STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

PAGE	ORDER DATE
1 of 2	06/02/16
BUSINESS UNIT	BUYER
25710178	MASON, COURTNEY C

VENDOR NUMBER: 1006592

VENDOR ADDRESS:

MERCER HEALTH & BENEFITS LLC
PO BOX 730182
DALLAS TX 75373-0182

DEPT OF HEALTH & HUMAN SVCS

CONTRACT NUMBER
71799 O4

THE CONTRACT PERIOD IS:

JUNE 13, 2016 THROUGH JUNE 12, 2017

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 84510 O3

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	FINAL PROJECT WORK PLAN	18,985.0000	$	1.0000	18,985.00
2	STAKEHOLDER ENGAGEMENT PLAN P1	14,415.0000	$	1.0000	14,415.00
3	STAKEHOLDER MATERIALS P1	15,565.0000	$	1.0000	15,565.00
4	STAKEHOLDER MEETINGS P1	106,390.0000	$	1.0000	106,390.00
5	SUMMARY REPORT P1	21,130.0000	$	1.0000	21,130.00
6	LTSS DELIVERY ASSESSMENT	99,505.0000	$	1.0000	99,505.00
7	DRAFT REDESIGN PLAN	86,135.0000	$	1.0000	86,135.00
8	STAKEHOLDER ENGAGEMENT PLAN P2	14,420.0000	$	1.0000	14,420.00
9	STAKEHOLDER MATERIALS P2	20,245.0000	$	1.0000	20,245.00
10	STAKEHOLDER MEETINGS P2	106,585.0000	$	1.0000	106,585.00
11	SUMMARY REPORT P2	24,210.0000	$	1.0000	24,210.00

AGENCY SIGNATURE

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DEPT OF HEALTH & HUMAN SVCS

CONTRACT NUMBER
71799 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
12	FINAL REDESIGN PLAN	40,375.0000	$	1.0000	40,375.00
13	STATUS REPORTS	15,750.0000	$	1.0000	15,750.00
	Total Order				**583,710.00**

INITIALS

ADDENDUM ONE to Contract Award

Terms and Conditions
Contract 71799 O4
Long Term Services and Supports Redesign
Between
The State of Nebraska and Mercer Health and Benefits, Inc.

The following Terms and Conditions, Addendum One of Contract 71799 O4 have been reviewed and agreed upon between Mercer Health Benefits, Inc. "Contractor" and the State of Nebraska "State." This addendum will become part of the contract for Long Term Care Services and Supports Redesign. The terms and conditions of this Addendum shall supersede, prevail and govern in the case of any inconsistencies with the Terms and Conditions indicated in Section III of the Request for Proposal.

By signing this Addendum the Contractor guarantees compliance with the provisions stated herein, agrees to the terms and conditions, and certifies Contractor maintains a drug free work place environment.

A. GENERAL

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. Amendment to Contract Award with the most recent dated amendment having the highest priority;
2. Contract Award and any attached Addenda;
3. The Request for Proposal form and the Contractor's Proposal signed in ink;
4. Amendments to RFP and any Questions and Answers; and
5. The original RFP document and any Addenda.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to Contract Award with the most recent dated amendment having the highest priority, 2) Contract Award and any attached Addenda, 3) the signed Request for Proposal form and the Contractor's Proposal, 4) Amendments to RFP and any Questions and Answers, 5) the original RFP document and any Addenda.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. AWARD

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, in whole or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.

By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once intent to award decision has been determined, it will be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html

Grievance and protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchase_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf.

Any protests must be filed by a vendor within ten (10) business days after the intent to award decision is posted to the Internet.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensations, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for services to be covered by any contract resulting from this Request for Proposal.

D. PERMITS, REGULATIONS, LAWS

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

The State of Nebraska shall have the unlimited right to publish, duplicate, use, and disclose all data developed or derived by the Contractor pursuant to this contract.

Notwithstanding anything to the contrary in the Contract, Contractor shall retain all patent, copyright, and other intellectual property rights in the methodologies, methods of analysis, ideas, concepts, know-how, models, tools, techniques, skills, knowledge and experience owned or possessed by Contractor before the commencement of, or acquired by Contractor during or after, the performance of the Services (collectively, "intellectual Property"). To the extent that any of Intellectual Property is embodied in any of the services performed under this contract, the State of Nebraska shall have the unlimited right to publish, duplicate, use, and disclose Intellectual Property for governmental purposes.

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that the State Purchasing Bureau has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any Subcontractors, the Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all Subcontractor (s). Contractor is also responsible for ensuring Subcontractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any Subcontractor to commence work on any Subcontract until all similar insurance required of the Subcontractor has been obtained and approved by the Contractor. Contractor's insurance does not extend to its Subcontractors, but Contractor shall require that its Subcontractors maintain substantially similar insurance to that set forth in the Contract. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Insurance coverages shall function independent of all other clauses in the contract, and in no instance shall the limits of recovery from the insurance be reduced below the limits required by this paragraph.

1. **WORKERS' COMPENSATION INSURANCE**

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Personal Injury and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned and Hired vehicles.

3. **INSURANCE COVERAGE AMOUNTS REQUIRED**

WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
USL&H Endorsement	Statutory
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
SUBROGATION WAIVER	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
LIABILITY WAIVER	
"Commercial General Liability & Commercial Automobile Liability policies shall be primary and any insurance or self-insurance carried by the State shall be considered excess and non-contributory."	

4. **EVIDENCE OF COVERAGE**

The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements, which shall be submitted to the attention of the Buyer.

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
301 Centennial Mall South
Lincoln, NE 68509
Facsimile: (402) 742-1155.

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to DHHS, MLTC when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.
2. The Contractor shall agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

H. INDEPENDENT CONTRACTOR

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the Contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the Contractor's proposal, and the resulting contract. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any Subcontractor's services, the Subcontractor's level of effort, tasks, and time allocation must be clearly defined in the Contractor's proposal. The Contractor shall agree that it will not utilize any Subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified Subcontractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work on the project.

Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or Subcontractor employee.

In respect to its employees, the Contractor agrees to be responsible for the following:

1. any and all employment taxes and/or other payroll withholding;
2. any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. damages incurred by Contractor's employees within the scope of their duties under the contract;

4. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
5. determining the hours to be worked and the duties to be performed by the Contractor's employees.

K. CONTRACT CONFLICTS

Contractor shall insure that contracts or agreements with sub-contractors and agents, and the performance of services in relation to this contract by sub-contractors and agents, does not conflict with this contract.

L. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

The Contractor shall not, at any time, employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project.

M. CONFLICT OF INTEREST

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

N. PROPOSAL PREPARATION COSTS

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this Request for Proposal.

O. ERRORS AND OMISSIONS

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

P. BEGINNING OF WORK

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

Q. ASSIGNMENT BY THE STATE

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

R. ASSIGNMENT BY THE CONTRACTOR

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

S. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal, mandatory requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

T. GOVERNING LAW

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

U. ADVERTISING

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

V. STATE PROPERTY

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

W. SITE RULES AND REGULATIONS

The Contractor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor. All site rules and regulations shall be provided to the Contractor in writing.

X. NOTIFICATION

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II. A., Procuring Office and Contact Person, of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title, and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests, or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

2. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the Contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give

such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Communication about the contract between Contractor and individuals not designated as points of contact by the State is strictly forbidden.

Y. EARLY TERMINATION

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided; or for reimbursable expenses incurred in accordance with the terms and conditions of the contract up to and including the notice date of termination; or for reimbursable expenses incurred in accordance with the terms and conditions of the contract after the notice date of termination but before the effective date of termination, provided said expenses were approved by DHHS in writing.

3. The State may terminate the contract immediately for the following reasons:

   a. If directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. A trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
   d. Fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
   e. An involuntary proceeding has been commenced by any party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
   f. A voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
   g. Contractor intentionally discloses confidential information;
   h. Contractor has or announces it will discontinue support of the deliverable;
   i. Second or subsequent documented "vendor performance report" form deemed acceptable by the Agency; or
   j. Contractor engaged in collusion or actions which could have provided Contractor an unfair advantage in obtaining this contract.

Z. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of any termination, and advise the Contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

AA. BREACH BY CONTRACTOR

The State may terminate the contract, in whole or in part, if the Contractor fails to perform its obligations under the contract in a timely and proper manner. The State may, by providing a written notice of default to the Contractor, allow the Contractor to cure a failure or breach of contract within a period of thirty (30) calendar days (or longer at State's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing the Contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

BB. ASSURANCES BEFORE BREACH

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the Contractor shall deliver assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

CC. ADMINISTRATION – CONTRACT TERMINATION

1. Contractor must provide confirmation that upon contract termination all deliverables prepares in accordance with this agreement shall become the property of the State of Nebraska; subject to the ownership provision (section E) contained herein, and is provided to the State of Nebraska at no additional cost to the State.

2. Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days. Notwithstanding the above, Contractor may retain one copy of any information as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures.

3. Contractor shall be permitted to retain copies of Confidential Information, but only in accordance with its legal, disaster recovery and records retention requirements, subject to all confidentiality obligations under the Contract.

DD. PENALTY

In the event that the Contractor fails to perform any substantial obligation under the contract, the State may withhold all monies due and payable to the Contractor, without penalty, until such failure is cured or otherwise adjudicated. Failure to meet the dates for the deliverables as agreed upon by the parties may result in an assessment of penalty due the State of $1,000 dollars per day, until the deliverables are approved. Contractor will be notified in writing when penalty will commence.

EE. FORCE MAJEURE

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

FF. PROHIBITION AGAINST ADVANCE PAYMENT

Payments shall not be made until contractual deliverable(s) are received and accepted by the State.

GG. PAYMENT

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services.

HH. INVOICES

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Invoices must classify the contract deliverable (per IV.F Deliverables) associated with each expense. Invoices are to be submitted no later than 30 calendar days following MLTC's approval of deliverable(s).

Should the State decide to award the scope of work in IV.C.4, the Contractor shall invoice DHHS monthly for actual hours worked on the 5th of the month following the month the work occurred. Invoices must provide at a detailed level, the work produced by individual personnel and the hours worked.

All invoices submitted for deliverables other than work conducted within IV.C.4 must follow the requirements set forth in the first paragraph of Section III.II.

A final invoice must be submitted within 30 days of the last day of the contract period.

Invoices should be sent to:

DHHS-MLTC Attn: Managed Care & HCBS Administrator
Post Office Box 95026
Lincoln, NE 68509

The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

II. RIGHT TO AUDIT

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit contract. The State and its authorized representatives shall have, upon reasonable prior, written notice, the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this contract kept by or under the control of the Contractor, including, but not limited to those kept by the Contractor, its employees, agents, assigns, successors, and Subcontractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence. Any audits involving the State physically reviewing records at the Contractor's place of business shall be during normal business hours.

Contractor shall, at all times during the term of this contract and for a period of five (5) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. If an audit has been initiated and audit findings have not been resolved at the end of six (6) years, the records must be retained until resolution of the audit finding. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the

event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and Subcontractors, and the obligations of these rights shall be explicitly included in any Subcontracts or agreements formed between the Contractor and any Subcontractors to the extent that those Subcontracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor. Contractor shall have a reasonable opportunity to review and challenge the results of an audit, but in no case shall that extend the period of time required for payment.

JJ. TAXES

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

KK. INSPECTION AND APPROVAL

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times, made upon reasonable prior written notice, done during normal business, and in a manner that will not unreasonably delay work.

LL. CHANGES IN SCOPE/CHANGE ORDERS

The State may, upon the written agreement of Contractor, make changes to the contract within the general scope of the RFP. The State may, at any time work is in progress, by written agreement, make alterations in the terms of work as shown in the specifications, require the Contractor to make corrections, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, or a pro-rated value.

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification.

Changes or additions to the contract beyond the scope of the Request for Proposal are not permitted; however, this Request for Proposal must meet all applicable federal legal requirements and regulations, including but not limited to Medicaid laws, rules and regulations, and any future amendments to this Request for Proposal that are required to bring Nebraska into compliance with federal Medicaid law shall be deemed part of the scope of the requested bid.

MM. SEVERABILITY

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

NN. CONFIDENTIALITY

All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be handled in accordance with federal and state law, and ethical standards. The Contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a Contractor; Contractor shall notify the State immediately of said breach and take immediate corrective action. The Contractor's subcontracts must explicitly state expectations about the confidentiality of information, and the subcontractor is held to the same confidentiality requirements as the consultant. Any releases of information to the media, the public, or other entities require prior approval from MLTC. This clause shall be included in all subcontracts.

It is incumbent upon the Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to Contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a Contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

OO. PROPRIETARY INFORMATION

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. **All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal, and provide supporting documents showing why such documents should be marked proprietary.** The separate package must be clearly marked PROPRIETARY on the outside of the package. **Bidders may not mark their entire Request for Proposal as proprietary.** Bidder's cost proposals may not be marked as proprietary information. Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

PP. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

By submission of this proposal, the bidder certifies, that it is the party making the foregoing proposal and that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted the proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

QQ. STATEMENT OF NON-COLLUSION

The proposal shall be arrived at by the bidder independently and be submitted without collusion with, and without any direct or indirect agreement, understanding or planned common course of action with, any person; firm; corporation; bidder; Contractor of materials, supplies, equipment or services described in this RFP. Bidder shall not collude with, or attempt to collude with, any state officials, employees or agents; or evaluators or any person

involved in this RFP. The bidder shall not take any action in the restraint of free competition or designed to limit independent bidding or to create an unfair advantage.

Should it be determined that collusion occurred, the State reserves the right to reject a bid or terminate the contract and impose further administrative sanctions.

RR. BEST AND FINAL OFFER

The State will compile the final scores for all parts of each proposal. The award may be granted to the highest scoring responsive and responsible bidder. Alternatively, the highest scoring bidder or bidders may be requested to submit best and final offers. If best and final offers are requested by the State and submitted by the bidder, they will be evaluated (using the stated criteria), scored, and ranked by the Evaluation Committee. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

SS. ETHICS IN PUBLIC CONTRACTING

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator, employee or evaluator based on the understanding that the receiving person's vote, actions or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau or any evaluator.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.
If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

TT. INDEMNIFICATION

1. GENERAL

The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Contractor agrees it will at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall at the Contractor's sole cost and expense promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same

functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

Contractor's indemnity obligations under this section, paragraph 2, shall not apply to any claim for infringement or misappropriation of intellectual property rights to the extent any such infringement or misappropriation is caused by: (i) information or materials provided by the State or a third party other than Contractor's subcontractors, if any, (ii) modifications made by the Sate or a third party other than the Contractor's subcontractors to services, work produce, or Contractor's other materials provided to the State in connection with the services, or any parts thereof, or (iii) the State's use of services, work product or such other materials or any parts thereof, in a manner materially inconsistent with the terms of the Contract.

3. **PERSONNEL**
The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the Contractor.

4. **SELF-INSURANCE**
The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 *et seq.* and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

5. **ALL REMEDIES AT LAW**
Nothing in this agreement shall be construed as an indemnification by one party of the other for liabilities of a party or third parties for property loss or damage or death or personal injury arising out of and during the performance of this lease. Any liabilities or claims for property loss or damages or for death or personal injury by a party or its agents, employees, contractors or assigns or by third persons, arising out of and during the performance of this lease shall be determined according to applicable law.

UU. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request that contract comply with the changed standard at a cost mutually acceptable to the parties.

VV. ANTITRUST

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

WW. DISASTER RECOVERY/BACK UP PLAN

Contractor shall maintain a Disaster Recovery and Business Resilience/Continuity Plan that addresses reasonably foreseeable events that could impair Contractor's ability to render the services under this contract. Contractor shall provide, at the State's request, a State of Recoverability that details Contractor's level of readiness to respond and recover from disaster or crisis situations. This Statement shall include a summary of the status of Contractor's Disaster Recovery and Business Resilience/Continuity Plan, programs and testing activities, as they relate to the services under this contract.

XX. TIME IS OF THE ESSENCE

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

YY. RECYCLING

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per Neb. Rev. Stat. § 81-15,159.

ZZ. DRUG POLICY

Contractor certifies that it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

AAA. EMPLOYEE WORK ELIGIBILITY STATUS

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an newly hired employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at: http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the Request for Proposal response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

BBB. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

The Contractor, by signature to this RFP, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The Contractor also agrees to include the above requirements in any and all Subcontracts into which it enters. The Contractor shall immediately notify the Department if, during the term of this contract, Contractor becomes debarred. The Department may immediately terminate this contract by providing Contractor written notice if Contractor becomes debarred during the term of this contract.

Contractor, by signature to this RFP, certifies that Contractor has not had a contract with the State of Nebraska terminated early by the State of Nebraska. If Contractor has had a contract terminated early by the State of Nebraska, Contractor must provide the contract number, along with an explanation of why the contract was terminated early. Prior early termination may be cause for rejecting the proposal.

CCC. POLITICAL SUB-DIVISIONS

The Contractor may extend the contract to political sub-divisions conditioned upon the honoring of the prices charged to the State. Terms and conditions of the Contract must be met by political sub-divisions. Under no circumstances shall the State be contractually obligated or liable for any purchases by political sub-divisions or

other public entities not authorized by Neb. Rev. Stat. § 81-145, listed as "all officers of the state, departments, bureaus, boards, commissions, councils, and institutions receiving legislative appropriations." A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

DDD. OFFICE OF PUBLIC COUNSEL

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

EEE. LONG-TERM CARE OMBUDSMAN

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

FFF. **LIMITATION OF LIABILITY**

1. The aggregate liability of the Contractor to the State for any and all Losses arising out of or relating to the provision of services shall not exceed one times the compensation for the services giving rise to such Loss. The Contractor shall have no liability for the acts or omissions of any third party (other than its subcontractors).

2. In no event shall the Contractor or the State be liable for any loss of profit or incidental, consequential, special, indirect, punitive or similar damages. This provision shall apply to the fullest extent permitted by law. Nothing in this section limiting the liability of the Contractor shall apply to any liability that has been finally determined by a court to have been caused by the fraud of the Contractor.

3. For purposes of this contract, "Loss" means damages, claims, liabilities, losses, awards, judgments, penalties, third party claims, interest, costs and expenses, including reasonable attorneys' fees, whether arising under any legal theory including, but not limited to claims sounding in tort (such as for negligence, misrepresentation or otherwise), contract (whether express or implied), by statute, or otherwise, claims seeking any kind of damages and claims seeking to apply any standard of liability such as negligence, statutory violation or otherwise. For the avoidance of doubt, multiple claims arising out of or based upon the same act, error or omission, or series of continuous, interrelated or repeated acts, errors or omissions shall be considered a single Loss.

4. This limitation shall be exclusive of insurance, indemnities, and any other express liability of the contractor contained herein, including that Contractor shall refund the pro rata price paid during any period of default, not to exceed 100% of the total contract price.

GGG. AMENDMENT

This contract may be modified only by written amendment, executed by both parties. No alteration or variation of the terms and conditions of this contract shall be valid unless made in writing and signed by the parties.

HHH. SURVIVAL

Any sections that by their nature or meaning should survive the termination or expiration of the Contract shall survive the termination or expiration of the Contract.

IN WITNESS WHEREOF, the parties have executed this Addendum as of the date of execution by both parties below.

Contractor: Mercer Health and Benefits, Inc.

By: _____

Name: Angie WasDyke

Title: Senior Partner

Date: June 3, 2016

State of Nebraska
Department of Health and Human Services
Division of Medicaid and Long Term Care

By: _____

Name: Calder Lynch

Title: Director, Division of Medicaid and Long Term Care

Date: 6/8/16

STATE OF NEBRASKA

United States of America, } ss.
State of Nebraska }

Secretary of State
State Capitol
Lincoln, Nebraska

I, John A. Gale, Secretary of State of the State of Nebraska, do hereby certify that

MERCER HEALTH & BENEFITS LLC

a Delaware limited liability company is authorized to transact business in Nebraska;

all fees, taxes, and penalties due under the Nebraska Uniform Limited Liability Company Act or other law to the Secretary of State have been paid;

the Company's most recent biennial report required by section 21-125 has been filed by the Secretary of State;

the Secretary of State has not revoked the Company's Certificate of Authority and has not filed a notice of cancellation.

This certificate is not to be construed as an endorsement, recommendation, or notice of approval of the entity's financial condition or business activities and practices.

In Testimony Whereof,

I have hereunto set my hand and affixed the Great Seal of the State of Nebraska on this date of

May 27, 2016

Secretary of State

Verification ID 04e74ac has been assigned to this document. Go to ne.gov/go/validate to validate authenticity for up to 12 months.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 05/27/2016

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Marsh USA, Inc.
1166 Avenue of the Americas
New York, NY 10036
Attn: NewYork.Certs@marsh.com Fax: 212-948-0500

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : National Union Fire Insurance Co. of Pittsburgh, PA	19445
INSURER B : Illinois National Insurance Company	23817
INSURER C : New Hampshire Insurance Company	23841
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Mercer Health & Benefits, LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016-4536

COVERAGES **CERTIFICATE NUMBER:** NYC-008480999-01 **REVISION NUMBER:** 4

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			3333326	09/30/2015	09/30/2016	EACH OCCURRENCE	$ 2,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 2,000,000
							MED EXP (Any one person)	$ 25,000
							PERSONAL & ADV INJURY	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 4,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 4,000,000
	OTHER:							$
A	AUTOMOBILE LIABILITY			7469937 (AOS)	09/30/2015	09/30/2016	COMBINED SINGLE LIMIT (Ea accident)	$ 5,000,000
A	X ANY AUTO			7469938 (VA)	09/30/2015	09/30/2016	BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$
	DED / RETENTION $							$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			067940212 (AOS)	09/30/2015	09/30/2016	X PER STATUTE / OTH-ER	
A	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N N	N/A		067940214 (CA)	09/30/2015	09/30/2016	E.L. EACH ACCIDENT	$ 2,000,000
B	(Mandatory In NH)			067940213 (FL)	09/30/2015	09/30/2016	E.L. DISEASE - EA EMPLOYEE	$ 2,000,000
C	If yes, describe under DESCRIPTION OF OPERATIONS below			067940215 (MA,ND,OH,WA,WI,WY)	09/30/2015	09/30/2016	E.L. DISEASE - POLICY LIMIT	$ 2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Nebraska Department of Health and Human Services is included as additional insured (except workers' compensation) where required by written contract.

CERTIFICATE HOLDER

Nebraska Department of
Health and Human Services
Division of Medicaid and Long-Term Care
301 Centennial Mall South
Lincoln, NE 68509

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Ricki Fitzsimmons

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The ACORD name and logo are registered marks of ACORD

EPSILON (US) INSURANCE COMPANY

48 South Service Road, Melville, N.Y. 11747

CERTIFICATE OF INSURANCE

****

NAMED INSURED:	Marsh & McLennan Companies, Inc.
ADDITIONAL INSURED:	Mercer Health & Benefits LLC 1166 Avenue of the Americas New York, NY 10036
INSURER:	Epsilon (US) Insurance Company
POLICY NUMBER:	09301516
POLICY PERIOD:	September 30, 2015 – September 30, 2016
LIMIT OF LIABILITY:	$50,000,000 per claim
TYPE OF INSURANCE:	Professional Liability

****

CERTIFICATE HOLDER:	Marsh & McLennan Companies, Inc. and any of its Subsidiaries 1166 Avenue of the Americas New York, NY 10036

Should the above described policy be cancelled before the expiration date thereof, the Insurer will endeavor to mail 30 days written notice to the certificate holder named above, but failure to mail such notice shall impose no obligation or liability of any kind upon the Insured, the Insurer, their manager, agents or representatives.

Nisala Weerasooriya

Epsilon (US) Insurance Company

Nisala Weerasooriya
Authorized Representative

Date: October 1, 2015

PLEASE REFER ALL INQUIRIES TO MARSH & MCLENNAN COMPANIES, INC., RISK MANAGEMENT DEPT., 1166 AVENUE OF THE AMERICAS, NEW YORK, NEW YORK 10036

MERCER
MAKE TOMORROW, TODAY

LONG-TERM SUPPORTS AND SERVICES (LTSS) REDESIGN CONSULTATION

REQUEST FOR PROPOSALS (RFP) 2016-LTSSZ1

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)

MAY 2, 2016

COST PROPOSAL – Best and Final Offer

Services provided by Mercer Health & Benefits LLC

MARSH & McLENNAN COMPANIES

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Cost Proposal Summary – Best and Final Offer (BAFO)

Mercer Health & Benefits LLC (Mercer) is pleased to submit this cost proposal in response to the Best and Final Offer (BAFO) request to Request for Proposal (RFP) 2016-LTSSZ1 for Long-Term Supports and Services (LTSS) Redesign Consultation. Having worked with several states on a variety of LTSS redesign initiatives allows Mercer to bring a unique understanding and knowledge to this effort. In addition to the depth of experience within our Mercer team, we are proud to partner with the National Association of States United for Aging and Disabilities (NASUAD) on this project. We believe the talent, resources, skills and depth of experience of the Mercer/NASUAD team will be unmatched by any other competitor.

