require analysis of cost effectiveness in lieu of a budget neutrality demonstration. The Federal government during the submission of amendments and renewals reviews current expenditures, growth trends, and policy changes.

Cost Effectiveness must be performed for every 1915c amendment and waiver renewal to demonstrate that providing waiver services won’t cost more than providing these services in an institutional setting.

iii. Medical Indemnity Fund (MIF)

The New York State Medical Indemnity Fund (MIF or “The Fund”) was established in accordance with Public Health Law Article 29-D, Title 4, for the purpose of paying or reimbursing the health care costs of individuals who have suffered birth-related neurological injuries as a result of medical malpractice. The Fund was designed to provide a funding source for future health care costs of “qualified plaintiffs” in medical malpractice actions who have suffered birth-related neurological injuries as the result of medical malpractice during a delivery admission. Per 10 NYCRR § 69-10.19, a quarterly actuarial calculation of the estimated liability of the Fund and the review

shall include various elements contributing to the amount of benefits paid by the Fund and expenses of the administration of the Fund must be conducted.

It is recommended that prospective Bidders review, at a minimum, the following: Public Health Law Article 29-D, Title 4, Medical Indemnity Fund (MIF) Regulations 10 NYCRR Subpart 69–10, especially those pertaining to Actuarial Services for the Fund (10.19 & 10.20), and historical MIF Quarterly Reports.

2.2 Important Information

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

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

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

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

2.3 Term of the Agreement

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

The pricing for years four (4) and five (5) of the Contract is subject to an annual increase or decrease as described in Section 4.7 (Payment).

3.0 BIDDERS' QUALIFICATIONS TO PROPOSE

3.1 Minimum Qualifications

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

- Bidder must have five (5) years of experience hiring actuaries who have at least one (1) of the following: the American Academy of Actuaries, a Fellow or Associate of the Society of Actuaries or the Casualty Actuarial Society, a Fellow of the Conference of Consulting Actuaries, a member or a Fellow of the American Society of Pension Professional and Actuaries, or a fully qualified member of another International Actuarial Association member organization;
- Bidder must have at least five (5) years of Medicaid managed care rate development experience with state Medicaid programs having annual Medicaid enrollment in excess of 1 million recipients;
- Bidder must have at least five (5) years of actuarial experience in the health care insurance industry; and
- Bidder must have at least three (3) years actuarial experience certifying Medicaid MC capitation premiums.

Experience acquired concurrently is considered acceptable.

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

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

3.2 Preferred Qualifications

- Five (5) years of experience working with Medicaid Management Information Systems (MMIS) inclusive of data extraction, code development and data analysis;
- Five (5) years of experience developing and implementing risk adjustment strategies in the healthcare field;
- Five (5) years of experience interacting with Centers for Medicare and Medicaid Services (CMS) on behalf of state agencies; and
- Five (5) years of experience working with 3M or Solventum risk and preventable based grouping software.

4.0 SCOPE OF WORK

This Section describes the actuarial, financial and consulting services that are required to be provided by the selected bidder. The selected bidder must be able to provide all of these services throughout the contract term.

PLEASE NOTE: Bidders will be requested to provide responses that address all of the requirements of this RFP as part of its Technical Proposal.

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

4.1 Performance Standards/Expectations

A. Methodology

1. Managed Care Programs

Currently, MC rate setting operates under the following capitation methodologies:

a. <u>Mainstream Medicaid Managed Care (MMC) and Health and Recovery Plans (HARP)</u>

1. Rate Methodology:

a. Beginning April 1, 2008, a risk-based rate setting method using health plan acuity was implemented for the MMC program. Under this risk adjusted methodology, all health plans are paid the same regional average premium, adjusted by a health plan-specific risk factor that accounts for differences in enrollee acuity across health plans. Maternity and newborn hospital costs are reimbursed using supplemental payment rates consistent with past payment methodology, except instead of plan-specific amounts, all health plans within a region receive the same delivery and newborn supplemental payment. The risk rate methodology was phased in over a four (4) year period beginning April 1, 2008. The HARP program became effective in NYS on October 1, 2015 and adopted a risk adjusted rate methodology effective April 1, 2019.

b. All health plans must offer a standard set of "core" medical services. The risk adjusted rate component for each health plan reflects the base regional average medical expenditures for the core benefits plus a regional average administrative expense. The base regional average expenditures described above are developed using historical Medicaid Managed Care Operating Reports (MMCOR) and encounter data submitted by each health plan participating in the MMC program. The MMCOR data is reported on an aggregate basis by rate region, rate cohort, and category of service and is submitted electronically on a quarterly basis. Encounter data, which is comparable to claims data, that details the specific services provided to an enrollee by a provider, is submitted by the health plans daily. MMCOR and encounter data is reviewed for accuracy and completeness. Through this review process additional adjustments are developed and applied to the base regional average expenditures to ensure that these costs reflect covered populations and services for the rating period.

c. The base regional average Per Member Per Month (PMPM) amounts derived from MMCORs and encounter data are adjusted for any applicable program changes to the MC benefit not included in base data and are then trended and adjusted by each health plan's relative risk score to derive the health plan specific risk adjusted rate. Emergency/non-emergency transportation are an optional add-on benefit in some counties. The regional average PMPM for each optional benefit provided by the plan is added to the risk adjusted rate. Additional non- medical expense loads are added to the PMPM amounts to develop the final PMPM premium.

2. Risk Methodology:

a. All health plan risk scores are developed using the Clinical Risk Group (CRG) software developed by Solventum. CRGs are one of several clinical categorical models being used by states to recognize differences in health status of enrollees across health plans. Each health plan enrollee is assigned to a single risk group based on the enrollee's diagnoses (using International Classification of Disease [ICD]-9 and ICD-10 codes), pharmaceuticals, and other demographics.

b. The CRG risk group assignment starts with ten core health status groups ranging from catastrophic to healthy as shown below. Assignment is done from the most serious to the least serious.

- Catastrophic Condition
- HIV
- Metastatic Malignancy
- Dominant Chronic Disease in 3 or more Organ Systems
- Significant Chronic Disease in Multiple Organ Systems
- Multiple Organ Systems

- Significant Chronic Disease
- Minor Chronic Disease in Multiple Organ Systems
- Minor Chronic Disease
- History of Significant Acute Diseases
- Healthy (including non-users)

c. Most categories are further divided into disease status at 4 to 6 severity “levels”. There are 1,408 specific CRGs at the most detailed level. The State uses the most granular level of CRG groupings based on rate cell size limitations for actuarial soundness.

d. Each individual’s diagnoses and pharmaceuticals are determined using health plan reported encounter data augmented by service based payment claims. Each enrollee is assigned to a single mutually exclusive CRG risk group based on diagnostic, procedure and pharmacy data during the applicable base data period.

e. Health plan encounter data is also used to determine the overall cost of services for enrollees in each CRG category. An average cost PMPM is calculated for each CRG and compared to the overall population cost PMPM to construct a set of relative weights. Some CRG cells within a health status group are too small to be actuarially sound and were combined with other cells within the group with a single cost weight. Separate sets of cost weights are developed for Temporary Assistance to Needy Families (TANF) Children, TANF Adults, Social Security Insurance (SSI), (Children and Adult combined) and HARP

f. Health plan specific risk scores are determined based a distribution of enrollees by CRG multiplied by the relative weight of each CRG. All health plan scores for a particular region are combined to determine the regional average risk score, and each health plan’s score is then compared to the regional average to create a “relative risk score” for each health plan. by submitted encounter data. However, scores may be updated more frequently based on determinations made by the Department.

g. Under the risk-based rate method, premium rates are established for nine geographic rate regions for the following rate cohort groupings:

1. TANF/Safety Net Children (ages 6 months to 20 years old)
2. TANF/Safety Net Adults (ages 21 and older)
3. SSI (ages 6 months and older)
4. HARP (ages 21 and older)
    i. In addition, a Nursing Home Transition (ages 21 and older) rate cell, two Integrated Benefit Dual (IB-Dual) rate cells (ages 18 to 64 years old and ages 65 and older), and supplemental payment rates for hospital deliveries and hospital births are developed but are currently not risk adjusted.

3. Non Risk Rates

    a. Effective April 1, 2022, the State developed per diem rates for health plans to bill for Institution for Mental Disease (IMD) stay days in excess of 15 days for populations age 21 – 64 outside of the risk based Managed Care capitation premiums. These rates are updated annually along with the risk based Managed Care capitation premiums.

4. Actuarial Memorandum:

    a. As part of the rate development process, an actuarial memorandum must be created by the contractor which documents all actuarial assumptions made as part of the rate development process along with all other data, materials, and methodologies used in the development of such rates to accompany the final health plan risk adjusted premiums.

b. HIV/Special Need Plans (HIV SNP)

1. Rate Methodology:

    a. All HIV SNP health plans must offer the same state plan services as covered under MMC including a standard set of "core" medical services comprised of acute, primary, specialty, long-term care and behavioral health care. In addition, the HIV SNPs offer specialized services for people living with HIV/AIDS including HIV specialist primary care providers, HIV care coordination services, information about HIV medications and side-effects, treatment adherence services, other specialty services, and HIV prevention and risk reduction education for HIV-negative members. The base premium rate component for each health plan reflects the base NYC Metro regional average medical expenditures for the core benefits plus a regional adjustment factor is applied to account for the cost variance in Long Island and Northern Metro regions. The base regional average expenditures described above are developed using historical Special Needs Plan Operating Reports (SNPOR) and encounter data submitted by each health plan participating in the HIV SNP program. The SNPOR data is reported on an aggregate basis by rate region, rate cohort, and category of service and is submitted electronically on a quarterly basis. Encounter data, which is comparable to claims data, that details the specific services provided to an enrollee by a provider, is submitted by the health plans daily. SNPOR and encounter data is reviewed for accuracy and completeness. Through this review process additional pre- and post- trend adjustments are developed and applied to the base regional average expenditures to ensure that these costs reflect covered populations and services for the rating period inclusive of any impact for administrative cost, underwriting gain and applicable MCO and premium based taxes.

    b. The base regional average PMPM amounts derived from SNPORs and encounter data are adjusted for any applicable program changes to the MC benefit not included in base data and are then trended to the applicable rating period. Additional non-medical expenses including Care Management are added to the PMPM amounts to develop the final PMPM premium.

    c. At this time, the following premium rates and supplemental "kick" payments are established for the New York City, Northern Metro and Long Island regions only:

        - HIV-positive (TANF/SN) for children age 6 months to 20 years
        - HIV-positive TANF/SN) for adults age 21 years and older
        - HIV-positive Social Security Income (SSI)
        - HIV-negative TANF/SN for children age 6 months to 20 years
        - HIV-negative SSI children age 6 months to 20 years
        - HIV-negative homeless TANF/SN for children age 6 months to 20 years
        - HIV-negative homeless TANF/SN for adults age 21 years and older
        - HIV-negative homeless SSI

- HIV-negative transgender TANF
- HIV-negative transgender SSI
- Nursing Home Transition age 21 years and older
- Maternity kick payment
- Newborn kick payment
- Newborn Low Birth Weight kick payment

2. Risk Methodology:
    a. HIV SNP does not currently have a risk adjustment methodology, but it is anticipated that a risk methodology may be developed during the term of the Agreement resulting from this RFP.
3. Non Risk Rates
    a. Effective April 1, 2022, the State developed per diem rates for health plans to bill for Institution for Mental Disease (IMD) stay days in excess of 15 days for populations age 21 – 64 outside of the risk based Managed Care capitation premiums. These rates are updated annually along with the risk based Managed Care capitation premiums.
4. Actuarial Memorandum:
    a. As part of the rate development process, an actuarial memorandum must be created by the contractor along with all actuarial assumptions made and all other data, materials, and methodologies used in the development of such rates to accompany the final plan premiums.

c. <u>Managed Long Term Care Partial Capitation (MLTCP), Medicaid Advantage Plus (MAP), and Program for All-Inclusive Care for the Elderly (PACE)</u>

1. Rate Methodology:
    a. Currently, a risk-based rate setting method based on information from plan cost reports, encounter data and information from the Uniform Assessment System (UAS) is used for all programs. Under the risk adjusted methodology, all plans are paid a regional average premium, adjusted by a plan specific risk factor that accounts for differences in enrollee acuity across plans.
    b. All plans must offer a standard set of “core” medical services. The base rate component for each plan reflects the regional average medical costs for the core benefits.
    c. The regional average costs are developed using program encounter data and cost reports submitted by each plan participating in the programs. The encounter data is reported by service, by enrollee and by program and is submitted at least weekly. Cost report data is reported on an aggregate basis by region, premium group and category of service and is submitted electronically on a quarterly basis. The encounter and cost report data are reviewed and adjusted for plan incurred but not reported (IBNR) claims adjustments and services identified as potentially preventable from specific categories of services.
    d. The regional average PMPM amounts derived from encounters and cost reports are then trended and adjusted for any applicable program changes impacting the rate period along with an adjustment for non- medical expense loads (i.e. administration, surplus, and applicable taxes) to arrive at a final regional average base premium rate.

2. Risk Methodology:

   a. A UAS-based risk adjustment model is developed based on long term care costs as reported within the MLTC programs encounter data and the UAS responses for the same time period. Analyses are performed to determine which UAS elements are statistically significant and have a positive relationship with long term costs. The regression coefficients associated with the model predictors are used as a basis in creating a long-term care cost index. The cost index is categorized and combined into mutually exclusive groups based on the criteria of monotonicity and sufficient sample size in each category. The cost weight for each category is developed by calculating the average per member per month of MLTC care costs, weighted by number of member months and divided by the overall average costs.

   b. As part of the risk-adjustment model development, the performance of the model is measured. The primary gauge typically used for determining the predictive performance of the risk- adjustment model is the R-squared statistic. The effectiveness of the model is further evaluated by sorting the population by descending level of predicted long term care costs and separating the recipients into distinct subpopulations. Predictive ratios based on these subpopulations are within a range that indicates a favorable relationship between actual and expected long term care costs. The consistency of the MLTC risk-adjustment results are also evaluated by comparing plan scores over three different points in time that span 18 months.

   c. Once the model and the corresponding cost weights are developed, more recent UAS responses are used to measure the risk of the plans that will be applied in the adjustment of the capitation payments for the State Fiscal Year. These risk scores are determined using a member's most recent assessment.

   d. Each plan's raw risk score is calculated by averaging the individual risk scores for all the members that are enrolled in the plan. Risk scores are developed separately for each of the four rating regions. The plan's raw score in a region is then divided by the overall regional average raw risk score to determine the relative risk score. Risk scores are not determined for plans under an identified member threshold in a region due to concerns regarding the credibility of the plan's risk score. In these instances, the plan is given a relative risk score of 1.0. The resulting risk scores are applied to all services covered by the program capitation rates.

   e. The list below provides the tasks associated with risk score development:

      - Extraction of Eligibility and Encounter Data for Standardized Pricing
      - Breakout of Encounter Data into Pricing Categories
      - Standardized Pricing of Encounter Data
      - Cost Report Comparison by Service Categories
      - Clinical Risk Group MDC and EDC Assignments from UAS data
      - Identification of Assessment Data for Model Development
      - Predictive Model Refinement / Coefficient Changes
      - Creation of MLTC Cost Index

- Cost Weight Development
- Raw and Relative Risk Score Development
- Rolling Risk Score Analysis
- Documentation of Methods

f. Risk Score model development occurs on an annual basis. However, plan specific risk scores based on the annual model may be updated more frequently based on determinations made by the Department.

g. Under the risk method, premium rates are established for four geographic rate regions for the following premium groups:
   - MLTCP:
     - Dual eligible and non-Dual eligible enrollees aged 18 years and older
   - MAP:
     - Dual eligible and non-Dual eligible enrollees aged 18-64 years
     - Dual eligible and non-Dual eligible enrollees aged 65 years and older
   - PACE:
     - Dual eligible aged 55 years and older
     - Non-Dual aged 55 years and older

3. Actuarial Memorandum:
   a. As part of the rate development process, an actuarial memorandum must be created by the contractor alongwith all actuarial assumptions made and all other data, materials, and methodologies used in the development of such rates to accompany the final plan risk adjusted premiums.

d. <u>Essential Plan (EP)</u>

1. Rate Methodology:
   a. NY is one of only three states that elected to implement the Basic Health Program option under the Patient Protection and Affordable Care Act (ACA), branded as the EP, effective April 1, 2015. Since April 2024, EP is operating under a Section 1332 State Innovation Waiver as a BHP look-alike program with expanded eligibility levels. The EP covers adults who would otherwise have been eligible to enroll in Qualified Health Plans with Premium Tax Credits and Cost-Sharing Reductions. EP enrollees must have income at or below 250 percent of the federal poverty level and be ineligible for Medicaid, the Children's Health Insurance Program and other minimum essential coverage. All EP health plans must offer a standard set of "core" medical services. The base premium rate component for each health plan reflects the base regional average medical expenditures for the core benefits plus a regional average administrative expense. The base regional average expenditures described above are developed using historical Essential Plan Operating Reports (EPPOR) and encounter data submitted by each health plan participating in the EP program. The EPPOR data is reported on an aggregate basis by rate region, rate cohort, and category of service and is submitted electronically on a quarterly basis. Encounter data, which is comparable to claims data, that details the specific services provided to an enrollee by a

provider, is submitted by the health plans daily. EPPOR and encounter data is reviewed for accuracy and completeness. Through this review process additional adjustments are developed and applied to the base regional average expenditures to ensure that these costs reflect covered populations and services for the rating period.

b. The base regional average PMPM amounts derived from EPPORs and encounter data are adjusted for any applicable program changes to the Managed Care benefit not included in base data and are then trended to the applicable rating period. Additional non-medical expense loads are added to the PMPM amounts to develop the final PMPM premium.

c. Premium rates are established for nine geographic rate regions and the following groups. The first two groups, referred to as the former Aliessa Medicaid population, are individuals who are lawfully present but not eligible for federal financial Medicaid participation, and who prior to the implementation of the EP subject to a state court decision in a case called *Aliessa v Novello* were covered by a state-funded Medicaid program.

