



Department of Health

Request for Proposals

RFP # - 18714

Actuarial Rate Certification Services and Support

Issued: February 18, 2021

DESIGNATED CONTACT:

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1.0 CALENDAR OF EVENTS

RFP#18714 – Actuarial Rate Certification Services and Support	
<u>EVENT</u>	<u>DATE</u>
Issuance of Request for Proposals	February 18, 2021
Deadline for Submission of Written Questions	March 4, 2021 By 4:00 p.m. ET
Responses to Written Questions Posted by DOH	On or About March 22, 2021
Deadline for Submission of Proposals	April 6, 2021 4:00 p.m. ET
<i>Anticipated</i> Contract Start Date	January 1, 2022

2.0 OVERVIEW

Through this Request for Proposals (“RFP”), the New York State (“NYS”) Department of Health (DOH) is seeking competitive proposals from organizations to provide actuarial consulting services and other related services as detailed in [Section 4.0](#) (Scope of Work). It is DOH’s intent to award one (1) contract from this RFP.

2.1 Introductory Background

A. **INTRODUCTION**

General Information for Prospective Contractors

This RFP is to secure actuarial services and support for Medicaid, including Medicaid Managed Care and other State health-related programs administered by the DOH 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 DOH. These programs currently include Mainstream Medicaid Managed Care (MMC), HIV/Special Need Plans (HIV SNP), Health and Recovery Plans (HARP), Managed Long Term Care (MLTC) Partial Capitation, Program All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus (MAP), Medicaid Advantage (MA), Essential Plan (EP) and Fully Integrated Dual Advantage for Individuals with Developmental Disabilities and Development (FIDA-IDD).

The Contractor selected as a result of this RFP will serve as DOH’s independent actuary responsible for certifying that managed care premium rates developed by DOH for existing and new 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 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 6.1 million members and totals \$71.6 billion annually. OHIP is also responsible for administering the Child Health Plus (CHP) program, the Essential Plan (EP), 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).

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

- **Donna Frescatore, Medicaid Director and Director of NYSoH**
- **Amir Bassiri, Chief of Staff**
- **Brett Friedman, Director of Strategic Initiatives**
- **Ryan Ashe, Medicaid Payment Reform**
- **Dr. Doug Fish, Medical Director:** 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.
- **Michael Ogborn, Chief Financial Officer and Director of 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.
- **Jonathan Bick, Director of 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.
- **Michael Thibdeau, Director of 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.
- **Lisa Sbrana, Director of Eligibility and Marketplace Integration:** This Division is responsible for eligibility and enrollment policy and operations for Medicaid, the Children's Health Insurance Program (CHIP), 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.
- **Greg Allen, Director of 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.
- **TBD, Director of Long Term Care:** This Division is responsible for the managed long-term care (LTC) program which includes MLTC Plan management and monitoring. The Division monitors LTC plan mergers/acquisitions, market withdrawals/changes activity and financial viability to ensure continuity of care and access to care.
- **Marci Natale, Director of 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.
- **Geza Hrazdina, Director of Employee and Program Support:** This Division is responsible for personnel, contracts and logistics.

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

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 DOH on the development of Medicaid policy, coverage and fin

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.

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.

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.

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

The Contractor must have the ability to allocate resources as required by DOH to support contract activities.

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)
- Medicaid Managed Long Term Care (MLTCP) Partial Capitation
- Program for All-Inclusive Care for the Elderly (PACE)
- Medicaid Advantage Plus (MAP)
- Medicaid Advantage (MA)
- Essential Plan (EP)
- Fully Integrated Dual Advantage for Individuals with Developmental Disabilities (FIDA-IDD)
-

Taken collectively, these MC programs provide needed health insurance coverage to over 7 million New Yorkers. Monthly managed care enrollment reports are available on DOH'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 these 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
- 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**

Budget Neutrality

NYS 1115 MRT Waiver was renewed on December 6, 2016 effective through March 31, 2021 with the expectation for an additional five-year renewal until March 31, 2026. 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 serving 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/2020-04-16_ny_stc.pdf).

Cost Effectiveness

NYS 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.

2.2 Important Information

The bidder is required to review, and is requested to have legal counsel review, [Attachment 8](#), "DOH Agreement", as the bidder must be willing to enter into an Agreement substantially in accordance with the terms of [Attachment 8](#) should the bidder be selected for contract award. Please note that this RFP and the awarded bidder's proposal 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 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 DOH and the successful bidder. By submitting a response to the RFP, the Bidder agrees to comply with all the provisions of Appendix A. Note, [Attachment 7](#), the bidder's Certifications/Acknowledgements, should be submitted 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. It also includes a statement that the bidder acknowledges that, should any alternative proposals or extraneous terms be submitted with the proposal, such alternate proposals or extraneous terms will not be evaluated by DOH.

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 1.0](#) (Calendar of Events). Any amendments DOH makes to the RFP as a result of questions and answers will be publicized on DOH's web site.

2.3 Term of the Agreement

This contract term is expected to be for a period of 5 years commencing on the date shown on the Calendar of Events in [Section 1.0](#), 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 5.4](#).

3.0 BIDDERS QUALIFICATIONS TO PROPOSE

3.1 Minimum Qualifications

DOH will accept proposals from organizations with the following types and levels of experience as a prime Contractor.

- Bidder must identify an actuary who will be assigned to the contract that is a member of at least one 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. Documentation of these credentials must be submitted with the Bidder's proposal;
- Bidder must have at least three (3) years of actuarial experience in the health care insurance industry;

and

- Bidder must have at least two (2) 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. However, a prime Contractor may not leverage a proposed subcontractor's experience in order to meet the minimum qualifications noted above.

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 Medicaid managed care rate development experience with state Medicaid programs having annual Medicaid enrollment in excess of 3 million recipients;
- 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;
- 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 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 "contractor(s)", "bidder(s)", "vendor(s)" and "proposer(s)" 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. Mainstream Medicaid Managed Care (MMC) and Health and Recovery Plans (HARP)

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 3M Company. 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, and Social Security Insurance (SSI), (Children and Adult combined).

- 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.
- g. by submitted encounter data. However, scores may be updated more frequently based on determinations made by DOH.
- h. Under the risk 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)
 - i. In addition, a Nursing Home Transition (Ages 21+) rate cell and supplemental payment rates for hospital deliveries and hospital births are developed but are currently not risk adjusted.