Mercer used the required BAFO Cost Proposal Worksheet to prepare our cost proposal specific to the deliverables outlined in the RFP. There are three exhibits included in our cost proposal. The first exhibit is the completed BAFO Cost Proposal Worksheet as provided by the Department of Health and Human Services (DHHS). As directed, the total cost for each deliverable represented on this worksheet is inclusive of travel and expenses.

The second worksheet, Hourly Rates for Staff, contains a list of staff assigned to this project, their role and the associated hourly rate during the contract period. While the client-facing team has been identified for each deliverable, we anticipate additional staff will be required to support our key client-facing consultants and those staff will be identified upon project award.

The last exhibit, Cost Proposal Detail, contains a more granular look at the hours for each deliverable identified in the scope of work by person. In addition to these exhibits, the draft project plan has been included as Appendix A, which outlines the key services to be provided as part of each deliverable.

As requested in the DHHS BAFO letter, the cost proposal has been provided for the Year 1 deliverables only and does not include the cost of any implementation tasks defined in our previously submitted Technical Proposal related to RFP Section IV.C.4. Costs for these services are not included in any exhibit; however, the work plan, included for your convenience, does reflect our proposed implementation tasks consistent with the BAFO letter, RFP directions and Mercer's previously submitted Technical Proposal.

The costs included in Mercer's BAFO are unchanged from the cost proposal originally submitted. Mercer submitted its original proposal anticipating that an opportunity for a BAFO request would not necessarily occur and, therefore, submitted our best and final price with our original proposal. Additionally, the original cost proposal was developed consistent with the instructions for the Attachment 4 - Revised Cost Proposal Template and this BAFO request. Mercer did consider a reduction to the hours and/or scope from our original proposal, but we strongly believe that the scope of services and hours proposed are necessary for a successful redesign and stakeholdering process and no changes were made from the original proposal. Mercer may be more expensive than our competitors; however, the knowledge and hands-on experience our collective team brings to the table for this project will pay dividends as DHHS moves through the redesign phases and into the implementation phase(s).

BAFO
COST PROPOSAL WORKSHEET
RFP 2016-LTSSZ1

Bidder Name: Mercer Health & Benefits LLC

Deliverable	Year 1	Year 2	Year 3	Total Deliverable Cost
Final project work plan	$18,985			$18,985.00
Stakeholder engagement plan for Research, Delivery System Assessment, and Preliminary Recommendations	$14,415			$14,415.00
Stakeholder meeting presentation materials for Research, Delivery System Assessment, and Preliminary Recommendations	$15,565			$15,565.00
Completion of stakeholder meetings prior to completing the assessment of Nebraska's LTSS delivery system with preliminary recommendations	$106,390			$106,390.00
Summary report of stakeholder engagement prior to completing the assessment of Nebraska's LTSS delivery system with preliminary recommendations	$21,130			$21,130.00
Assessment of Nebraska's LTSS service delivery system with preliminary recommendations	$99,505			$99,505.00
Draft redesign plan	$86,135			$86,135.00
Stakeholder engagement plan for soliciting feedback to draft redesign plan	$14,420			$14,420.00
Stakeholder meeting presentation materials for soliciting feedback to draft redesign plan	$20,245			$20,245.00
Completion of stakeholder meetings for soliciting feedback to draft redesign plan	$106,585			$106,585.00
Summary report of stakeholder engagement following the draft redesign plan	$24,210			$24,210.00
Final redesign plan	$40,375			$40,375.00
Status reports	$15,750			$15,750.00
Total Deliverables Cost	**$583,710.00**	**$0.00**	**$0.00**	**$583,710.00**

COMPLETE YELLOW HIGHLIGHTED CELLS ONLY. NO FORMATTING OR FORMULA CHANGES PERMITTED.

Mercer Health & Benefits LLC

Hourly Rates For Staff

RFP 2016-LTSSZ1

Team Member	Firm	Role	Year 1 Hourly Rate
Deidra Abbott	Mercer	Medicaid Regulatory Specialist	$ 280
Misti Beckman	Mercer	Medicaid Program Analyst	$ 275
Robert Butler	Mercer	Medicaid Program Analyst	$ 275
Camille Dobson	NASUAD	Medicaid Regulatory Specialist	$ 280
Jon Fortune	Mercer	Medicaid Program Analyst	$ 275
Fred Gibison	Mercer	Medicaid Program Analyst	$ 275
Stefanie Kurlanzik	Mercer	Medicaid Regulatory Specialist	$ 280
Lowell Ayre	NASUAD	Medicaid Program Analyst	$ 275
Carol Sala	NASUAD	Medicaid Program Analyst	$ 275
Martha Roherty	NASUAD	Medicaid Program Analyst	$ 275
Alan Schafer	Mercer	Project Manager	$ 285
Joel Schuenke	Mercer	Medicaid Program Analyst	$ 275
Angie WasDyke	Mercer	Mercer Client Leader	$ 280

Mercer Health & Benefits LLC

Cost Proposal Detail

RFP 2016-LTSSZ1

Deliverable	Start Date	End Date	Comments	Year 1 Hours	Year 1 Rate	Year 1 Dollars
Final Project Work Plan	5/16/2016	6/6/2016	Includes on-site kickoff meeting	**68.00**	**279.19**	**$ 18,985.00**
Deidra Abbott				8.00	280.00	$ 2,240.00
Robert Butler				8.00	275.00	$ 2,200.00
Camille Dobson				13.00	280.00	$ 3,640.00
Fred Gibison				4.00	275.00	$ 1,100.00
Lowell Ayre				1.00	275.00	$ 275.00
Carol Sala				1.00	275.00	$ 275.00
Martha Roherty				13.00	275.00	$ 3,575.00
Alan Schafer				16.00	285.00	$ 4,560.00
Angie WasDyke				4.00	280.00	$ 1,120.00
Stakeholder Engagement Plan for Research, Delivery System Assessment and Preliminary Recommendations	5/16/2016	6/15/2016		**52.00**	**277.21**	**$ 14,415.00**
Deidra Abbott				2.00	280.00	$ 560.00
Camille Dobson				13.00	280.00	$ 3,640.00
Lowell Ayre				11.00	275.00	$ 3,025.00
Carol Sala				9.00	275.00	$ 2,475.00
Martha Roherty				13.00	275.00	$ 3,575.00
Alan Schafer				4.00	285.00	$ 1,140.00
Stakeholder Meeting Presentation Materials for Research, Delivery System Assessement, and Preliminary Recommendations	5/18/2016	6/15/2016		**56.00**	**277.95**	**$ 15,565.00**
Deidra Abbott				4.00	280.00	$ 1,120.00
Camille Dobson				13.00	280.00	$ 3,640.00
Lowell Ayre				9.00	275.00	$ 2,475.00
Carol Sala				9.00	275.00	$ 2,475.00
Martha Roherty				13.00	275.00	$ 3,575.00
Alan Schafer				8.00	285.00	$ 2,280.00
Completion of Stakeholder Meetings Prior to Completing the Assessment of Nebraska's LTSS Delivery System with Preliminary Recommendations	6/20/2016	7/15/2016		**384.00**	**277.06**	**$ 106,390.00**
Deidra Abbott				8.00	280.00	$ 2,240.00
Robert Butler				8.00	275.00	$ 2,200.00
Camille Dobson				90.00	280.00	$ 25,200.00
Fred Gibison				4.00	275.00	$ 1,100.00
Lowell Ayre				77.00	275.00	$ 21,175.00
Carol Sala				77.00	275.00	$ 21,175.00
Martha Roherty				90.00	275.00	$ 24,750.00
Alan Schafer				30.00	285.00	$ 8,550.00
Summary Report of Stakeholder Engagement Prior to Completing the Assessment of Nebraska's LTSS Delivery System with Preliminary Recommendations	7/11/2016	7/29/2016		**76.00**	**278.03**	**$ 21,130.00**
Deidra Abbott				6.00	280.00	$ 1,680.00
Robert Butler				6.00	275.00	$ 1,650.00
Camille Dobson				16.00	280.00	$ 4,480.00
Fred Gibison				4.00	275.00	$ 1,100.00
Lowell Ayre				9.00	275.00	$ 2,475.00
Carol Sala				6.00	275.00	$ 1,650.00
Martha Roherty				17.00	275.00	$ 4,675.00
Alan Schafer				12.00	285.00	$ 3,420.00

Mercer Health & Benefits LLC

Cost Proposal Detail

RFP 2016-LTSSZ1

Deliverable	Start Date	End Date	Comments	Year 1		
				Hours	Rate	Dollars
Final Redesign Plan	4/3/2017	5/17/2017		**145.00**	**278.45**	**$ 40,375.00**
Deidra Abbott				20.00	280.00	$ 5,600.00
Misti Beckman				16.00	275.00	$ 4,400.00
Robert Butler				20.00	275.00	$ 5,500.00
Camille Dobson				10.00	280.00	$ 2,800.00
Fred Gibison				30.00	275.00	$ 8,250.00
Lowell Ayre				2.00	275.00	$ 550.00
Carol Sala				2.00	275.00	$ 550.00
Martha Roherty				10.00	275.00	$ 2,750.00
Alan Schafer				35.00	285.00	$ 9,975.00
Status Reports	5/16/2016	6/17/2019		**56.00**	**281.25**	**$ 15,750.00**
Camille Dobson				10.00	280.00	$ 2,800.00
Martha Roherty				10.00	275.00	$ 2,750.00
Alan Schafer				24.00	285.00	$ 6,840.00
Angie WasDyke				12.00	280.00	$ 3,360.00
Total Cost				**2,100.00**	**277.96**	**$ 583,710.00**

APPENDIX A

Work Plan

State of Nebraska
Draft Work Plan for LTSS Redesign Consultation

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
1	1	Contract Start Date	0 days	Mon 5/16/16	Mon 5/16/16		
2	**2**	**Final Project Work Plan**	**16 days**	**Mon 5/16/16**	**Mon 6/6/16**	**Alan Schafer with support from key team members**	
3	2.1	Develop information request	3 days	Mon 5/16/16	Wed 5/18/16		
4	2.2	Collect and review information to revise the draft work plan	9 days	Thu 5/19/16	Tue 5/31/16		
5	2.3	Project kick-off meeting	2 days	Tue 5/24/16	Wed 5/25/16		
6	2.4	Submit revised project work plan for review	0 days	Tue 5/31/16	Tue 5/31/16		
7	2.5	Discuss and review project work plan	2 days	Tue 5/31/16	Wed 6/1/16		
8	2.6	Finalize and submit project work plan	2 days	Thu 6/2/16	Fri 6/3/16		
9	2.7	Approve project work plan	0 days	Mon 6/6/16	Mon 6/6/16		Due 15 business days after contract start (June 6).
10	**3**	**Research, Delivery System Assessment and Preliminary Recommendations (RDSAPR)**	**55 days**	**Mon 5/16/16**	**Fri 7/29/16**		
11	**3.1**	**Stakeholder Engagement Plan (RDSAPR)**	**23 days**	**Mon 5/16/16**	**Wed 6/15/16**	**Deidra Abbott,Camille Dobson,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer**	
12	3.1.1	Identify stakeholders to be included in the stakeholder meetings and revise list	5 days	Mon 5/16/16	Fri 5/20/16		Proposed list of stakeholders is included in technical proposal as a starting point.
13	3.1.2	Develop and submit draft stakeholder engagement plan for review	9 days	Mon 5/23/16	Thu 6/2/16		Plan will include event dates and locations, methods for communication and engagement (e.g., use of social media, state website, listservs, comment features, etc.), meeting format, and information to obtain through the engagement process.

Draft - Subject to further review and revision.

State of Nebraska
Draft Work Plan for LTSS Redesign Consultation

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
14	3.1.3	Develop meeting schedule and secure locations	6 days	Fri 6/3/16	Fri 6/10/16		Note: Further detail will be added to the project work plan regarding meeting logistics once finalized. We will seek assistance from MLTC to secure public spaces to the extent possible.
15	3.1.4	Review stakeholder engagement plan	5 days	Fri 6/3/16	Thu 6/9/16		
16	3.1.5	Finalize and submit stakeholder engagement plan for MLTC approval	3 days	Fri 6/10/16	Tue 6/14/16		
17	3.1.6	Approve stakeholder engagement plan	0 days	Wed 6/15/16	Wed 6/15/16		Due 30 calendar days after contract start (June 15).
18	**3.2**	**Stakeholder Meeting Materials (RDSAPR)**	**21 days**	**Wed 5/18/16**	**Wed 6/15/16**	**Deidra Abbott,Camille Dobson,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer**	
19	3.2.1	Develop and submit materials for stakeholder meetings	11 days	Wed 5/18/16	Wed 6/1/16		Materials include: meeting communications, agendas, presentations, etc.
20	3.2.2	Review materials for stakeholder meetings	5 days	Thu 6/2/16	Wed 6/8/16		
21	3.2.3	Finalize and submit materials for stakeholder meetings	4 days	Thu 6/9/16	Tue 6/14/16		
22	3.2.4	Approve materials for stakeholder meetings	0 days	Wed 6/15/16	Wed 6/15/16		Due 30 calendar days after contract start (June 15).
23	**3.3**	**Statewide Stakeholder Meeting Facilitation (RDSAPR)**	**19 days**	**Mon 6/20/16**	**Thu 7/14/16**	**Deidra Abbott,Robert Butler,Camille Dobson,Fred Gibison,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer**	

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State of Nebraska
Draft Work Plan for LTSS Redesign Consultation

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
24	3.3.1	Facilitate first round of stakeholder meetings	10 days	Mon 6/20/16	Fri 7/1/16		See attached document entitled Proposed NE Stakeholder visits. Additional meetings with statewide constituencies will be accommodated with an extra day in Lincoln, if needed.
25	3.3.2	Debrief with MLTC on concerns requiring immediate attention	0 days	Fri 7/1/16	Fri 7/1/16		
26	3.3.3	Facilitate second round of stakeholder meetings	8 days	Tue 7/5/16	Thu 7/14/16		Due 60 calendar days after contract start (July 15).
27	3.3.4	Debrief with MLTC on concerns requiring immediate attention	0 days	Thu 7/14/16	Thu 7/14/16		
28	**3.4**	**Summary Report of Stakeholder Engagement (RDSAPR)**	**15 days**	**Mon 7/11/16**	**Fri 7/29/16**	**Deidra Abbott,Robert Butler,Camille Dobson,Fred Gibison,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer**	
29	3.4.1	Develop and submit draft stakeholder engagement report	7 days	Mon 7/11/16	Tue 7/19/16		
30	3.4.2	Review and discuss stakeholder engagement report	5 days	Wed 7/20/16	Tue 7/26/16		
31	3.4.3	Finalize stakeholder engagement report and submit for MLTC approval	2 days	Wed 7/27/16	Thu 7/28/16		
32	3.4.4	Approve stakeholder engagement report	0 days	Fri 7/29/16	Fri 7/29/16		Due 75 calendar days after contract start (July 29).
33	3.4.5	Respond to consumer/stakeholder questions	5 days	Mon 7/18/16	Fri 7/22/16		As part of continuous feedback loop with stakeholders, questions raised will be addressed, in consultation with the state, as soon as possible after the meetings conclude.

State of Nebraska
Draft Work Plan for LTSS Redesign Consultation

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
34	**4**	**Assessment of Nebraska's LTSS Service Delivery System with Preliminary Recommendations**	**65 days**	**Mon 5/16/16**	**Fri 8/12/16**	**Deidra Abbott,Misti Beckman,Robert Butler,Camille Dobson,Jon Fortune,Fred Gibison,Stefanie Kurlanzik,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer,Joel Schuenke,Angie Wasdyke**	
35	**4.1**	**Research the Current Nebraska LTSS Delivery System**	**43 days**	**Mon 5/16/16**	**Wed 7/13/16**	**Joel Schuenke,Jon Fortune**	
36	4.1.1	Collect and review publically available documents on Nebraska LTSS programs	15 days	Mon 5/16/16	Fri 6/3/16		
37	4.1.2	Develop follow-up questions and clarifications from documentation review and kick-off meeting	5 days	Mon 6/6/16	Fri 6/10/16		
38	4.1.3	Facilitate discussions with MLTC	23 days	Mon 6/13/16	Wed 7/13/16		May include targeted interviews with DHHS key staff and Divisions.
39	**4.2**	**Research Other States' Efforts to Improve LTSS Programs**	**43 days**	**Mon 5/16/16**	**Wed 7/13/16**	**Joel Schuenke,Jon Fortune**	
40	4.2.1	Gather data from existing Mercer LTSS clients	15 days	Mon 5/16/16	Fri 6/3/16		
41	4.2.2	Gather data from other states	10 days	Mon 6/6/16	Fri 6/17/16		May facilitate targeted discussions with other states, as needed.
42	4.2.3	Facilitate discussions with MLTC on findings	23 days	Mon 6/13/16	Wed 7/13/16		
43	**4.3**	**Identify Strengths and Challenges of Nebraska's LTSS Programs**	**19 days**	**Tue 7/5/16**	**Fri 7/29/16**	**Deidra Abbott,Robert Butler,Camille Dobson,Fred Gibison,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer**	

State of Nebraska
Draft Work Plan for LTSS Redesign Consultation

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
44	4.3.1	Summarize key strengths and challenges of Nebraska's LTSS programs based on research	11 days	Tue 7/5/16	Tue 7/19/16		
45	4.3.2	Facilitate discussions with MLTC on findings	8 days	Wed 7/20/16	Fri 7/29/16		
46	**4.4**	**Review Federal Requirements for Program Options and Limitations**	**38 days**	**Wed 5/25/16**	**Fri 7/15/16**	**Camille Dobson,Deidra Abbott,Stefanie Kurlanzik**	
47	4.4.1	Develop comprehensive list of CMS guidelines, federal regulations, and authorities for LTSS delivery systems	11 days	Wed 5/25/16	Wed 6/8/16		
48	4.4.2	Review options and limitations based upon knowledge of Nebraska's LTSS system and develop findings	12 days	Thu 6/9/16	Fri 6/24/16		
49	4.4.3	Compare findings with best practices identified from other state and Mercer LTSS clients	10 days	Mon 6/27/16	Fri 7/8/16		
50	4.4.4	Facilitate discussions with MLTC on findings	5 days	Mon 7/11/16	Fri 7/15/16		
51	**4.5**	**Report of Findings and Preliminary Recommendations for Improving MLTC's Current LTSS Service Delivery System**	**40 days**	**Mon 6/20/16**	**Fri 8/12/16**	**Deidra Abbott,Robert Butler,Camille Dobson,Fred Gibison,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer**	
52	4.5.1	Develop a report outline for MLTC approval	10 days	Mon 6/20/16	Fri 7/1/16		
53	4.5.2	Develop and submit a draft report of preliminary recommendations	14 days	Tue 7/5/16	Fri 7/22/16		
54	4.5.3	Discuss the report of findings, including preliminary recommendations	5 days	Mon 7/25/16	Fri 7/29/16		
55	4.5.4	Finalize preliminary recommendations report	7 days	Mon 8/1/16	Tue 8/9/16		
56	4.5.5	Approve preliminary recommendations report	0 days	Fri 8/12/16	Fri 8/12/16		Due 90 calendar days after contract start (Aug. 14).

Draft - Subject to further review and revision.

State of Nebraska
Draft Work Plan for LTSS Redesign Consultation

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
57	**5**	**Development of Draft Redesign Plan and Stakeholder Feedback**	**169 days**	**Mon 8/1/16**	**Fri 3/24/17**		
58	**5.1**	**Draft Redesign Plan**	**80 days**	**Mon 8/1/16**	**Fri 11/18/16**	**Deidra Abbott,Alan Schafer,Camille Dobson,Carol Sala,Fred Gibison,Lowell Ayre,Martha Roherty,Misti Beckman,Robert Butler**	
59	5.1.1	Consider stakeholder feedback and preliminary recommendations for MLTC's LTSS service delivery and assess operational and fiscal considerations	35 days	Mon 8/1/16	Fri 9/16/16		Consider key issues, concerns, and challenges raised by stakeholders. Address existing delivery system within Redesign Plan, including assessment of operational and fiscal considerations.
60	5.1.2	Facilitate discussion with MLTC around program goals and objectives	50 days	Mon 8/8/16	Fri 10/14/16		MLTC shares goals and objectives that meet the State's political, policy, programmatic and priority needs throughout the process, including an overview of all DHHS initiatives.
61	5.1.3	Craft working draft Redesign Plan	15 days	Mon 10/10/16	Fri 10/28/16		
62	5.1.4	Submit working draft of Draft Redesign Plan to MLTC for comments/feedback	0 days	Fri 10/28/16	Fri 10/28/16		
63	5.1.5	MLTC reviews and provides comments on working draft	5 days	Mon 10/31/16	Fri 11/4/16		
64	5.1.6	Revisions made to working draft	9 days	Mon 11/7/16	Thu 11/17/16		
65	5.1.7	Submit Draft Redesign Plan	0 days	Thu 11/17/16	Thu 11/17/16		Due 6 months after contract start (Nov. 17).
66	5.1.8	MLTC posts Draft Redesign Plan to public website for stakeholder comments	1 day	Fri 11/18/16	Fri 11/18/16		

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State of Nebraska
Draft Work Plan for LTSS Redesign Consultation

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
67	**5.2**	**Stakeholder Engagement Plan**	**40 days**	**Mon 11/14/16**	**Fri 1/6/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Lowell Ayre,Martha Roherty**	
68	5.2.1	Identify stakeholders to be included in the stakeholder meetings and revise stakeholder list	5 days	Mon 11/14/16	Fri 11/18/16		Proposed list of stakeholders is included in technical proposal as a starting point.
69	5.2.2	Develop draft stakeholder engagement plan	11 days	Mon 11/28/16	Mon 12/12/16		
70	5.2.3	Submit stakeholder engagement and communications plan for review	0 days	Mon 12/12/16	Mon 12/12/16		
71	5.2.4	Review stakeholder engagement and communications plan	9 days	Tue 12/13/16	Fri 12/23/16		
72	5.2.5	Develop meeting schedule and secure locations	5 days	Mon 12/12/16	Fri 12/16/16		Note: Further detail will be added to the project work plan regarding meeting logistics once finalized. We will seek assistance from MLTC to secure public spaces to extent possible.
73	5.2.6	Finalize stakeholder engagement and communications plan and submit for MLTC approval	3 days	Tue 1/3/17	Thu 1/5/17		
74	5.2.7	Approve stakeholder engagement and communications plan	0 days	Fri 1/6/17	Fri 1/6/17		Due 8 months after contract start (Jan. 17).
75	**5.3**	**Stakeholder Meeting Materials**	**42 days**	**Mon 11/21/16**	**Tue 1/17/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Fred Gibison,Lowell Ayre,Martha Roherty,Robert Butler**	
76	5.3.1	Develop materials for stakeholder meetings	20 days	Mon 11/21/16	Fri 12/16/16		
77	5.3.2	Submit materials for stakeholder meetings for review	0 days	Mon 12/19/16	Mon 12/19/16		

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State of Nebraska
Draft Work Plan for LTSS Redesign Consultation

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
78	5.3.3	Review materials for stakeholder meetings	12 days	Tue 12/20/16	Wed 1/4/17		
79	5.3.4	Finalize materials for stakeholder meetings and submit for final MLTC approval	6 days	Thu 1/5/17	Thu 1/12/17		
80	5.3.5	Approve materials for stakeholder meetings	0 days	Tue 1/17/17	Tue 1/17/17		Due 8 months after contract start (Jan. 17).
81	**5.4**	**Statewide Stakeholder Meeting Facilitation**	**40 days**	**Mon 1/23/17**	**Fri 3/17/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Fred Gibison,Lowell Ayre,Martha Roherty,Robert Butler**	
82	5.4.1	Facilitate first round of stakeholder meetings	10 days	Mon 1/23/17	Sat 2/4/17		Additional meetings with statewide constituencies will be accommodated with an extra day in Lincoln, if needed.
83	5.4.2	Debrief with MLTC on concerns requiring immediate attention	2 days	Mon 2/6/17	Tue 2/7/17		
84	5.4.3	Facilitate second round of stakeholder meetings	9 days	Tue 2/21/17	Sat 3/4/17		Due 10 months after contract start (March 17).
85	5.4.4	Debrief with MLTC on concerns requiring immediate attention	3 days	Mon 3/6/17	Wed 3/8/17		
86	5.4.5	Respond to consumer/stakeholder questions	10 days	Mon 3/6/17	Fri 3/17/17		As part of continuous feedback loop with stakeholders, questions raised will be addressed, in consultation with the state, as soon as possible after the meetings conclude.

