

ATTACHMENT A

SECTION C

DESCRIPTIONS, SPECIFICATIONS, STATEMENT OF WORK

C.1 SCOPE

C.1.1 The District of Columbia (District), Department of Health Care Finance (DHCF), Office of Rates, Reimbursement and Financial Analysis (ORRFA) is seeking a General Services Administrator (GSA) Contractor to provide Actuarial Consulting Services to the Department of Health Care Finance. Contractor shall provide actuarially sound capitation rates that have been developed in accordance with accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under Contract; and have been certified as meeting the requirements of regulation by actuaries who meet the qualification standards established by American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

C.2 APPLICABLE DOCUMENTS

C.2.1 Contractor shall comply with the most recent versions and future revisions to all Federal and District Laws, Court Orders, rules and regulations, policies and subsequent amendments in the development of capitation rates to health services and provision of health care and coverage. The following applicable documents are incorporated by reference and are available electronically as described below:

C.2.1.1 Title XIX of the Social Security Act, the Medicaid Statute;

C.2.1.2 Balanced Budget Act of 1997, P.L. 105-33;

C.2.1.3 Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs under Section 1128 of the Social Security Act (42 U.S.C. § 1320a-7);

C.2.1.4 Civil Monetary Penalties under Section 1128A of the Social Security Act (42 U.S.C. § 1320a-7a);

C.2.1.5 Criminal Penalties for Acts Involving Federal Health Care Programs under Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b);

C.2.1.6 Standards for Information Transactions and Data Elements under Section 1173 of the Social Security Act (42 U.S.C. § 1320d-2);

- C.2.1.7 The District of Columbia State Plan for Medical Assistance under Section 1902 of the Social Security Act (42 U.S.C. § 1396a);
- C.2.1.8 Definitions under Section 1905 of the Social Security Act (42 U.S.C. § 1396d);
- C.2.1.9 Payment for Covered Outpatient Drugs under Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8);
- C.2.1.10 Terms and provisions of the waiver of federal law granted to the District by the Secretary of Health and Human Services under Section 1915(b) of the Social Security Act (42 U.S.C. § 1396n(b)) or Section 1115 of the Social Security Act (42 U.S.C. § 1315);
- C.2.1.11 Provisions Related to Managed Care under Section 1932 of the Social Security Act (42 U.S.C. § 1396u-2);
- C.2.1.12 Section 504 of the Rehabilitation Act (29 U.S.C. § 794);
- C.2.1.13 Americans with Disabilities Act (ADA) (42 U.S.C. § 12101 *et seq.*);
- C.2.1.14 Confidentiality of Alcohol and Drug Abuse Patient Records under 42 C.E.R. Part 2;
- C.2.1.15 Medicare+Choice Program Provisions under 42 C.E.R. Part 422;
- C.2.1.16 State Organization and General Administration under 42 C.E.R. Part 431;
- C.2.1.17 Federal Financial Participation under 42 C.E.R. Part 434 Subpart F and Implementing Federal Regulations under 42 C.E.R. § 434 *et seq.*;
- C.2.1.18 State Organization and General Administration under 42 C.E.R. Part 435;
- C.2.1.19 Managed Care under 42 C.E.R. Part 438;
- C.2.1.20 Services: General Provisions under 42 C.E.R. Part 440 and Services: Requirements and Limits Applicable to Specific Services under 42 C.E.R. Part 441;
- C.2.1.21 Payment for Services under 42 C.E.R. Part 447;
- C.2.1.22 Provider Agreements and Supplier Approval under 42 C.E.R. Part 489;
- C.2.1.23 District of Columbia Medical Assistance Program under D.C. Code § 1-307.02;

- C.2.1.24 Insurance and Securities, D.C. Code § Title 31;
- C.2.1.25 Health Maintenance Organizations, D.C. Code § 31-34 et seq.
- C.2.1.26 District of Columbia Mental Health Information Act, D.C. Code §§ 7-1201.01 – 7-1208.07;
- C.2.1.27 Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage, D.C. Code § 31-31 *et seq.*;
- C.2.1.28 22 DCMR § 33 (published at 48 D.C. ReF. 9140);
- C.2.1.29 Court Orders pertaining to *Salazar v. The District of Columbia et al.*;
- C.2.1.30 Patient Protection and Affordable Care Act (PPACA) and the Health Care Education Reconciliation Act (HCERA) of 2010;
- C.2.1.31 Policies, Guidelines and Bylaws of the American Academy of Actuaries
- C.2.1.32 Terms and provisions of the Actuarial Standards Board
- C.2.1.33 Health Benefit Exchange Authority Financial Sustainability Act of 2014. In April 2014, DC City Council approved a broad tax on all health-related insurance products sold in the District of Columbia. In the first year, a 1 percent (1%) tax will be assessed on insurance premiums paid annually.