3. 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 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 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 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 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 expense loads 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 region 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
 - 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 would be developed 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 premiums.
- c. Medicaid Managed Long Term Care Partial Capitation (MLTCP), Medicaid Advantage Plus (MAP), Fully Integrated Dual Advantage (FIDA) and Program for All-Inclusive Care for the Elderly (PACE)
1. Rate Methodology:
 - a. Currently, a risk-based rate setting method based on information from plan cost reports 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 cost reports submitted by each plan participating in the programs. The 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 cost report data is 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 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:

Risk Score Model Development Tasks:

- 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 DOH.
 - 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
 - FIDA:

- o Dual eligible aged 21 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. Medicaid Advantage (MA)
 - 1. Rate Methodology:
 - a. The MA program plans receive Medicaid capitation which covers co-payments, any supplemental Medicare premiums, certain limited services covered by Medicaid but not Medicare (e.g. inpatient mental health in excess of the 190 day lifetime limit, non-Medicare covered home care, private duty nursing, and other optional services such as dental and non-emergency transportation).
 - b. The MA premium development process is currently based upon historical service based payments trended to the contract period. Programmatic changes that would materially impact the MA program and the underlying data are considered. The rate development also includes trend factor assumptions, MC adjustments, selection adjustments and non-medical expense loads such as administration and underwriting gain. Premiums are set for three (3) regions and include two (2) premium groups: age 18-64 and age 65+.
 - 2. 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 premiums.
- e. Essential Plan (EP)
 - 1. Rate Methodology:
 - a. NY is one of only two 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. 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 200 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. Dental and vision are optional benefits for some premium groups. 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

2. Risk Methodology:

- a. EP does not currently have a risk adjustment methodology, but it is anticipated that a risk methodology would be developed 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. Trust Fund Reconciliation:

- a. Pursuant to the ACA, the state receives funding from the federal government to support the delivery of health care services to EP enrollees. This funding is estimated based on projected enrollment for each quarter and deposited by the federal government into a Trust Fund where it can be used to fund the beneficiary health care costs associated with the EP program. Administrative costs may not be charged to the Trust. Based on the number and demographics of EP enrollees, the State works with the federal government to reconcile funding on a quarterly basis. The contractor will assist the state with Trust Fund revenue and expenditure projections as needed throughout the year.

f. Fully Integrated Dual Advantage for Individuals with Developmental Disabilities (FIDA-IDD)

1. Rate Methodology:

- a. Historical demographic, cost, and utilization data related to FIDA-IDD eligible population will be used as the basis for capitation rate development. The data encompasses FIDA-IDD covered services including Home and Community Based Services (HCBS) for individuals who are eligible for OPWDD's 1915(c) comprehensive waiver, Long-term Care services, some Behavioral Health services, and Acute Care services.

2. Actuarial Memorandum: As part of the rate development process, an actuarial memorandum must be created by the contractor 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.

<u>Managed Care Program</u>	<u>Rate Develop</u>	<u>Original Rate Package Effective Date</u>	<u>Anticipated Number of Annual Modifications to Original Rate Package*</u>
MMC, SNIP, HARP	Annually	April 1	3 to 4
MLTC Programs: MLTCP , PACE, MAP, FIDA	Annually	April 1	4 to 5
MA	Annually	January 1	1 to 2
EP	Annually	January 1	1 to 2
FIDA-IDD	Annually	January 1	2 to 3

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

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 DOH staff to improve the accuracy and efficiency of capitation rate development methodologies including modifications to DOH rate development tools 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 DOH 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 financial standards set forth by DOH 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 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 DOH, MCOs, and other outside stakeholders;
9. Work collaboratively with DOH to ensure applicable MC capitation premium rates incorporate aspects of the State's Value Based Payment (VBP) initiative specifically with regard to efficiency and quality. Supporting tasks include but not limited to development of capitation rate methodology to align with the State's Valued Based utilization and quality strategies for MC, development of metrics to measure MCO performance related to utilization and quality, and continued monitoring and reporting of these metrics; 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;
 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, VBP shared savings, administrative overhead, care management overhead, and appropriateness of medical costs incurred;
 4. Work collaboratively with DOH 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 DOH 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 DOH 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;
 - 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 DOH;
 4. Provide DOH staff training in methodologies used to develop rates and rate ranges, as requested by the Department. Trainings must occur at least annually;
 5. Develop a quarterly category of service specific “dashboard” for all applicable MC programs to support DOH/MCOs in reviewing and monitoring program financial performance. Associated tasks include but are not limited to MCO specific pharmacy 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 should 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 DOH 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

rates along with all associated exhibits supporting the development of capitation rates and rate ranges;

3. Prepare 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 DOH with regard to preprint strategies, attendance and participation in discussion and/or meetings related to preprint 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 DOH's rate setting discussions and meetings with stakeholders as determined by DOH;
5. Attend, participate, and defend DOH in DOH's rate setting discussions and meetings with CMS and the Office of the Actuary (OACT);
6. Provide DOH with an annual certification of projected pharmacy category of service expenditures and utilization for the MMC, HARP, and HIV SNP programs. Supporting tasks include but not limited to tracking and reporting of actual pharmacy expenditures and utilization on a quarterly basis for the referenced programs and support to DOH in analysis related to reimbursement methodologies contained in MCO submitted encounter data;
7. Provide DOH 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, 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
8. Provide DOH 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.

<u>Managed Care Program</u>	<u>Risk Score Develop</u>	<u>Risk Score Effective Date</u>	<u>Anticipated Number of Annual Modifications to Original Risk Score*</u>
MMC, HIV/SNIP, HARP	Annually	April 1	1 to 2
MLTC Programs: MLTCP , PACE, MAP, FIDA	Annually	April 1	1 to 2
Essential Plan	Annually	January 1	1 to 2
FIDA-IDD	Annually	January 1	2 to 3

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

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 DOH staff to improve the completeness, accuracy and efficiency of the existing data sources used for risk adjustment and cost weight development;
- d. Provide technical assistance in the modification of existing risk adjustment software or models and/or implement new software updates to risk adjustment methodology;
- e. Review risk adjustment outputs for consistency, accuracy and predicative ability;
- f. Provide DOH 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 DOH's discretion;
- h. Develop risk adjustment cost weights for applicable programs. Cost weights are updated annually or on a modified timeline at DOH's discretion;
- i. Create a "Summary of Methods" document for DOH 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 DOH and stakeholder distribution;
- k. Prepare all presentation material as well as attend, participate, and provide administrative support in DOH's risk adjustment discussions and meetings with stakeholders as determined by DOH;
- l. Provide DOH with administrative support, Contractor staffing resources, and technical support in the engagement of a risk adjustment workgroup with outside stakeholders as determined by DOH;
- m. Support DOH 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 DOH; and
- o. Provide DOH 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.).