State of Nebraska
Draft Work Plan for LTSS Redesign Consultation

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
87	**5.5**	**Summary Report of Stakeholder Engagement**	**18 days**	**Tue 2/28/17**	**Fri 3/24/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Fred Gibison,Lowell Ayre,Martha Roherty,Robert Butler**	
88	5.5.1	Develop and submit draft stakeholder engagement report	10 days	Tue 2/28/17	Mon 3/13/17		
89	5.5.2	Review and discuss stakeholder engagement report	5 days	Tue 3/14/17	Mon 3/20/17		
90	5.5.3	Finalize stakeholder engagement report and submit for MLTC approval	3 days	Tue 3/21/17	Thu 3/23/17		
91	5.5.4	Approve stakeholder engagement report	0 days	Fri 3/24/17	Fri 3/24/17		Due 15 calendar days following final stakeholder engagement meeting (March 31).
92	**5.6**	**DHHS Staff Training on Redesign Plan**	**40 days**	**Mon 11/21/16**	**Fri 1/13/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Fred Gibison,Lowell Ayre,Martha Roherty,Misti Beckman,Robert Butler**	
93	5.6.1	Determine appropriate DHHS staff for training	9 days	Mon 11/21/16	Thu 12/1/16		Mutually agree on number of DHHS staff to be trained.
94	5.6.2	Develop training schedule and location (if not at DHHS offices)	5 days	Mon 12/5/16	Fri 12/9/16		Assume training will be at DHHS offices.
95	5.6.3	Develop training materials	20 days	Mon 12/12/16	Fri 1/6/17		
96	5.6.4	Send training invitations to appropriate DHHS staff	2 days	Mon 1/2/17	Tue 1/3/17		Electronic (e.g., Outlook) invitations.
97	5.6.5	DHHS staff confirm acceptance	2 days	Wed 1/4/17	Thu 1/5/17		
98	5.6.6	Follow with non-responding DHHS staff (if needed)	1 day	Fri 1/6/17	Fri 1/6/17		

State of Nebraska
Draft Work Plan for LTSS Redesign Consultation

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
99	5.6.7	Conduct DHHS training	5 days	Mon 1/9/17	Fri 1/13/17		This may be multiple sessions with same group on different topics or repeat training with different groups. Details to be mutually agreed to.
100	**6**	**Development of Final Redesign Plan**	**33 days**	**Mon 4/3/17**	**Wed 5/17/17**		**This section of the plan will need further discussion with NE MLTC as many holidays fall herein.**
101	**6.1**	**Final Redesign Plan**	**33 days**	**Mon 4/3/17**	**Wed 5/17/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Fred Gibison,Lowell Ayre,Martha Roherty,Misti Beckman,Robert Butler**	
102	6.1.1	Assess stakeholder comments	10 days	Mon 4/3/17	Fri 4/14/17		Mercer and MLTC review and discuss comments regarding Draft Plan and decide approach to finalize Redesign Plan. Timeframe may be impacted by volume of feedback received.
103	6.1.2	Edit Draft Redesign Plan based on stakeholder comments	10 days	Mon 4/17/17	Fri 4/28/17		
104	6.1.3	Submit proposed Final Redesign Plan to MLTC for review	0 days	Fri 4/28/17	Fri 4/28/17		
105	6.1.4	MLTC reviews proposed Final Redesign Plan and provides final edits to Mercer	5 days	Mon 5/1/17	Fri 5/5/17		MLTC final input provided.
106	6.1.5	Finalize and submit Final Redesign Plan to MLTC	7 days	Mon 5/8/17	Tue 5/16/17		Due 12 months after contract start (May 16).
107	6.1.6	MLTC posts Final Redesign Plan to public website	1 day	Wed 5/17/17	Wed 5/17/17		

State of Nebraska
Draft Work Plan for LTSS Redesign Consultation

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
108	**6.2**	**Implementation Redesign Work Plans**	**33 days**	**Mon 4/3/17**	**Wed 5/17/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Fred Gibison,Lowell Ayre,Martha Roherty,Misti Beckman,Robert Butler**	**Process to begin after final approval of the Redesign Plan.**
109	6.2.1	Develop draft implementation work plans	20 days	Mon 4/3/17	Fri 4/28/17		
110	6.2.2	Review implementation work plans	5 days	Mon 5/1/17	Fri 5/5/17		
111	6.2.3	Finalize implementation work plans and submit for MLTC approval	5 days	Mon 5/8/17	Fri 5/12/17		
112	6.2.4	Approve implementation work plans	3 days	Mon 5/15/17	Wed 5/17/17		
113	**7**	**Monthly Status Reports**	**784 days**	**Wed 6/15/16**	**Mon 6/17/19**	**Alan Schafer,Angie Wasdyke,Camille Dobson,Martha Roherty**	**Provided 15 days after each calendar month.**

Draft - Subject to further review and revision.

MERCER
MAKE TOMORROW, TODAY

LONG-TERM SUPPORTS AND SERVICES (LTSS) REDESIGN CONSULTATION

REQUEST FOR PROPOSALS (RFP) 2016-LTSSZ1

STATE OF NEBRASKA
DEPARTMENT OF HEALTH & HUMAN SERVICES (DHHS)

APRIL 13, 2016

TECHNICAL PROPOSAL

Services provided by Mercer Health & Benefits LLC

MARSH & McLENNAN COMPANIES

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Section 1

Section 1: Request for Proposal Form

The Request for Proposal (RFP) Form is provided in this section as is Form A – Bidder Contact Sheet. Also included in Section III from the RFP, Terms and Conditions.

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BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions unless otherwise agreed to (see Section III) and certifies that bidder maintains a drug free work place environment.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

N/A NEBRASKA CONTRACTOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

N/A I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

FIRM: Mercer Health & Benefits LLC

COMPLETE ADDRESS: 333 South Seventh Street, Minneapolis, MN 55402

TELEPHONE NUMBER: +1 612 642 8892 FAX NUMBER: +1 612 642 8686

SIGNATURE: Angela WasDyke DATE: April 6, 2016

TYPED NAME AND TITLE OF SIGNER: Angie WasDyke, ASA, MAAA, Senior Partner

Form A

Bidder Contact Sheet

Request for Proposal Number 2016-LTSSZ1

The Bidder Contact Sheet should be completed and submitted with each response to this Request for Proposal. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response. Each bidder shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Preparation of Response Contact Information	
Bidder Name:	**Mercer Health & Benefits LLC**
Bidder Address:	**333 S. 7th Street, Suite 1400 Minneapolis, MN 55402**
Contact Person & Title:	**Angie WasDyke, ASA, MAAA, Senior Partner and Minneapolis GHSC Office Business Leader**
E-mail Address:	**angela.wasdyke@mercer.com**
Telephone Number (Office):	**+1 612 642 8892**
Telephone Number (Cellular):	**+1 612 747 8920**
Fax Number:	**+1 612 642 8686**

Each bidder shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	**Mercer Health & Benefits LLC**
Bidder Address:	**333 S. 7th Street, Suite 1400 Minneapolis, MN 55402**
Contact Person & Title:	**Angie WasDyke, ASA, MAAA, Senior Partner and Minneapolis GHSC Office Business Leader**
E-mail Address:	**angela.wasdyke@mercer.com**
Telephone Number (Office):	**+1 612 642 8892**
Telephone Number (Cellular):	**+1 612 747 8920**
Fax Number:	**+1 612 642 8686**

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III. TERMS AND CONDITIONS

By signing the "Request for Proposal for Contractual Services" form, the Bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions and certifies bidder maintains a drug free work place environment.

Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal. **Bidders must include completed Section III with their proposal response.**

The State of Nebraska is soliciting bids in response to the RFP. The State of Nebraska will not consider proposals that propose the substitution of the bidder's contract, agreements, or terms for those of the State of Nebraska's. Any License, Service Agreement, Customer Agreement, User Agreement, Bidder Terms and Conditions, Document, or Clause purported or offered to be included as a part of this RFP must be submitted as individual clauses, as either a counter-offer or additional language, and each clause must be acknowledged and accepted in writing by the State. If the Bidder's clause is later found to be in conflict with the RFP or resulting contract the Bidder's clause shall be subordinate to the RFP or resulting contract.

A. GENERAL

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. Amendment to Contract Award with the most recent dated amendment having the highest priority;
2. Contract Award and any attached Addenda;
3. The Request for Proposal form and the Contractor's Proposal signed in ink;
4. Amendments to RFP and any Questions and Answers; and
5. The original RFP document and any Addenda.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to Contract Award with the most recent dated amendment having the highest priority, 2) Contract Award and any attached Addenda, 3) the signed Request for Proposal form and the Contractor's Proposal, 4) Amendments to RFP and any Questions and Answers, 5) the original RFP document and any Addenda.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved In accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. AWARD

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, in whole or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.

By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Grievance and protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchase_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf.

Any protests must be filed by a vendor within ten (10) business days after the intent to award decision is posted to
the Internet.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			Contractor will comply with all laws, as then in effect, to the extent applicable to its Services performed pursuant to the finally negotiated Contract.

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensations, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for services to be covered by any contract resulting from this Request for Proposal.

D. PERMITS, REGULATIONS, LAWS

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			Contractor will comply with all laws, as then in effect, to the extent applicable to its Services performed pursuant to the finally negotiated Contract.

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	Deliverables created or developed by Contractor specifically and exclusively for the State pursuant to the Contract shall be considered 'work made for hire' and exclusively owned by the State (collectively, "Work"). Notwithstanding anything to the contrary in the Contract, Contractor should retain all patent, copyright and other intellectual property rights in the methodologies, methods of analysis, ideas, concepts, know-how, models, tools, techniques, skills, knowledge and experience owned or possessed by Contractor before the commencement of, or acquired by Contractor during or after, the performance of the Services (collectively, "Intellectual Property"). To the extent that any of Intellectual Property is embodied in any of the Work, Contractor will grant to the State a non-exclusive, non-transferable, royalty-free license to use the Intellectual Property for its internal use, but solely in connection with and to the extent necessary for use of the Work as contemplated by the Contract; provided that and so long as the State is not in breach of this Contract or otherwise misusing the Intellectual Property. Unless Contractor provides its prior written consent, the State will not use, or disclose to any third party, Contractor's advice or Work other than as mutually contemplated by the parties when Contractor first was retained to provide such advice or Work or as required by law.

The State of Nebraska shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or derived by the Contractor pursuant to this contract.

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	We accept the general provisions of this Section with the below noted modifications During the term of the Contract, Contractor will maintain the insurance coverage in the amounts set forth in the Contract. References to 'minimum amounts' and 'not less than' should be deleted throughout this Section. Workers' Compensation - Contractor will provide a waiver of subrogation for claims arising solely from Contractor's provision of services pursuant to the Contract excluding the requesting party's negligence, willful misconduct or recklessness. Contractor's insurance does not extend to Subcontractors, but Contractor shall require that its Subcontractor's maintain substantially similar insurance to that set forth in the Contract. Contractor's commercial general liability coverage does not include coverage for Independent Contractors. The State will be included as an additional insured under the Commercial General Liability and Commercial Automobile Liability coverages with respect to its vicarious liability arising from Contractor's provision of Services pursuant to the Contract. Coverage afforded to the additional insured may be primary and non-contributory for claims arising solely from Contractor's provision of Services pursuant to the Contract.

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all

required insurance for the life of this contract and shall ensure that the State Purchasing Bureau has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any Subcontractors, the Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all Subcontractor (s). Contractor is also responsible for ensuring Subcontractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any Subcontractor to commence work on any Subcontract until all similar insurance required of the Subcontractor has been obtained and approved by the Contractor. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Insurance coverages shall function independent of all other clauses in the contract, and in no instance shall the limits of recovery from the insurance be reduced below the limits required by this paragraph.

1. **WORKERS' COMPENSATION INSURANCE**

   The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

   The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

   The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned and Hired vehicles.

3. **INSURANCE COVERAGE AMOUNTS REQUIRED**

WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
USL&H Endorsement	Statutory
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
SUBROGATION WAIVER	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
LIABILITY WAIVER	
"Commercial General Liability & Commercial Automobile Liability policies shall be primary and any insurance or self-insurance carried by the State shall be considered excess and non-contributory."	

4. **EVIDENCE OF COVERAGE**

The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements, which shall be submitted to the attention of the Buyer.

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
301 Centennial Mall South
Lincoln, NE 68509
Facsimile: (402) 742-1155.

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the State, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to DHHS, MLTC when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			Contractor will reasonably cooperate with other contractors as necessary for the performance of Contractor's services. Such other contractors should be required to execute a confidentiality agreement with Contractor. Acts by Contractor that are not in breach of the Contract and that are in good faith should not constitute interference with other contractors' work.

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.
2. The Contractor shall agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

H. INDEPENDENT CONTRACTOR

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the Contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the Contractor's proposal, and the resulting contract. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any Subcontractor's services, the Subcontractor's level of effort, tasks, and time allocation must be clearly defined in the Contractor's proposal. The Contractor shall agree that it will not utilize any Subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			Contractor should be permitted to remove employees not identified in the Contract as essential for the provision of the Services without the State's prior consent. Contractor should not be required to obtain the State's prior consent with respect to employees identified as key-employees in the Contract if such employee (i) ceases to be employed by Contractor for any reason, (ii) is unable to work due to long term illness, disability or death or other reason beyond Contractor's reasonable control or (iii) takes maternity or parental leave or takes leave for any other extended period of time.

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified Subcontractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work on the project.

Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or Subcontractor employee.

In respect to its employees, the Contractor agrees to be responsible for the following:

1. any and all employment taxes and/or other payroll withholding;
2. any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. damages incurred by Contractor's employees within the scope of their duties under the contract;
4. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
5. determining the hours to be worked and the duties to be performed by the Contractor's employees.

K. CONTRACT CONFLICTS

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

Contractor shall insure that contracts or agreements with sub-contractors and agents, and the performance of services in relation to this contract by sub-contractors and agents, does not conflict with this contract.

L. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
	X		Contractor has a broad proactive recruitment effort and may unknowingly target individuals who are or have been associated with this RFP. Our team working on the Services under this RFP will not recruit or employ the State's personnel during the period that the Services are being performed.

The Contractor shall not, at any time, recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or

project.

M. CONFLICT OF INTEREST

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	It is Contractor's practice to serve multiple clients within industries, including those with potentially opposing interests. Accordingly, Contractor may have served, may currently be serving or may in the future serve other clients whose interests may be adverse to those of the State. In all such situations, Contractor is committed to maintaining the confidentiality of each client's information and will abide by non-disclosure procedures (such as firewall protocols and other safeguards) to ensure that all confidences are protected.

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

N. PROPOSAL PREPARATION COSTS

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this Request for Proposal.

O. ERRORS AND OMISSIONS

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

P. BEGINNING OF WORK

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

Q. ASSIGNMENT BY THE STATE

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

R. ASSIGNMENT BY THE CONTRACTOR

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			Contractor may assign the Contract to an affiliate with reasonable prior written notice to the State.

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations

hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

S. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal, mandatory requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

T. GOVERNING LAW

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	The parties should be permitted to bring any legal disputes in Federal or state courts located in Nebraska.

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

U. ATTORNEY'S FEES

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	Each party should be responsible for their own attorneys' fees in the event of a dispute. This Section should be deleted in its entirety.

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party.

V. ADVERTISING

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			This provision should be made mutual.

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

W. STATE PROPERTY

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

X. SITE RULES AND REGULATIONS

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			Any site rules and regulations should be provided to Contractor in writing.

The Contractor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor.

Y. NOTIFICATION

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II. A., Procuring Office and Contact Person, of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title, and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests, or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

2. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the Contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Communication about the contract between Contractor and individuals not designated as points of contact by the State is strictly forbidden.

Z. EARLY TERMINATION

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	Each party should be entitled to terminate the Contract upon reasonable notice to the other party or immediately upon a material breach by the other party which remains uncured after 30 days' notice from the non-breaching party. Upon any termination, the State should pay Contractor for all Services rendered and reimbursable

			expenses incurred in accordance with the terms of the Contract up to and including the effective date of termination.

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract immediately for the following reasons:

   a. If directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. A trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
   d. Fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
   e. An involuntary proceeding has been commenced by any party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
   f. A voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
   g. Contractor intentionally discloses confidential information;
   h. Contractor has or announces it will discontinue support of the deliverable;
   i. Second or subsequent documented "vendor performance report" form deemed acceptable by the Agency; or
   j. Contractor engaged in collusion or actions which could have provided Contractor an unfair advantage in obtaining this contract.

AA. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			The State acknowledges and agrees that Contractor is entitled to rely on the State's execution of the Contract or a statement of work, as the case may be, as certification that the State has complied with all applicable laws, necessary funds are available and all necessary approvals have been obtained by the State.

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon

legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of any termination, and advise the Contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

BB. BREACH BY CONTRACTOR

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	Each party should be entitled to terminate the Contract upon reasonable notice to the other party or immediately upon a material breach by the other party which remains uncured after 30 days' notice from the non-breaching party. Upon any termination, the State should pay Contractor for all Services rendered and reimbursable expenses incurred in accordance with the terms of the Contract up to and including the effective date of termination. Contractor does not agree to contractually provide cover. The payment of any replacement costs should be determined through the dispute resolution process in the Contract.

The State may terminate the contract, in whole or in part, if the Contractor fails to perform its obligations under the contract in a timely and proper manner. The State may, by providing a written notice of default to the Contractor, allow the Contractor to cure a failure or breach of contract within a period of thirty (30) calendar days (or longer at State's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing the Contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

CC. ASSURANCES BEFORE BREACH

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	Specific acceptance criteria should be mutually agreed upon and included in the Contract.

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the Contractor shall deliver

assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

DD. ADMINISTRATION – CONTRACT TERMINATION

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	Please include the following as item 3: Contractor shall be permitted to retain copies of Confidential Information in accordance with its legal, disaster recovery and records retention requirements, but subject to its confidentiality obligations under the Contract.

1. Contractor must provide confirmation that upon contract termination all deliverables prepares in accordance with this agreement shall become the property of the State of Nebraska; subject to the ownership provision (section E) contained herein, and is provided to the State of Nebraska at no additional cost to the State.

2. Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days. Notwithstanding the above, Contractor may retain one copy of any information as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures.

EE. PENALTY

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
	X		This Section should be deleted in its entirety. The parties should rely on the dispute resolution procedures in the Contract to resolve any disputes. Neither party should be permitted to unilaterally affect the other party's rights.

In the event that the Contractor fails to perform any substantial obligation under the contract, the State may withhold all monies due and payable to the Contractor, without penalty, until such failure is cured or otherwise adjudicated. Failure to meet the dates for the deliverables as agreed upon by the parties may result in an assessment of penalty due the State of $1,000 dollars per day, until the deliverables are approved. Contractor will be notified in writing when penalty will commence.

FF. FORCE MAJEURE

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

GG. PROHIBITION AGAINST ADVANCE PAYMENT

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

Payments shall not be made until contractual deliverable(s) are received and accepted by the State.

HH. PAYMENT

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			State's determination on whether the contract and specifications have been satisfactorily completed should not be unreasonable.

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services.

II. INVOICES

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Invoices must classify the contract deliverable (per IV.F Deliverables) associated with each expense. Invoices are to be submitted no later than 30 calendar days following MLTC's approval of deliverable(s). A final invoice must be submitted within 30 days of the last day of the contract period. Invoices
should be sent to:

DHHS-MLTC Attn: Managed Care & HCBS Administrator
Post Office Box 95026
Lincoln, NE 68509

The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

JJ. RIGHT TO AUDIT

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	Audits should be limited to during the term of the Contract and the 18 month period immediately following the termination of the Contract. Any audit or inspection should be limited to books and records directly relating to the Services, conducted at the State's expense, made upon reasonable prior written notice, during normal business hours and shall be subject to the execution of a confidentiality agreement reasonably satisfactory to Contractor. If upon final determination an audit discloses that the State overpaid Contractor for fees, expenses or other charges under the Contract for readily identifiable components of Services (as examples for illustrative purposes only: such as a billing in excess of actual hours worked, miscalculation of actual supplies consumed, etc.), Contractor will refund to the State the amount of that overpayment. In addition, if that audit discloses that

			such overpayment was for ten percent or more than the amount actually due to Contractor during the period covered by the audit, Contractor will also reimburse the State for the reasonable out-of-pocket expenses of the audit; provided that Contractor was first given a reasonable opportunity to review and challenge results of such audit. Contractor will agree to promptly correct any material weakness or condition reported to the State as agreed to by the parties.

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit contract. The State and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this contract kept by or under the control of the Contractor, including, but not limited to those kept by the Contractor, its employees, agents, assigns, successors, and Subcontractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence.

Contractor shall, at all times during the term of this contract and for a period of five (5) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. If an audit has been initiated and audit findings have not been resolved at the end of six (6) years, the records must be retained until resolution of the audit finding. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and Subcontractors, and the obligations of these rights shall be explicitly included in any Subcontracts or agreements formed between the Contractor and any Subcontractors to the extent that those Subcontracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor.

KK. TAXES

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

LL. INSPECTION AND APPROVAL

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	Any audit or inspection should be limited to books and records directly relating to the Services, conducted at the State's expense, made upon reasonable prior written notice, during normal business hours and shall be subject to the execution of a confidentiality agreement reasonably satisfactory to Contractor.

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

MM. CHANGES IN SCOPE/CHANGE ORDERS

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			The Contract shall not be amended except by a written document executed by both parties.

The State may, upon the written agreement of Contractor, make changes to the contract within the general scope of the RFP. The State may, at any time work is in progress, by written agreement, make alterations in the terms of work as shown in the specifications, require the Contractor to make corrections, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, or a pro-rated value.

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification.

Changes or additions to the contract beyond the scope of the Request for Proposal are not permitted; however, this Request for Proposal must meet all applicable federal legal requirements and regulations, including but not limited to Medicaid laws, rules and regulations, and any future amendments to this Request for Proposal that are required to bring Nebraska into compliance with federal Medicaid law shall be deemed part of the scope of the requested bid.

NN. SEVERABILITY

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	This Section should read as follows: "It is the intent of the parties that the provisions of this Contract shall be enforced to the fullest extent permitted by applicable law. To the extent that the terms set forth in this Contract or any word, phrase, clause or sentence is found to be illegal or unenforceable for any reason, such word, phrase, clause or sentence shall be modified, deleted or interpreted in such a manner so as to afford the party for whose benefit it was intended the fullest benefit commensurate with making this Contract as modified, enforceable and the balance of this Contract shall not be affected thereby, the balance being construed as severable and independent."

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

OO. CONFIDENTIALITY

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	Confidentiality obligations under the Contract should be reciprocal. Confidentiality obligations should be limited to information not generally known outside of a party's company that is identified as confidential or proprietary at or prior to disclosure or if not identified would appear to a reasonably prudent person to be non-public, confidential or proprietary in nature when provided that is given to the other party in connection with the Contract. Contractor should be permitted to retain copies of Confidential Information in accordance with its legal, disaster recovery and records retention requirements, but subject to its confidentiality obligations. Confidentiality obligations should not apply to information (i) that is publicly available (not as a result of a breach by the receiving party); (ii) already known to the receiving party; (iii) disclosed by a third party with a right to disclose; (iv) independently

			developed by the receiving party without reference to the other party's confidential information; or (v) required by law or court order. The receiving party will, unless prohibited by law, give prompt notice to the disclosing party of any disclosure required by law so that the disclosing party may seek a protective order. Contractor, in accordance with applicable privacy laws and regulations, agrees to notify the State promptly upon learning of Security Incidents involving State Confidential Information. Security Incidents are defined as (1) the actual unauthorized access to or use of unencrypted State Confidential Information by an unaffiliated third party, or (2) loss, theft, or unauthorized disclosure or manipulation of unencrypted State Confidential Information that has the potential to cause harm to [Client] systems, employees, information or the State brand name (i.e., potential breach).

All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be handled in accordance with federal and state law, and ethical standards. The Contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a Contractor; Contractor shall notify the State immediately of said breach and take immediate corrective action. The Contractor's subcontracts must explicitly state expectations about the confidentiality of information, and the subcontractor is held to the same confidentiality requirements as the Contractor. Any releases of information to the media, the public, or other entities require prior approval from MLTC. This clause shall be included in all subcontracts.

It is incumbent upon the Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to Contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a Contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

PP. PROPRIETARY INFORMATION

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. **All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal, and provide supporting documents showing why such documents should be marked proprietary.** The separate package must be clearly marked PROPRIETARY on the outside of the package. **Bidders may not mark their entire Request for Proposal as proprietary.** Bidder's cost proposals may not be marked as proprietary information. Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific

research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

QQ. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

By submission of this proposal, the bidder certifies, that it is the party making the foregoing proposal and that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted the proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

RR. STATEMENT OF NON-COLLUSION

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The proposal shall be arrived at by the bidder independently and be submitted without collusion with, and without any direct or indirect agreement, understanding or planned common course of action with, any person; firm; corporation; bidder; Contractor of materials, supplies, equipment or services described in this RFP. Bidder shall not collude with, or attempt to collude with, any state officials, employees or agents; or evaluators or any person involved in this RFP. The bidder shall not take any action in the restraint of free competition or designed to limit independent bidding or to create an unfair advantage.

Should it be determined that collusion occurred, the State reserves the right to reject a bid or terminate the contract and impose further administrative sanctions.