- Former Aliessa Medicaid Population between 0% - 100% Federal Poverty Level (FPL)
- Former Aliessa Medicaid Population between 101%-138% FPL
- Non-Medicaid Population between 139% - 150% FPL
- Non-Medicaid Population between 151% - 200% FPL
- Non-Medicaid Population between 201% - 250% FP

2. Risk Methodology:

a. EP currently has a risk adjustment methodology which mirrors the same methodology utilized for the Mainstream Medicaid Managed Care (MMC) and Health and Recovery Plans (HARP) as described above.

3. Actuarial Memorandum:

a. As part of the rate development process, an actuarial memorandum must be created by the contractor alongwith all actuarial assumptions made and all other data, materials, and methodologies used in the development of such rates to accompany the final plan risk adjusted premiums.

e. <u>Child Health Plus (CHPlus)</u>

1. Rate Methodology:

a. All CHPlus health plans must offer a standard set of “core” medical services. The base premium rate component for each health plan reflects the base regional average medical expenditures for the core benefits plus a regional average administrative expense. The base regional average expenditures described above are developed using historical Medicaid Managed Care Operating Reports (MMCOR) and encounter data submitted by each health plan participating in the CHPlus program. The MMCOR data is reported on an aggregate basis by rate region and category of service and is submitted electronically on a quarterly basis. Encounter data, which is comparable to claims data, that details the specific services provided to an enrollee by a provider, is submitted by the health plans daily. MMCOR and encounter data is reviewed for accuracy and completeness. Through this review process additional adjustments are developed and applied to the base regional average expenditures to ensure that these costs reflect covered populations and services for the rating period.

b. The base regional average PMPM amounts derived from MMCORs and encounter data are

adjusted for any applicable program changes to the Managed Care benefit not included in base data and are then trended to the applicable rating period. Additional non-medical expense loads are added to the PMPM amounts to develop the final PMPM premium.

c. Premium rates are established for nine geographic rate regions

2. Risk Methodology:

   a. CHPlus does not currently have a risk adjustment methodology, but it is anticipated that a risk methodology would be developed in accordance with 42 CFR § 457.1203 during the term of the Agreement resulting from this RFP.

3. Actuarial Memorandum:

   a. As part of the rate development process, an actuarial memorandum must be created by the contractor along with all actuarial assumptions made and all other data, materials, and methodologies used in the development of such rates to accompany the final plan risk adjusted premiums.

4.2 Deliverable Based Tasks

A. Direct Rate Setting Functions

The Contractor shall perform the following core tasks as it relates to direct rate setting functions:

1. Develop or assist in development of the rate methodology (if not prescribed by law); determine, certify, update, and defend, when necessary, actuarially sound rates for all MCO cohorts under the MC program within the context of applicable Federal and State laws and regulations, including appropriate sections of 42 CFR § 438, CMS rate setting checklist guidance, subsequent CMS issued rate setting guidance and the BBA, and rate development and financial management of the individualized service programs for which Medicaid rates are determined.
2. Rate determination must be completed at the beginning of each rate cycle for the appropriate MC program. Subsequent capitation rate updates may occur anytime during the state fiscal year. The table below reflects the known rates that are required as of this issuance for each program. A detailed timeline will be developed between the selected Contractor and the program after contract approval from OSC. It is expected that the Contractor will meet all deadlines stated in the developed timeline.

Managed Care Program	**Rate Develop**	**Original Rate Package Effective Date**	**Anticipated Number of Annual Modifications to Original Rate Package***
MMC, HIV SNP, HARP	Annually	April 1	3 to 4
MLTC Programs: MLTCP, PACE, MAP,	Annually	April 1	3 to 4
EP	Annually	January 1	1 to 2
CHPlus	Annually	January 1	1 to 2

**Rates may be updated more frequently, based on determinations made by the Department.*

Work performed under this contract for each task will depend on the requirements for that task. However, for all rate setting functions included in this RFP, work includes, but is not limited to the following:

a. Capitation Rate Methodology Development and Determination:

1. Develop MC cohorts and capitation rates, using a variety of parameters, including but not limited to, recipients' age, gender, category of eligibility, level of care, and geographic location;
2. Work collaboratively with the Department staff to improve the accuracy and efficiency of capitation rate development methodologies including modifications to the Department rate development tools (including rate automation files) and software;
3. Develop or assist in the development of capitation premium adjustments to account for improved efficiencies attainable in the MC program;
4. Analyze any changes resulting from Federal or State requirements, regulations or programmatic changes to the MC program that will be effective in the applicable rating period and use current and/or historical data to calculate adjustment factors to be applied to the existing capitation rates and rate ranges;
5. Provide support and technical assistance to the Department in the development of risk migration strategy methodologies, reconciliations, and rate adjustments for inclusion in applicable MC capitation premiums. Additionally, provide supporting documentation for these adjustments and attendance/participation in discussions and/or meetings with stakeholders;
6. Provide technical assistance and develop premiums related to reinsurance requirements and other risk mitigation financial standards set forth by the Department in the MCO contract agreements;
7. Calculate the actuarially sound Amount that Would Otherwise have been Paid (AWOP) capitation rate for applicable programs;
8. Calculate all applicable State and Federal premium based taxes and surcharges;
9. Calculate the actuarially sound rates and rate ranges and ensure the methodology used to develop overall premium rates and premium rate components is clear and can be easily comprehended by the Department, MCOs, and other outside stakeholders; and
10. Develop and maintain all supporting MCO data surveys to augment base data used for MC capitation premium rate development.

b. Data Analysis:

1. Analyze the financial statement and encounter data of the MCOs or other service providers along with service based payment Medicaid claims experience, Bidders will be advised by the Department the timeframe and source financial statements that will need to be analyzed;
2. Analyze medical and pharmacy service utilization and cost profile patterns by category of service for all MC cohorts;
3. Provide technical assistance in the evaluation of individual MCOs financial statement and encounter data, including areas such as IBNR claims adjustments, sub-capitation, non-system claim transactions, State Directed Payments, Value Based Purchasing (VBP) shared savings, premium withholds, administrative overhead, care management overhead, and appropriateness of medical costs incurred;
4. Work collaboratively with the Department staff to improve the completeness, accuracy and efficiency of the existing data sources and new data sources used for capitation rate development; and

5. Analyze inflation, economic, and health related trends.

c. Interim Reporting and Other Deliverables for Direct Rate Setting Functions:

1. Participate in weekly meetings with the Department staff to discuss the parameters, priorities, methodology, timelines, and ongoing results of capitation rate development in each MC program and rate cycle;
    a. Provide any relevant appendix documents and data, as directed by the Department staff, to discuss at these meetings;
    b. Contractor staff who are not working on site as described in Section 4.4 may attend such meetings remotely, if contractor is required to be on-site they will be notified in a reasonable timeframe prior to the status call;
    c. Provide project management staff and project/timeline updates for all tasks associated with the capitation rate setting process at the weekly meetings;
2. Develop work plans for rate development by MC program including milestones for completion;
3. Meet work plan milestones and timelines as agreed upon with the Department;
4. Provide the Department staff training in methodologies used to develop rates and rate ranges for all lines of business covered by this RFP, as requested by the Department. Trainings must occur at least annually. Trainings are to occur in the Albany office to an audience of eight to ten individuals. Training materials should be provided to Bureau Directors at least 48 hours in advance of training for approval and comment;
5. Develop a quarterly category of service specific “dashboard” for all applicable MC programs to support the Department/MCOs in reviewing and monitoring program financial performance. Associated tasks include but are not limited to MCO specific category of service expenditure and utilization dashboard, specific MCO solvency dashboard and additional dashboards to support State initiatives as needed;
6. Develop semi-annual and annual financial comparison reports based on cost report data and financial performance report data comparing all MCOs with each other and with a Contractor developed average of all MCOs. The Contractor must at a minimum analyze financial and medical management efficiency, MCO Medical Loss Ratio (MLR), profitability and financial solvency and net worth. Such reports must be delivered to the Department within 60 days from the close of the cost reporting period.
7. Analyze the impact of MCO premium rates based on overall MCO financial performance retrospectively; and
8. Provide MCO on-site audits as necessary including but not limited to financial, clinical and operational assessment in order to validate MCO financial performance relative to premium rate.

d. Capitation Rate Finalization:

1. Produce the statutorily required actuarial memorandum that provides a detailed description of the methodology for developing the capitation rates and rate ranges along with all actuarial assumptions made and all other data, and materials used in the development of rates and rate ranges;
2. Certify that capitation rates are actuarially sound in accordance with the appropriate sections of 42 CFR § 438, including but not limited to, 42 CFR § 438.4, CMS rate setting consultation guide and any subsequent CMS issued rate setting guidance and meet requirements of the BBA. Documentation includes attestations

of actuarial soundness and certification of MCO capitation;

3. Assist in preparing and/or reviewing any applicable 42 CFR § 438.6(c) directed payment preprint template submissions in support of developed capitation premium rates. Supporting tasks include but are not limited to support to the Department with regard to preprint strategies, attendance and participation in discussion and/or meetings related to preprint review and approval, and incorporation of approved preprint strategies in MC capitation rate development;
4. Prepare all presentation material as well as attend, participate, and provide administrative support in the Department's rate setting discussions and meetings with stakeholders as determined by the Department;
5. Attend, participate, and defend the Department in the Department's rate setting discussions and meetings with CMS and the Office of the Actuary (OACT);
6. Provide the Department with a model for the calculation of the Behavioral Health Expenditure Target (BHET) on an annual basis. These deliverables are concurrent with the annual capitation rate development cycle for the MMC, HARP, and HIV SNP programs. Supporting tasks include but are not limited to the production and revision of MCO specific behavioral health spending targets which incorporate modifications to these targets based on enacted State Budget and/or other policy related changes, quarterly reporting that will track MCO performance against the BHETs, annual reconciliation to established targets, review and final assessment of MCO BHET appeals, policy guidance directly related to the BHET (i.e. interaction with value based arrangements, quality improvement programs, MLR and/or other risk sharing mechanisms); and
7. Provide the Department support in the Centers for Medicare & Medicaid Services (CMS) and CMS Office of the Actuary (OACT) rate certification reviews or premium rate audits from Federal or State oversight agencies (e.g. Office of the State Comptroller, Division of the Budget, Office of the Medicaid Inspector General, etc.).

B. Risk Adjustment

1. Develop, support and/or modify a risk adjustment methodology for applicable Managed Care Programs.

2. Risk methodology and plan risk scores must be completed at the beginning of each rate cycle for the appropriate MC program. The table below reflects the known plan risk score modifications that are required for each program. A detailed timeline will be developed between the selected Contractor and the program after contract approval from OSC. It is expected that the Contractor will meet all deadlines stated in the developed timeline.

Managed Care Program	Risk Score Develop	Risk Score Effective Date	Anticipated Number of Annual Modifications to Original Risk Score*
MMC, HIV SNP, HARP	Annually	April 1	1 to 2
MLTC Programs: MLTCP, PACE, MAP	Annually	April 1	1 to 2
EP	Annually	January 1	1 to 2
CHPlus	Annually	January 1	1 to 2

**Plan risk scores and risk methodology may be updated more frequently, based on determinations made by the Department.*

Related tasks include but are not limited to the following:

a. Support for existing risk adjustment methodologies, software and models;

b. Develop a risk adjustment methodology for any new MC programs or programs which currently do not risk adjust premium rates;

c. Work collaboratively with the Department staff to improve the completeness, accuracy and efficiency of the existing data sources used for risk adjustment and cost weight development. For example; Work with the Department to increase Encounter Accuracy. Encounter accuracy is the precision, completeness, and timeliness of healthcare data submitted by providers/plans (like MCOs) to state;

d. Provide technical assistance and work collaboratively with the State's risk adjustment software provider and data vendor (3M/Solventum) in the modification of existing risk adjustment software or models and/or implement new software updates or incorporation of functional assessments to the risk adjustment methodology;

e. Review risk adjustment outputs for consistency, accuracy and predictive ability;

f. Provide the Department staff training in methodologies used to develop risk scores and cost weights;

g. Develop final risk scores for rating periods. Risk scores are updated annually or more frequently at the Department's discretion;

h. Develop risk adjustment cost weights for applicable programs. Cost weights are updated annually or on a modified timeline at the Department's discretion;

i. Create a "Summary of Methods" document for the Department and stakeholder distribution which details methodology used for risk score and cost weight development;

j. Create output reports of final risk scores and cost weights for the Department and stakeholder distribution;

k. Prepare all presentation material as well as attend, participate, and provide administrative support in the Department's risk adjustment discussions and meetings with stakeholders as determined by the Department;

l. Provide the Department with administrative support, Contractor staffing resources, and technical support in the engagement of a risk adjustment workgroup with outside stakeholders as determined by the Department;

m. Support the Department in individual health plan discussions or review of risk scores or data used for risk score and cost weight development;

n. Prepare individual health plan risk score data files as determined by the Department;

o. Provide the Department support in risk adjustment methodology audits from Federal or State oversight agencies (e.g. Office of the State Comptroller, Division of the Budget, Office of the Medicaid Inspector General, etc.);

p. Provide an annual evaluation of the risk adjustment model and the effectiveness of the current methodology to appropriately reflect costs based on acuity and provide recommendations for model updates or changes; and

q. Support the Department in ensuring the accuracy of data used for rate setting by helping to identify and solve data issues in the systems used to capture member, claims and encounter data.