4.3 TASK ORDER BASED PROJECTS

The following scope of work will be paid in accordance with developed task orders as identified in Section 5.4.D.

A. Encounter Reimbursement

1. The Contractor will work with DOH and the Office of the Medicaid Inspector General (OMIG) on a semi-annual basis to identify expenditures associated with Medicaid MC (all lines of business) enrollees that were determined ineligible for services. Contractor will summarize encounter data costs for the requested MCO enrollees by service month and prepare documentation describing how these encounters were identified and calculated and any considerations used in summarization of these encounters. The Contractor will also attend and participate in meetings with stakeholders to address methodologies and results.

B. Budget Neutrality

1. The Contractor will support DOH's 1115 Waiver Budget Neutrality team in analyzing and developing materials related to the following items:
 - a. Throughout the contract period, the Contractor will analyze the impact of new 1115 Waiver Amendments proposed by DOH. DOH approximates there to be five new amendments per Budget Neutrality Demonstration Year;

- b. For amendments currently in process the Contractor will re-development or adjust projected With Waiver (WW) and Without Waiver (WOW) PMPM expenditure projections;
- c. Development of additional waiver documentation to support the submission of budget neutrality summaries to CMS. This documentation will include a rebasing of future DY budget neutrality calculations. The Contractor will also extract and review historical data to assist DOH 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;
- d. The Contractor will develop 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 Special Terms and Conditions (STC), 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.
- e. The Contractor will 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:
 - a. 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. These extractions are due by the 14th of every month; and
 - b. An average of two-monthly related ad-hoc requests.
- f. The Contractor will assist with all extensions during this contract period. The next schedule extension is September 30, 2021 and historically occur every five-years. Expected tasks that the Contractor will be required to but not limited to perform are:
 - i. Rebasing the demonstration's budget ceiling using recent cost data and growth trends;
 - ii. Evaluate the carry-forward of accumulated savings from one approval period to the next; and
 - iii. Additional reporting and/or analysis related to the NYS MRT 1115 waiver as requested by CMS or the Department.
- g. The Contractor will serve as a subject matter expert (SME) and advise the budget neutrality team in its efforts to maintain policies and procedures;
- h. The Contractor will also attend and participate in meetings with stakeholders including CMS to address methodologies and results.

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

- 1. Provide DOH with service based payment rate setting, and policy and financial management consultation services, as requested by DOH 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 should 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, DOH'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 DOH 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. Support DOH in updating the OPWDD FFS rate model for rate setting process including the rebuild of acuity outlier methods across both IRA programs, higher than anticipated level of effort associated with the CFR rebasing, and additional revisions to the rate models; and updating the rate model and developing rates,
 9. Develop a CAS based acuity adjustment methodology for OPWDD FFS IRA (supervised and supportive) rates,
 10. 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,
 11. 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.

D. Policy and Financial Management Consulting Services

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 DOH in the refinement of DOH data intake, financial and encounter reporting documentation including MLR, financial monitoring tools, MCO on-site monitoring, and MCO engagement techniques which include but 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 DOH 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 DOH 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 DOH 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 DOH in operating the MC Stop Loss program. Associated tasks include but 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. Analyze and provide guidance related to Federal legislation and regulation impacting Medicaid MC and service based payment programs.
9. Provide DOH 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.
10. Support DOH in evaluating the efficiency, quality and financial impact of Medicaid and Medicare integrated programs.
11. Complete other ad hoc actuarial, consulting and financial/accounting technical assistance, as required.

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. 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 appropriate experience and credentials, who will be working directly with DOH staff on a consistent basis. The Contractor is required to house this core team, permanently, for the duration of the contract, in a single location within a fifteen (15) mile radius of the Capitol building in Albany, New York within four (4) months of signing the contract. Locality of this team is crucial, as it is expected of the team to work closely with DOH. The cost of this team should be included in Part A of the Cost Proposal, under the Deliverable Based Section Staffing of the core team will be subject to DOH approval. The team must consist of:
 - a. At least one (1) member being a certified actuary; and
 - b. Two (2) project coordinators who possess the appropriate knowledge and skills to assist DOH with the tasks outlined in this RFP. Skills include but not limited to strong management skills necessary to coordinate activities, analyze data, prepare rate packages and reports and respond to DOH'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. These project coordinators should be the sole liaisons between DOH and the Contractor. DOH should be able to direct all questions, and other correspondence to these individuals. These individuals are expected to be available to respond to DOH's management information needs on a daily basis via telephone and/or e-mail and to coordinate bi-weekly status meetings to apprise DOH of any issues and status updates. The project coordinators shall be part of the core team, located in the office described in Section 4.5.1.
2. Dedicate an on-site analytic team of 3-5 staff who have the authority to provide recommendations and distribute information to DOH and stakeholders on MC rates. This team will be expected to work full time at One Commerce Plaza, Albany, NY with the OHIP MC Rate Setting team. Within this team, at least two (2) staff must have experience with large datasets, 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 should have the internal authority to release information and analysis to DOH for direct release to the MCOs. Space, computers and phones will be provided to the on-site team. The cost of this team should be included in Part A of the Cost Proposal, under the Deliverable Based Section.
3. Staff assigned to work with the DOH Budget Neutrality team as identified in Section 4.4.B 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 DOH.
- 4. The Contractor shall provide additional staff who possess strong attributes to the appropriate tasks outlined in this RFP. These staff do not need to meet the location requirement of Section 4.3.A. Specifically, the Contractor should provide staff with:
 - a. Extensive experience related to various healthcare risk adjustment methodologies, models and risk adjustment software on this team;
 - b. Experience and knowledge related to MC risk mitigation strategies;
 - c. Extensive 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. Extensive 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; and
 - h. Familiarity with implementing and maintaining efficiency and quality-based payment methodologies in a Medicare and Medicaid MC environment.
- 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 DOH or caused by resignations or other situations which, in DOH's judgment, are beyond the Contractor's control. If a member of a team needs to be replaced, such replacements shall be evaluated by DOH and acceptance is subject to DOH approval. Upon DOH request, the Contractor must replace any assigned Contractor staff with an alternative staff member. If such instances arise, the Contractor must provide DOH with three (3) resumes of potential replacements within one (1) week of DOH's request.
- 7. The Contractor should anticipate that its billable hours for Task Order specific work under the contract period, shall be divided among the three Staff Levels. See Attachment B: Cost Proposal for details on specific staffing levels.