SS. PRICES

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
	X		This provision should be deleted in its entirety. Contractor provides professional services to an array of clients whose needs and circumstances are not readily comparable and, therefore, Contractor is unable to differentiate client status into "most-favored" customer. Rather, Contractor addresses the business needs of each client individually and provides services at agreed upon rates.

All prices, costs, and terms and conditions outlined in the proposal shall remain fixed and valid commencing on the opening date of the proposal until an award is made or the Request for Proposal is cancelled.

Contractor represents and warrants that all prices for services, now or subsequently specified, are as low as and no higher than prices which the Contractor has charged or intends to charge customers other than the State for the same or similar products and services of the same or equivalent quantity and quality for delivery or performance during the same periods of time. If, during the term of the contract, the Contractor shall reduce any and/or all prices charged to any customers other than the State for the same or similar products or services specified herein, the Contractor shall make an equal or equivalent reduction in corresponding prices for said specified products or services.

Contractor also represents and warrants that all prices set forth in the contract and all prices in addition, which the Contractor may charge under the terms of the contract, do not and will not violate any existing federal, state, or municipal law or regulations concerning price discrimination and/or price fixing. Contractor agrees to hold the State harmless from any such violation. Prices quoted shall not be subject to increase throughout the contract period unless specifically allowed by these specifications.

TT. BEST AND FINAL OFFER

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The State will compile the final scores for all parts of each proposal. The award may be granted to the highest scoring responsive and responsible bidder. Alternatively, the highest scoring bidder or bidders may be requested to submit best and final offers. If best and final offers are requested by the State and submitted by the bidder, they will be evaluated (using the stated criteria), scored, and ranked by the Evaluation Committee. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

UU. ETHICS IN PUBLIC CONTRACTING

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator, employee or evaluator based on the understanding that the receiving person's vote, actions or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau or any evaluator.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or Contractors to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or Contractors. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.

If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

VV. INDEMNIFICATION

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	General - Contractor will indemnify the State, its affiliates, officers, directors and employees against any liability incurred by the indemnified parties in connection with a third party claim only to the extent directly arising out of Contractor's negligent acts or omissions or bad faith conduct in connection with Contractor's performance of its obligations under the Contract or Contractor's breach of its representations and warranties under the Contract. Intellectual Property - Contractor will indemnify the indemnified parties against any liability incurred by the State to the extent directly arising out of a claim that any of its work product or the Services infringes or misappropriate any intellectual property rights of a third party. Contractor's indemnity obligations under this Section should not apply to any claim for infringement or misappropriation of intellectual property rights to the extent any such infringement or misappropriation is caused by: (i) information or materials provided by the

			State or a third party other than Contractor's subcontractors, if any, (ii) modifications made by the State or a third party other than Contractor's subcontractors to Services, work product or Contractor's other materials provided to the State in connection with the Services, or any parts thereof, or (iii) the State's use of Services, work product or such other materials or any parts thereof, in a manner inconsistent with the terms of the Contract. If Services or work product become, or in Contractor's reasonable opinion is likely to become, the subject of a claim of infringement ("Infringing Material"), Contractor shall, at its expense and discretion, (a) procure for the State the right to continue using the Infringing Material; (b) modify or replace the Infringing Material with compatible, functionally equivalent, non-infringing material; or (c) if (a) or (b) are not reasonably practicable, Contractor shall refund an equitable portion of the fees paid for the Infringing Material which shall be the State's sole remedy for an infringement claim. Limitation of Liability - To the extent permitted by law, the Contract should contain an appropriate financial limitation of liability. Contractor's standard limitation of liability for any and all losses, liabilities or damages arising out of or relating to the provision of services by Contractor is an amount not to exceed the greater of one times the compensation paid to Supplier for the Services giving rise to such loss. In no event should either party be liable in connection with the Contract for loss of profits or any indirect, incidental, punitive, special or consequential damages arising in any manner from the Contract regardless of foreseeability thereof. Contractor should have no responsibility for any losses, liabilities or damages to the extent they are attributable to the acts or omissions of an indemnified person or any third party other than Contractor's subcontractors.

1. **GENERAL**

The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, Contractors, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. **INTELLECTUAL PROPERTY**

The Contractor agrees it will at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result

from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, Contractors, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall at the Contractor's sole cost and expense promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. **PERSONNEL**
The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the Contractor.

4. **SELF-INSURANCE**
The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 *et seq.* and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

5. **ALL REMEDIES AT LAW**
Nothing in this agreement shall be construed as an indemnification by one party of the other for liabilities of a party or third parties for property loss or damage or death or personal injury arising out of and during the performance of this lease. Any liabilities or claims for property loss or damages or for death or personal injury by a party or its agents, employees, contractors or assigns or by third persons, arising out of and during the performance of this lease shall be determined according to applicable law.

WW. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	Contractor would like to discuss this provision further with the State if it is rewarded with the Contract. Contractor is a global company with thousands of clients. As such, it's not possible for Contractor to comply with each client's technology policies as they conflict with one another as well as with our internal policy. Consequentially, this Section should be replaced with the following: "Contractor agrees to maintain and use appropriate safeguards to prevent the unauthorized access to or use of the State information and data, and to implement

			administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of information or data that Contractor processes in the course of providing the services to the State covered within this Contract. Such safeguards shall include, but are not limited to, (a) security management policies and procedures including incident management procedures to address security events, (b) access controls, including password change controls, to ensure access to information resources is granted on a need to know and least privilege basis, (c) device and software management controls to guard against viruses and other malicious or unauthorized software, (d) industry standard encryption safeguards as appropriate and where required by law (e) security awareness to ensure employee understanding of their responsibilities in guarding against security events and unauthorized use or access to information, (f) logging procedures to proactively record user and system activity for routine review, and (g) facility access and protection controls to limit physical access to information resources and guard against environmental hazards (e.g., water or fire damage)."

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request that contract comply with the changed standard at a cost mutually acceptable to the parties.

XX. ANTITRUST

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

YY. DISASTER RECOVERY/BACK UP PLAN

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
		X	Contractor maintains disaster recovery and business resiliency/continuity plans that address reasonably foreseeable events that could impair Contractor's ability to render Services under this Contract. Contractor agrees to provide, upon request, a Statement of Recoverability that details Contractor's level of readiness to respond and recover from disaster or crisis situations. The report will include a summary of the status of the Disaster Recovery and Business Resiliency/Continuity programs and testing activities, as they relate to the Services.

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under these specifications in the event of a disaster.

ZZ. TIME IS OF THE ESSENCE

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

AAA. RECYCLING

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per Neb. Rev. Stat. § 81-15,159.

BBB. DRUG POLICY

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

Contractor certifies that it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

CCC. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an newly hired employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at: http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the Request for Proposal response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

DDD. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The Contractor, by signature to this RFP, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The Contractor also agrees to include the above requirements in any and all Subcontracts into which it enters. The Contractor shall immediately notify the Department if, during the term of this contract, Contractor becomes debarred. The Department may immediately terminate this contract by providing Contractor written notice if Contractor becomes debarred during the term of this contract.

Contractor, by signature to this RFP, certifies that Contractor has not had a contract with the State of Nebraska terminated early by the State of Nebraska. If Contractor has had a contract terminated early by the State of Nebraska, Contractor must provide the contract number, along with an explanation of why the contract was terminated early. Prior early termination may be cause for rejecting the proposal.

EEE. POLITICAL SUB-DIVISIONS

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

The Contractor may extend the contract to political sub-divisions conditioned upon the honoring of the prices charged to the State. Terms and conditions of the Contract must be met by political sub-divisions. Under no circumstances shall the State be contractually obligated or liable for any purchases by political sub-divisions or other public entities not authorized by Neb. Rev. Stat. § 81-145, listed as "all officers of the state, departments, bureaus, boards, commissions, councils, and institutions receiving legislative appropriations." A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

FFF. OFFICE OF PUBLIC COUNSEL

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
X			

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This

section shall survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

GGG. LONG-TERM CARE OMBUDSMAN

Accept (initial)	Reject (initial)	Reject and Provide Alternative within RFP Response (initial)	Notes/Comments
	X		Not Applicable to the Services Contractor provides.

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

Additional Terms Any contract between the parties should also contain the following provisions:

a. The Contract is made on the basis that each party is entitled to assume that the other has complied and will continue to comply with its obligations arising from data protection and privacy laws in force from time to time to the extent applicable to the Contract and the services, any obligation of the State to obtain any required consent(s) in respect of the transfer of information relating to an identified or identifiable individual that is subject to applicable data protection, privacy or other similar laws ("Personal Information") by the State or any third party to Contractor, the creation or collection of additional Personal Information by Contractor, and the use, disclosure and transfer by Contractor of Personal Information as necessary to perform the services. The parties acknowledge that any use or processing by Contractor of Personal Information supplied by or on behalf of the State in connection with the services shall be done solely on behalf of the State and for the State' purposes and Contractor shall deal with such Personal Information only in accordance with such reasonable instructions as the State may from time to time provide or as reasonably necessary for the purpose of providing the services. Contractor also confirms that it has taken appropriate technical and organizational measures against unauthorized or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data in accordance with applicable law.

b. The State will provide all necessary and reasonably requested information, direction and cooperation to enable Contractor to provide the Services, and any direction (whether verbal or written) shall be effective if contained expressly in the applicable Statement of Work or if received (whether verbally or in writing) from a person known to Contractor or reasonably believed by Contractor to be authorized to act on the State's behalf. Contractor shall be permitted to use all information and data supplied by or on behalf of the State without having independently verified the accuracy or completeness of it except to the extent required by generally accepted professional standards and practices. If any documentation or information supplied to Contractor at any time is incomplete, inaccurate or not up-to-date, or its provision is unreasonably delayed, then Contractor shall not be responsible for any delays or liability arising therefrom. In the event that it is necessary or appropriate to perform any additional work as a result, Contractor will obtain the State's prior approval before commencing such additional work; provided that if the State does not provide such prior approval, Contractor shall not be obligated to perform such additional work and Contractor shall have no liability for the Services to the extent any loss arises from or is related to the failure to perform such additional work.

c. EACH PARTY, ON BEHALF OF ITSELF AND ITS AFFILIATES, TO THE FULLEST EXTENT PERMITTED BY LAW, KNOWINGLY, VOLUNTARILY, AND INTENTIONALLY WAIVES ITS RIGHT TO A TRIAL BY JURY IN ANY ACTION OR OTHER LEGAL PROCEEDING ARISING OUT OF OR RELATING TO THIS CONTRACT OR ANY SERVICES PROVIDED BY CONTRACTOR OR ITS AFFILIATES. THE WAIVER APPLIES TO ANY ACTION OR LEGAL PROCEEDING, WHETHER SOUNDING IN CONTRACT, TORT OR OTHERWISE. EACH PARTY AGREES NOT TO INCLUDE ANY EMPLOYEE, OFFICER, DIRECTOR OR TRUSTEE OF THE OTHER AS A PARTY IN ANY ACTION, PROCEEDING OR COUNTERCLAIM RELATING TO SUCH DISPUTE.

d. Neither the Contract nor the provision of the Services is intended to confer any right or benefit on any third party. The provision of Services under this Contract cannot reasonably be relied upon by any third party.

e. For purposes of this Contract, the parties agree that "gross negligence" is defined as conduct that smacks of intentional wrongdoing or evinces a reckless indifference to the rights of others.

f. Any sections that by their nature or meaning shall survive the termination or expiration of the Contract should survive the termination or expiration of the agreement.

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Section 2

Section 2: Corporate Overview

A) BIDDER IDENTIFICATION AND INFORMATION
The bidder must provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

Mercer Health & Benefits LLC (Mercer) is a limited liability corporation, part of Mercer (US) Inc. incorporated in Delaware in 1975.

Company Headquarters:

1166 Avenue of the Americas
New York, New York 10036

Mercer has a long consulting history that began in the United States (US) in 1937 as the employee benefits department of Marsh & McLennan, Inc. Our company took the name William M. Mercer in 1959 when Marsh & McLennan acquired William M. Mercer, Ltd., a Canadian firm founded by William Manson Mercer in 1945. In 1975, William M. Mercer became a wholly owned subsidiary of Marsh & McLennan Companies, Inc. and was incorporated on July 9, 1975, in the State of Delaware. In 2002, we changed our corporate name to Mercer Human Resource Consulting. In 2007, we re-branded our global and US name as simply Mercer LLC and Mercer (US) Inc., respectively. Mercer and its separately incorporated operating entities around the world are part of Marsh & McLennan Companies, Inc., a publicly held company listed on the New York Stock Exchange and other major exchanges.

In October 2005, Marsh Employee Benefits Service was combined with Mercer Health Care and Group Benefits practice to create Mercer Health & Benefits LLC, a wholly owned subsidiary of Mercer (US) Inc. Today, Mercer Health & Benefits LLC is one of the largest health care and benefits consulting brokerage services companies in the world, with offices in more than 40 US locations.

The legal entity responsible for this contract is Mercer Health & Benefits LLC (Mercer). Mercer Health & Benefits LLC offers a wide range of health and benefits consulting to public and private entities. The Government Human Services specialty group within Mercer Health & Benefits LLC is dedicated to helping government entities efficiently and effectively purchase quality health care services. Among our staff are actuaries and accountants, clinicians (including doctors, psychologists, nurses, pharmacists, and social workers), information technologists, claims specialists and policy experts. We have over 250 professionals dedicated to helping government purchasers become more efficient purchasers of health care services.

B) FINANCIAL STATEMENTS

The bidder must provide financial statements applicable to the firm. If publicly held, the bidder must provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

Mercer is a wholly-owned subsidiary of Marsh & McLennan Companies. A separate financial audit is not performed and reported on Mercer LLC (global corporation), Mercer (US) Inc., or Mercer Health & Benefits LLC individually. Instead, all operations are reported in the consolidated statements of Marsh & McLennan Companies.

Marsh & McLennan Companies is a public company traded on stock exchanges around the world with 2015 revenue of approximately $13 billion (2015 Annual Report, page 1). The Consolidated Statements of Income is provided on page 47 and the Consolidated Balance Sheet is provided on page 49 of the March & McLennan Companies 2015 Annual Report.

The 2015 Annual Report is available at http://irnews.mmc.com/phoenix.zhtml?c=113872&p=irol-reportsAnnual and a copy is provided in Appendix A. The Annual Report includes three years (2013, 2014, and 2015) of financial information.

Specific information on Mercer is provided within the report as noted below.

- Mercer generated approximately 33% of the Company's total revenue in 2015. (2015 Annual Report, Introduction, page 5).
- Mercer's underlying revenue growth of 4% was strong and marked the fifth consecutive year of growth of 3% or higher. (2015 Annual Report, Introduction, page 3)
- Mercer's revenue was over $4.31 billion in 2015. (2015 Annual Report, page 28).
- Mercer's Health and Benefits LLC line of business increased 6% in 2015 and accounted for almost $1.56 billion of Mercer's total revenue. (2015 Annual Report, page 29).

In the ordinary course of business, Mercer is involved with litigation and other legal proceedings, investigations, and inquiries, some of which are conducted on an industry-wide basis. Based on information currently available, the outcomes of currently pending litigation, investigations, and inquiries are not expected to have any material adverse effect upon Mercer or its ability to service its clients in the ordinary course. Details regarding certain outstanding legal proceedings pertaining to Mercer and its affiliates are disclosed in the public Securities and Exchange

Commission filings of Marsh & McLennan Companies, available at http://news-investors.mmc.com/phoenix.zhtml?c=113872&p=irol-investors#sec_filings.

C) CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

Mercer does not anticipate any change in ownership or control of the company during the twelve (12) months following the proposal due date.

D) OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

The location of the office responsible for this bid is:

333 S. 7th Street, Suite 1400
Minneapolis, MN 55402 USA

E) RELATIONSHIPS WITH THE STATE

The bidder shall describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

Mercer had a long-term relationship with the State of Nebraska from 1993 until 2013. The table below provides information that identifies Mercer's historical contracts over the previous five years with the State.

Contract Identification	Duration	Description
22572-04	04/01/06 – 03/31/13	Actuarial Services and Medicaid Reform
DOI Sole Source Contract	03/28/12 – 06/30/12	DOI Essential Health Benefits Analysis
RFP 11-002Z1	04/08/11 – 08/08/11	DOI Exchange Planning Activities (subcontractor)
DHHS Sole Source Contract	12/21/09 – 12/21/10	Psychiatric Residential Treatment Facility Strategy Development
RFP 2346 Z-1	05/01/08 – 12/31/08	Medicaid Alternative Benefits Study

F) BIDDER'S EMPLOYEE RELATIONS TO STATE

If any party named in the bidder's proposal response is or was an employee of the State within the past thirty-six (36) months, identify the individual(s) by name,

State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

No party named in this proposal is or was an employee of the State of Nebraska within the past 36 months.

G) CONTRACT PERFORMANCE

If the bidder or any proposed Subcontractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other party's name, address and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.

To the best of our knowledge, Mercer has not had any contract terminated for default, convenience, non-performance, non-allocation of funds or for any other reason.

H) SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal. The bidder must address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Request for Proposal. These descriptions must include:

a) The time period of the project;
b) The scheduled and actual completion dates;
c) The Contractor's responsibilities;

d) For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and

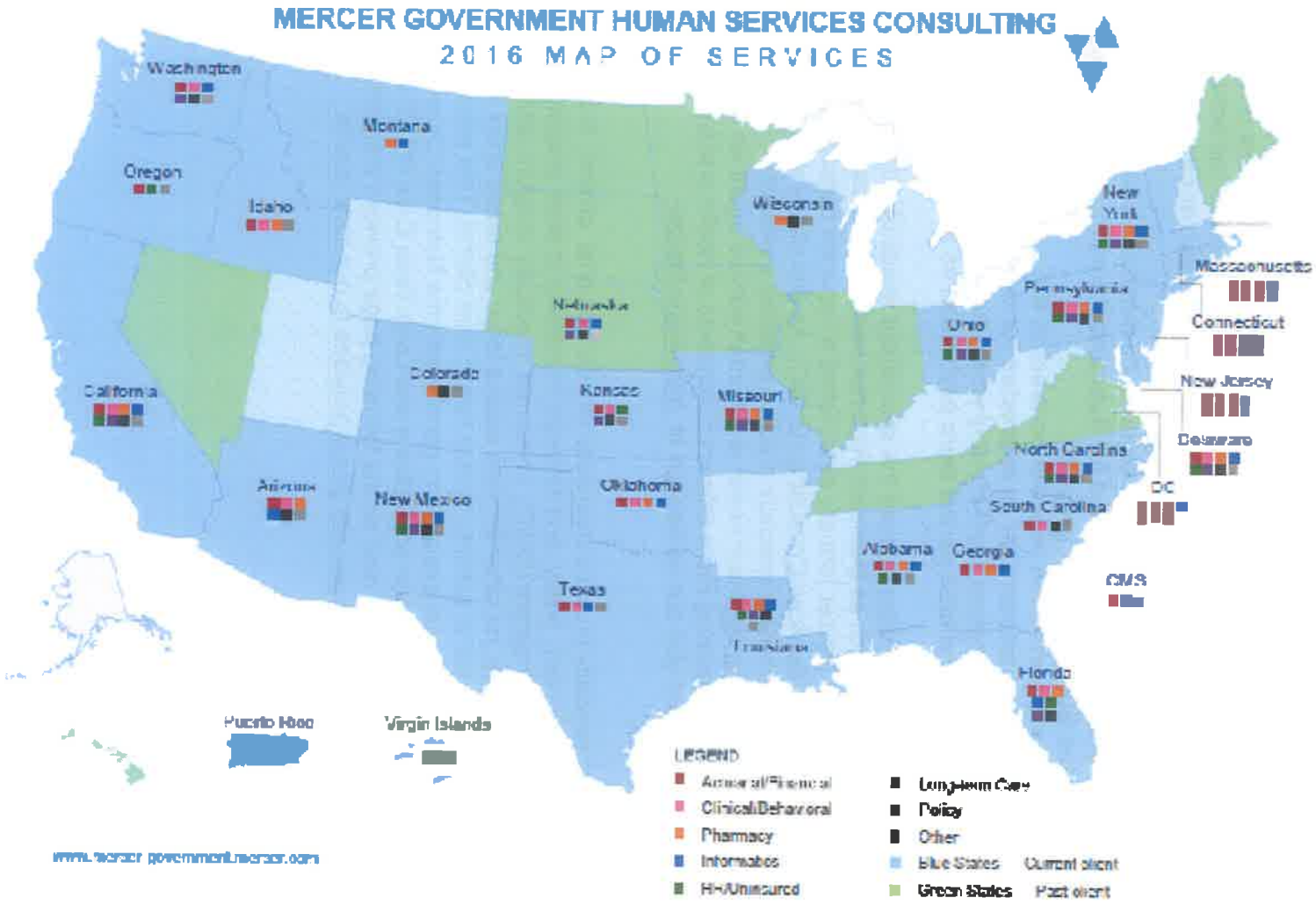
e) Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. Contractor and Subcontractor(s) experience must be listed separately. Narrative descriptions submitted for Subcontractors must be specifically identified as Subcontractor projects.

iii. **If the work was performed as a Subcontractor, the narrative description shall identify the same information as requested for the Contractors above. In addition, Subcontractors shall identify what share of contract costs, project responsibilities, and time period were performed as a Subcontractor.**

In 1992, after seven years of working to meet the specialized needs of publicly-sponsored health and welfare programs such as Medicaid, high-risk health insurance pools, and statewide health care reform initiatives, Mercer formally established a separate consulting practice – Mercer Government Human Services Consulting (GHSC). As one of several specialty practices within Mercer, Mercer's Government specialty practice provides a wide array of consulting services to state and federal government health and human service agencies across the country, assisting them in becoming more efficient purchasers of health and welfare services. For more information, please visit our homepage at: http://www.mercer-government.mercer.com/

Mercer's Government specialty practice's services include actuarial, clinical, financial, operational, systems, pharmacy, policy, and strategic consulting to state programs for Medicaid, Children's Health Insurance Program (CHIP), uninsured, medically indigent, and dually eligible populations. To our knowledge, no other firm has such a large and broad array of staffing resources specifically dedicated to publicly-funded health care clients. This ensures that we have the capabilities and resources available to partner with the Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care (MLTC) to accomplish all tasks delineated in this RFP. The map on the following page provides a pictorial summary of the services Mercer's Government specialty group provides to our state clients.


MERCER GOVERNMENT HUMAN SERVICES CONSULTING
2016 MAP OF SERVICES
Washington
Montana
Oregon
Idaho
Wisconsin
New York
Massachusetts
Pennsylvania
Connecticut
Nebraska
Ohio
Colorado
Kansas
Missouri
California
New Jersey
Delaware
North Carolina
Arizona
New Mexico
Oklahoma
DC
South Carolina
Alabama
Georgia
CMS
Texas
Louisiana
Florida
Puerto Rico
Virgin Islands
LEGEND
Actuarial/Financial
Clinical/Behavioral
Pharmacy
Information
HH/Uninsured
Long-term Care
Policy
Other
Blue States Current client
Green States Past client
www.mercer.governmentmercer.com

Mercer's experience with long-term services and supports (LTSS) is diverse and significant. As a leading national health care consulting firm, we have had the privilege of collaborating with many state Medicaid agencies in addressing LTSS opportunities and challenges. To meet the needs of our clients, Mercer employs over 250 dedicated health care professionals with a variety of experiences, skills, and backgrounds. Our team includes former Centers for Medicare and Medicaid (CMS) officials, Medicaid policy/regulatory specialists, ex-state Medicaid leaders, clinicians, social workers, pharmacists, actuaries, data managers, consultants, project managers, and analysts. Our subcontractor partner, the National Association of States United for Aging and Disabilities (NASUAD), augments the Mercer team with additional national perspectives, resource flexibility, and subject matter expertise. Below is a summary of Mercer's corporate experience that highlights previous projects similar in scope, size, and complexity to this RFP. Please note these are ongoing contracts that include numerous projects over significant lengths of time. Mercer works directly with each entity to ensure budget and timelines are completed on time. Any scope changes are included in the total contract value. We encourage MLTC staff to contact our references and hear from our clients what it is like to work with the Mercer team. We are confident that you will hear favorable comments.