All laws listed above shall specifically include and incorporate any implementing regulations promulgated in accordance with the laws.

C.3 DEFINITIONS

- C.3.1 **Actuarial Services:** Method(s) to determine, assess and plan for the financial impact of risk. Actuaries use mathematical and statistical models to evaluate risk in the insurance and finance industries.
- C.3.2 **Actuarially Sound Capitation Rates:** Rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered, and the services to be furnished under the contract; and have been certified, as meeting the requirements of this paragraph, by Actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.
- C.3.3 **Capitation Rates:** Payments agreed upon in a capitation contract by an MCO or CASSIP and the DHCE. A fixed, pre-arranged, per member per month payment received by the health plan.

- C.3.4 **Child and Adolescent Supplemental Security Income Program (CASSIP):** Managed Care program for children and adolescents with special health care needs.
- C.3.6 **Contractor:** An Actuary or Actuarial organization contracted with the District’s Department of Health Care Finance and including any of the Actuary’s employees, Providers, agents, or contractors.
- C.3.7 **Cost Ceiling:** Price control or limit on the amount charged for a product or service.
- C.3.8 **DC Exchange Tax:** Health Benefit Exchange Authority Financial Sustainability Act of 2014. A broad tax on all health-related insurance products sold in the District of Columbia.
- C.3.8 **DC Healthcare Alliance Program:** A public program designed to provide medical assistance to needy District residents who are not eligible for federally-financed Medicaid benefits. The Alliance Program provides comprehensive coverage of health care services for eligible residents of the District.
- C.3.9 **District:** Refers to the Government of the District of Columbia.
- C.3.10 **District of Columbia Healthy Families Program (DCHFP):** The District’s combination of the Medicaid Program and the Children’s Health Insurance Program (CHIP).
- C.3.11 **Encounter Data:** A record or report of any encounter provided to an Enrollee through the auspices of the MCO. This includes records or reports on all services rendered by the MCO, including services delivered by providers or subcontracted vendors under capitation, in addition to those services that the MCO paid for on a fee-for-service basis. Records or reports of encounters should contain all of the required data elements in the HIPAA EDI transaction sets as well as data elements required under trading partner agreements between DHCF’s fiscal agent and the MCO.
- C.3.12 **Health Insurance Provider Fee:** Section 9010 of the Patient Protection and Affordable Care Act (ACA) imposes a fee on each covered entity engaged in the business of providing health insurance for United States health risks.
- C.3.12 **Immigrant Children Program:** Undocumented children, 0 through twenty years of age that do not qualify for Medicaid or CHIP.
- C.3.13 **Independent Contractor:** Any person or organization to which Contractor has contracted or delegated some of its actuarial functions, services or responsibilities.
- C.3.14 **Invoice:** An itemized bill for services provided that contains individual prices, total charge and the terms or description of the services.

- C.3.15 **Managed Care Organization (MCO):** An entity that has (or is seeking to qualify for) a Contract and is:
- C.3.15.1 A Federally qualified HMO that maintains written policies and procedures that meet the advance directive requirements of 42 C.E.R. Part 489, Subpart I; or
- C.3.15.2 Any public or private entity that:
- C.3.15.2.1 Makes the services it provides to Enrollees as accessible in terms of timeliness, amount duration, and scope as those services are to other Medicaid beneficiaries in the District;
- C.3.15.2.2 Meets the solvency standards defined in 42 C.E.R. § 438.116; and
- C.3.15.2.3 Complies with the requirements of the D.C. HMO Act, D.C. Code Section 31-34
- C.3.16 **Medicaid Management Information System (MMIS):** A federally required mechanized claims processing and information retrieval system. The objectives of this system and its enhancements include the Title XIX program control and administrative costs; service to beneficiaries, providers and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.
- C.3.17 **Protected Health Information (PHI):** Individually identifiable health information that is:
- C.3.17.1 Transmitted by electronic media;
- C.3.17.2 Maintained in electronic media; or
- C.3.17.3 Transmitted or maintained in any other form or medium.
- C.3.17.2 Protected Health Information excludes individually identifiable health information:
- C.3.17.2.1 In education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g;
- C.3.17.2.2 In records described at 20 U.S.C. 1232g(a)(4)(B)(iv);
- C.3.17.2.3 In employment records held by a covered entity in its role as employer; and
- C.3.17.2.4 Regarding a person who has been deceased for more than 50 years.
- C.3.18 **Risk-Adjusted Capitation Rates:** Payment to health plans which reflects fixed payment amounts per member per month and then is adjusted further to take into account the lower or higher costs of providing care to individuals or groups of individuals, based on health status or pharmacy utilization.