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 this Agreement 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 DOH 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 DOH

personnel or the availability of DOH resources with the exception of such proposed actions of the Contractor which are specifically identified in this Agreement as requiring DOH 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 DOH, within three (3) 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 DOH 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 DOH;
7. Perform the responsibilities, reporting requirements and meet the deadlines in Section 4.1;
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 DOH 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 DOH 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 recognize and agree that DOH may require the Contractor to perform other related tasks, which although within the general scope of work required by this Agreement, are not specifically listed in this Agreement;
11. The Contractor shall implement changes within the scope of work of this Agreement, in accordance with a DOH approved schedule, including changes in policy, regulation, statute, or judicial interpretation;
12. The Contractor shall assume responsibility for providing and ensuring the compatibility of all electronic equipment and resource needs;
13. 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 DOH, forms an agreement between the Contractor (applicant) and DOH as to the terms and conditions under which a release will be made; and
14. The Contractor may be required to enter into a Business Associates Agreement (BAA), upon execution of the resulting contract.

4.5 Reporting

A. Managed Care Rate Development

1. The Contractor will be responsible for providing DOH with a final rate package. The final rate package should include the actuarial certified rate ranges, rate range certification letter, actuarial memorandum and all associated rate exhibits which support the development of the rate package. The Contractor shall timely submit all required rate packages in accordance with the format and schedule to be determined by DOH. A schedule of rate effective dates can be found in Section 4.2.A.2. Rate packages should contain all deliverables set forth by DOH in accordance with Section 4.2.A.1.a through 4.2.A.1.d. of this Agreement. 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 DOH, 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 DOH, 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. DOH 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 DOH timely access to the work papers as requested. If requested by DOH, the Contractor must provide copy of work papers and related material request by DOH within ten (10) business days of written request.
6. The Contractor will be responsible for providing DOH with a final risk scores and cost weights package. The final risk scores and cost weight package should 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 DOH. 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 should contain all deliverables set forth by DOH in accordance with Section 4.2.B.1.a through 4.2.B.1.o of this Agreement. 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 DOH, 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 DOH, 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. DOH 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 DOH timely access to the work papers as requested. If requested by DOH, 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 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** will be enacted on the subject invoice(s).

C. Other Reporting Requirements

1. Upon request from DOH and no less than once per month, the contractor shall provide DOH 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 DOH (<https://its.ny.gov/eiso/policies/security>) and applicable state and federal law and administrative guidance with respect to the performance of this contract. The Contractor is required, if applicable, to execute a number of security and privacy agreements with DOH 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 DOH. 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 contracts 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, DOH must be notified immediately.

The Contractor is required to maintain and provide to DOH 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.

The 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 DOH/HRI, as well as with all applicable State and federal requirements, in performance of this contract.

4.7 Transition

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

The Contractor shall ensure that any transition to DOH, DOH agency or successor Contractor be done in a way that provides DOH with uninterrupted actuarial and consulting services. This includes a complete and total transfer of all data, files, reports, and records generated from the inception of the contract through the end of the contract to DOH or another DOH 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 DOH to transition and assume contract requirements to DOH or another DOH 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.

The 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 DOH or another DOH agent should that be required during or upon expiration of its contract. The plan and documentation must be submitted to DOH no later than four (4) months before the last day of its contract with DOH of Health or upon request of DOH.

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 DOH and ending with the final contract award and approval by DOH and, where applicable, final contract approval by the Office of the State Comptroller.

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 DOH procurements for a period of four (4) years.

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

5.2 Questions

There will be an opportunity available for submission of written questions and requests for clarification with regard to this RFP. All questions and requests for clarification of this RFP should cite the particular RFP Section and paragraph number where applicable and must be submitted via email to OHIPContracts@health.ny.gov. It is the bidder’s responsibility to ensure that email containing written questions and/or requests for clarification is received at the above address no later than the Deadline for Submission of Written Questions as specified in [Section 1.0](#) (Calendar of Events). Questions received after the deadline may **not** be answered.

5.3 Right to Modify RFP

DOH 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 DOH, at any time prior to the Deadline for Submission of Proposals listed 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 DOH will be posted to DOH website.

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

If, prior to the Deadline for Submission of Proposals, a bidder fails to notify DOH 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 Payment

The Contractor shall submit invoices and/or vouchers to DOH'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 #:>>

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 DOH shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be:

- 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 DOH with the supporting documentation and rate certification. This rate and/or risk score package must be approved by DOH 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 DOH once the work is completed and supporting documentation and final rate certification is submitted to DOH 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 DOH 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, MAP and FIDA
 - iii. MA
 - iv. EP
 - v. FIDA-IDD
- D. Payments for Service Based Payment rate setting, financial management and other consultative assistance outlined in Section 4.3 will be made on an hourly basis, in compliance with a developed task order detailing the scope of the work and the staff level authorized by DOH to complete the work. Invoices may be submitted once the progress report has been submitted to DOH in the agreed format and approved. The requirements for the progress report are in section 4.5.B and include a 10% reduction penalty as identified in the referenced section.
- E. Subcontractor billing arrangements are not subject to the same requirements as this RFP and should be agreed upon between the Contractor and the subcontractor, prior to payment for work completed. The Contractor should include on the monthly progress report, the subcontractor's work performed.
- F. DOH 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 DOH.
- G. The Contractor shall, upon completion and DOH approval of each deliverable, submit to Department an invoice for payment on such forms and in such detail as required. All invoices submitted by the Contractor shall be submitted to Department no later than sixty (60) days after the end of the monthly reporting period.

Price Adjustment Clause

The pricing for years four (4) and five (5) of the contract is 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), All Items (CUUR0000SA0), as published by the United States Bureau of Labor Statistics, Washington, D.C., 2012 for the 12 month period ending ninety (90) days prior to the renewal date for years four (4) and five (5) of the contract.

5.5 Minority & Woman-Owned Business Enterprise Requirements

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

In 2006, the State of New York commissioned a disparity study to evaluate whether minority and women-owned business enterprises had a full and fair opportunity to participate in state contracting. The findings of the study were published on April 29, 2010, under the title "The State of Minority and Women-Owned Business Enterprises:

Evidence from New York" ("Disparity Study"). The report found evidence of statistically significant disparities between the level of participation of minority-and women-owned business enterprises in state procurement contracting versus the number of minority-and women-owned business enterprises that were ready, willing and able to participate in state procurements. As a result of these findings, the Disparity Study made recommendations concerning the implementation and operation of the statewide certified minority- and women-owned business enterprises program. The recommendations from the Disparity Study culminated in the enactment and the implementation of New York State Executive Law Article 15-A, which requires, among other things, that DOH establish goals for maximum feasible participation of New York State Certified minority- and women – owned business enterprises ("MWBE") and the employment of minority groups members and women in the performance of New York State contracts.