Client: State of Delaware, Department of Health and Social Services / Division of Medicaid & Medical Assistance	
Contract Duration:	2008 to Present for Actuarial Services Contract 2006 to Present for External Quality Review Organization Contract
Total Contract Value:	$9,503,800 for Actuarial Services Contract $2,365,234 for External Quality Review Organization Contract
Contractor Status:	Prime
Contracting Officer:	Steve Groff Director, Division of Medicaid & Medical Assistance PO Box 906, Lewis Building 1901 N. DuPont Highway New Castle, DE 19720 +1 302 255 9663 stephen.groff@state.de.us

Contractor Responsibilities

Mercer won a competitive procurement in 2008 to become the State of Delaware, Department of Health and Social Services / Division of Medicaid & Medical Assistance actuarial/financial consultant. Services include or have included:

LTSS Redesign

Mercer assisted Delaware with designing and implementing a new capitated, Medicaid managed long-term care program. The program, DSHP Plus, is a capitated risk model in which contracted managed care organizations (MCOs) provide both institutional and community-based services to dually eligible individuals (i.e., Medicare/Medicaid beneficiaries). Mercer was involved at the initial stages and provided technical assistance in the program redesign, development of 1115 waiver amendment and negotiations with CMS. Mercer updated the MCO contract to incorporate the new design features, developed the long-term care rates (including a case mix adjustment to address potential differences between the populations enrolled in

Client: State of Delaware, Department of Health and Social Services / Division of Medicaid & Medical Assistance

the two MCOs), developed FFS data book and provided other policy/operations support. Mercer also facilitated the consensus review process for State staff to evaluate RFP responses and actively participated with State staff in designing the MCO readiness review process and conducting the reviews. A copy of Mercer's LTSS Options research paper is included as part of our response as a sample Mercer work product. More information can be found at: http://dhss.delaware.gov/dhss/dmma/dshpplus.html

Actuarial

As Delaware's actuary, Mercer performs numerous tasks for the State's Medicaid/CHIP managed care program including: development of Medicaid/CHIP capitation rates and development of rates for an 1115 waiver expansion population; analyzing family planning expenses, in lieu of services for Institutions for Mental Disease, hospital/clinic FFS UPL issues; providing provider/premium tax strategic advice; and implementing diagnostic-based risk-adjustment into the capitated MCO program using the CDPS+Rx risk adjustment model. In 2012, with Mercer's assistance, the State expanded the risk-based managed care program to include full-benefit dual eligibles, nursing facility residents, and non-DD home and community-based (HCBS) waiver participants. In support of this major program expansion, Mercer completed a LTSS research options paper, 1115 waiver concept paper, 1115 waiver amendment, assisted with the stakeholder process, supported CMS waiver negotiations and developed LTSS capitation rates. In 2015, the managed care program was re-procured and at that time outpatient pharmacy was carved-into the program, some additional behavioral health services were carved-in and through the re-procurement, one plan was discontinued and one new plan joined the program. Mercer also provides the State with fee-for-service upper payment limits (UPLs) for their Program for the All-inclusive Care of the Elderly (PACE) program.

Financial Reporting and Monitoring

To improve the State's financial monitoring and oversight of the MCO program, Mercer created and implemented a new, comprehensive financial reporting and monitoring process including developing annual and quarterly financial reporting requirements (e.g., profit/loss schedules, balance sheet, income statement, utilization reports). Mercer accountants and financial staff collaborate with the State in reviewing the quarterly and annual financial reports, documenting questions/concerns that each MCO must respond to in writing and providing technical assistance on all matters related to financial reporting and monitoring.

Informatics

To support the data analyses provided through the actuarial and EQRO contracts, Mercer collects and validates the eligibility, enrollment, claims and encounter data for the Medicaid/CHIP and expansion populations. To the extent that issues are identified, Mercer works directly with the State's data vendor to resolve any identified issues and works with the plans, where necessary.

Behavioral Health Services

In December 2014, CMS approved two new programs that expanded the availability of HCBS options for Delaware Medicaid recipients. Pathways, effective January 1, 2015, is a program designed for persons age 14-25 with disabilities (intellectual disabilities, autism spectrum disorders, visual impairments, or physical disabilities) who want to work. PROMISE, also effective January 1, 2015, is a program that provides enhanced behavioral health services and supports for persons 18 and over who have severe and persistent mental illness and/or a substance abuse disorder and who require HCBS to live and work in integrated settings. Mercer provided extensive support in the development and implementation of both programs

Client: State of Delaware, Department of Health and Social Services / Division of Medicaid & Medical Assistance

including development of the federal application (1115 waiver amendment for PROMISE and 1915(i) and 1915(b)(4) applications for Pathways); technical assistance in negotiations with CMS; development of program manuals and operating guidance; rate development for new services; and facilitating staff implementation workgroups.

Clinical/Quality

Mercer is currently the External Quality Review Organization (EQRO) for the State's Medicaid/CHIP managed care program. Responsibilities under this contract include development of written Quality Management Strategy (QMS), completion of EQR compliance reviews and reporting, validation of performance improvement projects of the contracted managed care health plans (Title XIX and Title XXI PIPs), validation of the health plans' performance measures, providing technical assistance to the MCOs, conducting network adequacy studies and ad hoc quality of care projects related to the managed care program.

Similarities Between Experience and Nebraska LTSS Redesign

Delaware has had risk-based managed care since the mid-1990s via an 1115 waiver, but LTSS, duals and institutional/HCBS individuals were originally excluded from the program. The State also operated multiple 1915c HCBS waivers for the Elderly/Disabled, HIV/AIDS, Traumatic Brain Injury (TBI) and intellectually disabled (ID). Delaware's Medicaid population is approximately 240,000 individuals and total Medicaid program expenditures are approximately $1.7 billion. Beginning in 2010, Delaware began exploring options to redesign its LTSS delivery system. In July 2010, Mercer completed the LTSS Options research paper, in May 2011 we completed an 1115 Concept Paper, and in July 2011 we completed an 1115 waiver Amendment. Through many meetings, strategic planning sessions, stakeholder input, research reports, and careful deliberation, Delaware decided to expand its managed care program to include LTSS. To simplify administration of the program moving forward, Mercer worked with the State to convert the existing non-DD 1915c waivers into the 1115 operating authority thus relieving the State of having additional waivers to maintain. The LTSS managed care expansion went live on April 1, 2012 under the program name Diamond State Health Plan Plus (DSHP Plus). Delaware also has one PACE organization. Not only is Delaware's Medicaid program similar in size to Nebraska, but the construct and recent changes to the managed care delivery system bear resemblance as well. The combination of LTSS policy, program design, operating authorities, research, and strategic planning with Delaware are all very similar to the requirements in Nebraska's RFP.

Client: State of New Jersey, Department of Human Services, Division of Medical Assistance & Health Services	
Contract Duration:	1994 to Present
Total Contract Value:	$12,107,213
Contractor Status:	Prime
Contracting Officer:	David P. Moran Manager, Managed Care Finance, Office of Managed Care Finance P.O. Box 712 5 Quaker Bridge Plaza Building 7, 3rd Floor Trenton, NJ 08625-0712 +1 609 588 2858 David.Moran@dhs.state.nj.us

Contractor Responsibilities

Mercer won a competitive procurement with the State of New Jersey, Department of Human Services, Division of Medical Assistance & Health Services. Services include or have included:

Actuarial

Mercer is New Jersey's actuary for its Medicaid managed care program, which includes the TANF, FamilyCare, CHIP, ABD, newly eligible expansion, institutional and HCBS programs. Specific activites include: incorporate cutting-edge efficiency analyses/adjustments directly into capitation rate setting, such as unnecessary emergency room use, preventable hospitalizations and improved pharmacy management; developed PACE UPLs; design and implement risk adjusted rates for most populations enrolled in managed care; and worked with the State on Section 1202 PCP fee increase.

Financial Modeling and Reporting

Mercer's financial modeling and reporting assistance to the State includes: developed a budget projection model that projects costs associated with moving clients out of nursing homes into the community, to support a rebalancing initiative in New Jersey; and developed a web-based reporting system that captures MCO financial information on a quarterly basis and produces standardized benchmarking dashboard reports.

Shared Savings/ACO and P4P Program

Mercer worked with the State on evaluating various options related to a shared savings/ACO program and on evaluating various performance based contracting approaches for managed care plans.

Managed Behavioral Health Implementation

As New Jersey transitioned to behavioral health integration, Mercer provided the following support: worked with the State to implement a managed behavioral health adminstrative services only (ASO) program; assisted with program and financial requirements related to implementation and overall strategy related to program implementation; and assisted with stakeholder meetings.

Similarities Between Experience and Nebraska LTSS Redesign

Client: State of New Jersey, Department of Human Services, Division of Medical Assistance & Health Services

The following is an overview of Mercer's assistance in reviewing, analyzing and designing New Jersey's LTSS system of care.

LTSS Program Policy and Waiver Development

Mercer assisted New Jersey in the development of an 1115 comprehensive waiver. This waiver focuses on streamlining the State's Medicaid program, and promoting delivery system innovations including expansion of managed care, managed long term care, managed behavioral health, managing supports for intellectual and developmental disabilities and I/DD with dual mental health diagnosis. Incentive programs and use of medical homes are also included in the waiver design.

Managed LTSS (MLTSS) Dessign/Onsite Project Assistance

Mercer's support to implement the new waiver 1115 comprehensive waiver includes: developing the long term care risk adjustment model; developing managed LTSS capitation rates; project manage overall implementation efforts with on-site staffing resource; assist the State with developing program, clinical and financial contract requirements and updating the MCO contract; and leading the MCO readiness reviews.

Client: State of New Mexico, Human Services Department, Medical Assistance Division	
Contract Duration:	1997 to Present
Total Contract Value:	$7,000,000
Contractor Status:	Prime
Contracting Officer:	Nancy Smith-Leslie Director 2025 South Pacheco Santa Fe, NM +1 505 827 7704 nancy.smith-leslie@state.nm.us

Contractor Responsibilities

Mercer has been working with the State of New Mexico, Human Services Department, Medical Assistance Division on several projects for many years. Services include or have included:

Actuarial

Mercer is the actuary for New Mexico's Medicaid program and as such tasks include: develop the capitation rates for MCOs; develop the rate-setting methodologies for the State's Medicaid managed care programs which include acute care physical health, behavioral health, long term care, Medicaid expansion and PACE; review MCO encounter and financial data reports for completeness and accuracy and incorporating the data into the development of rates; and assist the State in assess the impact of numerous programmatic changes which includes making financial impact estimates and addressing operational and implementation effects.

Clinical/Quality

Mercer provides consulting assistance related to clinical/quality related issues including implementation of health home and identification of clinical efficiency opportunities within the managed care programs.

Pharmacy

Mercer worked with the State to design a specialty pharmacy Maximum Allowable Cost program.

Similarities Between Experience and Nebraska LTSS Redesign

Mercer has been intimately involved in the State's MLTSS redesign process and implementation. Mercer's assistance includes consulting on cost containment opportunities in the Medicaid managed care programs and identification of pharmacy efficiency opportunities within the managed care programs. Additional details specific to the experience for the Nebraska LTSS redesign is noted below

LTSS Redesign

In 2011, Mercer was contracted to assist with the design, development, implementation, and ongoing operations of the Centennial Care program (a fully-integrated Medicaid managed long term services and supports program operating under an 1115 waiver). Each phase of the project (design, development, implementation, etc.) required different resources, had specific requirements, and was subject to different risks, dependencies, and constraints.

At the initial phase, Mercer provided policy guidance regarding development of the concept and program design to meet the State's objectives, facilitated forums with stakeholders for feedback on the concept, including an initiative to improve the public meeting process. Mercer developed the 1115 waiver application

Client: State of New Mexico, Human Services Department, Medical Assistance Division

and STCs and developed the budget neutrality calculations and provided technical assistance in state negotiations with CMS. Program design and development also included: facilitating combined stakeholder and staff workgroups for program design; developing the RFP for MCO selection; developing the MCO procurement; facilitating the consensus RFP evaluation process; developing report templates; and designing the readiness review process and readiness review materials and working with staff to conduct onsite and desk reviews. Regarding implementation, Mercer was actively involved in developing the process, tools, and reports for implementation, including heavy onsite presence the first three months to support initial implementation. Ongoing monitoring has included project management; review and analysis of MCO reports and ongoing technical assistance and support on various program issues.

I) SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH
The bidder must present a detailed description of its proposed approach to the management of the project.

The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles (as described in Section IV.D Staffing Requirements) of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder shall provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

Mercer has assembled a team of experienced consultants with relevant experience for this project. We believe it is critical that this team be seen as reputable in the industry, credible, and impartial such that research, program assessment, stakeholdering, redesign recommendations and implementation tasks are effective and presented objectively. The unique needs and requirements of the Nebraska LTSS redesign will require a team with complementary skills and years of experience. Our proposed team combines the resources and extensive experience of Mercer and NASUAD for unparalleled experience in LTSS and stakeholdering and thus represents the best value for MLTC in completing the scope of work required by this RFP.

To support the MLTC, Mercer will bring real-life, practical experience to the table that has been successful in other state Medicaid programs to help Nebraska think creatively and evaluate the many options that are available to impact your LTSS delivery system. Our experience has also

shown us that although similarities exist between state Medicaid programs, no state programs are identical. Each new initiative must be designed to consider the unique policies, populations, priorities, and politics of each state. Therefore, Mercer cannot and will not operate in a vacuum nor "sell" Nebraska on a singular strategy. Instead, this will be a collaborative process to find solutions that work for you. Our team thrives on problem-solving; this is why many of us got into consulting in the first place. We are looking forward to being your trusted, independent, and objective partner to explore ways to improve your LTSS delivery system.

Our goal is to consult to Nebraska in a manner that supports your goals and initiatives and strengthens your program. To accomplish this, Mercer will continue to strive to understand the LTSS challenges you are facing and proactively address these challenges with practical solutions that also consider regulatory implications. Our solutions are constructed from experience supporting other state programs to evaluate similar LTSS issues. We understand that no project is unaffected by the personalities involved. You work in a challenging political environment with limited resources and almost unlimited demands. The team members we have included are able to listen, communicate respectfully, and be an impartial partner.

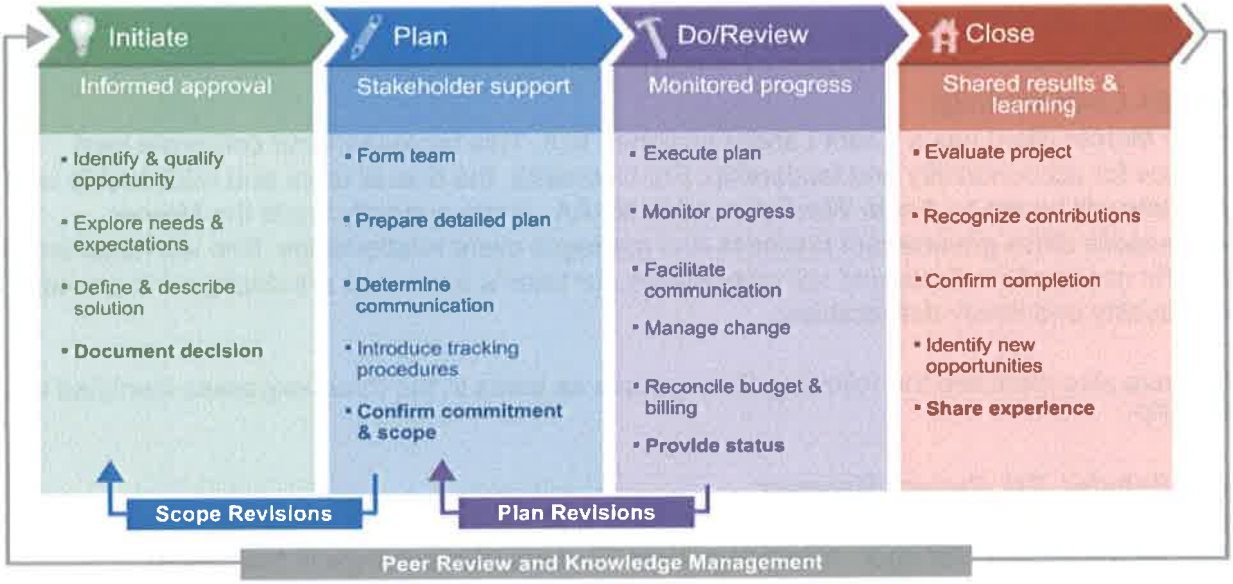
The scope of work presents certain challenges including sufficient time to engage the necessary stakeholders and State staff to complete the deliverables within the required timelines. To address these challenges, our team's approach to fulfilling the requirements of this scope of work starts with the development of a strong project work plan, which results in deliverables completed on time and efficiently through the application of sound principles and analysis, within the framework of strong project management. A good project plan coupled with regular communications can proactively address pinch-points, outstanding information requests, and major upcoming milestones. We also believe a well-managed project requires the State to identify a lead person who can be Mercer's first point-of-contact to help keep the project moving forward.

Our approach to project management begins by meeting with the State's key team members to discuss and review the work plan included in this proposal that outlines the necessary project steps that must be managed to meet project objectives. We want to understand your expectations for this engagement and agree on the format up front for work products so that we can be developing the content as the project matures rather than wait until the end to hope we have the "right stuff." You will read in this proposal that we have provided some concrete approaches to completing the scope of services, but once we have an opportunity to talk with you, we can modify our strategy. We are flexible and want to align the final agreed-to work activities with the budget to meet your needs. During the kick-off meeting, Mercer will review the following information to finalize the work plan with the State:

- Project stakeholders and their influence on/role in the project.
- A communication plan that establishes frequency and type of communication, including monthly status reports as required in the RFP.
- Project resources for each task.
- Specific deliverables for each task.
- Measures and processes for controlling and assuring quality.
- Project risks and mitigation/contingency plans (including documenting the process for risk management).
- A tool to track risks, actions, issues, and decisions.
- Criteria and processes to measure and influence project success.

Shortly following this kick-off meeting, Mercer will provide an updated work plan to the State for review and final approval. The final work plan will be the "master plan" of work to be completed and will identify key milestones, project team members assigned to complete each task, target completion dates, and an explicit list of expected deliverables.

We believe a sound management approach centers around good communication at every stage of the project. To be effective, communication must be timely, clear, and candid. This includes communication within the Mercer team, but equally important is the communication between the Mercer team and MLTC staff. We want to avoid unnecessary delays due to a lack of clear direction on next steps or be in a situation where the "left hand is not sure what the right hand" is doing. While we know we cannot control everything that goes on within DHHS/MLTC, we can at least effectively manage our team and be organized and ready for each step in the process. The following graphic illustrates our approach to project management:



To ensure high-quality consulting and work products, all work performed by the Mercer team is subject to a strict quality assurance process. Mercer has clear, professional standards regarding the process of "peer review" (i.e., quality control) at various steps in product development. Mercer believes peer review of professional work delivers the highest-quality service to our clients. Peer review ensures our work is consistent with best practice and conforms to our objective of delivering work that is both excellent and error free. Mercer requires that all our professional work be thoroughly peer reviewed by properly qualified colleagues before being released to the client. We apply peer review from a number of perspectives, reviewing all work products for:

- Technical accuracy of all calculations and work products including overall reasonableness.
- Consulting appropriateness to ensure soundness of the approach and that the appropriate issue/question has been completely addressed in a clear manner.
- Editorial correctness.
- Final look to ensure a professional work product appearance that meets delivery and other specifications.

In addition to monitoring individual contributions, Mercer also monitors the project as a whole to ensure that it is on track to meet the requirements established in the work plan. It is Mercer's mission to deliver what we commit to and, therefore, it is critical that Mercer's Project Manager continually measure, monitor, and balance competing project constraints to make sure that we:

- Stick to the schedule.
- Anticipate and manage risks.
- Communicate effectively.
- Deliver results.

Our team is fully staffed with Mercer and NASUAD resources with no pending positions needing to be filled if awarded a contract. The team will be able to immediately work with the State since resources are already available and highly experienced. The State will benefit from focusing their selection criteria on a vendor that has the requisite experience to hit the ground running and get the job done.

Team Leadership

Every Mercer client has a Client Leader assigned to it. This represents our corporate best practice for accountability and leadership. For Nebraska, the overall team and relationship with the State will be led by Angie WasDyke, ASA, MAAA. Angie currently leads the Mercer Minneapolis office government business and manages client relationships. She will focus on the specific needs of the State and will help ensure our team's resources are deployed to provide high quality and timely deliverables.

We have also identified the following three people as leads in the three key areas identified in the RFP:

Alan Schafer, RN, Project Manager
Alan will lead the consulting team in the completion of the work activities as described in this RFP. As the Project Manager, Alan brings over 27 years of experience in the design, implementation, and management of LTSS programs. Alan will conduct the day-to-day management of the project and resources and provide regular communication to the State. He will also provide the monthly status updates as required by the RFP.

Deidra Abbott, MPH, Medicaid Regulatory Specialist Lead
Deidra has over 28 years of experience in the analysis and evaluation of federal and state regulations and the design of Medicaid managed LTSS programs and waivers. She has been assigned as the Medicaid Regulatory Specialist Lead for this project. She will lead efforts on research, interpreting regulations, and determining options for the State in terms of program policy decisions and the federal authority for the program. She will guide the other Medicaid Regulatory Specialists and their work efforts in completing the necessary deliverables in a timely fashion.

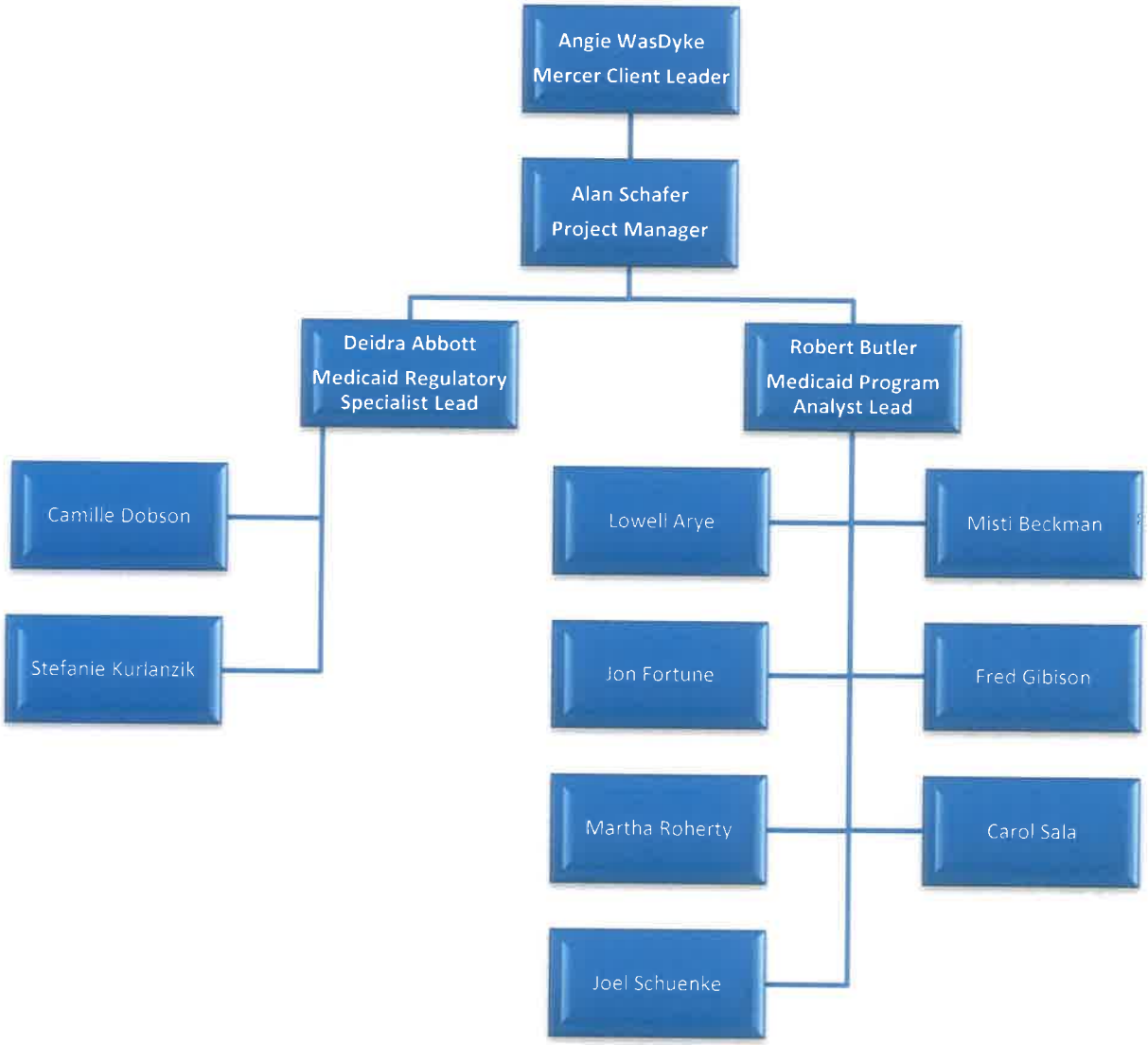
Robert Butler, Medicaid Program Analyst Lead
Robert will lead the team of Medicaid Program Analysts in the research of other LTSS programs and the assessment of the State's existing LTSS program. Robert has over 22 years of experience in Medicaid LTSS. He will also coordinate the efforts regarding information for stakeholder meetings and follow-up analysis resulting from those meetings.

Interface and Support Functions

As part of the initial kick-off meeting with the State, the team will work with the State to identify the needed communication plan with MLTC. The communication plan will include the monthly status reports, as well as other communications such as regular conference calls to review findings, identify questions, and determine next steps to facilitate timely completion of the final work plan. Additionally, as needed, we have a robust team of administrative/junior staff who will provide support functions and additional teamwork in support of our key client-facing consultants.