C. Budget Neutrality

To support the Department's efforts related to Budget Neutrality, the Contractor will be required to complete the following deliverables:

1. Quarterly Reporting
    a. The Contractor will extract and process data to produce quarterly budget neutrality enrollment and expenditure reports according to the specifications detailed in the 1115 Special Terms and Conditions (STCs). The Contractor also will populate the CMS-provided Budget Neutrality Reporting Tool template using data from the Schedule C. Expected tasks associated with this deliverable that the Contractor will be required to but not limited to perform are:
        i. Maintain a Budget Neutrality Specifications Manual that outlines the Medicaid coverage expenditures and enrollment data for all Member Eligibility Groups (MEG) identified in Section IX of the STCs, Group VIII and Aliessa Aliens that will be extracted from New York's Medicaid Management Information system (MMIS) and reported on the CMS-64 Waiver sheets. The Budget Neutrality Specifications Manual will need to be updated each time the STCs are updated and/or amended.
        ii. Use the above-mentioned Budget Neutrality Specifications Manuals to extract expenditures and enrollment data from New York's MMIS. The Contractor will be expected to provide quarterly enrollment and expenditure extractions based on MEG, service date, and category of service. Each quarter will provide expenditures on a 0-, 3- and 21- month lags due by the 14th of the first month of the quarter.
        iii. Process budget neutrality and Group VIII quarterly data reporting, including development of templates and other reporting materials, reviewing data quality, report preparation for reporting required by CMS, and any other related ad hoc requests.
        iv. Reconcile quarterly reports against the Schedule C and assist with research, analysis, and resolution of reporting errors and discrepancies related to 1115 waiver budget neutrality reporting, including audits and other State research requests.
        v. Attend and participate in meetings with stakeholders, including state staff and CMS to address methodologies and results. It is anticipated that 8-10 meetings will occur per quarter.
    b. Processed quarterly reports are due to the Department by the last day of the second month of each quarter for review and approval. The Budget Neutrality Reporting Tool Template is due by the last day of the month after the Schedule C becomes available (typically the first month of the quarter).
    c. It is anticipated that 20 quarterly reports will be due from the Contractor over the life of the contract.
2. Amendment Models and Support
    a. The Contractor will develop Budget Neutrality models for new 1115 amendments proposed by the Department and assist with the amendment submission and approval process. Expected tasks associated with this deliverable that the Contractor will be required to but not limited to perform are:
        i. Analyze the impact of 1115 Waiver Amendments, extract and review historical data, and assist with preparation of budget neutrality deliverables as detailed in the STCs for amendment submission and negotiation, including the amendment budget neutrality model, CHIP allotment worksheet, budget neutrality related amendment language, and other supporting materials requested by the Department.
        ii. Re-develop or adjust projected With Waiver (WW) and Without Waiver (WOW) PMPM expenditure projections based on the impact of the amendment;

iii. Attend and participate in meetings with stakeholders, including state staff and CMS to address methodologies and results. It is anticipated that 3-4 meetings will occur per month.

b. It is anticipated that the Contractor will develop 3-5 Budget Neutrality Models per contract year.

3. Renewal Models

a. The Contractor will assist with all extensions during this contract period. It is possible that the contractor will have to work with the incumbent on the next scheduled extension. The next scheduled extension is March 31, 2027 to be submitted by March 31, 2026 and historically occur every five-years. Expected tasks that the Contractor will be required to but not limited to perform are:

i. Research recent renewal actions by other states and make recommendations based on observed trends and policy changes;

ii. Rebase the demonstration's budget ceiling using recent cost data and growth trends;

iii. Evaluate the carry-forward of accumulated savings from one approval period to the next;

iv. Develop a budget neutrality model for renewal, accounting for any programmatic changes to the 1115 sought by the state at renewal that is consistent with STC requirements and any additional parameters as dictated by the Department or CMS;

v. Attend and participate in meetings with stakeholders, including state staff and CMS to address methodologies and results.

b. It is anticipated that the Contractor will assist with 1-2 Renewal Models over the life of the contract.

D. Preprint Support

1. CMS managed care regulations govern how states may direct plan expenditures in connection with implementing delivery system and provider payment initiatives under Medicaid managed care contracts. Under the resulting contract, the Contractor must provide support to the Department in the options development for directed payment preprint templates, as well as activities related to the operationalization of the preprint arrangement, including reconciliations. The Department anticipates the need for the Contractor to complete six (6) full Preprint Support Deliverables, which encompasses all phases outlined below. Related tasks for each phase include but are not limited to the following:

Preprint Support Phase	**Description/Tasks**
Pre-Submission Data Analytics	Develop Preprint Options by developing supplemental files/material as needed to support the Department's decision making in preprint options. This may include but is not limited to: 1. Pull actual data from multiple data sources including the Medicaid Data Warehouse (MDW) and All-Payor Database (APD) 2. Review data for accuracy and completeness 3. Advise on availability of data and/or alternative data sources
Implementation Support	1. Assist in the implementation of Preprint Logistics by providing a summary of operational Logistics required to implement the Preprint when approved by CMS. 2. Prepare supplemental files/materials as needed to support the Department's discussions with internal and external stakeholders.

Final Reconciliations	1. Commencing 6 months after the close of the fiscal period, develop data templates for plans to submit claims information including claims counts and identifying information in order to validate all payments made as State Directed Payments. 2. Review and approve plan submitted data to ensure data is complete and accurate. 3. Provide data necessary to fulfill CMS data reporting requirements, including but not limited to pulling additional data from multiple sources, validation of plan submitted data, and providing information and guidance on best practices of submission of DPT payment data.
Related Analysis/Evaluation	1. Provide ad hoc analysis based on current and pending State Directed Payments. Such analysis shall include but not be limited to running utilization counts, inquiries into plan or facility specific claiming and reporting questions or concerns, validation of data for a given period, and CMS data requests.
H+H Specific Preprint Support	Assist the State in the design and evaluation of financial arrangements with New York City Health + Hospitals including: 1. Support the design, calculation, reconciliation, and support of NYC Health + Hospital's funding adjustments that were enacted beginning in the SFY2020-21 rate period to convert NYC Health + Hospital's historical UPL payments to rate add-ons; 2. Evaluate NYC Health + Hospitals special populations total cost of care proposal; 3. Assist in the development of the NYC Health + Hospital Physician Upper Payment Limit proposal; 4. Analyze other NYC Health + Hospital financial proposals as requested; and 5. Deliverables may include providing exhibits and documentation on the managed care funding increase adjustments by plan, region, and cohort for the MMC program. Providing exhibit with actual utilization increases compared to the local shares transfers to understand any funding modifications and supplemental files/materials as needed to support the Department's discussions with internal and external stakeholders.

E. Reimbursement Development and Management of OPWDD Rate-Based Programs

1. Assist the State in reimbursement development and management for OPWDD rate-based programs.
2. The Contractor shall support the Department in the intake, review of data, and development of FFS rates for rate-based OPWDD program. Related tasks include but are not limited to the following:
   a. Support data collection, review, and data management processes with a focus on streamlining

manual processes

b. Management of the rate models and supporting data shells for OPWDD's rate-based programs (Group Day Habilitation, Facility-based Prevocational Services, Supervised IRAs, Supportive IRAs, and Intermediate Care Facilities) and other programs managed by the Department's Mental Hygiene unit, as requested

c. The Department anticipates the need for the Contractor to provide the services outlined above for three (3) rate periods per year.

F. Support Encounters Penalty Work

As enacted in SFY 2020-21 budget, the NYS Medicaid program imposes financial consequences to the MCOs for failing to comply with encounter data requirements. Penalties can be imposed for submitting untimely, inaccurate or incomplete encounter data.

The Contractor will assist the State with the implementation of the encounter metrics aimed at improving encounter data quality and allowing for increased encounter reliance and use of those for various program and rate setting activities. This includes, but is not limited to, the following work:

1. On an annual basis, develop two encounter to cost report comparisons (initial and final) and corresponding reconciliation worksheets to be shared with the Managed Care Organizations operating in governmental insurance products in the State.
    a. Encounter to Cost report comparisons will be plan-specific and will contain category of service comparisons based on encounter, and cost report submissions.
    b. Reconciliation worksheets will be developed and exchanged with the plans as means of explaining and justifying any variances between the encounter and cost report data submitted by the MCOs and validated by the contractor.
    c. Perform enhance encounter to cost comparison analytics and validation to support penalty recommendations.
    d. Review encounter to cost report comparisons and reconciliation worksheets to support penalty calculations.
    e. Develop plan-specific submitted encounter reports to support encounter metrics and penalties.
    f. Respond to plan questions around the penalty metrics and reconciliation worksheets
        i. Assist the Department with one round of reviews and plan meetings after the initial encounter to cost report metric reports and reconciliations are completed as necessary to explain and defend results. These meetings to be held in Albany, NY.
    g. Assist the state with developing materials for and facilitating plan webinars for each published rate update and supplemental updates. It is estimated that there will be three to four webinars a year for each line of business.
    h. Issue final results of the encounter to cost report analysis and reconciliation and assist the Department in preparing penalty materials to be shared with the MCOs and initiate penalty collection.
2. Modify and improve penalty methodologies and processes for future years.
3. Develop short-term and long-term suggestions on restructuring Managed Medicaid Cost and Operating Reports (MMCOR) categorization.
4. Throughout the course of the contract, it is anticipated the contractor will need to support the categorization of data for new programs and services, as well as assist the Department in educating the plans on submitting Encounters data for the new programs
5. Provide subject matter knowledge for encounter penalty enhancements for future years
    a. Provide technical support and expertise on data management to support the Department's goal of increasing Encounter's data accuracy.
6. Additionally, the contractor must develop a process to conduct an annual independent audit of the above noted work to assure accuracy, truthfulness, and completeness of the encounter and financial data submitted to the state by, or on behalf of, each MCO; and
    a. Issue the final audit report to the state on the truthfulness, completes and accuracy of the

encounter data that will be posted on the Department's website.

b. The Contractor will complete these audits by desk audit reviews of date submitted by the MCOs. The Contractor will provide, as requested (up to two [2] times per audit), an analysis of data related to any information included in the reports.

c. The timetable for each annual Encounter Data Audit (finalization dates are subject to change and will be defined before the initiation of the audit):

Report Year (Calendar Year)	Data Provided by DOH for Audit	Finalization of Audit
2024	July 2027	September 2027
2025	July 2028	September 2028
2026	July 2029	September 2029
2027	July 2030	September 2030
2028	July 2031	September 2031

G. Medical Indemnity Fund (MIF) Actuarial Services

Pursuant to Public Health Law, Chapter 45, Article 29-D, Title 4, Section 2999-I, MIF Regulation 69-10.19 and 69-10.20, the Contractor shall provide actuarial services, including, but not limited to, those outlined below:

i. Quarterly Reporting;
ii. Liabilities Analysis;
iii. Ad Hoc Reporting;

The Contractor shall utilize various actuarial techniques, including, but not limited to, expected loss methods, weighted averages, and the Bornhuetter-Ferguson technique to accomplish the scope identified below.

1. Implementation:

   a. The Contractor will be afforded an initial 90 calendar days from the contract start date or contract approval by OSC, whichever is later, to ramp up services and develop various methodologies or algorithms required to provide the MIF Actuarial Services outlined below.

   b. Within 45 days of the contract start date or contract approval by OSC, whichever is later, the Contractor will be required to submit to the Department an Implementation Plan outlining:

      i. How the Contractor will ensure the appropriate staff are assigned to perform the below services;

      ii. How the Contractor will successfully develop any and all formulas, methodologies, and algorithms needed to perform the scope; and

      iii. A detailed timeline associated with each task below.

   c. The Implementation Plan is subject to the Department's review and approval. If any revisions are required by the Department, the Contractor will revise the Implementation Plan and submit back to the Department within 5 business days.

2. Quarterly Reporting:

   The Contractor will be required to develop Quarterly Reports including a report narrative and exhibits based on the data provided by the Fund Administrator. The Quarterly Reports will follow the guidelines set forth below, including at a minimum, the following:

   a. Provide Quarterly Reports to the Department that include updated projections of the number of enrollees and the estimated claims payments. Such Quarterly Reports shall include a comparison of actual versus expected results for the quarter and year-to-date, along with discussion of the causes for the variances. The Quarterly Reports

must include complete documentation of Contractor's results, methodology and assumptions. If requested by the Department, the Contractor will schedule a formal report presentation/consultation to discuss Contractor's findings, methods, factors, and assumptions. These actuarial reports are required per MIF Regulation 69-10.19.

b. Provide Quarterly Reports upon quarter end (March 31, June 30, September 30, and December 31). Data will be submitted to the Contractor within fourteen (14) calendar days by the MIF Fund Administrator or Department. The Contractor has ten (10) calendar days to review, analyze, generate, and send the draft Quarterly Reports and Exhibits to the Department for review.

c. Once Quarterly Reports are submitted to the Department, the Contractor will remain actively engaged and collaborate with the Department during the editing process, updating Reports and Exhibits as requested.
    i. Minor administrative changes must be made within three (3) business days, unless otherwise agreed to by the Department.
    ii. Changes requiring additional actuarial analysis must be made within five (5) business days, unless otherwise agreed to by the Department.
    iii. Once drafts are approved by the Department, the Contractor must return the finalized and publishable versions to the Department within one (1) business day, unless otherwise agreed to by the Department.

d. The Contractor will generate and provide draft Reports and Exhibits in a format that is editable by the Department, indicating changes made by the Contractor via track-changes. The Reports and Exhibits must also allow for commenting by the Department.
    i. Exhibits requested by the Department can include any charts, graphs, tables, figures, or other data visualization tools used to represent the data analyzed.
    ii. Generate and provide draft Exhibits in a format that is editable by the Department, indicating changes made by the Contractor via track-changes. The exhibits must also allow for commenting by the Department. Exhibits requested by the Department can include any charts, graphs, tables, figures, or other data visualization tools used to represent the data analyzed.

e. The Contractor shall generate and provide two sets of all finalized Reports, Exhibits, and Supporting Documentation, one with all enrollee information redacted and removed per industry standards. To protect the data integrity, a risk assessment needs to be completed to certify the data is de-identified.

f. The Contractor will ensure the Report Narrative and Exhibits are accurate, updated, and ready to be published by the Department on the MIF Website, upon Department approval.

Quarterly Report Format

The Contractor will be required to format the Quarterly Reports, following the guidelines set forth below, including at a minimum, the following:

I. Notice Letter
II. Table of Contents
III. Purpose & Scope
IV. Executive Summary
V. Background of the Fund
VI. Data, Methods & Assumptions
    a. Analysis of Enrollees who haven't utilized benefits, those with less than $25,000 and more than $400,000, $1 Million and $2 Million.
VII. Discussion and Analysis

a. Number of Qualifying Participants
b. Mortality Experiences and Life Expectancy
c. Actuarial Calculation of Estimated Fund Liabilities
d. Benefits Paid
e. Patterns of Utilization
f. Benefit Payments and Injury Type
g. Inflationary Patterns of Types of Services
h. Prospective Annual Funding
i. Administrative Expenses
j. Impact of Available Health Insurance
k. Investment Earnings
l. Charts, Figures and Graphs throughout the narrative and analysis which visually demonstrate the data.