Business Participation Opportunities for MWBEs

For purposes of this solicitation, DOH hereby establishes an overall goal of **30%** for MWBE participation, **15%** for Minority-Owned Business Enterprises ("MBE") participation and **15%** for Women-Owned Business Enterprises ("WBE") participation (based on the current availability of qualified MBEs and WBEs and outreach efforts to certified MWBE firms). A Contractor ("Contractor") on the subject contract ("Contract") must document good faith efforts to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract and Contractor agrees that DOH may withhold payment pending receipt of the required MWBE documentation. For guidance on how DOH will determine "good faith efforts," refer to 5 NYCRR §142.8.

The directory of New York State Certified MWBEs 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 strongly encouraged and all communication efforts and responses should be well documented.

By submitting a bid, a bidder agrees to complete an MWBE Utilization Plan ([Attachment 5](#), Form #1) of this RFP. DOH will review the submitted MWBE Utilization Plan. If the plan is not accepted, DOH 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 of receipt. DOH may disqualify a Bidder as being non-responsive under the following circumstances:

- a) If a Bidder fails to submit a MWBE 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 DOH determines that the Bidder has failed to document good-faith efforts;

The Contractor will be required to attempt to utilize, in good faith, any MBE or WBE identified within its MWBE 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 DOH, 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 DOH, by the 10th day following each end of quarter over the term of the Contract documenting the progress made toward achievement of the MWBE goals of the Contract.

If the Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such finding will constitute a breach of Contract and DOH may withhold payment from the Contractor as liquidated damages.

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

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 DOH'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 [doh.sm.OHIPcontracts@health.ny.gov] before the Deadline for Questions as specified in [Section 1.0](#) (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.

5.6 Equal Employment Opportunity (EEO) Reporting

By submission of a bid in response to this solicitation, the Bidder agrees with all of the terms and conditions of [Attachment 8](#) Appendix A including Clause 12 - Equal Employment Opportunities for Minorities and Women. Additionally, the successful bidder will be required to certify they have an acceptable EEO (Equal Employment Opportunity) policy statement in accordance with Section III of Appendix M in [Attachment 8](#).

Further, pursuant to Article 15 of the Executive Law (the "Human Rights Law"), all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor and sub-contractors will not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

The Contractor is required to ensure that it and any subcontractors awarded a subcontract over \$25,000 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work"), except where the Work is for the beneficial use of the Contractor, undertake or continue programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, equal opportunity shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, termination, and rates of pay or other forms of compensation. This requirement does not apply to: (i) work, goods, or services unrelated to the Contract; or (ii) employment outside New York State.

To ensure compliance with this Section, the Bidder should submit with the bid or proposal an Equal Employment Opportunity Staffing Plan ([Attachment 5](#), Form #4) identifying the anticipated work force to be utilized on the Contract. Additionally, the Bidder should submit a Minority and Women-Owned Business Enterprises and Equal Employment Opportunity Policy Statement ([Attachment 5](#), Form # 5), to DOH with their bid or proposal.

5.7 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 Contractors' 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 offerer 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 DOH 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>.

Forms are 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

5.8 Contract Insurance Requirements

Prior to the start of work under this Contract, the CONTRACTOR shall procure, at its sole cost and expense, and shall maintain in force at all times during the term of this 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.

5.9 Subcontracting

Bidder's may propose the use of a subcontractor. The Contractor shall obtain prior written approval from NYSDOH before entering into an agreement for services to be provided by a subcontractor. The Contractor is solely responsible for assuring that the requirements of the RFP are 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 DOH and the Contractor. DOH reserves the right to request removal of any bidder's staff or subcontractor's staff if, in DOH's discretion, such staff is not performing in accordance with the Agreement.

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.

5.10 DOH's Reserved Rights

DOH 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 agency'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 agency'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 DOH 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 offer is subject to withdrawal communicated in a writing signed by the offerer; 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 an offerer's proposal and/or to determine an offerer's compliance with the requirements of the solicitation.

5.11 Freedom of Information Law (“FOIL”)

All proposals may be disclosed or used by DOH to the extent permitted by law. DOH may disclose a proposal to any person for the purpose of assisting in evaluating the proposal or for any other lawful purpose. All proposals will become State agency records, which will be available to the public in accordance with the Freedom of Information Law. **Any portion of the proposal 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 proposal as directed in [Section 6.1 \(D\)](#) of the RFP.** If DOH agrees with the proprietary claim, the designated portion of the proposal 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.

5.12 Lobbying

Chapter 1 of the Laws of 2005, as amended by Chapter 596 of the Laws of 2005, made significant changes as it pertains to development of procurement contracts with governmental entities. The changes included:

- a) made the lobbying law applicable to attempts to influence procurement contracts once the procurement process has been commenced by a state agency, unified court system, state legislature, public authority, certain industrial development agencies and local benefit corporations;
- b) required the above mentioned governmental entities to record all contacts made by lobbyists and Contractors about a governmental procurement so that the public knows who is contacting governmental entities about procurements;
- c) required governmental entities to designate persons who generally may be the only staff contacted relative to the governmental procurement by that entity in a restricted period;
- d) authorized the New York State Commission on Public Integrity, (now New York State Joint Commission on Public Ethics), to impose fines and penalties against persons/organizations engaging in impermissible contacts about a governmental procurement and provides for the debarment of repeat violators;
- e) directed the Office of General Services to disclose and maintain a list of non-responsible bidders pursuant to this new law and those who have been debarred and publish such list on its website;
- f) required the timely disclosure of accurate and complete information from offerers with respect to determinations of non-responsibility and debarment; (Bidders responding to this RFP should submit a completed and signed [Attachment 1](#), “Prior Non-Responsibility Determination”.)
- g) increased the monetary threshold which triggers a lobbyist's obligations under the Lobbying Act from \$2,000 to \$5,000; and
- h) established the Advisory Council on Procurement Lobbying.

Subsequently, Chapter 14 of the Laws of 2007 amended the Lobbying Act of the Legislative Law, particularly as it related to specific aspects of procurements as follows: (i) prohibiting lobbyists from entering into retainer agreements on the outcome of government grant making or other agreement involving public funding; and (ii) reporting lobbying efforts for grants, loans and other disbursements of public funds over \$15,000.

The most notable, however, was the increased penalties provided under Section 20 of Chapter 14 of the Laws of 2007, which replaced old penalty provisions and the addition of a suspension option for lobbyists engaged in repeated violations. Further amendments to the Lobbying Act were made in Chapter 4 of the Laws of 2010.