Reporting Relationships

The Mercer team will also draw upon the expertise of senior level consultants who have extensive and diverse LTSS experience. The proposed team will be structured as outlined in the organizational chart on the following page. Some of these individuals may have a small role based on their specific subject matter expertise and the needs of MLTC, but we wanted to demonstrate our depth and breadth of resources available to support this project. This chart is consistent with the staffing outlined above with Angie WasDyke, ASA, MAAA as Mercer's Client Leader, Alan Schafer, RN as Project Manager, Deidra Abbott, MPH as Medicaid Regulatory Specialist Lead, and Robert Bulter as Medicaid Program Analyst Lead.


Angie WasDyke
Mercer Client Leader
Alan Schafer
Project Manager
Deidra Abbott
Medicaid Regulatory Specialist Lead
Robert Butler
Medicaid Program Analyst Lead
Camille Dobson
Stefanie Kurianzik
Lowell Arye
Misti Beckman
Jon Fortune
Fred Gibison
Martha Roherty
Carol Sala
Joel Schuenke

The table below provides a full list of the proposed team members and the activities each will be involved in for this project if Mercer is awarded this contract.

Key Client-Facing Consultants	Role/Staffing Category	Primary Work Assignment
Angie WasDyke, ASA, MAAA	Mercer Client Leader	Overall client satisfaction
Alan Schafer, RN	Project Manager	Team leadership, Mercer first point-of-contact, project management
Deidra Abbott, MPH	Medicaid Regulatory Specialist Lead	Medicaid health policy, operating authorities, CMS strategy
Robert Butler	Medicaid Program Analyst Lead	LTSS program design, assessment of current system, redesign plan
Lowell Arye, MS (subcontractor)	Medicaid Program Analyst	Stakeholder process
Misti Beckman	Medicaid Program Analyst	Redesign plan, FFS LTSS program design options, provider payment rates.
Camille Dobson, MPA (subcontractor)	Medicaid Regulatory Specialist	Stakeholder process, redesign plan
Jon Fortune, EdD	Medicaid Program Analyst	Stakeholder process, ID/DD specialists, level-of-care issues
Fred Gibison, MBA	Medicaid Program Analyst	Redesign plan, managed care LTSS options, alternative payment strategies
Stefanie Kurlanzik, JD	Medicaid Regulatory Specialist	Medicaid health policy specialist, assessment of current system
Martha Roherty, MPP (subcontractor)	Medicaid Program Analyst	Stakeholder process
Carol Sala (subcontractor)	Medicaid Program Analyst	Stakeholder process
Joel Schuenke	Medicaid Program Analyst	Assessment of delivery system, redesign plan

Resumes

Resumes are included in Appendix B.

J) SUBCONTRACTORS
If the bidder intends to Subcontract any part of its performance hereunder, the bidder must provide:

- **i. Name, address, and telephone number of the Subcontractor(s);**
- **ii. Specific tasks for each Subcontractor(s);**
- **iii. Percentage of performance hours intended for each Subcontract; and**
- **iv. Total percentage of Subcontractor(s) performance hours.**

Mercer is proud to partner with the National Association of States United for Aging and Disabilities (NASUAD) for this project. The information required is included in the table below.

Subcontractor	National Association of States United for Aging and Disabilities (NASUAD)
Address	1201 15th Street, NW Suite 350 Washington, DC 20005
Telephone #	+1 202 898 2478
Specific Tasks	• Developing stakeholder communication plan and materials • Facilitating stakeholder meetings • Summarizing results of stakeholder meetings and developing recommendations to MLTC • Technical assistance/peer review support on redesign plan
Percentage of performance hours intended for each Subcontract	Approximately 48%
Total percentage of Subcontractor(s) performance hours	Approximately 48%

Section 3

Section 3: Draft Project Work Plan

The bidder must provide a draft work plan, preferably in Microsoft Project, that describes each task the bidder will conduct to complete the scope of work described in Section IV. Task begin and end dates must be included that comply with the deliverable due dates described in Section IV.F.

The draft work plan provided in this section identifies key milestones, project team members assigned to complete each task, target completion dates, and an explicit list of expected deliverables. While the task-specific dates comply with the RFP, some of the in-between steps may need to be revised throughout the project's lifespan to address unforeseen issues, holidays, and the occasional scheduling conflicts. This work plan will be updated as new information becomes available. Mercer also included a kick-off meeting following the State's review of the work plan to discuss additions needed and any concerns, and to make necessary adjustments to the plan. Microsoft Project software will be used to track deliverables and key milestones. We anticipate discussing the project scope in more detail during our kick-off meeting to finalize the project plan and ensure our vision for the process aligns with MLTC's expectations

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State of Nebraska
Draft Work Plan for LTSS Redesign Consultation

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
1	1	Contract Start Date	0 days	Mon 5/16/16	Mon 5/16/16		
2	**2**	**Final Project Work Plan**	**16 days**	**Mon 5/16/16**	**Mon 6/6/16**	**Alan Schafer with support from key team members**	
3	2.1	Develop information request	3 days	Mon 5/16/16	Wed 5/18/16		
4	2.2	Collect and review information to revise the draft work plan	9 days	Thu 5/19/16	Tue 5/31/16		
5	2.3	Project kick-off meeting	2 days	Tue 5/24/16	Wed 5/25/16		
6	2.4	Submit revised project work plan for review	0 days	Tue 5/31/16	Tue 5/31/16		
7	2.5	Discuss and review project work plan	2 days	Tue 5/31/16	Wed 6/1/16		
8	2.6	Finalize and submit project work plan	2 days	Thu 6/2/16	Fri 6/3/16		
9	2.7	Approve project work plan	0 days	Mon 6/6/16	Mon 6/6/16		Due 15 business days after contract start (June 6).
10	**3**	**Research, Delivery System Assessment and Preliminary Recommendations (RDSAPR)**	**55 days**	**Mon 5/16/16**	**Fri 7/29/16**		
11	**3.1**	**Stakeholder Engagement Plan (RDSAPR)**	**23 days**	**Mon 5/16/16**	**Wed 6/15/16**	**Deidra Abbott,Camille Dobson,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer**	
12	3.1.1	Identify stakeholders to be included in the stakeholder meetings and revise list	5 days	Mon 5/16/16	Fri 5/20/16		Proposed list of stakeholders is included in technical proposal as a starting point.
13	3.1.2	Develop and submit draft stakeholder engagement plan for review	9 days	Mon 5/23/16	Thu 6/2/16		Plan will include event dates and locations, methods for communication and engagement (e.g., use of social media, state website, listservs, comment features, etc.), meeting format, and information to obtain through the engagement process.

Draft - Subject to further review and revision.

MERCER

ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
14	3.1.3	Develop meeting schedule and secure locations	6 days	Fri 6/3/16	Fri 6/10/16		Note: Further detail will be added to the project work plan regarding meeting logistics once finalized. We will seek assistance from MLTC to secure public spaces to the extent possible.
15	3.1.4	Review stakeholder engagement plan	5 days	Fri 6/3/16	Thu 6/9/16		
16	3.1.5	Finalize and submit stakeholder engagement plan for MLTC approval	3 days	Fri 6/10/16	Tue 6/14/16		
17	3.1.6	Approve stakeholder engagement plan	0 days	Wed 6/15/16	Wed 6/15/16		Due 30 calendar days after contract start (June 15).
18	**3.2**	**Stakeholder Meeting Materials (RDSAPR)**	**21 days**	**Wed 5/18/16**	**Wed 6/15/16**	**Deidra Abbott,Camille Dobson,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer**	
19	3.2.1	Develop and submit materials for stakeholder meetings	11 days	Wed 5/18/16	Wed 6/1/16		Materials include: meeting communications, agendas, presentations, etc.
20	3.2.2	Review materials for stakeholder meetings	5 days	Thu 6/2/16	Wed 6/8/16		
21	3.2.3	Finalize and submit materials for stakeholder meetings	4 days	Thu 6/9/16	Tue 6/14/16		
22	3.2.4	Approve materials for stakeholder meetings	0 days	Wed 6/15/16	Wed 6/15/16		Due 30 calendar days after contract start (June 15).
23	**3.3**	**Statewide Stakeholder Meeting Facilitation (RDSAPR)**	**19 days**	**Mon 6/20/16**	**Thu 7/14/16**	**Deidra Abbott,Robert Butler,Camille Dobson,Fred Gibison,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer**	

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
24	3.3.1	Facilitate first round of stakeholder meetings	10 days	Mon 6/20/16	Fri 7/1/16		See attached document entitled Proposed NE Stakeholder visits. Additional meetings with statewide constituencies will be accommodated with an extra day in Lincoln, if needed.
25	3.3.2	Debrief with MLTC on concerns requiring immediate attention	0 days	Fri 7/1/16	Fri 7/1/16		
26	3.3.3	Facilitate second round of stakeholder meetings	8 days	Tue 7/5/16	Thu 7/14/16		Due 60 calendar days after contract start (July 15).
27	3.3.4	Debrief with MLTC on concerns requiring immediate attention	0 days	Thu 7/14/16	Thu 7/14/16		
28	**3.4**	**Summary Report of Stakeholder Engagement (RDSAPR)**	**15 days**	**Mon 7/11/16**	**Fri 7/29/16**	**Deidra Abbott,Robert Butler,Camille Dobson,Fred Gibison,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer**	
29	3.4.1	Develop and submit draft stakeholder engagement report	7 days	Mon 7/11/16	Tue 7/19/16		
30	3.4.2	Review and discuss stakeholder engagement report	5 days	Wed 7/20/16	Tue 7/26/16		
31	3.4.3	Finalize stakeholder engagement report and submit for MLTC approval	2 days	Wed 7/27/16	Thu 7/28/16		
32	3.4.4	Approve stakeholder engagement report	0 days	Fri 7/29/16	Fri 7/29/16		Due 75 calendar days after contract start (July 29).
33	3.4.5	Respond to consumer/stakeholder questions	5 days	Mon 7/18/16	Fri 7/22/16		As part of continuous feedback loop with stakeholders, questions raised will be addressed, in consultation with the state, as soon as possible after the meetings conclude.

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
34	4	**Assessment of Nebraska's LTSS Service Delivery System with Preliminary Recommendations**	**65 days**	**Mon 5/16/16**	**Fri 8/12/16**	**Deidra Abbott,Misti Beckman,Robert Butler,Camille Dobson,Jon Fortune,Fred Gibison,Stefanie Kurlanzik,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer,Joel Schuenke,Angie Wasdyke**	
35	4.1	**Research the Current Nebraska LTSS Delivery System**	**43 days**	**Mon 5/16/16**	**Wed 7/13/16**	**Joel Schuenke,Jon Fortune**	
36	4.1.1	Collect and review publically available documents on Nebraska LTSS programs	15 days	Mon 5/16/16	Fri 6/3/16		
37	4.1.2	Develop follow-up questions and clarifications from documentation review and kick-off meeting	5 days	Mon 6/6/16	Fri 6/10/16		
38	4.1.3	Facilitate discussions with MLTC	23 days	Mon 6/13/16	Wed 7/13/16		May include targeted interviews with DHHS key staff and Divisions.
39	4.2	**Research Other States' Efforts to Improve LTSS Programs**	**43 days**	**Mon 5/16/16**	**Wed 7/13/16**	**Joel Schuenke,Jon Fortune**	
40	4.2.1	Gather data from existing Mercer LTSS clients	15 days	Mon 5/16/16	Fri 6/3/16		
41	4.2.2	Gather data from other states	10 days	Mon 6/6/16	Fri 6/17/16		May facilitate targeted discussions with other states, as needed.
42	4.2.3	Facilitate discussions with MLTC on findings	23 days	Mon 6/13/16	Wed 7/13/16		
43	4.3	**Identify Strengths and Challenges of Nebraska's LTSS Programs**	**19 days**	**Tue 7/5/16**	**Fri 7/29/16**	**Deidra Abbott,Robert Butler,Camille Dobson,Fred Gibison,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer**	

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
44	4.3.1	Summarize key strengths and challenges of Nebraska's LTSS programs based on research	11 days	Tue 7/5/16	Tue 7/19/16		
45	4.3.2	Facilitate discussions with MLTC on findings	8 days	Wed 7/20/16	Fri 7/29/16		
46	**4.4**	**Review Federal Requirements for Program Options and Limitations**	**38 days**	**Wed 5/25/16**	**Fri 7/15/16**	**Camille Dobson,Deidra Abbott,Stefanie Kurlanzik**	
47	4.4.1	Develop comprehensive list of CMS guidelines, federal regulations, and authorities for LTSS delivery systems	11 days	Wed 5/25/16	Wed 6/8/16		
48	4.4.2	Review options and limitations based upon knowledge of Nebraska's LTSS system and develop findings	12 days	Thu 6/9/16	Fri 6/24/16		
49	4.4.3	Compare findings with best practices identified from other state and Mercer LTSS clients	10 days	Mon 6/27/16	Fri 7/8/16		
50	4.4.4	Facilitate discussions with MLTC on findings	5 days	Mon 7/11/16	Fri 7/15/16		
51	**4.5**	**Report of Findings and Preliminary Recommendations for Improving MLTC's Current LTSS Service Delivery System**	**40 days**	**Mon 6/20/16**	**Fri 8/12/16**	**Deidra Abbott,Robert Butler,Camille Dobson,Fred Gibison,Lowell Ayre,Carol Sala,Martha Roherty,Alan Schafer**	
52	4.5.1	Develop a report outline for MLTC approval	10 days	Mon 6/20/16	Fri 7/1/16		
53	4.5.2	Develop and submit a draft report of preliminary recommendations	14 days	Tue 7/5/16	Fri 7/22/16		
54	4.5.3	Discuss the report of findings, including preliminary recommendations	5 days	Mon 7/25/16	Fri 7/29/16		
55	4.5.4	Finalize preliminary recommendations report	7 days	Mon 8/1/16	Tue 8/9/16		
56	4.5.5	Approve preliminary recommendations report	0 days	Fri 8/12/16	Fri 8/12/16		Due 90 calendar days after contract start (Aug. 14).

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
57	**5**	**Development of Draft Redesign Plan and Stakeholder Feedback**	**169 days**	**Mon 8/1/16**	**Fri 3/24/17**		
58	**5.1**	**Draft Redesign Plan**	**80 days**	**Mon 8/1/16**	**Fri 11/18/16**	**Deidra Abbott,Alan Schafer,Camille Dobson,Carol Sala,Fred Gibison,Lowell Ayre,Martha Roherty,Misti Beckman,Robert Butler**	
59	5.1.1	Consider stakeholder feedback and preliminary recommendations for MLTC's LTSS service delivery and assess operational and fiscal considerations	35 days	Mon 8/1/16	Fri 9/16/16		Consider key issues, concerns, and challenges raised by stakeholders. Address existing delivery system within Redesign Plan, including assessment of operational and fiscal considerations.
60	5.1.2	Facilitate discussion with MLTC around program goals and objectives	50 days	Mon 8/8/16	Fri 10/14/16		MLTC shares goals and objectives that meet the State's political, policy, programmatic and priority needs throughout the process, including an overview of all DHHS initiatives.
61	5.1.3	Craft working draft Redesign Plan	15 days	Mon 10/10/16	Fri 10/28/16		
62	5.1.4	Submit working draft of Draft Redesign Plan to MLTC for comments/feedback	0 days	Fri 10/28/16	Fri 10/28/16		
63	5.1.5	MLTC reviews and provides comments on working draft	5 days	Mon 10/31/16	Fri 11/4/16		
64	5.1.6	Revisions made to working draft	9 days	Mon 11/7/16	Thu 11/17/16		
65	5.1.7	Submit Draft Redesign Plan	0 days	Thu 11/17/16	Thu 11/17/16		Due 6 months after contract start (Nov. 17).
66	5.1.8	MLTC posts Draft Redesign Plan to public website for stakeholder comments	1 day	Fri 11/18/16	Fri 11/18/16		

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
67	**5.2**	**Stakeholder Engagement Plan**	**40 days**	**Mon 11/14/16**	**Fri 1/6/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Lowell Ayre,Martha Roherty**	
68	5.2.1	Identify stakeholders to be included in the stakeholder meetings and revise stakeholder list	5 days	Mon 11/14/16	Fri 11/18/16		Proposed list of stakeholders is included in technical proposal as a starting point.
69	5.2.2	Develop draft stakeholder engagement plan	11 days	Mon 11/28/16	Mon 12/12/16		
70	5.2.3	Submit stakeholder engagement and communications plan for review	0 days	Mon 12/12/16	Mon 12/12/16		
71	5.2.4	Review stakeholder engagement and communications plan	9 days	Tue 12/13/16	Fri 12/23/16		
72	5.2.5	Develop meeting schedule and secure locations	5 days	Mon 12/12/16	Fri 12/16/16		Note: Further detail will be added to the project work plan regarding meeting logistics once finalized. We will seek assistance from MLTC to secure public spaces to extent possible.
73	5.2.6	Finalize stakeholder engagement and communications plan and submit for MLTC approval	3 days	Tue 1/3/17	Thu 1/5/17		
74	5.2.7	Approve stakeholder engagement and communications plan	0 days	Fri 1/6/17	Fri 1/6/17		Due 8 months after contract start (Jan. 17).
75	**5.3**	**Stakeholder Meeting Materials**	**42 days**	**Mon 11/21/16**	**Tue 1/17/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Fred Gibison,Lowell Ayre,Martha Roherty,Robert Butler**	
76	5.3.1	Develop materials for stakeholder meetings	20 days	Mon 11/21/16	Fri 12/16/16		
77	5.3.2	Submit materials for stakeholder meetings for review	0 days	Mon 12/19/16	Mon 12/19/16		

Draft - Subject to further review and revision.

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
78	5.3.3	Review materials for stakeholder meetings	12 days	Tue 12/20/16	Wed 1/4/17		
79	5.3.4	Finalize materials for stakeholder meetings and submit for final MLTC approval	6 days	Thu 1/5/17	Thu 1/12/17		
80	5.3.5	Approve materials for stakeholder meetings	0 days	Tue 1/17/17	Tue 1/17/17		Due 8 months after contract start (Jan. 17).
81	5.4	**Statewide Stakeholder Meeting Facilitation**	**40 days**	**Mon 1/23/17**	**Fri 3/17/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Fred Gibison,Lowell Ayre,Martha Roherty,Robert Butler**	
82	5.4.1	Facilitate first round of stakeholder meetings	10 days	Mon 1/23/17	Sat 2/4/17		Additional meetings with statewide constituencies will be accommodated with an extra day in Lincoln, if needed.
83	5.4.2	Debrief with MLTC on concerns requiring immediate attention	2 days	Mon 2/6/17	Tue 2/7/17		
84	5.4.3	Facilitate second round of stakeholder meetings	9 days	Tue 2/21/17	Sat 3/4/17		Due 10 months after contract start (March 17).
85	5.4.4	Debrief with MLTC on concerns requiring immediate attention	3 days	Mon 3/6/17	Wed 3/8/17		
86	5.4.5	Respond to consumer/stakeholder questions	10 days	Mon 3/6/17	Fri 3/17/17		As part of continuous feedback loop with stakeholders, questions raised will be addressed, in consultation with the state, as soon as possible after the meetings conclude.

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
87	**5.5**	**Summary Report of Stakeholder Engagement**	**18 days**	**Tue 2/28/17**	**Fri 3/24/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Fred Gibison,Lowell Ayre,Martha Roherty,Robert Butler**	
88	5.5.1	Develop and submit draft stakeholder engagement report	10 days	Tue 2/28/17	Mon 3/13/17		
89	5.5.2	Review and discuss stakeholder engagement report	5 days	Tue 3/14/17	Mon 3/20/17		
90	5.5.3	Finalize stakeholder engagement report and submit for MLTC approval	3 days	Tue 3/21/17	Thu 3/23/17		
91	5.5.4	Approve stakeholder engagement report	0 days	Fri 3/24/17	Fri 3/24/17		Due 15 calendar days following final stakeholder engagement meeting (March 31).
92	**5.6**	**DHHS Staff Training on Redesign Plan**	**40 days**	**Mon 11/21/16**	**Fri 1/13/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Fred Gibison,Lowell Ayre,Martha Roherty,Misti Beckman,Robert Butler**	
93	5.6.1	Determine appropriate DHHS staff for training	9 days	Mon 11/21/16	Thu 12/1/16		Mutually agree on number of DHHS staff to be trained.
94	5.6.2	Develop training schedule and location (if not at DHHS offices)	5 days	Mon 12/5/16	Fri 12/9/16		Assume training will be at DHHS offices.
95	5.6.3	Develop training materials	20 days	Mon 12/12/16	Fri 1/6/17		
96	5.6.4	Send training invitations to appropriate DHHS staff	2 days	Mon 1/2/17	Tue 1/3/17		Electronic (e.g., Outlook) invitations.
97	5.6.5	DHHS staff confirm acceptance	2 days	Wed 1/4/17	Thu 1/5/17		
98	5.6.6	Follow with non-responding DHHS staff (if needed)	1 day	Fri 1/6/17	Fri 1/6/17		

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
99	5.6.7	Conduct DHHS training	5 days	Mon 1/9/17	Fri 1/13/17		This may be multiple sessions with same group on different topics or repeat training with different groups. Details to be mutually agreed to.
100	6	**Development of Final Redesign Plan**	**33 days**	**Mon 4/3/17**	**Wed 5/17/17**		**This section of the plan will need further discussion with NE MLTC as many holidays fall herein.**
101	6.1	**Final Redesign Plan**	**33 days**	**Mon 4/3/17**	**Wed 5/17/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Fred Gibison,Lowell Ayre,Martha Roherty,Misti Beckman,Robert Butler**	
102	6.1.1	Assess stakeholder comments	10 days	Mon 4/3/17	Fri 4/14/17		Mercer and MLTC review and discuss comments regarding Draft Plan and decide approach to finalize Redesign Plan. Timeframe may be impacted by volume of feedback received.
103	6.1.2	Edit Draft Redesign Plan based on stakeholder comments	10 days	Mon 4/17/17	Fri 4/28/17		
104	6.1.3	Submit proposed Final Redesign Plan to MLTC for review	0 days	Fri 4/28/17	Fri 4/28/17		
105	6.1.4	MLTC reviews proposed Final Redesign Plan and provides final edits to Mercer	5 days	Mon 5/1/17	Fri 5/5/17		MLTC final input provided.
106	6.1.5	Finalize and submit Final Redesign Plan to MLTC	7 days	Mon 5/8/17	Tue 5/16/17		Due 12 months after contract start (May 16).
107	6.1.6	MLTC posts Final Redesign Plan to public website	1 day	Wed 5/17/17	Wed 5/17/17		

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ID	Outline Number	Task Name	Duration	Start	Finish	Resource Names	Notes
108	**6.2**	**Implementation Redesign Work Plans**	**33 days**	**Mon 4/3/17**	**Wed 5/17/17**	**Alan Schafer,Camille Dobson,Carol Sala,Deidra Abbott,Fred Gibison,Lowell Ayre,Martha Roherty,Misti Beckman,Robert Butler**	**Process to begin after final approval of the Redesign Plan.**
109	6.2.1	Develop draft implementation work plans	20 days	Mon 4/3/17	Fri 4/28/17		
110	6.2.2	Review implementation work plans	5 days	Mon 5/1/17	Fri 5/5/17		
111	6.2.3	Finalize implementation work plans and submit for MLTC approval	5 days	Mon 5/8/17	Fri 5/12/17		
112	6.2.4	Approve implementation work plans	3 days	Mon 5/15/17	Wed 5/17/17		
113	**7**	**Monthly Status Reports**	**784 days**	**Wed 6/15/16**	**Mon 6/17/19**	**Alan Schafer,Angie Wasdyke,Camille Dobson,Martha Roherty**	**Provided 15 days after each calendar month.**

Section 4

Section 4: Technical Approach

Section IV.C.1
Research, Service Delivery System Assessment, and Preliminary Recommendations

1. **Considering the projects for which the bidder provided narrative project descriptions in its corporate overview, describe the successes and challenges with LTSS projects of this type and scope.**

LTSS redesign of the magnitude under consideration by the State is a huge, resource intensive undertaking. At the end of the day, with any system redesign there are two critical activities that must occur no matter what – participants must receive services (there is no disruption in service delivery) and providers must be paid. But these are just minimum standards. A successful LTSS redesign involves many more elements, some of which may not be that visible to the outside public.

Mercer has definitely experienced successes and challenges with other LTSS projects of similar type and scope. Challenges that we have experienced are not too dissimilar to the list of potential risks described in response to question #16. Indeed, challenges often remain in memory longer than successes because challenges require action to solve where successes are the result of actions taken. The following is a summary of some of the challenges the Mercer team has experienced with our clients on various LTSS project engagements:

- **Trying to please everyone**. As much as we would like to have everyone's opinion heard, their concerns reflected in the final work product, and everyone feeling like they got "their way", in reality compromises are required. Our state clients want to be seen as being fair, open-minded, and unbiased, but ultimately someone at the state needs to make decisions and when a decision is made, generally somebody somewhere will feel a bit left out of the loop.