VIII. Reliances & Limitations

IX. Exhibits shall include, but not be limited to, the following:
a. Fund Payments by Benefit and Injury Categories
b. Future Fund Balances by Fiscal Year as of that Quarter
c. Actual vs. Expected Enrollee Counts & Benefit Payments
d. Average Payments per Enrollee by Admittance Quarter
e. Projected Incremental Payments by Admittance Quarter – Nominal and Discounted
f. Estimated Fund Payments by Admittance Year and Admittance Quarter
g. Enrollee Profile
h. Administrative Expense Summary – Fund Administrator
i. Consumer Price Index
j. Benefit Payments Per Living Enrollee by Quarter

X. Appendices

3. Liabilities Analysis:

The Contractor will be required to analyze liabilities, following the guidelines set forth below, including at a minimum, the following:

a. Estimate liabilities of the Fund for the year following annual deposit and upon request by the Department. Per MIF Regulation 69-10.20, Suspension of the Fund, this includes analyzing data for the quarterly reports to calculate when the Fund's current liabilities equal or exceed 80% of the Fund's assets. This analysis must appear in the Executive Summary of the Quarterly Reports.

b. On a quarterly basis, the Contractor will provide projections of the number of enrollees and the estimated claims payments for each of the next five (5) years and the tenth (10^{th}) year. In the development of updates to the projections for the Fund, the Contractor shall:
i. Review data from the Department related to plan documents for the Fund.
ii. Identify additional data needs, if any.
iii. Develop short-term and long-term projections for the Fund, including:
a. An actuarial calculation of the estimated liabilities of the Fund for the coming year resulting from the qualified plaintiffs enrolled in the Fund.
b. Updates to examine Fund claims projections over ten-year periods, until it reaches more of a mature, steady state condition.
c. Adjustments for discounting and inflationary trend, as necessary.
d. Documentation and support for all material assumptions.

c. Pursuant to 10 NYCRR § 69-10.19, the Contractor must review the various elements contributing to the amount of benefits paid by the Fund and administration expenses of the Fund, including:

i. The number of qualified plaintiffs admitted in the Fund, and estimates of the number of qualified plaintiffs not yet admitted;
ii. The mortality experience of the qualified plaintiffs admitted to the Fund;
iii. The amounts of benefits paid by the Fund by types of services provided;
iv. The patterns of utilization by types of services provided;
v. The inflationary patterns by types of services provided;
vi. The expenses of administration of the Fund;
vii. The impact available health insurance has on the benefits paid by the Fund;
viii. The investment earnings on the assets held by the Fund; and,
ix. Comparisons to similar funds such as Virginia and Florida to provide context.

d. The Contractor will project annual funding amounts, based upon analysis of the ten-year rolling average medical component of the U.S. Consumer Price Index as published by the U.S. Department of Labor, Bureau of Labor Statistics, for the preceding ten years pursuant to the Public Health Law, Chapter 45, Article 29-D, Title 4, Section 2999-i(7).

e. The Contractor is estimated to perform approximately 200 hours of Liability Analysis each contract year. Actual amount of hours may be higher or lower.

4. Ad Hoc Reporting:

Ad hoc reports are typically an alteration to an existing Quarterly Report Exhibit, to provide additional examination of the Fund's assets and liabilities under various scenarios. These ad hoc reports typically use the existing standard formulas utilized in developing the Quarterly Reports.

a. The Contractor shall perform such additional actuarial analysis and reports as requested by the Department and provide within a mutually agreed timeframe. Formatting of the ad hoc reports will be discussed with the Department after contract execution.

b. The Contractor shall perform special studies, scenario and solvency projections and testing any other internal reports as requested by the Department. Criteria for these special studies and scenario and solvency projections and testing may include, but is not limited to: fund projections based on an increase in enrollment; if current rates do not sunset; any potential funding holidays; an increase in any category of benefit payments; if interest rates remain low; or inflation increases significantly.

c. The Contractor shall provide the Department with work papers supporting individual analyses and assumptions as well as draft Exhibits for the Department's review and consideration.

d. As necessary, the Contractor shall participate in discussions and provide guidance to the Department on the actuarial theory, the basis for assumptions, and all other actuarial matters in language that is easily understood.

e. The Contractor is estimated to perform approximately 25 hours of Ad Hoc Reporting each contract year. Actual amount of hours may be higher or lower.

4.3 Hourly Consulting Projects

Under the resulting contract, the Contractor shall provide consulting services in relationship to the following programs and initiatives. The following scope of work will be paid on an hourly basis, as identified in Section 4.8.2.

A. Service Based Payment Rate Setting, Policy and Financial Management Consulting Services

1. Provide the Department with service-based payment rate setting, and policy and financial management consultation services, as requested by the Department including but not limited to the following:

   a. Service Based Payment Rate Methodology Development and Determination:

      1. Develop and determine rates for OASAS that consider volume, payer mix, service mix, geographic and labor differentials in cost. Each of these variables should be evaluated against available outcome data, efficiency standards, and optimal clinical mix of services. Some services will be non-reimbursable across all payers but may add significant value based on outcomes. Overhead differences without a basis in regional cost differential should be smoothed and the Contractor will make recommendations on service mix for optimal value for OASAS as a payer. The result of the analysis should yield payment rates in per diem or per service rates for each service provided across modalities. The service payment rates should reflect regional rate differentials and may include additional differences based on other structural cost differences across modalities that may not be based on geographic region;
      2. Research national data sets, the Department's program specific Consolidated Fiscal Reporting data, other relevant real estate and labor cost data sets, and program models to determine reasonable rates for OASAS to purchase services on a per diem or per service basis for each of the funded settings;
      3. Develop methodology to construct and implement a foster care residual per diem to cover costs that will not be paid through the MC per capita rates and determine MC per capita rates for transition of foster care population to MC;
      4. Develop or assist in the development of a service-based payment premium methodology to reflect the utilization of service-based payment data for applicable programs;
      5. Develop or assist in the development of service-based payment capitation rates for those programs still authorized for such payments;
      6. Understand the interaction of fee schedules/rates across programs. Determine reasonable fee levels such that the estimated total program costs remain similar at either the aggregate 1115 waiver or NY agency level so as to provide for consistency from a budgetary perspective;
      7. In support of the SPA Rate effort, the Contractor will continue to provide the Department with support where needed as well as development of additional materials, analyses and responses to questions or feedback received from various stakeholders including CMS;
      8. In support of the OPWDD FFS model enhancement and due to significant requested revisions to the rate model approach during rate development process, additional model edits need to be reconciled. To align with final rate methods, the Contractor will integrate updates to data, approaches, etc. related to the final approved rates for applicable services (e.g. Prevocational, ICF, etc.) within the OPWDD FFS rate model;
      9. Support the Department's processes for Intermediate Care Facilities Upper

Payment Limit demonstrations by pulling and analyzing data, performing calculations, and summarizing and presenting methods, as requested;

10. In support of the OPWDD FFS management, support the Department with the capital management process which includes but is not limited to, planning for a data management process change to migrate property backup data into a database format;

11. In support of the OPWDD FFS management, provide ad hoc analysis and fiscal projections needed for various stakeholders and purposes, as requested;

12. Develop or assist in the development and implementation of a service-based payment rate methodology for foster care agencies incorporating utilization and expenditure service-based payment data;

13. Assist the Department in the development and/or rebasing of fee-for-service rates for various services including but not limited to: hospice, homecare, Children's Home and Community-Based Services, Children and Family Treatment and Support Services, Traumatic Brain Injury, and Nursing Home Transition and Diversion;

14. Assist the Department in the design and evaluation of financial arrangements with NYC Health + Hospitals;
15. Develop a state-only per diem amount that will be paid to plans separate from capitation rates for the costs associated with long term Institution for Mental Diseases (IMD) stays in excess of 15 days per month; and
16. Work with staff from the OMH, OASAS, and OHSQA to review and provide feedback on HARP Quality metrics included as part of the HARP Quality Withhold to ensure the metrics are reasonably achievable by health plans. Additionally, work with the Department staff to calculate HARP Quality Withhold payment amounts annually.

B. Policy and Financial Management Consulting Services

The Contractor will be required to provide the following Policy and Financial Management Consulting Services throughout the course of the contract:

1. Provide technical assistance in evaluating MCO management agreements, contracts between related parties, and cost sharing and cost allocation methods as they impact MC programs;
2. Assist the Department in the refinement of the Department's data intake, financial and encounter reporting documentation including MLR, financial monitoring tools, MCO on-site monitoring, and MCO engagement techniques which include but are not limited to internal data intake policies, procedures, and monitoring; financial report instructions; encounter reporting instructions, MCO encounter validation reports and MCO financial vs. plan encounter data comparison reports;
3. Track and analyze financial impacts of populations transitioning from service-based payments programs to MC;
4. Work with the Department to increase the efficiency of the Medicaid and MC delivery system. This includes identifying opportunities to responsibly slow the growth rate of service costs; optimize utilization; and improve health outcomes;
5. Develop a data analytics team to assist the Department in various financial and clinical analysis related to changes impacting the Medicaid and Medicare landscape. This team may be inclusive of staff of the on-site analytic team but will be distinct in its operations;

6. Support the Department in analyzing the impact of various legislative and budgetary proposals that arise from the State's Executive Budget process. Analyses will be used to value proposals, evaluate efficacy, and determine impacts, if any, on Medicaid and MC programs;
7. Support the Department in operating the MC Stop Loss program. Associated tasks include but are not limited to maintenance and development of the Stop Loss program claim processing methodology and payment systems, updates to the Stop Loss program manual and other associated stakeholder documentation and communication, and overall evaluation of the Stop Loss program;
8. Support the Department in the development, maintenance, and use of software based rate models which produce MCO rate schedules and fiscal impacts based on rate exhibits developed for MC programs;
9. Analyze and provide guidance related to Federal legislation and regulation impacting Medicaid MC and service-based payment programs;
10. Provide the Department with support in the determination of the reasonability of MCO In Lieu of Service (ILS) proposals. Contractor will engage in a cost benefit analysis of each new MCO submitted ILS proposal based on an established methodology;
11. Support the Department in evaluating the efficiency, quality and financial impact of Medicaid and Medicare integrated programs;
12. Complete other ad hoc actuarial, consulting and financial/accounting technical assistance, as required;
13. Assist the Department in the implementation and reporting of the State's proposals submitted to CMS pertaining to the 10% enhanced Federal Medical Assistance Percentage (FMAP) for Home and Community Based funding, including the development of the methodologies for the dispersal of funds per the request of the Department and/or State Partner Agencies who submitted proposals;
14. Develop additional waiver documentation to support the submission of budget neutrality summaries to CMS. This documentation will include a rebasing of future Demonstration Year (DY) budget neutrality calculations. The Contractor will also extract and review historical data to assist the Department in fulfilling the requirements of the most recent 1115 Waiver Special Terms and Conditions (STCs) which can be found at the following link: https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm;
15. Support the Office of Health Insurance Programs (OHIP) with Executive-level leadership transitions, such as assistance with Knowledge Transfer documentation, providing new leadership with historical context and general support;
16. Assist OHIP with the continued organization, and strategic direction of data and analytics;
17. Assist the Department in the strategic, financial, and programmatic changes related to the development of its Section 1332 State Innovation Waiver for Essential Plan Expansion; and
18. Assist the Department in defining future goals and identifying the changes and capabilities needed to modernize how Medicaid is delivered and administered centrally.

4.4 Staffing

A. Staffing Requirements

The Contractor will assume responsibility for organizing and training a staff to support tasks as described in 4.2.A and 4.2.B. The Contractor will also be responsible for coordinating and managing all tasks assigned. To accomplish this, the Contractor shall:

1. Dedicate a core team consisting of approximately 10-15 staff including individuals with the experience and credentials, who will be working directly with the Department staff on a consistent basis. Staff assigned to the core team will be required to attend meetings and work from the Department's current office at One Commerce Plaza, Albany, NY, 12237, as well as any successor Department office, as requested by the Department. It is anticipated that the core team will be required to work on site approximately 3-5 days during the first six (6) months of the contract, and approximately 4-6 times per year thereafter, or as otherwise requested by the Department. The cost of this team must be included in Part A of the Cost Proposal, under the Deliverable Based Section. The Contractor will not be able to bill for any travel costs associated with the core team. Staffing of the core team will be subject to the Department's approval. The core team must consist of:
    a. At least one (1) member being a certified actuary; and
    b. Two (2) project coordinators who possess the knowledge and skills to assist the Department with the tasks outlined in this RFP. Skills include but are not limited to strong management skills necessary to coordinate activities, analyze data, prepare rate packages and reports and respond to the Department's management information needs. One project coordinator will be dedicated to all MC rate setting and related tasks and one project coordinator will be dedicated to service-based payment rate related tasks. Each project manager must have knowledge and experience in their assigned functions and will be the sole liaisons between the Department and the Contractor. The Department expects to be able to direct all questions, and other correspondence to these individuals. These individuals are expected to be available to respond to the Department's management information needs on a daily basis via telephone and/or e- mail and to coordinate bi-weekly status meetings to apprise the Department of any issues and status updates. The project coordinators shall be part of the core team, located in the office described in Section 4.4.1.
2. Dedicate an analytic team of 3-5 staff (separate from the core team) who have the authority to provide recommendations and distribute information to the Department and stakeholders on MC rates. Staff assigned to the analytic team will be required to attend meetings and work from the Department's current office at One Commerce Plaza, Albany, NY, 12237, as well as any successor Department office, as requested by the Department. It is anticipated that the analytic team will be required to work on site 3-5 days during the first six (6) months of the contract, and approximately 4-6 times per year thereafter, or unless otherwise requested by the Department. This team will be expected to work full time with the OHIP MC Rate Setting team.
    a. Within this team, at least two (2) staff must have experience with large datasets (larger than a terabyte and more than a billion rows with complicated schemas), MC encounter data, knowledge of the State's Medicaid data systems, X12 Electronic Data Interchange (EDI) and National Council for Prescription Drug Programs (NCPDP) data format standards, Medicaid programs and be proficient in Standard Query Language (SQL) Tableau, and or Statistical Analysis System (SAS). At least one (1) staff must be an actuary. All staff leads must have the internal authority to release information and analysis to the

Department for direct release to the MCOs.

b. Space will be provided to the on-site team. The cost of this team must be included in Part A of the Cost Proposal, under the Deliverable Based Section. The Contractor will not be able to bill for any travel costs associated with the core team.

3. Staff assigned to work with the Department's Budget Neutrality team as identified in Section 4.2.C must:

   a. Have three (3) years of experience working on the NYS 1115 Waiver in the areas outlined in Section 4.4.B; **OR** five (5) years of 1115 Waiver experience (ex. other states or CMS) in the areas outlined in Section 4.4.B;

   b. Be available for weekly conference calls; and

   c. Possess availability to meet in Albany, NY for in-person meeting with at least a one (1) week notice. Required in-person meetings will occur approximately once per month but may occur more frequently at the discretion of the Department.

4. The Contractor shall provide additional staff who possess relevant experience with the appropriate tasks outlined in each respective section of the RFP. These staff do not need to meet the location requirements of Section 4.4.A. Specifically, the Contractor must provide staff with:

   a. Emodels and risk adjustment software on this team;

   b. Experience and knowledge related to MC risk mitigation strategies;

   c. Knowledge of federal and State public healthcare programs and policy which include but are not limited to proficiency in the programmatic aspects of federal Medicaid funding and federal waivers;

   d. Experience in pharmacy utilization trends, new drug therapies and strategies on pharmacy benefit management;

   e. Knowledge and background of CMS laws and regulations;

   f. Actuarial backgrounds and certifications;

   g. Experience with data analytics, including experience with large datasets, MC encounter data, knowledge of the State's Medicaid data systems, Medicaid programs and proficiency in SQL, Tableau and SAS;

   h. Familiarity with implementing and maintaining efficiency and quality-based payment methodologies in a Medicare and Medicaid MC environment; and

   i. Prior experience and expertise specific to the scope of work staff will be assigned.

5. The Contractor shall provide sufficient additional management and administrative support staff necessary to organize, prepare and carry out all administrative tasks associated with conducting the above-described tasks and submitting resultant reports.

6. The Contractor shall maintain the staffing levels and personnel as provided in the Contractor's proposal, except as approved by the Department or caused by resignations or other situations which, in the Department's judgment, are beyond the Contractor's control. If a member of a team needs to be replaced, such replacements shall be evaluated by the Department and acceptance is subject to Department approval. Upon Department request, the Contractor must replace any assigned Contractor staff with an alternative staff member. If such instances arise, the Contractor must provide the Department with three (3) resumes of potential replacements within one (1) week of the Department's request.