- C.3.19 **Risk-Based Capital (RBC):** A method of measuring the minimum amount of capital appropriate for a reporting entity (MCOs and CASSIP) to support its overall business operations in consideration of its size and risk profile.
- C.3.20 **Risk Corridor:** A risk sharing mechanism in which the District and contractors share in both profits and losses that fall outside of certain predetermined threshold amounts specified in the contract, so that after an initial corridor in which a contractor is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits.
- C.3.21 **Risk Sharing Arrangement:** See definition for Risk Corridor in C.3.20
- C.3.22 **Stop-Loss Arrangement:** Protection against the risk of large losses or severe adverse claim experience.
- C.3.23 **Subcontract:** Any written agreement between Contractor and another party that requires the other party to provide services or items that Contractor is obligated to furnish under the Contract. Subcontracts shall incorporate the requirements found in **Sections G.1**.

C.4 BACKGROUND

- C.4.1 The Department of Health Care Finance (DHCF) is the single state agency with the responsibility for implementation and administration of the District of Columbia's Medicaid Program (Title XIX of the Social Security Act) and Children's Health Insurance Program (CHIP, Title XXI of the Social Security Act). DHCF is also responsible for administering: (1) the D.C. Health Care Alliance Program (Alliance), a health benefits program for low-income individuals who do not qualify for Medicaid; (2) the Immigrant Children's program, which covers undocumented children up to age 21 and do not qualify for Medicaid or CHIP; (3) the District's Child and Adolescent Supplemental Security Income Program (CASSIP), the District's managed care program for children and adolescents with special health care needs.
- C.4.2 DHCF currently contracts with MCOs to ensure the delivery of quality health care under the D.C. Healthy Families Program (DCHFP) to District residents enrolled in the Temporary Assistance to Needy Families (TANF) Medicaid, CHIP, the Immigrant Children's Program, and the Alliance Program. For these populations, enrollment in an MCO is mandatory. Medicaid beneficiaries who qualify for Medicaid as aged, blind or disabled (ABD) are not required or permitted to enroll in MCOs.

C.4.3 The District also contracts with one (1) organization to manage the delivery of health care to individuals enrolled in the Child and Adolescent Supplemental Security Income Program (CASSIP). Enrollment in CASSIP is voluntary.

C.4.4 The District contracts with three (3) MCOs, which are for one base year with the option of renewal for four (4) additional years (“option years”) and became effective July 1, 2013. The contract with the CASSIP became effective **August 1, 2008**. It is also a one (1) year contract with four (4) additional option years. Approximately **177,000** individuals are currently enrolled in the three MCOs. Approximately **5,800** individuals are enrolled in the CASSIP.

C.4.5 The MCO contracts are full risk contracts. The CASSIP contract involves risk-sharing via a risk corridor and stop-loss reinsurance.

C.4.6 **Goals and Objectives**

The District is seeking to contract with an organization to provide, but not limited to rate setting activities that result in actuarially sound capitation rates to the District’s Medicaid Managed Care Organizations (MCOs) and Child and Adolescent Supplemental Security Income Program (CASSIP). The Contractor will assist with development of the quarterly MCO Report Card and assessment and evaluation of encounter data submitted by the health plans. The Managed Care contracts are risk-based and the risk is shared between DHCF and the CASSIP. The capitation rates must be certified, by Actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board. DHCF is unable to independently perform these required functions due to the absence of Actuaries on staff at the Agency.