- **Personal agendas getting in the way**. In a prior LTSS redesign effort, a state that Mercer worked with did a very comprehensive job at involving stakeholders, even having stakeholders participate on a variety of work groups. In one work group, a provider representative boldly proclaimed to the group "I'm here to stop this from happening." While the rest of the group and other work groups were trying to find creative solutions and address challenges, this individual had an agenda to roadblock any effort.

- **Insufficient time**: There is rarely enough time to evaluate the Medicaid LTSS delivery system. It is so complex and multi-faceted that unless a state has the patience, resources,

and time on its side, the window for accepting change often means that progress has to be made quickly before priorities, politics, or policies change. "Make hay when the sun shines" is an apt description of some LTSS redesign efforts.

- **Lack of state awareness of its own programs**: Assessing current delivery systems, but more importantly discussing changes to the existing system, will often reveal operational elements that some people in the state may not even be aware of. In many ways this is also a success because Mercer helps facilitate increased awareness, understanding, and knowledge of the state's programs. But in the meantime, there is a challenge of dealing with situations where even the state staff say "I didn't know we did that" or "Is that the right way we should be saying that?" Sometimes uncovering these issues creates new problems that need to be solved in addition to the LTSS redesign effort.

- **Inconsistent, incomplete, or invalid data:** Medicaid programs are awash in data, but finding good, useable, actionable data is still difficult. Assessing population needs to evaluate program design options is difficult when the underlying assessment of needs is done with different standards and tools. Standardized processes are important in order to have better identification of needs and alignment and use of services and supports across the system. This can also lead to greater administrative efficiencies.

- **Revenue protection**: There is a lot of money spent on LTSS. For example, Nebraska directed over $326 million to over 200 nursing facilities in SFY 2015 alone. It is thus natural for providers that are on the receiving end of these large sums to be concerned about protecting that revenue source because their business model may be dependent on that source of financial income.

- **Too many choices**: CMS has opened a lot of opportunities for states to do things differently, but understanding what each choice means, how it differs, what it can and can't be used for and what "strings" are attached to it takes time. The list of program options reads like some sort of alpha-numeric buffet: 1915(c), 1915(b), 1115(a), 1915(i), 1915(j), state plan option, waiver, CFC (Community First Choice), BIP (Balancing Incentives Program), Section 2703 Health Homes, PCMH (patient-centered medical homes), ACOs (accountable care organizations), and the list goes on.

- **Lacking State vision/change leaders**: Redesigning the Medicaid LTSS system takes leadership. This often starts in the Governor's Office, but requires a "field General(s)" to oversee the process and effectuate the decision-making process. One person with a vision can do more to effectuate change than five people who are collecting "options papers" but not acting on those options.

- **Lost in the system**: For one LTSS client, understanding the history of an influential stakeholder group that felt as if they were largely ignored by the state, Mercer worked with the state to ensure that special care was given to actively engage the stakeholder group in the redesign process. In the end, the state created new services to support this group. However, the group still felt that their needs were not being met. Even the best efforts will

not necessarily create a system in which everyone feels as if their needs are adequately addressed.

Conversely, there are also many successes to celebrate and often successes are derived directly from a specific challenge that was identified. The following is a summary of some of the successes the Mercer team has experienced with our clients:

- **State empowerment**: We enjoy working collaboratively with our state clients and we most enjoy when our ideas empower state staff to effectuate positive change. While we can do much of the heavy-lifting, ultimately we know that state staff are the ones that have to administer the program a minimum of 8 hours a day 5 days week, to own it and are held accountable for the outcomes. When state staff get onboard and are agents of change, much progress can be made in a remarkably short period of time.

- **Stakeholder goodwill**: Most rational people will acknowledge that perhaps not every one of their requests will be met with fanfare, but by making a good faith effort to listen to what stakeholders have to offer, the process can go more smoothly. When stakeholders are openly supportive of the state's efforts, the goodwill that is created can carry forward into other endeavors.

- **Getting it right with CMS**: It seems that is it getting harder for states to stay in compliance with CMS rules and regulations, not easier. When Mercer helps a state get an initial waiver approved or an existing waiver renewed, navigate 50 questions about their HCBS program, implement an objective fee methodology for residential services, or successfully procure a managed long-term services and supports (MLTSS) program, Mercer takes pride in helping our clients get it right with CMS.

- **Implementing MLTSS**: Mercer has first-hand experience of working with a state from the day one brainstorming session all the way through to implementing risk-based MLTSS. To witness and be a part of a new program evolving from an idea to an actual delivery system is a major success. But the work doesn't stop there, any new program needs constant oversight, monitoring and occasional adjustment in response to real-life operational, changing political environment and evolving population needs.

- **Standardizing provider fee schedules**: When nearly each HCBS service provider has their own fee, the system is cumbersome, clunky and lacks objectivity. After working through the inter-dependent elements of service definitions, provider qualifications, unit of service and setting of care, we enjoy hearing our clients say "Now the fee schedule makes sense."

- **Helping participants get the right services**: As noted previously, at the end of the day, helping people live more productive, healthier, and independent lives is one of the core tenets of the Medicaid program. When we help state's design better programs, provide more choices for receiving appropriate care and stretch a state's dollar further we are directly supporting the goals of the Triple Aim.

- **Maximizing Medicaid's federal match**: Mercer has found that outside of the core state Medicaid agency staff, there can be a lack of Medicaid knowledge in "sister" agencies

responsible for other program elements related to mental health/substance abuse or intellectually disabled services. In these other state agencies, Mercer has uncovered situations where state general fund revenues were being used to pay for services that could be eligible for federal Medicaid matching funds. To get federal match sometimes requires changes to State Plan documents or revisions to provider qualifications or credentialing, but these can be relatively minor one-time changes for an ongoing source of federal matching funds.

2. Describe the bidder's understanding of Nebraska's LTSS delivery system and the solutions that will be considered to make improvements.

Definition of Nebraska's LTSS delivery systems

"All processes for provision of LTSS, from an individual's initial eligibility determination and assessment, through care planning, service delivery, documentation, claims payment, monitoring and quality improvement activities. This also includes infrastructure associated with provision of services such as statutory and regulatory authorities, information systems, policies and procedures, and responsible entities."

Nebraska shares several common attributes with other state Medicaid programs, not all of which are positive from an efficient LTSS delivery system perspective:

- Long history and heavy penetration of risk-based managed care except for LTSS.
- Active stakeholder community and past efforts to roll-out MLTSS.
- Multiple 1915(c) waivers targeting specific populations.
- Multiple initiatives all intended to achieve a similar goal of more community-based care and choices, but still a lot of "irons in the fire" (e.g., PACE, money follows the person (MFP), BIP initiative, Heritage Health).
- A disproportionate amount of spending on individuals who use LTSS as measured on a per member per month (PMPM) basis, but good progress made in rebalancing percentage of LTSS dollars spent on institutional care versus community care.
- Multiple state entities share some level of responsibility for enrollment intake, eligibility verification, care plan development, monitoring, and quality reporting.
- A comprehensive set of state plan benefits with additional services available through HCBS waivers.
- Nebraska is a relatively large state in square miles, but most of the population is concentrated in the east. This creates a large rural/frontier area to serve and associated provider/access challenges.
- Lack of standardized assessment tools across all programs, challenges with inter-rater reliability and inconsistent standards.
- Inconsistent care management practices or no care management at all.
- Variable provider payment rates that leads to Nebraska essentially competing against itself for provider participation across waivers and programs.
- Lack of integrated systems, purchasing philosophy, and care coordination.
- Insufficient focus on improving outcomes and quality of life through service offerings, program integration, and person-centeredness.
- An aging population, insufficient direct care workforce capacity and fragmented delivery system.

- In the 2014, State Long-Term Services and Supports Scorecard Results, AARP ranked Nebraska 20th overall; 37th for Affordability and Access, and 10th for Quality of Care/Quality of Life.

Mercer is also aware of the transition of the current Medicaid managed care program to Heritage Health with a planned effective date of January 2017. With the inclusion of LTSS populations, but still carving out LTSS, the State is making a significant step forward in redesigning the LTSS delivery system. The three MCOs selected after the re-evaluation process – UnitedHealthcare, Nebraska Total Care, and WellCare of Nebraska – give the State large, well-established MCOs to partner with and perhaps further expand Heritage Health to integrate LTSS into a comprehensive, high-performing, person-centered and outcomes-based managed care program.

Important as it is to understand Nebraska's current LTSS delivery system, it is also necessary to understand the State's LTSS redesign principles so that potential solutions can be vetted within an established framework. Staying "true" to these principles should result in a program design that can resolve many of the challenges with the current LTSS deliver system.

Nebraska LTSS Redesign Principles

- *Improve the quality of services and health outcomes of recipients.*
- *Promote independent living in the least restrictive setting through the use of consumer focused and individualized services and living options.*
- *Strengthen access, coordination, and integration of care through streamlined LTSS eligibility processes and collaborative care management models.*
- *Improve the capacity to match available resources with individual needs through innovative benefit structures.*
- *Streamline and better align the programmatic and administrative framework to decrease fragmentation for clients and providers.*
- *Refocus and rebalance the system in order to match growing demand for supports in a sustainable manner.*

The State has identified several potential areas of opportunities to improve the LTSS delivery system. The potential areas identified for improvement are not at all uncommon issues faced by many states, but the underlying factors will be unique to Nebraska as will the potential solutions. Mercer expects that through the stakeholdering and the review of the State's current LTSS delivery system that several potential solutions will be identified. Not all solutions may be practical or politically feasible for Nebraska, but the discussion, sharing of ideas and assessment of the current system will empower the State to make informed decisions about moving forward.

As much as "form follows function" solutions have to address specific problems, there is little sense in using the State's precious time and resources to develop yet another program if some of the fundamental program design elements like enrollment intake and care planning are not operating efficiently. If care management isn't happening on a consistent basis, then the State needs to get at the root-cause and fix it. Fixing something sometimes means reducing the number of "cooks in the kitchen" not adding more. Has Nebraska ever mapped out how many different people, entities, and organizations touch somebody in the LTSS delivery system? This

can be a real eye-opener to see just how many different interactions are occurring, on what level, and for what purpose. Consolidating these various touch-points into the fewest needed to achieve specific outcomes can make a significant impact on consumer experience within the LTSS delivery system. If a participant's care plan is dependent on *who* is asking the questions as opposed to *how* the participant is answering those questions, there is a disconnect among a person's needs and the quality of care they will ultimately receive. Incorporating individual HCBS budgets into the redesign plan might be getting the "cart-before-the-horse" if participant needs are not appropriately, consistently, and impartially assessed.

Adding more services to the array of services already available sounds like a good idea, but if there are already direct care worker shortages, creating more demand may only further exacerbate supply-side challenges. Instead, perhaps the state needs to look at creating more incentives for direct care workers, additional educational/training programs for workers, or partnering with vocational training organizations to promote work in the health care realm. Solutions can perhaps focus on consolidating services, adopting consistent provider qualification standards (where applicable), standardizing fee schedules, or repurposing housing alternatives to support more choice in care setting.

Expanding Heritage Health to cover LTSS appears to be a logical next step for the State based on history to date, and perhaps rightly so. But Mercer knows from experience that outsourcing LTSS to risk-based MCOs does not solve all the issues associated with provider capacity, eligibility/enrollment, data collection, and administrative simplicity. Indeed, three MCOs have three different management philosophies, provider negotiation/contracting strategies, payment approaches, and care management philosophies. However, the infrastructure offered by the MCOs does give the State a platform to consider taking advantage of. Perhaps a combination of DHHS-improved front-end intake, eligibility, and assessment processes and an MCO integrated delivery system, data reporting, outcomes reporting and network development can better leverage the State's finite resources. Regardless, the number of solutions is quite voluminous and Mercer looks forward to supporting the State with an objective and impartial evaluation of solutions over the course of this project.

3. Describe how the bidder proposes to complete the research and the service delivery assessment part of this project and what resources will be used.

Within the time constraints of the RFP's deliverable due dates, Mercer will complete the research and service delivery assessment portion of the project by completing the following five major steps:

1. Review the current LTSS delivery system.
2. Research other states efforts to improve LTSS delivery.
3. Identify strengths and challenges of the State's existing LTSS program.
4. Review federal requirements for program options and limitations.
5. Issue a report of key findings and preliminary recommendations.

Review the Current LTSS Delivery System

Mercer will work closely with MLTC to complete a comprehensive review of the current LTSS programs. Our process begins with completing a review of documents publicly available, or

supplied by the State, which describe the State's current LTSS programs. Examples of the type of documents and information to review include, but are not limited to:

- Existing HCBS waivers to assess similarities and differences in areas such as eligibility criteria, operational processes, and services covered.
- Previous studies performed by MLTC or on behalf of MLTC such as the PAS review.
- MLTC reports available on quality metrics and outcomes.
- Comments from stakeholders during the initial series of stakeholder meetings.

Mercer has found it is helpful to develop early in the process a data request of information to be reviewed and to discuss that list with the State as there are times when the information publicly available may not be the most current information or may address key concerns the State has identified. Once the data request is developed and information reviewed, Mercer will have a baseline understanding of the Nebraska LTSS programs from which to begin further exploration of options. As our review of the available documents is completed, key topics will be identified for further discussion with MLTC. Mercer has found a face-to-face meeting early in the process is beneficial to both parties to discuss the review effort, preliminary findings, and additional areas to focus.

Mercer will develop a list of topics and/or questions to be shared with the State in advance of a face-to-face meeting. This list allows the State to understand the areas where Mercer needs additional information to make certain the appropriate State staff is present at the meeting. After the face-to-face meeting, Mercer will follow-up with additional questions or clarifications related to the current LTSS programs. Mercer will utilize a cross-functional team with experience in LTSS programs including operational and regulatory backgrounds to complete this step.

Research Other State Efforts to Improve LTSS Programs
Mercer has worked directly with many states in various capacities related to their LTSS programs including Connecticut, Delaware, Louisiana, New Jersey, New Mexico, New York, Pennsylvania, and Massachusetts. Therefore, Mercer has first-hand, in-depth knowledge of these programs that allows us to share different experiences for MLTC to consider in their LTSS redesign effort. In addition to working closely with these states, Mercer staff and our contracted partner have contacts and maintain ongoing discussions and relationships with many other states, which brings a breadth of knowledge and understanding of initiatives tried, or currently underway, across the nation. To assess LTSS programs and initiatives in other states, Mercer will also look to published literature, CMS information and data and our existing relationships and contacts with various LTSS organizations such as National Association of State Directors of Development Disabilities Services, National Association of Medicaid Directors, and National Association for Participant-Directed Services to inform MLTC on the landscape and experience in other states. We will also draw upon the extensive knowledge and expertise of our partner, NASAUD, in this assessment. NASUAD is a go-to source for information on other state programs, a repository of LTSS information, and a nationally known and respected entity.

Identify Strengths and Challenges of Nebraska's LTSS programs
Mercer will use all of the information gathered from the initial steps of reviewing the current State LTSS delivery system and researching other state LTSS programs to assist in developing the strengths and challenges of the current program. To develop the strengths and challenges it

is critical that staff have a broad base of LTSS program experience including FFS based programs to full-risk MLTSS delivery systems. Mercer's team of experienced consultants has a broad background in LTSS programs including operations, regulatory, and financial/actuarial. Mercer's extensive background will allow us to draw on that experience to develop the strengths and challenges based on seeing best in class LTSS program components from other states.

Review Federal Requirements for Program Options and Limitations
Mercer's process to review the federal requirements for program options and limitations is addressed in detail in our response to question #4 below.

Preliminary Recommendations
At the conclusion of the research and assessment phase, Mercer will use the information gathered to produce an assessment report, including preliminary recommendations for improving the current LTSS service delivery system. Recognizing that the assessment report is completed shortly after the initial stakeholder sessions, relevant information gained through the stakeholdering process will be incorporated into our report.

4. **Describe how CMS LTSS guidelines and regulations will be reviewed and incorporated into the research, service delivery system assessment, and preliminary recommendations part of the project.**

It will be important to understand the impact of all relevant CMS LTSS guidelines and regulations in the LTSS system redesign. This federal guidance will serve as the foundation upon which the redesign is built and without which will result in a system that does not meet federal requirements and therefore not approvable (delaying CMS approval).

Initial consideration will be given to the relevant CMS regulations. Please note that the lists that follow may not be exhaustive, but instead are intended to focus on the critical federal guidance. The key CMS regulations to consider that will have a direct impact on the delivery of LTSS are the following:

- **HCBS Final Rule** (effective March 14, 2015) – Among other things, this rule provides the parameters for determining the appropriate provider settings in which HCBS can be received as well as the person-centered process driving assessment of need, development of service plans and ongoing monitoring for service delivery and quality of care.

- **Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability Proposed Rules** (aka Managed Care Proposed Rule) – This draft regulation would impose far reaching requirements for all components of state LTSS programs operating under a managed care delivery system including: rate setting, service delivery, access to services, quality of care, network development, quality measurement and monitoring, care coordination, stakeholder engagement and participation education and support. This guidance is not yet final, however, Mercer expects final guidance to be released shortly that will look very similar to the requirements

There are CMS regulations that do not directly impact the delivery of LTSS but guide provision of other services provided to LTSS populations and therefore will influence the overall redesign and system of care. These regulations include the following:

- **Methods for Assuring Access to Covered Medicaid Final Rule** (aka Access Rule, effective January 4, 2016) – This rule implements standards to ensure equal access to services and providers of services provided under FFS delivery systems. While this rule does not have direct implications for LTSS, to the extent LTSS populations in Nebraska will receive state plan services via FFS, these requirements will need to be addressed.

- **Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans Final Rule** (aka Mental Health Parity, effective May 31, 2016) – CMS has issued a final rule that applies Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requirements to MCOs and federal programs and creates consistency between the Medicaid and commercial markets. Specifically, this rule will require that plans that cover mental health and substance use disorder (MH/SUD) services must provide this coverage at a level no more restrictive than the predominant level applied to substantially all medical/surgical benefits. This rule will have implications for the State to the extent MH or SUD services are provided to LTSS populations.

- **Medicaid Program; Covered Outpatient Drugs Final Rule** (effective April 1, 2016) – The final rule imposes reimbursement, federal rebate, drug coverage and price calculations for states electing to provide optional coverage of outpatient drugs. The issue to contend will be what drug coverage will look like for LTSS populations.

In addition to relevant CMS regulations, it will also be important to understand the impact of Department of Labor (DOL) Fair Labor Standards Act (FLSA) requirements and implementing DOL guidance as it relates to minimum wage and overtime for homecare workers.

CMS guidelines will also be an integral component of the assessment process. In lieu of regulations, CMS will often use guidelines to convey federal expectations. The primary guidelines Mercer will review for the LTSS redesign project will include those around FFS provider fee development and MLTSS program design. Other guidelines or CMS State Medicaid Director Letters on delivery system options related to Section 2703 Health Homes, patient centered medical homes or accountable care organizations may be reviewed depending on whether DHHS is interested in pursuing any of these alternative delivery systems. However, similar to review of regulations, this is not an exhaustive list of CMS guidelines but instead represents the primary areas of focus.

Within the last 12 months, Mercer and our client states have experienced a new, enhanced CMS review process related to FFS provider fee methodology, including 1915(c) HCBS waiver amendments and renewals. This has often resulted in dozens if not hundreds of CMS questions around amendments that in the past would have been relatively simple and straightforward. The result of this enhanced federal review process has been increased pressure on states in

developing FFS provider rates and delays in obtaining CMS approval for program modifications and enhancements. In March 2016, CMS disseminated guidelines reinforcing CMS expectations for rate setting methodologies for 1915(c) HCBS waiver programs and for completing the reimbursement methodology in the HCBS waiver application (Appendix I-2-a). Mercer works with several states to develop HCBS FFS provider fees, so we were keenly interested in the new guidelines.

As it pertains to risk-based managed care for LTSS (aka MLTSS), CMS has established 10 key design principles that must be addressed as part of every program implementation and design. These key principles were initially released May 21, 2013 and are reinforced in the Managed Care Proposed Rule, published June 1, 2015. The 10 key principles are straight-forward, logical and reinforce elements that everyone should be able to find common ground on:

1. Allow adequate time for planning in advance of program implementation.
2. Ensure meaningful stakeholder engagement in the development and implementation of program implementation.
3. Ensure that program is implemented consistent with the Americans with Disabilities Act (ADA) and the Supreme Court's Olmstead v. L.C. decision and must be delivered in the most integrated fashion possible for active community and workforce participation.
4. Align payment structures so that they support the goals of the MLTSS program.
5. Develop sufficient supports for beneficiaries (conflict-free education, enrollment and disenrollment assistance, and consumer-friendly advocacy).
6. Foster and require person-centered processes for needs assessment and service plan development.
7. Offer comprehensive, integrated service package that coordinates the provision of all physical and behavioral health services and LTSS (including institutional and non-institutional) and ensures that participants receive services and supports in the amount, duration, scope, and manner as identified through the person-centered assessment and service planning process.
8. Ensure that MCOs develop and maintain a network of qualified providers who meet state licensing, credentialing, or certification requirements and which is sufficient to provide adequate access to all services covered under the MCO contract.
9. Establish participant protections to ensure that participant health and welfare is assured (e.g., participant rights and responsibilities, critical incident management system with safeguards to prevent abuse, neglect and exploitation, and fair hearing protections including the continuation of services during an appeal).
10. Maintain the highest level of quality in all program operations and service through the development and implementation of a comprehensive quality strategy that is integrated with any existing state quality strategies.

From our experience, these 10 key principals are best practices applicable to any comprehensive LTSS program design, regardless of the service delivery system. Mercer has also developed our own robust process for LTSS design that we commonly refer to as the "100 first questions." These questions are organized around key domains that align with the CMS 10 key MLTSS design features.

Each of the aforementioned regulations and guidelines will be reviewed with an eye towards determining:

- Where there are gaps in the State's LTSS delivery system that need to be addressed.
- Relevant design components that need to be incorporated into the LTSS redesign.
- Inherent components of the current system that are not compliant with federal guidance.
- The extent to which the federal guidance helps to support and facilitate the State's goals and objectives for LTSS redesign as noted in Section IV.B of the RFP.

In addition to drawing upon the expertise of our Mercer Regulatory Specialists, NASUAD will provide consultation on LTSS program design elements. Camille Dobson of NASUAD was the primary author of the CMS 2013 MLTSS guidance and guided the policy development for MLTSS regulatory requirements in the Managed Care Proposed Rule.

An additional step in the process will be to assist MLTC in determining the appropriate federal authority(ies) to consider for the LTSS redesign. Currently Nebraska operates LTSS using multiple authorities as noted in Section IV of the RFP. Adding to this list is the new Heritage Health managed care program which we understand will operate under a combined 1932(a) state plan option and 1915(b) waiver. One of the questions for consideration will be if the State will expand the Heritage Health managed care program to fold in LTSS and if yes will the existing 1932(a)/1915(b) authorities be appropriate for such an expansion? This will be part of the conversation Mercer will have with MLTC as there are other federal authorities that can enable DHHS perhaps more flexibility.

A section 1115(a) demonstration waiver is the most appropriate federal authority to use if the State is considering demonstrating a new program design feature that cannot be otherwise implemented through the state plan or concurrent 1915(b)/(c). An example of a unique program design feature used by several states operating MLTSS programs is a recipients' rewards program in which enrollees receive services or goods for performing prescribed healthy behaviors. Section 1115(a) demonstration waivers can be cumbersome in that they do not have a federally prescribed time period in which CMS has to approve the waiver; therefore the approval process can be lengthy. Also, the federal Office of Management and Budget (OMB) is involved in reviewing the budget neutrality cost demonstration, which adds time and an additional level of complexity to the approval process. Still another challenge for many states is the budget neutrality cost demonstration associated with 1115(a) demonstration waivers.

Many states with MLTSS programs operate under concurrent 1915(b) waiver and 1915(c) waivers. The 1915(b) waiver provides the payment delivery system while the 1915(c) waiver provides the program operations infrastructure. The 1915(c) waiver affords states the ability to place a cap on the number of people served and to target the benefit, if desired, to certain geographic areas in the state. Operating concurrent 1915(b) and 1915(c) waivers became less burdensome administratively as a result of the HCBS final rules, published January 14, 2014, which allowed MLTSS programs targeted to dual eligible persons to operate under an aligned five-year cycle. Prior to this time, states operating concurrent waivers were tied to a 1915(b) waiver operating under a two-year waiver cycle and a 1915(c) waiver operating initially under a three-year cycle or five-year cycle for renewed programs.

Both the 1915(b) and 1915(c) federal authorities hold CMS to an initial 90 day review period, with a subsequent 90 day review period in the event CMS has questions regarding the application. The cost demonstration test for a 1915(c) waiver is cost neutrality and cost effectiveness for a 1915(b) waiver, both of which are much less challenging than the budget neutrality demonstration of an 1115(a) demonstration waiver. A disadvantage is that two separate and distinct waiver applications need to be completed. Given that Nebraska currently operates several existing 1915(c) waivers, it is logical that these waivers could be amended to become a single, comprehensive waiver.