7. The Contractor must anticipate that its billable hours for the Hourly Consulting Projects (Section 4.3) under the contract period, shall be divided among the three Staff Levels. See Attachment B: Cost Proposal for details on specific staffing levels and anticipated number of hours.

B. General Contractor Duties

It shall be the obligation of the Contractor to:

1. Assume complete responsibility for the cost and timely completion of all activities and duties required of the Contractor by the resulting contract and carrying out those activities and duties in a competent and timely manner;

2. The Contractor shall conduct all work in accordance with the actuarial performance standards and schedule set forth in the RFP and the Contractor's proposal as modified or supplemented by the terms of this Agreement;

3. Maintain the levels of staffing and personnel expertise as provided in the Contractor's proposal, except as approved by the Department or caused by resignations or other situations beyond the control of the Contractor;

4. Agree that no aspect of Contractor's performance under this Agreement will be contingent upon Department personnel or the availability of Department resources with the exception of such proposed actions of the Contractor which are specifically identified in this Agreement as requiring Department approval, policy decisions, policy approvals, exceptions stated in this Agreement or which require the normal cooperation which would be expected in such a contractual relationship;

5. Submit in writing to the Department, within three (3) business days of learning of any situation which can reasonably be expected to adversely affect the operation of the task assigned, a description of the situation including a recommendation for resolution whenever possible;

6. At the end of the contract period, the Contractor will work cooperatively with the Department and any of its specified contracting organizations to develop and successfully implement a plan to transition all data, methodologies, documentation, and ongoing projects that resulted from this contract to the succeeding contracting organization, vendor, or firm or to the Department;

7. Perform the responsibilities, reporting requirements and meet the deadlines in Section 4.0;

8. Furnish, or make available, accounts, records, or other information pertaining solely to this Agreement as required to substantiate any estimate, expenditures or reports as requested by the Department or the Office of the State Comptroller, as may be necessary for auditing purposes regarding this Agreement, or to verify that expenditures were made only for the purposes authorized by this Agreement;

9. Accept responsibility for compensating the Department for any exceptions, for payments made under this Agreement, which are revealed on audit by the Office of the State Comptroller or another State agency, after due process and an opportunity to be heard has been afforded;

10. The Contractor shall implement changes within the scope of work of this Agreement, in accordance with a Department approved schedule, including changes in policy, regulation, statute, or judicial interpretation;

11. The Contractor shall assume responsibility for providing and ensuring the compatibility of all electronic equipment and resource needs;

12. The Contractor may be required to sign and adhere to the New York State Department of Health Medicaid Data Exchange Application and Agreement (DEAA). In addition, the DEAA, when approved by the Department, forms an agreement between the Contractor (applicant) and the Department as to the terms and conditions under which a release will be made; and

13. The Contractor may be required to enter into a Business Associates Agreement (BAA), upon execution of the resulting contract.

14. In performance of the scope of this RFP, the Contractor shall ensure that staff are made available to Department staff before and after normal working hours (7am-7pm EST), as requested by the Department.

4.5 Reporting

A. Managed Care Rate Development

1. The Contractor will be responsible for providing the Department with a final rate package. The final rate package must include the actuarial certified rate ranges, rate range certification letter, actuarial memorandum and all associated rate exhibits which support the development of the Department's final rates and impacts. The Contractor shall timely submit all required rate packages in accordance with the format and schedule to be determined by the Department. A schedule of rate effective dates can be found in Section 4.2.A.2. Rate packages should contain all deliverables set forth by the Department in accordance with Section 4.2.A.1.a through 4.2.A.1.d. of this RFP. Rate packages must contain the original signature of the Partner in Charge or other duly authorized person who is a Certified Actuary;
2. The Contractor shall submit rate packages, which in the reasonable judgment of the Department, are fully supported by work papers, which are neat, organized, accurate and signed and dated by both the preparer and the preparer's supervisor;
3. The Contractor shall maintain rate work papers that, in the reasonable judgment of the Department, contain sufficient detail so as to allow a conclusion to be drawn without oral explanation and/or clarification being required by the preparer;
4. The Contractor shall maintain rate work papers and evidence containing sufficient information to enable an experienced actuary consultant, having no previous connection with the work, to validate the actuary's significant conclusions and judgments. Such evidence shall include, but not be limited to, documentation, analyses, electronic spreadsheets, and data;
5. The Department shall be the owner of the rate work papers. The Contractor will retain the work papers for the balance of the calendar year in which they were generated and for six (6) additional years thereafter and will provide the Department timely access to the work papers as requested. If requested by the Department, the Contractor must provide copy of work papers and related material requested by the Department within ten (10) business days of written request;
6. The Contractor will be responsible for providing the Department with a final risk scores and cost weights package. The final risk scores and cost weight package must include the scores and weights, risk adjustment "Summary of Methods" documentation, and all associated risk adjustment exhibits which support the development of the risk score and cost weight package. The Contractor shall timely submit all required risk score and cost weight packages in accordance with the format and schedule to be determined by the Department. A schedule of risk score and cost weight effective dates can be found in Section 4.2.B.2. Risk score and cost weight packages shall contain all deliverables set forth by the Department in accordance with Section 4.2.B of this RFP. Risk score and cost weight packages must contain the original signature of the Partner in Charge or

other duly authorized person who is a Certified Actuary;

7. The Contractor shall submit risk score and cost weight packages, which in the reasonable judgment of the Department, are fully supported by work papers, which are neat, organized, accurate and signed and dated by both the preparer and the preparer's supervisor;
8. The Contractor shall maintain risk score and cost weight work papers that, in the reasonable judgment of the Department, contain sufficient detail so as to allow a conclusion to be drawn without oral explanation and/or clarification being required by the preparer;
9. The Contractor shall maintain risk score and cost weight work papers and evidence containing sufficient information to enable an experienced actuary consultant, having no previous connection with the work, to validate the actuary's significant conclusions and judgments. Such evidence shall include, but not be limited to, documentation, analyses, electronic spreadsheets, and data;
10. The Department shall be the owner of the risk score and cost weight work papers. The Contractor will retain the work papers for the balance of the calendar year in which they were generated and for six (6) additional years thereafter and will provide the Department timely access to the work papers as requested. If requested by the Department, the Contractor must provide copy of work papers and related material, as requested, within ten (10) business days of written request;
11. The Contractor shall provide Quarterly Reports related to Budget Neutrality, as identified in Section 4.2.C;
12. The Contractor shall provide Quarterly Reports related to the MIF Fund, as identified in Section 4.2.G.3 and Ad-Hoc Reports as identified in Section 4.2.G.4; and
13. The Contractor shall also provide weekly status reports to document the parameters, priorities, methodology, timelines, and ongoing results of capitation rate development in each MC program and rate cycle. Weekly status reports must be delivered within five (5) business days from the close of the preceding week.

B. Service Based Payment Rate and Non-Rate Development

1. The Contractor shall also provide weekly status reports to document the parameters, priorities, methodology, timelines, and ongoing results of service-based payment rate and non-rate activities. Weekly status reports must be delivered within five (5) business days from the close of the preceding week;
2. The Contractor shall also submit monthly progress reports with the submission of invoices. Monthly progress reports must accompany the delivered invoice. The progress report and invoice must be submitted to the Department within ten (10) business days from the close of the preceding month.

   These progress reports shall consist of:

   a. Activity conducted in the invoice month;
   b. A summary and highlight of significant progress areas;
   c. A summary of accomplishments in each activity area where work was performed;
   d. A listing of all developed materials for each activity;
   e. All counts of meetings attended by activity;
   f. A breakdown of hours by Contractor staff Title for each activity; and
   g. A summary of overall updates and changes to each activity.

If the progress report and invoice are not received within the ten (10) business days from the close of the preceding month, a **10% reduction penalty** may be enacted on the subject invoice(s). See Section 4.8: Payment.

C. Other Reporting Requirements

1. Upon request from the Department and no less than once per month, the contractor shall provide the Department with a report identifying all staff currently providing services under the contract, which includes the following components:
    a. Name and title of each staff member currently providing services;
    b. General service area and main tasks provided of each staff member;
    c. Identification of any new staff member added to the contract;
    d. Identification of any staff member rolled off the contract including reasons for the departure; and
    e. Work site location of staff.

4.6 Security

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

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

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

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

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

4.7 Transition

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

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

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

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

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

4.8 Payment

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

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

Preferred Method: Email a pdf copy of your signed voucher to the BSC at:
AccountsPayable@ogs.ny.gov with a subject field as follows:

Subject: **<<Unit ID: 3450445>> << Contract #:C042625>>**

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

NYS Department of
Health Unit ID
3450445
c/o NYS OGS BSC Accounts
Payable Building 5, 5th Floor
1220 Washington Ave.
Albany, NY 12226-1900

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

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9 must be on file

with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at http://www.osc.state.ny.us/epay.

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

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

Payment of such invoices and/or vouchers by the Department shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be:

1. Deliverable Payments

A. Payments for all work related to the development of the annual Managed Care Program rates and risk scores as described in section 4.2.A and 4.2.B will be made once the rate and/or risk scores are completed and submitted to the Department with the supporting documentation and rate certification. This rate and/or risk score package must be approved by the Department before payment will be authorized.

B. Modifications for the annual Managed Care rates and risk scores shall be billed on a deliverable basis. A payment shall be made for the completion and calculation of each rate and/or risk score modification requested by the Department once the work is completed and supporting documentation and final rate certification is submitted to the Department and approved. In instances where a rate modification does not result in a revised rate certification or a modification to risk scores is needed, a payment shall be made once the work is completed and final supporting documentation is submitted to the Department and approved.

C. The programs for which one payment for the initial development and/or for each modification of the annual Managed Care rates and/or risk scores (if applicable) shall be made are:

   i. Mainstream Managed Care: MMC, HIV SNP and HARP
   ii. MLTC Programs: MLTC Partial Capitation, PACE, and MAP
   iii. MA
   iv. EP
   v. CHPlus

D. The Contractor shall be paid an all-inclusive deliverable price for each deliverable related to Budget Neutrality in accordance with Sections 4.2.C, 6.3, and Attachment B.

E. The Contractor shall provide an all-inclusive deliverable price for the completion of all Preprint Support Phases detailed in Sections 4.2.D, 6.3, and Attachment B.
   i. The Contractor will be paid a percentage of its all-inclusive deliverable price upon the completion of each phase as outlined below:
      1. The Contractor will be paid **20%** of its deliverable price upon completion and subsequent approval of the Department for the **Pre-Submission Data Analytics Phase;**
      2. The Contractor will be paid **20%** of its deliverable price upon completion and subsequent approval of the Department for the **Implementation Support Phase;**
      3. The Contractor will be paid **20%** of its deliverable price upon completion and subsequent approval of the Department for the **Related Analysis/Evaluation Phase and**
      4. The Contractor will be paid **40%** of its deliverable price upon completion and subsequent

approval of the Department for the **Final Reconciliations Phase.**

ii. The Department anticipates 6 full Preprint Support Deliverables on an annual basis. However, if upon request of the Department, an active Preprint Support Deliverable does not proceed to the Final Reconciliation Phase, the Contractor will be paid its allocated percentage through whichever phase has been fully completed and subsequently approved by the Department.

F. The Contractor shall be paid an all-inclusive deliverable price for services related to Reimbursement Development and Management of OPWDD Rate-Based Programs in accordance with Sections 4.2.E, 6.3, and Attachment B.
   i. The Contractor will be paid 25% of its all-inclusive deliverable price on a quarterly basis for all services identified in Section 4.2.E.

G. The Contractor shall be paid an all-inclusive deliverable price for both the initial and final encounter to cost report comparisons and corresponding reconciliation worksheets, which will be billed on an annual basis and are further detailed in Section 4.2.F.1, 6.3, and Attachment B.
   i. The Contractor shall also be paid an all-inclusive deliverable price for each annual audit as further detailed in Section 4.2.F.6, 6.3, and Attachment B.

H. The Contractor shall be paid an all-inclusive deliverable price for services related to Medical Indemnity Fund (MIF) Actuarial Services in accordance with Sections 4.2.G, 6.3, and Attachment B, as detailed below:
   i. The Contractor shall be paid an all-inclusive deliverable price for completion of all Implementation services as identified in Sections 4.2.G.1;
   ii. After the initial 90 days of the contract, the Contractor shall be paid an all-inclusive quarterly deliverable price for completion of each quarterly report as identified in Section 4.2.G.2;
   iii. After the initial 90 days of the contract, the Contractor shall be paid an all-inclusive quarterly deliverable price for completion of the Liabilities Analysis and Ad-Hoc Reporting as identified in Sections 4.2.G.3 and 4.2.G.4.
      - The Contractor is estimated to perform approximately 200 hours of Liability Analysis and approximately 25 hours of Ad-Hoc Reporting each contract year. Actual amount of hours may be higher or lower.
   iv. Total payment for MIF Actuarial Services **may not** exceed $120,000 in Contract Year 1 and $479,000 total in Contract Years 2-5.

I. The Contractor shall, upon completion and the Department's approval of each deliverable, submit to Department an invoice for payment on such forms and in such detail as required.

2. Hourly Payments

A. Payments for Hourly Consulting Projects outlined in Section 4.3 will be made on an hourly basis in accordance with actual hours worked for each project. Attachment B: Cost Proposal contains an estimated number of hours per Staff Level for each project identified in Section 4.3. This is an estimated number of hours. Actual hours may be higher or lower. The Department is not guaranteeing the level of hours for each project. Invoices must be submitted monthly once the monthly progress report has been submitted to the Department in the agreed format and approved. The requirements for the progress report are in section 4.5.B.2 and include a 10% reduction penalty as identified in the referenced section.

3. General Payment Requirements

A. The Department will not authorize payment for any additional costs beyond those specified in the contract. In the event of misunderstanding of any requirements, deliverables, or services to be provided, the Contractor shall make the necessary

adjustments or corrections at no additional cost to the Department.

B. All invoices submitted by the Contractor shall be submitted to the Department no later than ten (10) business days from the close of the preceding month. If an invoice is not received within ten (10) business days from the close of the proceeding month, a **10% reduction penalty** may be enacted on the subject invoice(s).

Price Adjustment Clause

The pricing for years four (4) and five (5) of the Contract will be subject to an annual increase or decrease of the lesser of three percent (3%) or the percent increase or decrease in the National Consumer Price Index for All Urban Consumers (CPI-U) (CUUR0000SA0) as published by the United States Bureau of Labor Statistics, Washington, D.C. 20212, for the 12 month period ending ninety (90) days prior to the commencement date for years four (4) and five (5) of the Contract.

4.9 Subcontracting

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

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

4.10 Contract Insurance Requirements

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

4.11 Minority & Women-Owned Business Enterprise (M/WBE) Requirements

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

Business Participation Opportunities for M/WBEs

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

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

By submitting a Bid in response to this RFP, for contracts with an MWBE goal above, a Bidder agrees to complete and submit an M/WBE Utilization Plan (Attachment 5, Form #1) prior to award. The Department will review the submitted M/WBE Utilization Plan. If the Plan is not accepted, the Department may issue a notice of deficiency. If a notice of deficiency is issued, Bidder agrees that it shall respond to the notice of deficiency within seven (7) business days after Bidder's receipt of such notice.

The Department may disqualify a Bidder as being non-responsive to this RFP under the following circumstances:

a) If a Bidder fails to submit a M/WBE Utilization Plan;

b) If a Bidder fails to submit a written remedy to a notice of deficiency;

c) If a Bidder fails to submit a request for waiver (if applicable); or

d) If the Department determines that the Bidder has failed to document good-faith efforts to provide meaningful participation by M/WBEs under the Contract in accordance with the goals for this RFP established by the Department.