Questions regarding the registration and operation of the Lobbying Act should be directed to the New York State Joint Commission on Public Ethics.

5.13 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 DOH, the Office of the State Comptroller, and Department of Civil Service.

State Consultant Services Form A: Contractor's Planned Employment and Form B: Contractor's Annual Employment Report may be accessed electronically at: <http://www.osc.state.ny.us/agencies/forms/ac3271s.doc> and <http://www.osc.state.ny.us/agencies/forms/ac3272s.doc>.

5.14 Debriefing

Once an award has been made, bidders may request a debriefing of their proposal. Please note the debriefing will be limited only to the strengths and weaknesses of the bidder's proposal, and will not include any discussion of other proposals. Requests must be received no later than fifteen (15) calendar days from date of award or non-award announcement.

5.15 Protest Procedures

In the event unsuccessful bidders wish to protest the award resulting from this RFP, bidders should 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 Guide to Financial Operations (GFO). Available on-line at: <http://www.osc.state.ny.us/agencies/guide/MyWebHelp/>

5.16 Iran Divestment Act

By submitting a bid in response to this solicitation or by assuming the responsibility of a Contract awarded hereunder, Bidder/Contractor (or any assignee) certifies that it is not on the "Entities Determined To Be Non-Responsive Bidders/Offerers Pursuant to The New York State Iran Divestment Act of 2012" list ("Prohibited Entities List") posted on the OGS website (currently found at this address: <http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf>) and further certifies that it will not utilize on such Contract any subcontractor that is identified on the Prohibited Entities List. Additionally, Bidder/Contractor is advised that should it seek to renew or extend a Contract awarded in response to the solicitation, it must provide the same certification at the time the Contract is renewed or extended.

During the term of the Contract, should DOH receive information that a person (as defined in State Finance Law §165-a) is in violation of the above-referenced certifications, DOH will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then DOH shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not limited to, seeking compliance, recovering damages, or declaring the Contractor in default. DOH reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

5.17 Piggybacking

New York State Finance Law section 163(10)(e) (see also <http://www.ogs.ny.gov/purchase/snt/sflxi.asp>) allows the Commissioner of the NYS Office of General Services to consent to the use of this contract by other New York State Agencies, and other authorized purchasers, subject to conditions and the Contractor's consent.

5.18 Encouraging Use of New York Businesses in Contract Performance

Public procurements can drive and improve the State's economic engine through promotion of the use of New York businesses by its Contractors. New York State businesses have a substantial presence in State contracts and strongly contribute to the economies of the state and the nation. In recognition of their economic activity and leadership in doing business in New York State, bidders/proposers for this contract for commodities, services or technology are strongly encouraged and expected to consider New York State businesses in the fulfillment of the requirements of the contract. Such partnering may be as subcontractors, suppliers, protégés or other supporting roles. All bidders should complete [Attachment 6](#), Encouraging Use of New York Businesses in Contract Performance, to indicate their intent to use/not use New York Businesses in the performance of this contract.

5.19 Diversity Practices Questionnaire

Diversity practices are the efforts of contractors to include New York State-certified Minority and Women-owned Business Enterprises ("MWBEs") in their business practices. Diversity practices may include past, present, or future actions and policies, and include activities of contractors on contracts with private entities and governmental units other than the State of New York. Assessing the diversity practices of contractors enables contractors to engage in meaningful, capacity-building collaborations with MWBEs.

5.20 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 certified Service-Disabled Veteran-Owned Businesses ("SDVOBs"), thereby further integrating such businesses into New York State's economy. DOH 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 DOH 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, DOH 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.

5.21 Intellectual Property

Any work product created pursuant to this agreement and any subcontract shall become the sole and exclusive property of DOH, which shall have all rights of ownership and authorship in such work product.

5.22 Vendor Assurance of No Conflict of Interest or Detrimental Effect

All bidders responding to this solicitation should submit [Attachment 4](#) to attest that their performance of the services outlined in this IFB does not create a conflict of interest and that the bidder will not act in any manner that is detrimental to any other State project on which they are rendering services.

5.23 Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination

The New York State Human Rights Law, Article 15 of the Executive Law, prohibits discrimination and harassment based on age, race, creed, color, national origin, sex, pregnancy or pregnancy-related conditions, sexual orientation, gender identity, disability, marital status, familial status, domestic violence victim status, prior arrest or conviction record, military status or predisposing genetic characteristics. In accordance with Executive Order No. 177, the Offeror certifies that they do not have institutional policies or practices that fail to address those protected status under the Human Rights Law.

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.

DOH 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. A 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.

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

Submit a completed and signed [Attachment 1](#), "Prior Non-Responsibility Determination."

B. Freedom of Information Law – Proposal Redactions

Bidders must clearly and specifically identify any portion of the proposal that a Bidder believes constitutes proprietary information entitled to confidential handling as an exception to the Freedom of Information Law. See [Section 4.10](#), (Freedom of Information Law)

C. Vendor Responsibility Questionnaire

Complete, certify, and file a New York State Vendor Responsibility Questionnaire. DOH recommends that vendors 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 <https://portal.osc.state.ny.us>.

Vendors 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.

Vendors 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. Bidder's should complete and submit the Vendor Responsibility Attestation, [Attachment 3](#).

D. Vendors Assurance of No Conflict of Interest or Detrimental Effect

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

E. 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."

F. Bidder's Certified Statements

Submit [Attachment 7](#), "Bidder's Certified Statements", which includes information regarding the Bidder. Attachment A 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. DOH reserves the right to reject a proposal that contains an incomplete or unsigned [Attachment 7](#) or no [Attachment 7](#).

G. Encouraging Use of New York Businesses in Contract Performance

Submit [Attachment 6](#), "Encouraging Use of New York State Businesses" in Contract Performance to indicate which New York Businesses you will use in the performance of the contract.

H. References

Provide references using [Attachment 9](#), (References) for three similar engagements, Provide firm names, addresses, contact names, telephone numbers, and email addresses.

I. Diversity Practices Questionnaire

DOH has determined, pursuant to New York State Executive Law Article 15-A, that the assessment of the diversity practices of respondents of 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.

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

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.

6.2 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 DOH 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 proposal.