C.5 REQUIREMENTS

C.5.1 The Contractor shall perform and coordinate with DHCF the following actuarial services:

C.5.1.1 Provide a contact person responsible for interaction with the DHCF staff and have primary responsibility for contract deliverables. The Contractor shall be available in the District for face-to-face interaction as needed per DHCF; and

C.5.1.2 The Contractor shall be required to prepare and be available to provide periodic and routine process reports and contract related tasks, as necessary, to D.C City Council, the Mayor’s Office, the MCOs, the CASSIP, CMS and other advisory or oversight entities on any aspect of managed care rate setting with which the Contractor is involved.

C.5.1.3 Calculate and develop risk-adjusted capitation rates for three (3) MCO contracts every six (6) months, including:

C.5.1.3.1 Evaluate existing capitation rates and the methodology used to determine the risk-adjusted capitation rates; make recommendations to DHCF on possible revisions to the

rate setting development and methodology for the Medicaid, CHIP and Alliance Programs;

- C.5.1.3.2 Validate the data submitted by the MCOs for the purpose of risk-adjusted capitation rate calculation;
- C.5.1.3.3 Develop and support rate setting methodologies for DCHF for the contract period;
- C.5.1.3.4 Perform an actuarial analysis of the rate structure for Medicaid Enrollees in the MCOs consistent with the requirements of the Centers for Medicare and Medicaid Services (CMS), including the Affordable Care Act (ACA);
- C.5.1.3.5 Calculate and validate the annual Health Insurance Providers Fee (HIPF) as required for each qualifying MCO; and
- C.5.1.3.6 Calculate and validate the DC Exchange Tax as required for each qualifying MCO.
- C.5.2. Contractor shall perform an actuarial analysis of the rate structure for the DC Healthy Families Program (DCFHP) and DC Healthcare Alliance Enrollees in the MCOs in accordance with the standards established by the American Academy of Actuaries.
- C.5.3 Contractor shall prepare an actuarial certification letter for submission to CMS stating that the risk-adjusted capitation rates for Medicaid Enrollees are actuarially sound, have been developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract; in accordance with 42 C.E.R. § 438.6(c)(1)(i)(C).
- C.5.4 Contractor shall respond to written and oral inquiries from CMS, DHCF, and other stakeholders identified by DHCF regarding rate-development methodology and rates.
- C.5.5 Contractor shall assist the District in implementing the rates with the MCOs, including presentation of the data books and rate setting methodology and development to the MCOs and other interested parties; once the rates have been developed.
- C.5.6 Contractor shall provide an actuarial opinion and determine impact on premium rate for any changes in benefits to MCOs as directed by DHCE.
- C.5.7 Contractor shall calculate and implement capitation rates for CASSIP, including:
 - C.5.7.1 Evaluate existing capitation rates and the methodology used to determine the capitation rates; and make recommendations to DHCF on possible revisions to its rate setting methodology;
 - C.5.7.2 Validate the data submitted by the CASSIP for the purpose of capitation rate calculation;
 - C.5.7.3 Support a rate setting methodology for CASSIP, including a risk-sharing arrangement, for the contract period;