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

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

If (a) the Department determines that the Contractor is not in compliance with the M/WBE requirements of the Contract and the Contractor refuses to comply with such requirements, or (b) the Department finds that the Contractor has willfully and intentionally failed to comply with the M/WBE participation goals established in the Contract, the Contractor may be required to pay to the Department liquidated damages and will be considered during future Vendor Responsibility Profile reviews should the bidder bid on future opportunities with the Department

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

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

Please Note: Failure to comply with the foregoing requirements may result in a finding of non-responsiveness, non-responsibility and/or a breach of the Contract, leading to the withholding of

funds, suspension or termination of the Contract or such other actions or enforcement proceedings as allowed by the Contract.)

4.12 Participation Opportunities for NYS Certified Service-Disabled Veteran-Owned Businesses

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

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

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

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

5.0 ADMINISTRATIVE INFORMATION

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

5.1 Restricted Period

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

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

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

5.2 Questions

Potential Bidders may submit written questions and requests for clarification pertaining to this RFP between the issuance of this RFP and the deadline for the submission of written questions specified in Section 1

(Calendar of Events). All questions and requests for clarification of this RFP should cite the relevant RFP, including the RFP number and title (RFP #C042625: Actuarial Rate Certification Services and Support), the section and paragraph number of this RFP or of the Attachment to this RFP to which the question relates, where applicable, and must be submitted via email to *OHIPcontracts@health.ny.gov* no later than the Deadline for Submission of Written Questions specified in Section 1. (Calendar of Events). Questions received after the deadline **may not** be answered.

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

5.3 Right to Modify RFP

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

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

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

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

5.4 DOH's Reserved Rights

The Department of Health reserves the right to:

1. Reject any or all proposals received in response to the RFP;
2. Withdraw the RFP at any time, at the Department's sole discretion;
3. Make an award under the RFP in whole or in part;
4. Disqualify any bidder whose conduct and/or proposal fails to conform to the requirements of the RFP;
5. Seek clarifications and revisions of proposals;
6. Use proposal information obtained through site visits, management interviews and the State's investigation of a bidder's qualifications, experience, ability or financial standing, and any material or information submitted by the bidder in response to the Department's request for clarifying information in the course of evaluation and/or selection under the RFP;
7. Prior to the bid opening, amend the RFP specifications to correct errors or oversights, or to supply additional information, as it becomes available;
8. Prior to the bid opening, direct bidders to submit proposal modifications addressing subsequent RFP amendments;
9. Change any of the scheduled dates;
10. Eliminate any mandatory, non-material specifications that cannot be complied with by all of the prospective bidders;
11. Waive any requirements that are not material;

12. Negotiate with the successful bidder within the scope of the RFP in the best interests of the State;
13. Conduct contract negotiations with the next responsible bidder, should the Department be unsuccessful in negotiating with the selected bidder;
14. Utilize any and all ideas submitted in the proposals received;
15. Every offer shall be firm and not revocable for a period of three hundred and sixty-five days from the bid opening, to the extent not inconsistent with section 2-205 of the uniform commercial code. Subsequent to such three hundred and sixty- five days, any bid is subject to withdrawal communicated in a writing signed by the bidder; and,
16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of a bidder's proposal and/or to determine a bidder's compliance with the requirements of the solicitation.

5.5 Debriefing

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

5.6 Protest Procedures

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

5.7 Freedom of Information Law ("FOIL")

All Bids may be disclosed or used by the Department to the extent permitted by law. The Department may disclose a Bid to any person for the purpose of assisting in evaluating the Bid or for any other lawful purpose. All Bids will become State agency records, which will be available to the public in accordance with the New York State Freedom of Information Law. **Any portion of the Bid that a Bidder believes constitutes proprietary information entitled to confidential handling, as an exception to the Freedom of Information Law, must be clearly and specifically designated in the Bid as specified in Section 6.1.2. of this RFP.** If the Department agrees with the proprietary claim, the designated portion of the Bidder's Bid will be withheld from public disclosure. Blanket assertions of proprietary material will not be accepted, and failure to specifically designate proprietary material may be deemed a waiver of any right to confidential handling of such material.

5.8 Piggybacking

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

5.9 Intellectual Property

Any work product created pursuant to this RFP and the Contract awarded hereunder and any subcontract shall become the sole and exclusive property of the New York State Department of Health, which shall have all rights of ownership and authorship in such work product.

6.0 PROPOSAL CONTENT

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

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

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

6.1 Administrative Proposal

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

6.1.1. Bidder's Disclosure of Prior Non-Responsibility Determinations

Submit a completed and signed Attachment 1, "Prior Non-Responsibility Determinations."

6.1.2. Freedom of Information Law – Proposal Redactions

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

6.1.3. Vendor Responsibility Questionnaire

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

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

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

6.1.4. Vendor Assurance of No Conflict of Interest or Detrimental Effect

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

6.1.5. M/WBE Forms

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

6.1.6. Encouraging Use of New York Businesses in Contract Performance

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

6.1.7. Bidder's Certified Statements

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

6.1.8. References

Provide references using Attachment 9, (References) for thr*ee (3) similar engagements.* Provide firm names, addresses, contact names, telephone numbers, and email addresses.

6.1.9. Diversity Practices Questionnaire

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

6.1.10. Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination

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

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

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

6.1.12. State Finance Law Consultant Disclosure Provisions

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

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

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

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

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

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

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

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

Submit these Forms, available through these links:

- ST-220 CA: http://www.tax.ny.gov/pdf/current_forms/st/st220ca_fill_in.pdf
- ST-220 TD: http://www.tax.ny.gov/pdf/current_forms/st/st220td_fill_in.pdf

6.1.14. Gender-Based Violence and the Workplace Certification

New York State Finance Law §139-M requires bidders on competitive state procurements to certify that they have a written policy addressing gender-based violence and the workplace and that such policy meets the minimum requirements outlined on Attachment 14. Bidders should review, sign, date and include as part of their submission Attachment 14.

6.2 Technical Proposal

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

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

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

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

A. Title Page

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

B. Table of Contents

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

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

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

1. Bidders must be able to meet all the requirements stated in Section 3.0 of the RFP. The bidder must submit documentation that provides sufficient evidence of meeting the criterion. This documentation may be in any format needed to demonstrate how they meet the minimum qualifications identified below:

    - Bidder must have five (5) years of experience hiring actuaries who have at least one (1) of the following: the American Academy of Actuaries, a Fellow or Associate of the Society of Actuaries or the Casualty Actuarial Society, a Fellow of the Conference of Consulting Actuaries, a member or a Fellow of the American Society of Pension Professional and Actuaries, or a fully qualified member of another International Actuarial Association member organization;

    - Bidder must have at least five (5) years of Medicaid managed care rate development experience with state Medicaid programs having annual Medicaid enrollment in excess of 1 million recipients;

    - Bidder must have at least five (5) years of actuarial experience in the health care insurance industry; and

- Bidder must have at least three (3) years actuarial experience certifying Medicaid MC capitation premiums.

2. The bidder should submit documentation that provides sufficient evidence of meeting any applicable Preferred Qualifications identified below. This documentation may be in any format needed to demonstrate how they meet the minimum qualifications identified below:

    - Five (5) years of experience working with Medicaid Management Information Systems (MMIS) inclusive of data extraction, code development and data analysis;

    - Five (5) years of experience developing and implementing risk adjustment strategies in the healthcare field;

    - Five (5) years of experience interacting with Centers for Medicare and Medicaid Services (CMS) on behalf of state agencies; and

    - Five (5) years of experience working with 3M or Solventum risk and preventable based grouping software.

D. Technical Proposal Narrative

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

Elements of the Technical Proposal are as follows:

1. Organization, Personnel and Experience

a. Bidders should provide, in relation to responsibilities set forth in Section 4.0 of this RFP and referenced attachments:

i. A description of the bidder's organizational structure, background and experience as it relates to the MC programs and MC rate methodologies as defined in Section 4.1 of this RFP;

ii. An organizational chart which clearly demonstrates how the bidder intends to staff, as required in Section 4.4 of this RFP, and manage rate setting functions, as defined in Section 4.2 of this RFP for each of the following MC programs:
    - MMC
    - HARP
    - HIV/SNP
    - EP
    - CHPlus
    - MLTCP
    - PACE
    - MAP

iii. A description of the bidder's understanding and experience in conducting and certifying the rate setting functions as defined in Section 4.2 of this RFP for each of the following MC programs:
    - MMC
    - HARP

- HIV/SNP
- EP
- CHPlus
- MLTCP
- PACE
- MAP

iv. A description of the bidder's organizational structure, background, understanding and experience as it relates to staffing and managing the projects as defined in Section 4.3 of this RFP;

v. A description of the bidding organization's data processing and analytical experience and capabilities, relevant to Sections 4.2 and 4.3 of this RFP; and

vi. A summary of bidder's training initiatives utilized to ensure that all staff that will be assigned to this contract will be appropriately trained and that training protocols provide for consistency among all staff.

The bidder's experience should be relevant to the scope of work to be performed in accordance with this RFP. Experience gained within the last five years should be included.

2. Implementation Plan

a. Bidders should propose a plan for implementing the activities and data responsibilities set forth in Sections 4.0 - 4.5 of this RFP. The plan should include at a minimum:

i. A description of the bidder's plan to develop or assist in development of the rate methodology (if not prescribed by law); determine, certify, update, and defend, when necessary, actuarially sound rates for the following programs:

- MMC
- HARP
- HIV/SNP
- EP
- CHPlus
- MLTCP
- PACE
- MAP

ii. A description of the bidder's plan to develop, support, certify and/or modify a risk adjustment methodology for the following programs:

- MMC
- HARP
- HIV/SNP
- EP
- CHPlus
- MLTCP
- PACE
- MAP

iii. A description of the bidder's plan to support the Department's efforts in Budget Neutrality and how the bidder plans to accomplish each deliverable identified in Section 4.2.C;

iv. A description of how the bidder will provide Preprint Support and how the bidder plans to support each phase identified in Section 4.2.D;

v. A description of the bidder's plans to assist with the reimbursement development and management of OPWDD Rate-Based Programs as identified in Section 4.2.E;

vi. A description of how the bidder plans to provide the Encounters Penalty work identified in Section 4.2.F of the RFP;

vii. A description of how the bidder plans to provide the Medical Indemnity Fund (MIF) Actuarial Services as described in Section 4.2.G of the RFP;

viii. A description of the bidder's plan to each of the Hourly Consulting Projects as identified in Section 4.3 of the RFP:

- Service Based Payment Rate Setting, Policy and Financial Management Consulting Services as described in 4.3.A.
- Policy and Financial Management Consulting Services as described in Section 4.3.C.

ix. A description of the bidder's plan to perform and meet all reporting requirements associated with Section 4.5 of this RFP;

x. A description of the bidder's plans to comply with all privacy and security policies and procedures identified in Section 4.6 of the RFP;

xi. A description of the bidder's plan to provide the transition identified in Section 4.7 of the RFP;

xii. An identification of the bidder's timeframes for tasks to be completed to ensure timely implementation of the proposed tasks by the dates proposed in Section 4.1. Consideration of timing should be given for Department edits and reviews;

xiii. A description of electronic data processing equipment to be utilized;

xiv. A description of all computer software to be utilized;

xv. A description of a Quality Control Plan for the work covered by this RFP; and

xvi. A description of the methods to be utilized to maintain the level of cooperation with the Department necessary for proper performance of all contractual responsibilities and to apprise the Department of any issues and status.

6.3 Cost Proposal

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

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

A. Payments for all work related to the development and calculation of the annual Managed Care rates for the following programs (see Section 4.2.A) will be made once work is completed and the supporting documentation and rate certification is submitted to the Department and approved. The programs for which one payment shall be made for the initial rate and one payment for each modification are:

Managed Care Program	Rate Develop	Original Rate Package Effective Date	Anticipated Number of Annual Modifications to Original Rate Package*
a. Mainstream Managed Care	Annually	April 1	3 to 4
HIV/SNP	Annually	April 1	3 to 4
HARP	Annually	April 1	3 to 4
b. MLTC Programs	-	-	-
MLTCP	Annually	April 1	3 to 4
PACE	Annually	April 1	3 to 4
MAP	Annually	April 1	3 to 4
c. Essential Plan	Annually	January 1	1 to 2
d. CHPlus	Annually	January 1	1 to 2

**Rates may be updated more frequently, based on determinations made by the Department.*

B. Payment for all work related to the development and calculation of the annual Managed Care risk scores for the following programs (see Section 4.2.B) will be made once work is completed and the supporting documentation is submitted to the Department and approved. The programs for which one payment shall be made for the initial risk score completion and one payment for each modification are:

Managed Care Program	Risk Score Develop	Risk Score Effective Date	Anticipated Number of Annual Modifications to Original Risk Score*
a. Mainstream Managed Care	Annually	April 1	1 to 2
HIV/SNP	Annually	April 1	1 to 2
HARP	Annually	April 1	1 to 2
b. *MLTC Programs*	-	-	-
MLTCP	Annually	April 1	1 to 2
PACE	Annually	April 1	1 to 2
MAP	Annually	April 1	1 to 2
c. Essential Plan	Annually	January 1	1 to 2
d. CHPlus	Annually	January 1	1 to 2

C. Modifications for the Managed Care rates and Risk Scores outlined above shall be billed on a deliverable basis. A payment shall be made for the development and calculation of each rate modification requested by the Department once the work is completed and supporting documentation and rate certification is submitted to the Department and approved. The anticipated number of modifications outlined in the above table are to assist in your price determination. Actual number of needed rate modifications may vary and will be made per the Department's request. These modifications may include, but are not limited to, recipients' age, gender, category of eligibility, level of care, and geographic location.

D. The Contractor shall be paid an all-inclusive deliverable price for each deliverable related to Budget Neutrality in accordance with Sections 4.2.C, 4.8, and Attachment B.

E. The Contractor shall provide an all-inclusive deliverable price for the completion of all Preprint

Support Phases detailed in Sections 4.2.D, 4.8, and Attachment B.

i. The Contractor will be paid a percentage of its all-inclusive deliverable price upon the completion of each phase as outlined below:
   1. The Contractor will be paid **20%** of its deliverable price upon completion and subsequent approval of the Department for the **Pre-Submission Data Analytics Phase;**
   2. The Contractor will be paid **20%** of its deliverable price upon completion and subsequent approval of the Department for the **Implementation Support Phase;**
   3. The Contractor will be paid **20%** of its deliverable price upon completion and subsequent approval of the Department for the **Related Analysis/Evaluation Phase and**
   4. The Contractor will be paid **40%** of its deliverable price upon completion and subsequent approval of the Department for the **Final Reconciliations Phase.**

ii. The Department anticipates 6 full Preprint Support Deliverables on an annual basis. However, if upon request of the Department, an active Preprint Support Deliverable does not proceed to the Final Reconciliation Phase, the Contractor will be paid its allocated percentage through whichever phase has been fully completed and subsequently approved by the Department.

F. The Contractor shall be paid an all-inclusive deliverable price for services related to Reimbursement Development and Management of OPWDD Rate-Based Programs in accordance with Sections 4.2.E, 4.8, and Attachment B.
   i. The Contractor will be paid 25% of its all-inclusive deliverable price on a quarterly basis for all services identified in Section 4.2.E.

G. The Contractor shall be paid an all-inclusive deliverable price for both the initial and final encounter to cost report comparisons and corresponding reconciliation worksheets, which will be billed on an annual basis and are further detailed in Section 4.2.F.1, 4.8, and Attachment B.
   i. The Contractor shall also be paid an all-inclusive deliverable price for each annual audit as further detailed in Section 4.2.F.6, 4.8, and Attachment B.