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

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 identify an actuary who will be assigned to the contract that is a member of at least one 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. Documentation of these credentials will be required to be submitted with the Bidder's proposal;
 - Bidder must have at least three (3) years of actuarial experience in the health care insurance industry; and
 - Bidder must have at least two (2) 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 Medicaid managed care rate development experience with state Medicaid programs having annual Medicaid enrollment in excess of 3 million recipients;
 - 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;
 - 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 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
 - MLTCP
 - PACE
 - MAP
 - FIDA
 - MA
 - FIDA-IDD
 - 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
 - MLTCP
 - PACE
 - MAP
 - FIDA
 - MA
 - FIDA-IDD
 - 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, including any technologies, special techniques, skills or abilities that the organization considers necessary to accomplish the goals and objectives of this RFP;
 - 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
 - MLTCP
 - PACE
 - MAP
 - FIDA
 - MA
 - FIDA-IDD
 - 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
 - MLTCP
 - PACE
 - MAP
 - FIDA
 - FIDA-IDD
 - iii. A description of the bidder's plan to perform all Task Order Related Projects including:
 - Encounter Reimbursement
 - Budget Neutrality
 - Service Based Payment Rate Setting
 - Policy and Financial Management Consulting Services
 - iv. A description of the bidder's plan to perform and meet all reporting requirements associated with Section 4.5 of this RFP;
 - v. 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 DOH edits and reviews;
 - vi. A description of electronic data processing equipment to be utilized;
 - vii. A descriptions of all computer software to be utilized;
 - viii. A description of a Quality Control Plan for the work covered by this RFP;
 - ix. A description of the methods to be utilized to maintain the level of cooperation with DOH necessary for proper performance of all contractual responsibilities and to apprise DOH 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 document 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 said services, including but not limited to travel, materials, equipment, overhead, profit and labor to the satisfaction of DOH 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 DOH and approved. The programs for which one payment shall be made for the initial rate and one payment for each modification are:

<u>Managed Care Program</u>	<u>Rate Develop</u>	<u>Original Rate Package Effective Date</u>	<u>Anticipated Number of Annual Modifications to Original Rate Package*</u>
a. Mainstream Managed Care	Annually	April 1	2 to 3
HIV/SNP	Annually	April 1	2 to 3
HARP	Annually	April 1	2 to 3
b. <i>MLTC Programs</i>	-	-	-
MLTCP	Annually	April 1	4 to 5
PACE	Annually	April 1	4 to 5
MAP	Annually	April 1	4 to 5
FIDA	Annually	April 1	4 to 5
c. MA	Annually	January 1	0
d. Essential Plan	Annually	January 1	1 to 2
e. FIDA-IDD	Annually	January 1	2 to 3

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

- 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 DOH and approved. The programs for which one payment shall be made for the initial risk score completion and one payment for each modification are:

<u>Managed Care Program</u>	<u>Risk Score Develop</u>	<u>Risk Score Effective Date</u>	<u>Anticipated Number of Annual Modifications to Original Risk Score*</u>
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. <i>MLTC Programs</i>	-	-	-
MLTCP	Annually	April 1	1 to 2
PACE	Annually	April 1	1 to 2
MAP	Annually	April 1	1 to 2
FIDA	Annually	April 1	1 to 2
c. Essential Plan	Annually	January 1	1 to 2
d. FIDA-IDD	Annually	January 1	2 to 3

- D. 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 DOH once the work is completed and supporting documentation and rate certification is submitted to DOH 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 DOH's request. These modifications may include, but are not limited to, recipients' age, gender, category of eligibility, level of care, and geographic location.
- E. Payments for service based payment rate setting, financial management and other consultative assistance outlined in Section 4.3 will be made on an hourly basis, in compliance with a developed task order detailing the scope of the work and the staff needed to complete the work. Monthly vouchers may be submitted once the progress report has been submitted to DOH in the agreed format. The requirements for the progress report are included in Section 4.5.B.
- F. 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 hour rates for the job categories listed in Attachment B.
- a. 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 C: Cost Proposal for specific details on each staffing level.
- G. Subcontractor billing arrangements are not subject to the same requirements as this RFP and should be agreed upon between the contractor and the subcontractor, prior to payment for work completed. The contractor should include on the monthly progress report, the subcontractor's work performed and may bill the State the same hourly rate as the contractor or a lump sum price.
- H. 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 proposal must be received by the NYSDOH, no later than the Deadline for Submission of Proposals specified in [Section 1.0](#), (Calendar of Events). Late bids will not be considered.

a. *By E-Mail*

Proposals must also be submitted via separate searchable PDF file electronically through email to OHIPcontracts@health.ny.gov.

NOTE: You should request a receipt containing the time and date received.

Submission of proposals in a manner other than as described in these instructions (e.g., fax) will not be accepted.

7.1 No Bid Form

Bidders choosing not to bid are requested to complete the No-Bid form [Attachment 2](#).

8.0 METHOD OF AWARD

8.1 General Information

DOH 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 offerers” shall be selected for award (State Finance Law, Article 11, §163(1)(j)).

DOH at its sole discretion, will determine which proposal(s) best satisfies its requirements. DOH 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 document 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 DOH to clarify the contents of their proposals. Other than to provide such information as may be requested by DOH, 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 MWBE participation.

8.2 Submission Review

DOH 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 DOH, 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 DOH 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 technical 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 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 proposals 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 evaluation is **30% (up to 30 points)** of the final score.

8.5 Composite Score

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

8.6 Interviews

For all bids, and as part of the bid review process, DOH reserves the right to interview proposed project participants. The purpose of an interview is to allow the evaluators to validate the Bidder's experience and qualifications.

8.7 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 qualifications to propose (Section 3.0).

8.8 Best and Final Offers

DOH reserves the right to request best and final offers. In the event DOH 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.

8.9 Award Recommendation

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

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

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 Determination](#)
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](#)

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 #18714-Actuarial Rate Certification Services and Support		
FOR THE ADMINISTRATIVE PROPOSAL		
RFP §	SUBMISSION	INCLUDED
§ 6.1.A	Attachment 1 – Bidder’s Disclosure of Prior Non-Responsibility Determinations, completed and signed.	<input type="checkbox"/>
§ 6.1.B	Freedom of Information Law – Proposal Redactions (If Applicable)	<input type="checkbox"/>
§ 6.1.C	Attachment 3- Vendor Responsibility Attestation	<input type="checkbox"/>
§ 6.1.D	Attachment 4 - Vendor Assurance of No Conflict of Interest or Detrimental Effect	<input type="checkbox"/>
§ 6.1.E	M/WBE Participation Requirements:	<input type="checkbox"/>
	Attachment 5 Form 1	<input type="checkbox"/>
	Attachment 5 Form 2 (If Applicable)	<input type="checkbox"/>
§ 6.1.F	Attachment 7 - Bidder’s Certified Statements, completed & signed.	<input type="checkbox"/>
§ 6.1.G	Attachment 6- Encouraging Use of New York Businesses	<input type="checkbox"/>
§ 6.1.H	Attachment 9 – References	<input type="checkbox"/>
§ 6.1.I	Attachment 10 - Diversity Practices Questionnaire	<input type="checkbox"/>
§ 6.1.J	Attachment 11 - Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination	<input type="checkbox"/>
FOR THE TECHNICAL PROPOSAL		
RFP §	SUBMISSION	INCLUDED
§ 6.2.A	Title Page	<input type="checkbox"/>
§ 6.2.B	Table of Contents	<input type="checkbox"/>
§ 6.2.C	Documentation of Bidder’s Eligibility (Requirement)	<input type="checkbox"/>
§ 6.2.D	Technical Proposal Narrative	<input type="checkbox"/>
FOR THE COST PROPOSAL REQUIREMENT		
RFP §	REQUIREMENT	INCLUDED
§ 6.3	Attachment B- Cost Proposal	<input type="checkbox"/>