- C.5.7.4 Calculate the capitation rates, risk corridor, stop loss and reinsurance parameters for the CASSIP for contracts beginning in 2015;
- C.5.7.5 Perform an actuarial analysis to provide capitation rate adjustments for the CASSIP consistent with the requirements of the Centers for Medicare and Medicaid Services (CMS), including the Affordable Care Act (ACA);
- C.5.7.6 Calculate and validate the annual Health Insurance Providers Fee (HIPF) as required for each qualifying CASSIP; and
- C.5.7.7 Calculate and validate the DC Exchange Tax as required for each qualifying CASSIP.
- C.5.8 Contractor shall prepare an actuarial certification letter for submission to CMS stating that the capitation rates for the CASSIP are actuarially sound, have been developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract; in accordance with 42 C.E.R. § 438.6(c)(1)(i)(C).
- C.5.9 Contractor shall respond to written and oral inquiries from CMS, DHCF, and other stakeholders identified by DHCF regarding the rate-setting methodology and capitation rates for the CASSIP; in accordance with 42 C.E.R. § 438.6(c)(1)(i)(C).
- C.5.10 Contractor shall assist the District to implement the rates with the CASSIP, including presentation of the data books and rate setting methodology to the CASSIP once the rates have been developed.
- C.5.11 Contractor shall provide an actuarial opinion and determine impact on premium rate for any changes in benefits to CASSIP as directed by DHCE.
- C.5.12 Contractor shall ensure that the methodology developed and rates calculated under all tasks meet all Federal and District of Columbia requirements.
- C.5.13 Contractor shall provide training to DHCF staff regarding the rate setting and development methodologies for the Managed Care and CASSIP, including training agenda and materials for specific sessions and delivery of training related to use of rate setting methodology and capitation rates.
- C.5.14 Contractor shall provide technical assistance to DHCF as needed concerning the rate setting methodologies. Request for assistance will include statistical data analysis, consulting services and litigation support if litigation involves rates or rate setting..
- C.5.15 Contractor shall assist DHCF in the presentation of rate setting methodologies to the D.C. City Council, the Mayor's Office, the MCOs, the CASSIP, and other persons, agencies; and entities designated by DHCF Contractor shall keep DHCF informed of its findings, conclusions, and progress of items in development, and to provide any additional information that may be requested. Contractor shall accompany DHCF to present materials to CMS and/or to connect by telephone as determined by DHCF.

- C.5.16 Contractor shall participate in meetings with the MCOs, CASSIP, and other provider groups, and other concerned parties as determined by DHCF.
- C.5.17 Contractor shall provide documentation detailing methodology background, and calculations per rate cell for current and future waiver years to be used by DHCF for procurement, and waiver application and renewal. This would include documentation and spreadsheets for cost effectiveness and completion of relative narrative portions of the waiver renewal applications in accordance with CMS requirements. Information about DHCF's current waivers are found on dhcf.dc.gov.
- C.5.18 Contractor shall provide additional consultation to DHCF on the actuarial and payment implications of policy proposals under consideration, and develop rate adjustments that are needed based on program changes, and contract modifications, as requested by DHCF.
- C.5.19 Contractor shall provide support to DHCF in estimating managed care program costs in current and future budget cycles; and develop rate trends to be used for future budget development and policy planning.
- C.5.20 Contractor shall provide consulting services to DHCF, as it relates to the financial reporting, and monitoring of the MCOs and CASSIP.
- C.5.21 Contractor shall provide analysis and validation of the managed care plan Encounter Data, including:
 - C.5.21.1 Receive over twenty (20) weekly automated submission report files from the District's MMIS vendor;
 - C.5.21.2 Analyze and document over twenty (20) weekly encountered results from all Managed Care plans and CASSIP, including the number, and type of encounters submitted;
 - C.5.21.3 Advise DHCF of any unusual or new encountered denial issues, late and absent files;
 - C.5.21.4 Coordinate and schedule conference calls with three (3) MCOs and one (1) CASSIP to discuss any anomalies or questions arising from weekly submissions;
 - C.5.21.5 Prepare agenda, and host conference calls for bi-weekly encounters. Coordinate meetings with designated DHCF staff. Prepare a record of all meetings held, and distribute copies of the minutes of the meetings;
 - C.5.21.6 Review Corrective Action Plans;
 - C.5.21.7 Assist DHCF to identify deficiencies within the MCO and CASSIP, and assist in identifying issues for a corrective action plans (CAPs);
 - C.5.21.8 Provide input into the functionality of MMIS vendor, and propose solutions for the identified issues;
 - C.5.21.9 Reconcile files and reports of irregularities for the MCO and CASSIP entity for Medical clinicians who may need to review and comment on specific provider issues on a monthly basis;