H. The Contractor shall be paid an all-inclusive deliverable price for services related to Medical Indemnity Fund (MIF) Actuarial Services in accordance with Sections 4.2.G, 4.8, and Attachment B, as detailed below:
   i. The Contractor shall be paid an all-inclusive deliverable price for completion of all Implementation services as identified in Sections 4.2.G.1;
   ii. After the initial 90 days of the contract, the Contractor shall be paid an all-inclusive quarterly deliverable price for completion of each quarterly report as identified in Section 4.2.G.2;
   iii. After the initial 90 days of the contract, the Contractor shall be paid an all-inclusive monthly deliverable price for completion of the Liabilities Analysis and Ad-Hoc Reporting as identified in Sections 4.2.G.3 and 4.2.G.4.
      • The Contractor is estimated to perform approximately 200 hours of Liability Analysis and approximately 25 hours of Ad-Hoc Reporting each contract year. Actual amount of hours may be higher or lower.
   iv. Total payment for MIF Actuarial Services may not exceed $120,000 in Contract Year 1 and $479,000 total in Contract Years 2-5.

I. Payments for Hourly Consulting Projects outlined in Section 4.3 will be made on an hourly basis in accordance with actual hours worked for each project. Attachment B: Cost Proposal contains an estimated number of hours per Staff Level for each project identified in Section 4.3. This is an estimated number of hours. Actual hours may be higher or lower. The Department is not guaranteeing the level of hours for each project/initiative.

J. All bidders are required to complete the attached Cost Proposal Form (Attachment B). Bidders shall be evaluated on their given prices for each program and their given per hourly rates for the job categories listed in Attachment B for each project/initiative.
   1. It is estimated that billable hours for the contract period shall be divided among the

three Staff Levels as 30% for Level 1, 45% for Level 2 and 25% for Level 3. Percent of billable hours is based on historical data and both the proportions of hours and actual hours will likely vary from these estimates. See Attachment B: Cost Proposal for specific details on each staffing level.

K. All administrative and travel shall be included in the prices included in the Cost Proposal.

7.0 PROPOSAL SUBMISSION

A proposal consists of three distinct parts: (1) the Administrative Proposal, (2) the Technical Proposal, and (3) the Cost Proposal. The table below outlines the requested format and volume for submission of each part. Proposals should be submitted in all formats as prescribed below.

	Electronic Submission
Administrative Proposal	1 email PDF(s) labeled "Administrative Proposal" containing a standard searchable PDF file with copy/read permissions only.
Technical Proposal	1 email PDF(s) labeled "Technical Proposal" containing a standard searchable PDF file with copy/read permissions only.
Cost Proposal	1 email PDF(s) "Cost Proposal" containing standard searchable PDF file(s) with copy/read permissions only.

1. Submit three (3) separate, searchable, and open and permission password protected, PDF proposals in three (3) separate emails to: OHIPContracts@health.ny.gov. Use this naming convention for the subject line of each email: <Type of Proposal Submission, Bidder Name, RFP#C042625>.
2. Include, as attachment to each email, the distinct PDF file labeled "Administrative Proposal", "Technical Proposal", or "Cost Proposal" followed by Company name and RFP number. Example: "Technical Proposal Submission, ABC Company, RFP#12345".
3. All electronic bid submissions should be clear and include page numbers at the bottom of each page.
4. All electronic bid submissions should be in PDF Optical Character Recognition (OCR) searchable format.
5. The body of the email should also include the password to the file, contact information, and indicate the total number of pages intended, and, where indicated, each subset of pages listed. **Example: Administrative Proposal 14 pages total, Attachment 3 – 1 page.**
6. A font size of eleven (11) points or larger should be used. All submitted documents should contain appropriate header and footer information.
7. In the event an electronic submission cannot be read by the Department, the Department reserves the right to request a hard copy and/or electronic resubmission of any unreadable files. Offeror shall have 2 business days to respond to such requests and must certify the resubmission is identical to the original submission.
8. Where signatures are required, the proposals should have a handwritten signature (wet ink) and be signed in blue ink. A scan of the handwritten (wet ink) signature can be used for electronic submission in the PDF. The Department reserves the right to request hard copy originals of all signature pages at any time.
9. The Department discourages overly lengthy Bids. Therefore, marketing brochures, user manuals or other materials beyond that sufficient to present a complete Bid, are not desired and will not be reviewed or evaluated. Elaborate artwork or expensive paper is not necessary or desired. In order for the Department to evaluate bids fairly and completely, all Bids should follow the format described in this RFP and provide all requested information and no extraneous or additional information or material.
10. Audio and/or videotapes are not allowed. Any submitted audio or videotapes will be ignored by the evaluation teams.

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

7.1 No Bid Form

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

8.0 METHOD OF AWARD

8.1 General Information

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

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

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

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

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

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

8.2 Submission Review

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

8.3 Technical Evaluation

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

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

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

The scores will be normalized by using the following formulas:
Z = (X/Y)*70
X is the average raw technical score of the proposal being scores;
Y is the average raw technical score of the highest raw Technical Proposal; and
Z is the Total Technical Score.

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

8.4 Cost Evaluation

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

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

C = (A/B)* 30
A is Total price of lowest Cost Proposal;
B is Total price of Cost Proposal being scored; and
C is the Cost score.

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

8.5 Composite Score

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

8.6 Reference Checks

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

8.7 Best and Final Offers

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

8.8 Award Recommendation

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

The Department will notify the awarded Bidder(s) and Bidders not awarded. The awarded Bidder(s) will enter into a Contract substantially in accordance with the terms of Attachment 8, DOH Agreement, to provide the required

product(s) or services as specified in this RFP. The resultant Contract shall not be binding until fully executed and approved by the New York State Office of the Attorney General and the Office of the State Comptroller.

9.0 ATTACHMENTS

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

1. Bidder's Disclosure of Prior Non-Responsibility Determinations
2. No-Bid Form
3. Vendor Responsibility Attestation
4. Vendor Assurance of No Conflict of Interest or Detrimental Effect
5. Guide to New York State DOH M/WBE Required Forms & Forms
6. Encouraging Use of New York Businesses in Contract Performance
7. Bidder's Certified Statements
8. DOH Agreement (Standard Contract)
9. References
10. Diversity Practices Questionnaire
11. Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination
12. Executive Order 16 Prohibiting Contracting with Business Conducting Business in Russia
13. State Finance Law 193M Attestation Gender Based Violence

The following attachments are attached and included in this RFP:

A. Proposal Document Checklist
B. Cost Proposal
C. Program Definitions

ATTACHMENT A
PROPOSAL DOCUMENT CHECKLIST

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

RFP C042625 – Actuarial Rate Certification Services and Support		
FOR THE ADMINISTRATIVE PROPOSAL		
RFP §	**SUBMISSION**	**INCLUDED**
§ 6.1.1	Attachment 1 - Bidder's Disclosure of Prior Non-Responsibility Determinations	☐
§ 6.1.2	Freedom of Information Law – Proposal Redactions (If Applicable)	☐
§ 6.1.3	Attachment 3 - Vendor Responsibility Attestation	☐
§ 6.1.4	Attachment 4 - Vendor Assurance of No Conflict of Interest or Detrimental Effect	☐
§ 6.1.5	M/WBE Participation Requirements:	☐
	Attachment 5 - Form 1	☐
	Attachment 5 - Form 2 (If Applicable)	☐
	Attachment 5 - Form 4	☐
	Attachment 5 - Form 5 (If Applicable)	☐
§ 6.1.6	Attachment 6 - Encouraging Use of New York Businesses	☐
§ 6.1.7	Attachment 7 - Bidder's Certified Statements	☐
§ 6.1.8	Attachment 9 - References	☐
§ 6.1.9	Attachment 10 - Diversity Practices Questionnaire	☐
§ 6.1.10	Attachment 11 - EO 177 Prohibiting Contracts with Entities that Support Discrimination	☐
§ 6.1.11	Attachment 12 – EO 16 Contracting with Businesses Conducting Business in Russia	☐
§ 6.1.12	State Finance Law Consultant Disclosure	☐
§ 6.1.13	Sales and Compensating Use Tax Certification	☐
§ 6.1.14	Gender-Based Violence and the Workplace Certification	☐
FOR THE TECHNICAL PROPOSAL		
RFP §	**SUBMISSION**	**INCLUDED**
§ 6.2.1	Title Page	☐
§ 6.2.2	Table of Contents	☐
§ 6.2.3	Documentation of Bidder's Eligibility (Requirement)	☐
§ 6.2.4	Technical Proposal Narrative	☐
FOR THE COST PROPOSAL REQUIREMENT		
RFP §	**REQUIREMENT**	**INCLUDED**
§ 6.3	Attachment B- Cost Proposal	☐

ATTACHMENT B
COST PROPOSAL
RFP #C042625

Name of Bidder: _____

A. DELIVERABLE BASED PRICING: Managed Care Rate Setting Functions

1. Managed Care Programs Rate Setting (See Section 4.2.A)

Submit a price in the last two columns that reflects the total price for the completion of the annual rate for **each** of the programs below, and the price for each rate modification. These rates will be held firm for years one (1) through three (3) of the contract. See Section 4.8 Payment for price adjustment clause for years four (4) and (5).

This will be the price paid to the contractor for the completion of the initial rates and for each rate modification, in accordance with Sections 4.2.A, 4.8 and 6.3 of this RFP.

Managed Care Program	Effective Date	Rate Price	Modification Price
a. Mainstream Managed Care	April 1		
HIV/SNP	April 1		
HARP	April 1		
b. *MLTC Programs**	--	--	--
MLTCP	April 1		
PACE	April 1		
MAP	April 1		
c. Essential Plan	January 1		
d. CHPlus	January 1		

**This is just a title, does not require a rate or modification price*

2. Managed Care Programs Risk Score (See Section 4.2.B)

Submit a price in the last two columns that reflects the total price for the annual risk score completion for **each** of the programs below, and the price for each risk score modification. These rates will be held firm for years one (1) through three (3) of the contract. See Section 4.8 Payment for price adjustment clause for years four (4) and (5).

This will be the price paid to the contractor for the completion of the annual risk score and for each modification, in accordance with Sections 4.2.B, 4.8 and 6.3 of this RFP.

Managed Care Program	Risk Score Effective Date	Risk Score Development Price	Modification Price
a. Mainstream Managed Care	April 1		
HIV/SNP	April 1		
HARP	April 1		
b. *MLTC Programs*	-	-	-

MLTCP	April 1		
PACE	April 1		
MAP	April 1		
c. Essential Plan	January 1		
d. CHPlus	January 1		

**This is just a title, does not require a rate or modification price*

3. Budget Neutrality (See Section 4.2.C)

Submit a single per deliverable price in the last column that reflect the total price for **each** deliverable related to Budget Neutrality below. These rates will be held firm for years one (1) through three (3) of the contract. See Section 4.8 Payment for price adjustment clause for years four (4) and (5).

This will be the price paid to the contractor for the completion of each Budget Neutrality deliverable, in accordance with Sections 4.2.C, 4.8 and 6.3 of this RFP.

Deliverable	**Total Anticipated Quantity**	**Price Per Deliverable**
Quarterly Reporting	20	
Amendment Models and Support	25	
Renewal Models	2	

4. Preprint Support (See Section 4.2.D)

Submit a single per deliverable price in the last column that reflects the total price for completion for **each** Preprint Support Phase identified in Section 4.2.D. The Contractor will be paid a percentage of its deliverable price in accordance with Section 4.8 and 6.3 of this RFP. This rate will be held firm for years one (1) through three (3) of the contract. See Section 4.8 Payment for price adjustment clause for years four (4) and (5).

Preprint Support	**Annual Quantity**	**Price Per Deliverable**
Preprint Support All-Inclusive Deliverable Price	6	

5. Reimbursement Development and Management of OPWDD Rate-Based Programs (Section 4.2.E)

Submit a single per deliverable price in the last column for services related to Reimbursement Development and Management of OPWDD Rate-Based Programs in accordance with Sections 4.2.E, 4.8, and 6.3 of the RFP. The Contractor will be paid 25% of its all-inclusive deliverable price on a quarterly basis for all services identified in Section 4.2.E. This rate will be held firm for years one (1) through three (3) of the contract. See Section 4.8 Payment for price adjustment clause for years four (4) and (5).

Deliverable	Annual Anticipated Quantity	Price Per Deliverable
Reimbursement Development and Management of OPWDD Rate Based Programs All-Inclusive Deliverable Price	3	

6. Support Encounters Penalty Work (Section 4.2.F)

Submit a single per deliverable price in the last column for both the initial and final encounter to cost report comparisons and corresponding reconciliation worksheets, which will be billed on an annual basis and are further detailed in Section 4.2.F.1, 4.8, and 6.3. These prices will be held firm for years one (1) through three (3) of the contract. See Section 4.8 Payment for price adjustment clause for years four (4) and (5).

Submit an all-inclusive deliverable price for each annual audit as further detailed in Section 4.2.F.6, 4.8, and 6.3.

Deliverable	Annual Anticipated Quantity	Price Per Deliverable
Initial Encounter to Cost Report Comparison and Corresponding Reconciliation Worksheets	1	
Final Encounter to Cost Report Comparison and Corresponding Reconciliation Worksheets	1	
Annual Encounters Audit	1	

7. Medical Indemnity Fund (MIF) Actuarial Services (See Section 4.2.G)

Submit a price in the last column that reflects the total price for each deliverable related to MIF Actuarial Services below. These rates will be held firm for years one (1) through three (3) of the contract. See Section 4.8 Payment for price adjustment clause for years four (4) and (5).

This will be the price paid to the contractor for the completion of each MIF Actuarial Services deliverable, in accordance with Sections 4.2.G, 4.8 and 6.3 of this RFP.

Please note: Bid prices for MIF Actuarial Services MAY NOT exceed $120,000 in Contract Year 1 and $479,000 in Contract Years 2-5

Deliverable	Total Anticipated Quantity Contract Year 1	Total Anticipated Quantity Contract Years 2-5	Price Per Deliverable
Implementation	1	-	
Quarterly Reports	3	16	
Liabilities Analysis and Ad-Hoc Reporting Monthly Fee	9	48	

B. HOURLY BASED PRICING: Hourly Consulting Projects (See Section 4.3)

Complete the information below based on the assumptions contained in Sections 4.3 and 6.3 of the RFP and the information provided below. These estimated hours shall include all work identified in Section 4.3 of the RFP.

For purposes of this proposal, use the following guidelines in assigning staff to one of the three levels listed below, provide one hourly rate for each Staff Level for each project/initiative. It is estimated that billable hours for the contract period, shall be divided among the three Staff Levels as 30% for Level 1, 45% for Level 2 and 25% for Level 3 for each project/initiative. Percent of billable hours is an estimate based on historical data. Both the proportions of hours and actual hours will likely vary from these estimates during the term of the contract.

1. Service Based Payment Rate Setting, Policy and Financial Management Consulting Services (See Section 4.3.A)

Level of Staff	(A) Proposed Hourly Rate Per Staff Level (Years 1-3)	(B) Annual Anticipated Hours*	(A*B) Annual Total Cost Per Staff Level (Years 1-3)	List Titles Assigned to Each Level
Level 1		1,875		
Level 2		2,812.50		
Level 3		1,562.50		
Annual Total		6,250		

**This is an annual estimate. Actual hours may increase or decrease based on the need of the Department.*

2. Policy and Financial Management Consulting Services (Section 4.3.C)

Level of Staff	(A) Proposed Hourly Rate Per Staff Level (Years 1-3)	(B) Annual Anticipated Hours*	(A*B) Annual Total Cost Per Staff Level (Years 1-3)	List Titles Assigned to Each Level
Level 1		12,485		
Level 2		28,612		
Level 3		17,883		
Annual Total		58,980		

**This is an annual estimate. Actual hours may increase or decrease based on the need of the Department*

These hourly rates will be held firm for years one (1) through three (3) of the contract. See Section 4.8: Payment for price adjustment clause for years four (4) and (5).