ATTACHMENT B

COST PROPOSAL

Name of Bidder: _____

A. DELIVERY BASED PRICING: Managed Care Rate Setting Functions

1. Managed Care Programs Rate Setting

Submit a price in the last two columns that reflect the total price for the completion of the annual rate for each of the programs below, and the price for each rate modification. This rate will be held firm for years one (1) through three (3) of the contract. See Section 5.4 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, 5.4 and 6.3 of this RFP.

<u>Managed Care Program</u>	<u>Effective Date</u>	<u>Rate Price</u>	<u>Modification Price</u>
a. Mainstream Managed Care	April 1		
HIV/SNP	April 1		
HARP	April 1		
b. <i>MLTC Programs*</i>	--	--	--
MLTCP	April 1		
PACE	April 1		
MAP	April 1		
FIDA	April 1		
c. MA	January 1		--
d. Essential Plan	January 1		
e. FIDA-IDD	January 1		

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

2. Managed Care Programs Risk Score

Submit a price in the last two columns that reflect the total price for the annual risk score completion for each of the programs below, and the price for each risk score modification. This rate will be held firm for years one (1) through three (3) of the contract. See Section 5.4 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, 5.4 and 6.3 of this RFP.

<u>Managed Care Program</u>	<u>Risk Score Effective Date</u>	<u>Risk Score Development Price</u>	<u>Modification Price</u>
a. Mainstream Managed Care	April 1		
HIV/SNP	April 1		
HARP	April 1		
b. <i>MLTC Programs*</i>	-	-	-
MLTCP	April 1		
PACE	April 1		
MAP	April 1		
FIDA	April 1		
c. Essential Plan	January 1		
d. FIDA-IDD	January 1		

**This is just a title, does not require a risk score development or modification price*

B. HOURLY BASED PRICING: Task Order Based Projects (Service Based Payment Rate Setting Functions and Policy and Financial Management Consulting Services)

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. 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 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.

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	\$	9,600	\$	
Level 2	\$	14,400	\$	
Level 3	\$	8,000	\$	
Total			\$	

**This is an annual estimate. Actual hours may increase or decrease based on the need of the State. It is estimated that 25,750 of these hours will be allocated to policy and financial management consulting services, 6,000 of these hours for OASAS service based payment rate setting functions and 250 hours for Foster Care service based payment rate setting functions, annually.*

These hourly rates will be held firm for years one (1) through three (3) of the contract. See Section 5.4 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

1. 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 January 2020, there are a total of 4,169,377 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/mc_managed_care_fhp_hiv-snp_model_contract.pdf

Known future Transition of Services to Managed Care as of September 2015: January 1, 2017 is the targeted implementation date for behavioral health services for children in New York City to transition to Managed Care, and July 1, 2017 is the expected implementation date for the children’s transition for the rest of the state.

i. HIV/Special Needs Plan (SNP)

The AIDS Institute oversees three HIV Special Needs Plans (SNPs) that are currently operational only in New York City. 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 January 2020, there are 14,092 individuals enrolled in HIV SNPs, mostly persons who are HIV-infected and their uninfected dependents.

ii. 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.

a. 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.

There is also a Fully Integrated Duals Advantage (FIDA) MLTC demonstration that ended December 31, 2019. This model also provided long term care services similar to the other MLTC programs. There are still retroactive rate-setting functions for this demonstration, however, these plans no longer serve members.

i. 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.

ii. 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 May 1, 2015.

iii. 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.

iv. Fully Integrated Dual Advantage (FIDA)

The Fully Integrated Duals Advantage demonstration ended December 31, 2019. It was a three-year demonstration program that was a collaboration between NYSDOH and CMS. FIDA participants received Medicare services (including Part D prescription drugs) and Medicaid long term care services as well as behavioral health, wellness programs, and home and community based waiver services through one plan. FIDA plans received a capitated payment from both Medicare and Medicaid. Central to the FIDA program was an interdisciplinary approach in which care is person-centered and based on the participant's specific preferences and need. This also includes the delivery of services with respect to linguistic and cultural competence and dignity.

The program was ended with most enrollment transitioning to the MAP program.

b. Medicaid Advantage (MA)

The Medicaid Advantage program allows dual-eligible Medicaid recipients to receive a covered copayment and certain Medicaid covered services. A specific Medicare Advantage benefit package must be offered by plans to participate in this model. Plans receive, in addition to the Medicare capitation, Medicaid capitation which covers co-payments, any supplemental Medicare premium, certain limited services covered by Medicaid but not Medicare, such as inpatient mental health in excess of the 190 day lifetime limit, non-Medicare covered home care, private duty nursing, dental (optional) and non-emergency transportation (optional).

c. Essential Plan (EP)

Through the Basic Health Program, called Essential Plan in New York, states can provide coverage to 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 200 percent of the federal poverty level (FPL). 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.

d. Fully Integrated Duals Advantage for Individuals with Developmental Disabilities (FIDA-IDD)

Fully Integrated Duals Advantage for Individuals with Developmental Disabilities (IDD-FIDA) is expected to potentially enable enrollment of dual eligibles of Medicaid and Medicare, for individuals with Developmental Disabilities. The IDD-FIDA program began enrolling dual eligibles in April 2016. This program is monitored by the Office of Persons with Developmental Disabilities (OPWDD).

2. 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:

i. 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.

ii. 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.

iii. 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.

iv. 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.

v. 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.

vi. 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.

vii. 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.

viii. 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.

ix. 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.

x. 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.

xi. 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.

- i. 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.

- ii. 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.

- iii. 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.

iv. Prevocational Services

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