- C.5.21.10 Coordinate agenda, timing and location of quarterly encounter data meetings with all four (4) MCOs;
- C.5.21.11 Prepare quarterly and annual reports on encounter data for DHCF; and
- C.5.21.12 Evaluate the completeness of encounter data via comparisons with other states.
- C.5.22 Contractor shall monitor financial reporting, including:
 - C.5.22.1 Provide quarterly collection of MCO administrative and medical expenditures that comprise medical and administrative loss ratios;
 - C.5.22.2 Perform a quarterly review of CASSIP expenditures to assist DHCF in implementation of risk corridor , and stop-loss arrangements; and
 - C.5.22.3 Perform quarterly collection of financial indicators from three (3) MCOs and one (1) CASSIP.
- C.5.23 Contractor shall develop and prepare a quarterly Report Card that demonstrates the performance of three (3) MCOs performance, including:
 - C.5.23.1 Developing a template for reporting that includes, but not limited to the following:
 - C.5.23.1.1 High-level summary of financial performance;
 - C.5.23.1.2 MCO Financial Reports:
 - C.5.23.1.3 Financial statements submitted to the Department of Insurance, Securities and Banking (DISB);
 - C.5.23.1.4 Monitoring of Risk-Based Capitol (RBC); and
 - C.5.23.1.5 Program growth and MCO profitability.
 - C.5.23.2 High-level view of care coordination metrics and outcomes;
 - C.5.23.3 Detailed view and analysis of Low Acuity Non-Emergent (LANE) visits; and
 - C.5.23.4 Detailed view and analysis of Potentially Preventable Admissions (PPA).
 - C.5.23.5 Monitoring of MCO Expense and Trend Analysis that includes, but not limited to:
 - C.5.23.5.1 Per Member Per Month (PMPM) and Utilization Analysis;
 - C.5.23.5.2 Expenses and Trends; and
 - C.5.23.5.3 Collection, validation and analysis of each MCO financial and encounter data to comprise quarterly outcomes of the items indicated in Section C.5.23.

C.6 KEY PERSONNEL

C.6.1 Contractor shall maintain all Key Personnel to carry out the requirements as defined in Section C.5 above. Key Personnel shall be members of the American Academy of Actuaries; and are considered to be essential to the work being performed under the provisions the Contract.

C.6.2 Contractor shall not reassign Key Personnel or appoint replacements, without written permission from DHCE.

C.6.3 Key Personnel shall include:

C.6.3.1 A Lead Actuary who is:

C.6.3.1.1 A member of the American Academy of Actuaries;

C.6.3.1.2 Has at least five (5) years experience managing similar projects;

C.6.3.2 A Project Manager; who shall be responsible for the logistics of transmitting data, project deliverables, and communicate with parties for the entire project; and attend meetings as needed during contract performance.

C.6.3.3 A Data Manager.

C.6.4 Contractor shall identify the individuals who are Key Personnel upon contract award.

C.7 ORGANIZATIONAL STRUCTURE

C.7.1 Contractor shall have an organizational structure sufficient to ensure:

C.7.1.1 the production of written materials as required by the Contract;

C.7.1.2 attend meetings as directed by DHCF and required by the Contract;

C.7.1.3 resources and staff to fulfill its obligations in a timely manner and of quality that is acceptable to DHCF;

C.7.1.4 experience in developing capitation rates and risk-adjusted rates for the District of Columbia's DCHFP, Alliance and CASSIP;

C.7.1.5 advanced knowledge and expertise with validating encounter data for the District's diverse programs, including but not limited to the DCHFP, Alliance and CASSIP.

C.8 DELIVERABLE SCHEDULE

C.8.1 Unless otherwise directed in writing by the CA, Contractor shall submit three (3) hard copies, one (1) soft copy sent via email, and one (1) CD-Rom (if requested by the CA) for each deliverable below in accordance with the due dates presented in the table below.

C.8.2 The following table describes the Deliverables under the Contract. All Deliverables that describe a notice, notification, or request of DHCF shall be by written letter to the CA describing in detail the required notice, notification or request. In the event that Contractor fails to submit a Deliverable as described in Section C.8 below, DHCF will apply the remedies described in paragraph C.8.3 below.

No.	RFP Section Reference	Deliverable	Due Date
1	C.5.1.2.1	Written report that includes an evaluation of the current MCO risk-adjusted capitation rates and the methodology used to develop the capitation rates	December 1, 2014
2	C.5.1.2.1	Written report that includes recommendations to DHCFP on possible revisions to the rate setting methodology	December 1, 2014
3	C.5.1.2.2	Written report on the validation of the data submitted by the MCOs for the purpose of capitation rate calculation	January 15, 2015
4	C.5.1.2.3	Rate setting methodology and development for DCHFP for 2015	February 1, 2015
5	C.5.1.2.4	Rate structure for the DCHFP population for 2015 The rate structure shall be presented in separate data books for each population in DCHFP (TANF, CHIP, Alliance and Immigrant Children)	February 15, 2015
6	C.5.1.2.5	An actuarial analysis of the rate structure for the DCHFP that is consistent with the requirements of the Centers for Medicare and Medicaid Services (CMS).	February 15, 2015
7	C.5.1.2.5.1	An actuarial analysis of the rate structure for the Healthy DC program rates	December 15, 2015
8	C.5.1.2.5.1	An actuarial analysis of the rate structure for the Alliance program rates	February 15, 2015
9	C.5.1.2.6	An actuarial certification letter for submission to CMS prepared that states, in accordance with 42 C.E.R. § 438.6(c)(1)(i)(C), that the capitation rates for Medicaid Enrollees are actuarially sound, have been developed in	April 1, 2015