By signing this Cost Proposal Form, bidder agrees that the prices above are binding for 365 days from the proposal due date.

_____ _____

Bidder's Authorized Signature Date

_____ _____

Printed Name Title

Examples of Experience and Duties by Staffing Level:

This is only to be used as a guide and is not all inclusive of staff types, experience and/or duties, but is representative of the level of staff DOH may require to perform such task.

Level 1 Staff:

Staff Types: Principals, Partners, Project Leaders, Lead Consultants, or other staff with similar responsibilities.

Experience: These staff have extensive experience and knowledge of actuarial activities related to setting rates and evaluating methodologies. These upper-level staff are seasoned professionals with generally 10-15 years of experience, and may be an actuary, accountant or a Fellow of the Society of Actuaries (FSA).

General Duties: Project oversight, management of Contractor's team, liaison with DOH, client relationships, and global policy development.

Level 2 Staff:

Staff Types: Associates, Consultants, Senior Analysts, or other staff with similar responsibilities.

Experience: These staff are mid-level professionals with generally 5-10 years of increasing responsibility and independent analysis work and experience, require little supervision

General Duties: Analyze data and form preliminary conclusions and/or recommendations, but report to Level 1 staff for overall direction on project, specific policy interpretation, and may supervise lower level staff.

Level 3 Staff:

Staff Types: Analysts, Consulting Assistants, or other staff with similar responsibilities.

Experience: These staff are entry level professionals with less than 5 years' experience. They work under direct supervision of Level 2 staff

General Duties: Technical support and data manipulation, but not necessarily drawing conclusions or making recommendations.

ATTACHMENT C

Program Definitions

Managed Care Programs

Mainstream Medicaid Managed Care

The Partnership Plan, referred to as "mainstream" Medicaid, covers most of the non-elderly, non-institutionalized Medicaid population in the State. The Terms and Conditions of the Partnership Plan define specific populations who are either excluded or exempt from joining managed care.

As of November 2012, MMC programs are operating in all counties of the state, including New York City.

As of August 2025, there are a total of 4,447,263 individuals enrolled in mainstream Medicaid managed care. A copy of the Medicaid managed care model contract that describes in greater detail the Medicaid Managed Care benefit package is available at: https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

a. HIV/Special Needs Plan (SNP)

The AIDS Institute oversees three HIV Special Needs Plans (SNPs) that are currently operational in the New York City, Northern Metro and Long Island regions. As a Medicaid managed care program, the HIV SNPs seek to improve access to high quality health care and essential supportive services for their members. Enrollment in these three HIV SNPs is currently available to HIV-positive Medicaid recipients and their HIV-negative dependents and to HIV-negative Medicaid recipients who are homeless or are transgender. As of May 2025, there are 17,927 individuals enrolled in HIV SNPs, mostly persons who are HIV- positive and their uninfected dependents.

b. Health and Recovery Plan (HARP)

Adults enrolled in Medicaid and 21 years or older with select Serious Mental Illness (SMI) and Substance Use Disorder (SUD) diagnoses having serious behavioral health issues are eligible to enroll in HARP, HARP. This specialty line of business operated by an MCO is available statewide. Participating HARP MCOs must meet special MLR requirements and are also subject to a BHET. Individuals meeting the HARP eligibility criteria who are already enrolled in an HIV Special Needs Plan may remain enrolled in the current plan and receive the enhanced benefits of a HARP. HARPs and SNPs will arrange for access to a benefit package of Home and Community Based Services (HCBS) for members who are determined eligible. HARPs and SNPs will contract with Health Homes, or other State designated entities, to develop a person-centered care plan and provide care management for all services within the care plan, including the HCBS. As of January 2020, there are a total of 136,351 individuals enrolled in HARP.

c. Medicaid Managed Long Term Care (MLTC) Programs

Enrollment in a MLTC plan is mandatory for those who are dual eligible (eligible for both Medicaid and Medicare) age 21 and over and in need of community based long term care services for more than 120 days.

Enrollment in a MLTC plan is voluntary for:

- Dual eligibles age 18 through 20 years in need of nursing home level of care and community based long term care services for more than 120 days
- Non-dual eligible and over age 18 who are assessed as both nursing home eligible and require community based long term care services for more than 120 days.
- Dual eligibles age 18 and over who were previously determined as permanently placed in a nursing home, effective October 1, 2015.

There are three different MLTC program models; Partial Capitation, Program of All-inclusive Care for the Elderly (PACE) and Medicaid Advantage Plus (MAP)that currently enroll members. These models provide health and long term care services to adults with chronic illness or disabilities, to better address their needs and to prevent or delay nursing home placement. There are currently twenty-six (263) Partial Capitation, eight (8) PACE and nine(9) MAP.

d. MLTC Partial Capitation Program (MLTCP)

MLTC Partial Capitation plans are entities specifically licensed to offer long term care benefits. Many plans are sponsored by or related to nursing homes and/or home health agencies. These programs are not capitated for any Medicare services, and are billed by providers on a service based payment basis.

There are 123,522 enrollees in MLTC Partial Capitation plans as of May 1, 2015.

e. Program for All Inclusive Care for the Elderly (PACE)

PACE is a federal managed care model that includes long term care services as well as acute care and physician services. The PACE program is a service for Medicare and Medicaid eligible enrollees. PACE programs receive a capitated payment for both Medicare and Medicaid. The PACE model revolves around a care management team that works to provide social and medical services primarily at a PACE center which provides clinic and day care services.

PACE enrollees must be at least 55 years old, be able to live safely in the community and be certified as eligible for nursing home care by the state. There are 5,451 enrollees in PACE plans as of May1, 2015.

f. Medicaid Advantage Plus (MAP)

MAP plans must be certified by the NYSDOH as MLTC plans and by the Centers for Medicare and Medicaid Services (CMS) as a Medicare Advantage Plan. As with the PACE model, the plan receives a capitation payment from both Medicare and Medicaid. The enrollee must use the Plan’s

Medicare product and must choose a primary care physician from the MAP plan. In addition to services included in the Partial Capitation model, MAP Medicare services include doctor visits, specialty care, clinic visits, hospital stays, mental health services, x-ray and radiology services, chiropractic care, Medicare Part D drug benefits and Ambulance services.

MAP enrollees must be 18 years of age or older and eligible for nursing home placement. There are 6,055 enrollees in MAP plans as of May 1, 2015.

g. Essential Plan (EP)

The Essential Plan is a BHP look-alike program that offers comprehensive, affordable coverage as an alternative to Qualified Health Plan coverage in New York. Individuals who are citizens or lawfully present non-citizens, who do not qualify for Medicaid, Children's Health Insurance Program (CHIP), or other minimum essential coverage and have income between 133 percent and 250 percent of the federal poverty level (FPL) are eligible for the Essential Plan in New York. People who are lawfully present non- citizens who have income that does not exceed 133 percent of FPL but who are unable to qualify for Medicaid due to such non-citizen status, are also eligible to enroll.

Consistent with the statute, benefits will include at least the ten essential health benefits specified in the Affordable Care Act. The monthly premium and cost sharing charged to eligible individuals will not exceed what an eligible individual would have paid if he or she were to receive coverage from a Qualified Health Plan (QHP) through the Health Insurance Marketplace.

h. Child Health Plus (CHPlus)

Child Health Plus provides free or low-cost comprehensive health insurance to children who are residents of New York, under the age of 19 who do not qualify for Medicaid and do not have other health insurance coverage or access to the State Health Benefits Plan, the New York State Health Insurance Program (NYSHIP). Depending on household income and family size, coverage may be free or at a low cost. Children in households with income over the limit for subsidized coverage may purchase coverage at the full premium cost.

- Children in households up to 222% of the Federal Poverty Level are fully subsidized.
- Children in households with income between 223 and 250% of the Federal Poverty Level have a monthly family premium contribution of $15 per child per month with a monthly family maximum of $45.
- Children in households with income between 251 and 300% of the Federal Poverty Level have a monthly family premium contribution of $30 per child per month with a monthly family maximum of $90.
- Children in households with income between 301 and 350% of the Federal Poverty Level have a monthly family premium contribution of $45 per child per month with a monthly family maximum of $135.
- Children in households with income between 351 and 400% of the Federal Poverty Level have a monthly family premium contribution of $60 per child per month with a monthly family maximum of $180.

Benefits package includes well-child visits, physical examinations, immunizations, inpatient hospital and surgical care, laboratory testing and imaging, short-term physical and occupational therapy, prescription and non-prescription drugs if ordered by a licensed professional, inpatient and outpatient mental health,

alcohol and substance abuse services, speech and hearing services, emergency room care, dental and vision services and more.

3. Services Based Payment Programs

a. Assistance to the Office of Alcoholism and Substance Abuse Services (OASAS)

OASAS is transitioning to a payment for service method by establishing per service prices that are risk adjusted and adjusted for regional cost differences for much of the net deficit financed system for inpatient, crisis and residential levels of care. The major service areas provided through OASAS are as follows:

1. OASAS System of Care

OASAS certifies a continuum of treatment services. Admission to each service is determined through a level of care assessment and admission criteria for each service that is identified in regulation for each service category. Any OASAS certified program may receive OASAS net deficit financing, although levels of care with fewer third party payment opportunities would receive higher level of funding from OASAS than a program with less third party payment opportunities. However, any service could receive net deficit financing and OASAS is requesting a per service cost analysis for each service category.

2. Medically Managed Detoxification Service

Medically managed withdrawal and stabilization services are designed for patients who are acutely ill from alcohol-related and/or substance-related addictions or dependence, including the need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms, and may include individuals with or at risk of acute physical or psychiatric co-morbid conditions. This level of care includes the forty-eight (48) hour observation bed. Patients who have stabilized in a medically managed detoxification service may step-down to a medically supervised service.

3. Medically Supervised Withdrawal Service

This service provides treatment of moderate withdrawal symptoms and non-acute physical or psychiatric complications. Medically supervised withdrawal services must provide: biopsychosocial assessment, medical supervision of intoxication and withdrawal conditions; pharmacological services; individual and group counseling; level of care determination; and referral to other appropriate services. Medically supervised withdrawal and stabilization services are appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from mild to moderate withdrawal, coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications. Patients who have stabilized in a medically managed or medically supervised inpatient withdrawal service may step-down to a medically supervised outpatient service.

4. Inpatient Rehabilitation

This service occurs at an OASAS-certified treatment setting with 24-hour medical coverage and oversight provided to individuals with significant acute medical, psychiatric and substance use disorders with 12 significant associated risks. Inpatient rehabilitation services provide intensive management of substance dependence symptoms and medical management/monitoring of medical or psychiatric complications to individuals who cannot be

effectively served as outpatients and who are not in need of medical detoxification or acute care. These services can be provided in a hospital or free-standing facility. Services are short-term and intensive.

5. Opioid Treatment Program (OTP)

OASAS-certified sites where methadone or other approved medications are administered to treat opioid dependency following one or more medical treatment protocols defined by State regulation. OTPs offer rehabilitative assistance including counseling and educational and vocational rehabilitation. OTP also includes the Narcotic Treatment Program (NTP) as defined by the federal Drug Enforcement Agency (DEA) in 21 CFR Section 13.

6. Outpatient Clinic Services

OASAS-certified Outpatient Services have multi-disciplinary teams that include medical staff and a Medical Director. These programs provide the following procedures: group and individual counseling; education about, orientation to, and opportunity for participation in, relevant and available self-help groups; alcohol and substance abuse disease awareness and relapse prevention; HIV and other communicable disease, education, risk assessment, supportive counseling and referral; and family treatment. In addition, social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation must be available either directly or through written agreements. Procedures are provided according to an individualized assessment and treatment plan.

7. Intensive Outpatient

Intensive Outpatient is an OASAS-certified treatment service provided by a team of clinical staff for patients who require a time-limited, multi-faceted array of services. A team of clinical and medical staff must provide this service. The treatment program consists of, but is not limited to, individual, group and family counseling, relapse prevention and coping skills training, motivational enhancement, and drug refusal skills training.

8. Outpatient Rehabilitation

OASAS-certified services designed to assist individuals with chronic medical and psychiatric conditions. These programs provide: social and health care services; skill development in accessing community services; activity therapies; information and education about nutritional requirements; and vocational and educational evaluation. Individuals initially receive these procedures three to five days a week for at least four hours per day. There is a richer staff to client ratio for these services compared to other outpatient levels and these services are required to have a half-time staff person qualified in providing recreation and/or occupational services and a half-time nurse practitioner, physician's assistant, or registered nurse. Like medically supervised outpatient, outpatient rehabilitation services mandate that medical staff be part of the multi-disciplinary team and include the designation of a medical director, who provides for medical oversight and involvement in the provision of outpatient services.

9. Stabilization in a Residential Setting

This setting provides medical and clinical services including: medical evaluation, ongoing medication management and limited medical intervention, ancillary withdrawal and medication assisted substance use treatment, psychiatric evaluation and ongoing management, group, individual and family counseling focused on stabilizing the patient and increasing coping skills until the patient is able to manage feelings, urges and craving, co-occurring psychiatric

symptoms and medical conditions within the safety of the residence.

10. Rehabilitation Services in a Residential Setting

In this setting medical staff is available in the residence, however, it is not staffed with 24 hour medical/nursing services. This setting provides medical and clinical services including: medical evaluation, ongoing medication management and limited medical intervention, medication assisted substance use treatment when medically necessary, psychiatric evaluation and ongoing management, group, individual and family counseling focused on rehabilitation and increasing coping skills until the patient is able to manage feelings, urges and craving, co-occurring psychiatric symptoms and medical conditions within the community. The treatment includes at least 30 hours of structured treatment of which at least 10 hours are individual, group or family counseling. Programs are characterized by their reliance on the treatment community as a therapeutic agent. It is also to promote abstinence from substance use and interpersonal behaviors to effect a global change in participants' lifestyles, attitudes, and values. Individuals typically have multiple functional deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values.

11. Re–integration Services in a Residential Setting

This is a residential setting with access to limited medical and clinical services that are generally provided in the community. There is 24-hour oversight by on-site staff and structured activities to promote increasing independence in independent living skills. The residential program may provide some individual, family or group counseling to support the development of intra and interpersonal coping skills, recovery oriented peer supports and support for activities for daily living skills. There is access to ongoing medical, psychiatric and other clinical services through the residence or by agreements with outpatient or clinic providers.

b. Foster Care

In 2011, New York State's Medicaid Redesign Team (MRT) recommended that all children and adolescents being served in the foster care system should be enrolled in Medicaid Managed Care. As part of the transition to managed care, the New York State Department of Health needs to establish premiums/payment rates for managed care organizations.

c. Office of People with Developmental Disabilities (OPWDD)

The OPWDD coordinates services for New Yorkers with intellectual and developmental disabilities, providing services directly and through a network of over 500 nonprofit agencies across the
state. Nearly 40,000 people receive housing supports in the form of group homes or other community- based settings and over 28,000 are enrolled in work-related services and/or supported employment.

1. Individualized Residential Alternatives (IRA)

IRAs are supervised or supportive housing opportunities certified by New York State OPWDD and available for eligible individuals with developmental disabilities.

2. Intermediate Care Facilities (ICF)

A facility operated by or subject to certification by the OPWDD. Such facilities provide active

programming, room and board, and continuous 24 hour per day supervision. They are located within the population areas of non-developmentally disabled persons. They are not of the facility type known as developmental center or school as defined by Section 13.17 of the Mental Hygiene Law.

3. Day Habilitation

Day Habilitation services provide assistance with acquisition, retention or improvement in self- help, socialization and adaptive skills including communication, and travel that regularly takes place in a nonresidential setting, separate from the person's private residence or other residential arrangement.

4. Prevocational Services

A service that prepares individuals for paid or unpaid employment. Services include teaching task completion, problem solving and safe.