No.	RFP Section Reference	Deliverable	Due Date
		accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract	
10	C.5.1.2.7	Responses to written and oral inquiries from CMS regarding rate-setting methodology and rates	Ongoing
11	C.5.1.2.8	Presentation of the data books and rate setting methodology to the MCOs	February 15, 2015
12	C.5.1.3.1	Written report including (1) evaluation of the current capitation rates for CASSIP and the methodology used to determine the capitation rates (including the risk sharing arrangement)	March 1, 2015
13	C.5.1.3.1	Written report including recommendations to DHCFP on possible revisions to the CASSIP rate setting methodology	March 1, 2015
14	C.5.1.3.2	Written report on the validation of the data submitted by the CASSIP for the purpose of capitation rate calculation	April 15, 2015
15	C.5.1.3.3	Rate setting methodology, including a risk-sharing arrangement, for the CASSIP for 2015	May 1, 2015
16	C.5.1.3.4	Rate structure for the CASSIP for 2015	May 15, 2015
17	C.5.1.3.5	An actuarial analysis of the rate structure for the CASSIP that is consistent with the requirements of the Centers for Medicare and Medicaid Services (CMS)	May 15, 2015
18	C.5.1.3.6	An actuarial certification letter for submission to CMS that states, in accordance with 42 C.E.R. § 438.6(c)(1)(i)(C), that the capitation rates for the CASSIP are actuarially sound, have been developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the population to be covered and the services to be furnished under the contract	July 1, 2015
19	C.5.1.3.7	Responses to written and oral inquiries from CMS regarding rate-setting methodology and capitation rates	Ongoing
20	C.5.1.3.8	Presentation of the data book and rate setting methodology	May 15, 2015

No.	RFP Section Reference	Deliverable	Due Date
		to the CASSIP	
21	C.5.1.5	Training materials, schedule of trainings, and completed training attendance lists for training of DHCF staff regarding the rate setting methodologies for DCHFP and CASSIP	March 15, 2015
22	C.5.1.6	Technical assistance to DHCF as needed concerning the rate setting methodologies, including, but not limited to, statistical data analysis	Ongoing
23	C.5.1.7	Assistance to DHCF in presentations of the rate setting methodologies (including preparing presentation materials and participation in the presentations) to the D.C. City Council, the Mayor's Office, the MCOs, the CASSIP, and other persons, agencies and entities designated by DHCF	Ongoing
24	C.5.1.8	Attendance at meetings and presentations at meetings with managed care entities, other provider groups, and other concerned parties, as requested by DHCF	Ongoing
25	C.5.1.10	Consultation to DHCF on the actuarial and payment implications of policy proposals under consideration; development of rate adjustments based on program changes and contract modifications, as requested by DHCF	Ongoing
26	C.5.1.11	Written report (1) estimating Managed Care program costs in current and future budget cycles and (2) developing rate trends to be used for future budget development and policy planning	March 15, 2015
27	C.5.1.9	Written documentation detailing methodology background and calculations per rate cell for current and future waiver years to be used by DHCF for procurement, and waiver application and renewal.	August 1, 2015
28	C.5.1.12	Consultation related to the financial reporting by, and monitoring of, the MCOs and the CASSIP	Ongoing
29	C.5.1.13	Written reports analyzing and validating managed care plan Encounter Data, as requested by DHCF	Monthly

C.8.3 Any reports that are required are to be submitted to DHCF as a deliverable. If the report is not submitted as part of the deliverable, payment during the time period to the Contractor, shall be withheld pending authorization by the CA.