Yet another option is the 1915(i) HCBS state plan authority which is the newest of the HCBS federal authorities available to states, effective January 1, 2007. It allows for many of the same flexibilities afforded to states via a 1915(c) waiver but instead through the state plan, such as a variety of HCBS (including self-direction) and person-centered planning processes. Unlike a 1915(c) waiver, states are not limited to providing services to persons who meet an institutional level of care. Also, there is no cost demonstration test. Instead, states are required to note their payment methodology in the application. CMS is also held to a 90 day review period with a subsequent 90 day review period in the event there are questions regarding the proposal. Unlike a 1915(c) waiver, under a 1915(i) states cannot cap the number of people served in the program or limit the program to one or more geographic areas.

Ultimately Mercer's recommendations will focus on making the redesigned LTSS system as administratively efficient as possible, but several factors will need to be considered in order to reach this decision and to determine what this looks like for the State. Among other considerations, MLTC will need to evaluate its tolerance for and the availability of resources to develop new federal authority program requests and manage the new program(s) upon receiving CMS approval.

5. **Provide a proposed work plan that covers all the activities required in the RFP, including start and completion dates and the staff person(s) to complete each specified task.**

We have included a complete, draft work plan covering all activities required in the RFP in Section 3 above.

6. **Provide a sample work product for a project similar in scope and size to this project, and that includes research, a program assessment, and program recommendations. A LTSS project is preferred but not mandatory.**

We have included the following samples in Appendix C at the end of this proposal:

LTSS Individual Service Plan Operational Assessment: At the request of a large state, Mercer performed an operational assessment of the State's HCBS intake process and specifically the development of the individual service plans (ISPs). The purpose of this assessment was to identify bottlenecks, squeeze points, duplication of efforts and administrative complexities with the goal to simplify and expedite the process for the benefit of consumers, families, and providers. Mercer provided recommendations for both short-term and long-term

changes. The sample work product found in Appendix C is an excerpt from a larger presentation that Mercer produced for our client. Some terminology and references have been modified.

LTSS Research Options Report: To support Delaware's strategic planning and LTSS redesign process, Mercer completed a research report on LTSS. Our research report covered a multitude of program elements including an overview of the current delivery system, analysis of Delaware's demographic factors, discussion of Medicare's role in LTSS, presentation of options for Medicaid LTSS redesign, and offering highlights of key operational issues. After this report was completed, Mercer presented our report to the Governor's Long-Term Care Commission. The full report is included in Appendix C and is also available on-line at: http://dhss.delaware.gov/dhss/dmma/reports.html

Section IV.C.2
Engagement of Stakeholders

7. Describe the bidder's proposed approach to engaging and communicating with stakeholders.

As the membership association for state aging and disability agencies, NASUAD has worked closely with a number of states as they redesign and implement new LTSS delivery systems. NASUAD is a national and respected voice of state agencies, with a long history of working cooperatively with its member state agencies to help achieve their goals.

A hallmark of the most successful transitions is consistent and meaningful engagement with stakeholders. NASUAD and Mercer have observed that when a robust stakeholder engagement process is *not* implemented, the following can occur:

- Significant, misleading media attention about the proposed change, including elevation to national media coverage.
- National advocacy activation against the proposed change.
- Enhanced scrutiny by CMS Central and Regional Offices.
- State legislative hearings and legislation against the proposed changes.
- Ongoing negative references to the State at national conferences.

It is imperative that communications with stakeholders are multi-directional; a cursory, presentation-only engagement tends to leave stakeholders frustrated and angry. Their concerns must be heard and communication must be transparent, even if issues are not specifically addressed. The initial goal is to build as much trust and collaboration as possible *before* beginning the redesign process. Once established, this trust will carry through to the redesign phase as long as communication continues to be open and transparent.

To begin this work, NASUAD and Mercer will work with MLTC to develop a communication plan that reflects the conditions unique to Nebraska and the State's goals for the LTSS redesign process. We will recommend developing a communication plan with overarching goals that:

- Communicates the imperative for the LTSS redesign.

- Delivers a consistent message to all stakeholders.
- Uses the right language to provide an effective, audience-appropriate message.
- Communicates with the appropriate levels of clarity and detail.
- Answers stakeholder questions accurately and in a timely manner.
- Tracks stakeholder feedback, concerns, and questions in order to use stakeholder input to help structure the LTSS redesign that Nebraska seeks.

A communication plan that reflects these priorities will be developed for both internal and external stakeholders. The plan will include templated communications documents that can be tailored for specific audiences. Our communication strategy will take advantage of the available technologies including the use of the DHHS website and listservs for external communications with stakeholders, and a Mercer Connect site for internal communications with the Department. We will capitalize on existing communication vehicles like state agency websites and social media accounts, trade association newsletters, or email listservs. NASUAD will research to obtain updated contact information for stakeholder groups and will maintain a robust distribution list.

Communicating with stakeholders means making sure the message is right for the audience. Different stakeholders will have different points-of-view and the same message may not be appropriate for all audiences. For example, a family with an autistic child is going to be more concerned with how their child will continue to access services, ensuring no disruption in caregivers and quality of care as opposed to federal operating authority options or fiscal impact to the state's budget. This is not the same discussion MLTC might have with MCOs, budget officials or even the PACE organization. Often there needs to be three forms of communication, but the underlying tenant is that all communication reinforces the same theme so there is consistency in the message:

- **Mission statement**: This is a brief communication that can be used to summarize MLTC's goals and objectives in easy to understand terms. Sometimes referred to as an "elevator speech", this communication is intended to answer the basic question of "What is MLTC doing with LTSS?"

- **Individual messaging**: When discussing LTSS redesign with individuals, the communication needs to be tailored accordingly. Is the person coming from a health policy background? Is the individual a provider inquiring how it will get paid for services in the future? Is it legislator wanting to know how to respond to questions from her constituents?

- **Group messaging**: When speaking to diverse groups, it is often better to use broader themes, general terminology, and simple clear examples. Talk to the audience, don't talk over the audience. Meet the audience at their level and they will better appreciate the message.

We recommend, and know that DHHS already has, establishing a separate webpage on the MLTC website focused on the LTSS redesign project, with a mailbox that could accommodate questions from the public. We further recommend reviewing comments regularly throughout the process and completing and uploading frequently asked questions and other relevant materials.

Ongoing and transparent communications will facilitate trust with stakeholders but will also assist in complying with CMS' expectations for early and regular interaction with stakeholders.

We propose to include meetings in each of the required locations during the day and evenings to support maximum participation of consumer groups. At least one webinar will also be hosted to ensure that stakeholders who are unable to participate in the in-person events have the opportunity to review the same materials and weigh in. Providing real opportunities for stakeholders to provide feedback and meaningful input into the process is vital to the overall success of any initiative.

NASUAD/Mercer will host additional stakeholder sessions with DHHS in 1Q2017 to share the draft redesign proposal and seek feedback. Each of the sites visited in the first round of stakeholder meetings will be re-visited with at least two sessions (one during the day/one in the evening will be held). Lessons learned from the first series of stakeholder meetings can be put into practice during the second round (e.g., meeting logistics/times, locations, content). Based on the draft redesign plan, we may determine that it would be effective to hold additional meetings with key groups most affected by the State's proposed changes.

At the conclusion of each of the stakeholder events, we will inform the State of any immediate concerns expressed by the stakeholders and also work with the State to answer any specific questions asked by the stakeholders. Our experience has taught us that stakeholders respond in a more favorable way to any change if you acknowledge and, to the maximum extent possible, answer their questions and concerns in a timely fashion, even if the answer is not the one that they hope to hear. Therefore we have built that process into our stakeholder engagement activities.

8. Provide sample reports and presentations from previous, similar contracts that demonstrate the bidder's capabilities and qualifications for effective stakeholder engagement.

Connecticut LTSS Right Sizing Stakeholder Report: Included in Appendix C is an example of a Mercer work product related to engaging stakeholders. This Mercer report was the result of participating in a strategy session with Connecticut state staff as well as a large group of stakeholders on right-sizing the state's LTSS system. Mercer helped facilitate the strategy session and our report was the result of the input received from all stakeholders. The Mercer report was shared with all stakeholder participants.

Idaho SIM Stakeholder Communication Plan: Mercer developed a Communication Plan to assist Idaho in engaging stakeholders in planning and implementing a statewide model to transform the State's multi-payer health care delivery and payment system. The Plan targets both internal stakeholders to promote cooperation, participation, and coordination between key groups, and external stakeholders such as health care consumers, advocates, and the general public. Mercer's Communication Plan for Idaho identifies tools and processes that provide information in the right format, at the right time, to the right audience and with the right impact. Excerpts from our work product can be found in Appendix C.

New Mexico Tribal Stakeholder Presentation: Appendix C includes a sample Mercer work product for the State of New Mexico to support an 1115 Waiver application that resulted in the program now known as Centennial Care. This presentation was used to facilitate a stakeholder meeting with Tribal representatives to discuss Medicaid reforms and the potential impact on Native American Members. The approach used in these meetings allowed for Tribal representatives to openly comment and ask questions but was focused on several design considerations the State was discussing internally to achieve culturally sensitive and effective outcomes within the program. Mercer uses the opportunity to frame discussions with Stakeholders that inform design recommendations and represent to CMS, the desires and needs of the Members on the most important topics.

Stakeholder Meeting Agendas: One of NASUAD's hallmarks is its technical assistance to its member states. NASUAD is often called upon to engage with stakeholders when states are undertaking Medicaid/aging system design and/or agency reorganizations. Attached in Appendix C are examples of stakeholder meeting agendas from NASUAD's work in Indiana and Oklahoma.

9. Provide a tentative list of stakeholders suggested to be included in the stakeholder meetings.

Our experience in providing technical assistance and consultation to states as they are moving through changes in their delivery system suggests that widespread and vigorous ongoing engagement with stakeholders provides the best chance of long-term success in moving consumers, providers and other groups in concert with the State. Soliciting concerns and proposed solutions is best handled with some key groups in individual meetings, while others welcome large scale gatherings to share feedback.

As part of the required 36 meetings outlined in the RFP (two in each of the nine specified Nebraska cities done before and after the draft redesign plan), NASUAD and Mercer, in close collaboration with MLTC, will develop an approach to permit different constituencies to share their unique concerns while discussing the broad issues of LTSS system redesign. Specifically, we have identified the following tentative list of stakeholders to be included in the process. The final list of stakeholder participants will be constructed with input from MLTC.

- **Individuals with intellectual/developmental disabilities and their family members**: Experience has indicated that this group is one of the most engaged constituencies in any Medicaid delivery system redesign. It is critical to explain possible changes to the delivery system and how they will impact their LTSS services, existing care manager/provider relationships, and service plans. Any redesign plan that includes ID/DD populations will need careful consideration of stakeholder input.

- **Adults with disabilities and their family members**: Of the 43% of population age 18 to 64 receiving LTSS in Nebraska, a large percentage are those are between 18 and 30. A discussion of employment, inclusion, and person-centered service delivery is essential for this constituency; it is also likely that concerns will be raised about transition between the children's system and adult services.

- **The Aging and Disability Network – including both Area Agencies on Aging (AAA) and Centers for Independent Living (CILs)**: Both AAAs and CILs are a critical part of Nebraska's LTSS delivery system. Other entities such as the Nebraska's Statewide Independent Living Council (NESILC) and The League of Human Dignity are also on the tentative list. Any system redesign should take into account the impact on the aging and disability network.

- **Individual Service Providers:** HCBS waiver providers are an important constituency to engage with as redesign thinking begins. Compared to other states, the bulk of service providers in Nebraska are individuals (4,800) compared to agencies (51). As it is possible that many of these individual providers deliver services in a self-direction program, they and the consumers they serve will want to share concerns about any negative impact to self-direction in the system redesign.

- **Nursing Homes**: 42% of Nebraska's LTSS budget is devoted to institutional services – the largest component of the State's system. It is our experience that given the significant concerns that the nursing home industry has expressed in other states, at least one meeting focused on their issues is well-advised.

- **Provider Associations:** In addition to individual providers, the key associations representing elements of Nebraska's LTSS delivery system (e.g., Assisted Living, home care, hospice) must be included in stakeholder meetings. The Nebraska Health Care Association and Nebraska Home Care Association are two examples of groups that can represent a larger member base.

- **Nebraska Commission on Indian Affairs**: Working with the Commission will enable engagement with Nebraska's four headquartered tribes: Ponca; Santee Sioux; Omaha; and Winnebago, as well as the other tribes represented in the State (Pawnee tribe, Oglala Sioux, Ioway, Sac, and Fox). Direct dialogue with tribal representatives is critical for sound program design as well as to comply with CMS' requirements for substantive tribal engagement for any Medicaid program changes.

- **Protection and Advocacy Agencies**: Nationally, these agencies are extremely engaged in system redesign conversations; as the focus on persons with disabilities, they bring a unique voice to the conversation. Disability Rights Nebraska and Nebraska Consortium for Citizens with Disabilities should feature prominently in those conversations.

- **Legislators and Key Legislative Staff**: A key group to engage early and often. The complicated Medicaid LTSS delivery system is rarely well-understood, so constituent concerns about changes will quickly drive their perceptions about the proposed changes. It's imperative to build an atmosphere of trust and collaboration – to the maximum extent possible – between the agency and influential legislators and staff.

- **Existing Advisory Committees**: Committees such as the Medicaid Assistance Advisory Committees and any groups which advise MLTC on their HCBS waiver programs should also be engaged.

- **DHHS Service Coordinators**: Having first-hand experience with the needs of the population, the concerns and suggestions from this internal stakeholder group will be a valued addition to the process.

In addition, we recognize that State staff who will be involved, either directly or indirectly, with system redesign need to be educated and engaged in the effort. State employees in MLTC as well as the State Unit on Aging can be powerful advocates and communicators to their constituencies as well as friends, families and neighbors.

10. Describe three projects that the bidder completed for which stakeholder meetings were included. Discuss how adequate attendance was ensured.

I. State Healthcare Innovations Plan Implementation in Idaho

In 2013, Mercer was selected by the Idaho Department of Health and Welfare to assist in implementing the design of the State Healthcare Innovations Plan (SHIP), an initiative to redesign Idaho's health care system, evolving from a FFS, volume-based system of care to a value-based system of care that rewards improved health outcomes. In developing recommendations for the model, Idaho was committed to engaging a broad group of stakeholders in the process. To ensure adequate attendance/stakeholder opportunity, Mercer actively participated in the design and facilitation of *more than 60 focus groups and public town hall meetings* across the State.

It was important to ensure that there was appropriate stakeholder representation at each of the meetings. Mercer worked with State staff to develop and update a stakeholder registry which contained contact information (e.g., email address and organization represented) for all identified key stakeholders (i.e., individuals and organizations). Targeted messages were sent to contacts on the stakeholder registry in advance of meetings noting the date, time, and location of stakeholder meetings. These messages were followed by reminder invitation notices closer to the meeting date. At each meeting, participants were asked to sign in to verify attendance. Names and contact information provided on sign-in sheets not already captured on the stakeholder registry were added to the list.

In 2015 Mercer was further contracted to assist the Idaho Department of Health and Welfare in planning for and implementing the SHIP model design which was informed by the stakeholder engagement activities noted above. The State Innovations Model (SIM) Communication Stakeholder Communication Plan described in response to question #8 and included as a sample Mercer work product was used by the State to conduct the stakeholder engagement for the 2015 program implementation.

II. Virginia Agency Redesign

In 2011, Virginia contacted NASUAD regarding how to best structure a redesign of their state agencies on aging and disability. Under the economic pressure of the great recession, Virginia was trying to provide the same or better level of services to seniors and people with disabilities at a reduced cost. At the same time, the federal government had pending litigation against the Commonwealth for Olmstead violations as well as Office of Civil Rights violations for their high

level of institutionalization. Further pressure to work more collaboratively between agencies was also being placed on aging and disability agencies by new grant funding opportunities offered by CMS and the Administration on Aging creating Aging and Disability Resource Centers.

As a result, one of the first decisions newly appointed cabinet Secretary Hazel made was to merge the agencies on aging and physical disabilities into one department. Although the decision had sound facts supporting it, there was little stakeholder input prior to the decision being made and the Commonwealth was overwhelmed by the strong negative reaction to the proposal.

NASUAD was engaged by the Commonwealth to help garner support for the consolidation of state agencies. There were over 20 various state agencies working with seniors and individuals with physical disabilities at the beginning of the transformation process. Each had a defined constituency that needed a voice in the process. NASUAD worked with the Commonwealth to host a series of forums with state staff, family members, providers, consumers, educators, and state lawmakers to provide the background on what the Commonwealth was proposing and why, to provide for the exchange of information for stakeholder voices, and to allow for input into the decision making process by the stakeholders.

While the Commonwealth served as the convener of the forums, NASUAD served as the moderator and allowed and encouraged the state to let NASUAD take the fault for any negative fall-out for decisions made without consumer engagement. Over the course of the year, NASUAD hosted nearly a dozen meetings of consumers. At the conclusion of the engagement, all of the various departments with the exception of services for the deaf and hard of hearing were successfully merged into a single state agency—the Department of Aging and Rehabilitative Services.

III. Colorado Data Study Input

Since 1964, states have received grant funding under the Older Americans Act program to provide LTSS to non-Medicaid eligible recipients. Regrettably, states have not been able to document whether or not the programs are effective or not because the data that states collect is largely output data (e.g., counting number of units delivered) rather than outcome level data (e.g., whether or not the service is effective). The Colorado state legislature, concerned with the rapidly growing population of seniors and the pressure that the growing Medicaid budget places on the rest of the state budget, set funding aside for a project to assess ways to better collect outcome data.

NASUAD was awarded a contract by the State Unit on Aging for this project. NASUAD began the project by assembling a steering committee comprised of a wide array of stakeholders from State staff, area agency on aging staff, centers for independent living, health IT vendors, federal Administration on Aging staff, CMS staff, county officials, rural providers, academics, and state Medicaid staff.

NASUAD involved the Colorado Healthcare Policy and Finance Agency, the single state Medicaid agency, early in the process in recognition of the fact that any true outcome measurement data on the effectiveness of non-Medicaid LTSS services will require the

assistance of the Medicaid agency. Buy-in by both agencies into whatever process is developed will be critical to the success of the new data collection effort.

A series of stakeholder meetings were conducted throughout the State. Special attention was given to ensure that rural access points, areas with diverse populations, as well as large urban settings were represented in the meetings across the state. Presentations were developed that were shared at each of the various locations along with a common set of interview questions for each of the audiences. At each of the locations, stakeholders were asked to also suggest further interviews that we should conduct to further inform our process. For those stakeholders unable to participate in one of the locations throughout the state, NASUAD staff conducted telephone interviews and webinars. Additionally, a questionnaire was emailed.

A national survey of state LTSS agency staff and state aging and disability staff will be shortly conducted to inform the Colorado study of promising practices in other states. At the conclusion of the study, NASUAD will present the State with a report outlining key considerations and recommendations for improving their data collecting system. NASUAD will also present the findings to the stakeholders throughout the State.

Section IV.C.3
Development of a Redesign Plan

11. Describe the bidder's proposed approach to completing the redesign plan, including redesign of the current program and then the possible incorporation of delivery system changes.

To facilitate the development of a redesign plan, Mercer will work closely with MLTC to ensure all key aspects of the delivery system (current and future) are addressed. Leveraging the information gained through both the research and service delivery system assessment phase and stakeholdering phase of this effort, as well as discussing and understanding all DHHS initiatives that may influence the time and resources available for aspects of the LTSS redesign effort (e.g., other DHHS procurements, IT/system changes, etc.), will be instrumental in developing the redesign plan. Crafting a system redesign that is responsive to the needs of Nebraskans and sustainable for future generations requires a comprehensive plan to ensure systematic changes are accounted for and sufficient time allowed for a successful implementation.

Mercer will work with MLTC and stakeholders to identify program design considerations that address these key questions:

- Who: Who are the specific eligibility groups served (including consideration of individuals eligible for Medicare and Medicaid)?

- What: What does LTSS redesign mean in terms of delivery system to achieve your goals? What programs/services do you wish to include or change and what impact does that have on all existing programs?

- When: What is a timeline sufficient to achieve the objectives?

- How: What tools (i.e., contract structures, payment strategies, quality oversight techniques) will position Nebraska to achieve objectives?

In working with other states, Mercer has developed a robust process that we commonly refer to as the "100 first questions." These questions and the redesign plan are organized into key domains such as:

- Stakeholder input
- Program authority, regulatory and policy review
- LTSS procurement and contracting requirements
- Eligible populations and services
- Enrollment policies, care management policies, level of care determination and re-determination
- Provider capacity
- Quality management
- Administration/organizational changes
- IT/systems requirements and changes and data collection
- Payment design and restructuring
- Communication strategy (internal and external)
- Training (internal and external)

These domains would be established based on the program design and structure envisioned by MLTC and an evaluation of the operational, fiscal and stakeholder considerations that need to be addressed through the transition. While program authority is toward the top of the list, the overall objectives and specific programmatic decisions will help identify which Medicaid authorities will be possible and most advantageous for the State and will drive subsequent redesign features. For example, a Medicaid waiver may not be needed if a State Plan Amendment (SPA) will suffice. Some federal authorities are prescriptive as to the type and extent of the input that states must solicit, thus directly impacting implementation timelines. The complexity of MLTC's objectives, some of which have been articulated in the Concept Paper, may require the use of various payment structures, quality measurement and oversight, contract provisions and other tools to ensure that the program is effectively executed and that its operation yields desired outcomes.

The redesign plan document itself should be a manageable size. Some redesign plans can be akin to a Concept Paper. For this project, a Concept Paper is likely too short of a document to layout and articulate the LTSS redesign, but conversely, a document that is hundreds of pages long is not "readable" by many stakeholders. Therefore, we anticipate the redesign plan to be less than 50 pages that uses common language, simple to understand terms and terminology and is an easy read. This will be appreciated by stakeholders.

The 100 first questions identify key issues under each domain that need to be addressed and considered as part of the redesign plan. In addition to identifying the issues and decision points needed, this process allows for comments, considerations and options to be analyzed from all aspects – operational, financial and stakeholder considerations – and for resolution to be

documented. This process allows the State to ensure all systematic issues have been addressed and sets the framework of developing the final redesign vision and implementation timeline.

While the LTSS redesign framework is yet to be determined, there are several issues that need to be considered under each domain that will impact the redesign plan. Outlined below are high-level issues that may need to be considered when transitioning from a FFS delivery system to a risk-based, managed care delivery system. The sample issues highlighted in the following table are not intended to be comprehensive or representative of Nebraska's system or direction, but offer insight to the types of issues that will need to be discussed in developing a redesign plan.

Sample Issue	Stabilize Existing FFS Delivery System	Possible Delivery System Changes Involving MLTSS
Administrative/Organizational Changes - Streamline and Simplify	• DHHS reorganization or reporting structure changes to ensure consistency across programs. • Potential changes in roles for external partners (e.g., AAAs, ADRCs, etc.). • Reduce/Eliminate duplication of efforts. • Simplify enrollment process. • Person-centered planning.	• Redirect staff resources with LTSS experience for vendor interaction, program development and oversight (e.g., MCOs, EQRO). • Potential changes in roles for external partners (e.g., AAAs, ADRCs, etc.). • Define the partnership between the Nebraska MLTC and the MCOs in terms of system of care, management, and accountability.
Enrollment policies and Level of Care Determination - Better Align Services to Needs	• Develop standard approach to assessment for both functional eligibility and service planning, including re-assessment. • Implement across program offices • Consider whether managed care wants to establish higher thresholds for	• Establish who will determine eligibility. • Allow time for validation and reliability testing and training if Nebraska MLTC will develop tool. • Determine how long MCOs must honor existing service plans

Sample Issue	Stabilize Existing FFS Delivery System	Possible Delivery System Changes Involving MLTSS
	institutional care than for HCBS.	
Eligible services - Independence Through Employment Opportunities	• Establish and implement new services promoting paid employment.	• Include revised services in MCO contracts and capitation and consider methods to incentivize plans to actively support Employment First initiative.
Regulatory/Policy Changes – Innovative Delivery System Options/Promote Quality	• Re-align across waivers. • Collect feedback from stakeholder groups. • Waiver consolidation. • Standard service definitions.	• Develop to support managed care. • Collect feedback from stakeholder groups.
Eligible population - Enrollment Waiting List Considerations	• Need to assess FFS provider capacity to serve (e.g., if wait list reduced). • Assess State budget implications.	• Assess provider capacity to serve (e.g., if wait list reduced) and MCO ability to "grow" new provider capacity to meet demand effectively and efficiently.
Provider workforce and payment design and restructuring - Rebalance and Refocus	• Determine if existing provider community is sufficient • Evaluate program requirements and facilitate provider training and monitoring. • Evaluate the impact of rate stabilization and service realignment on provider capacity. • Develop and utilize purchasing strategy to drive desired	• Determine if MCOs will be required to pay FFS rates to certain providers (e.g., NF, ICF/ID, HCBS) and how long this policy will exist. • Develop program requirements (e.g., network development) to establish expectations between the MCOs and existing provider community. • Develop and utilize purchasing strategy to drive desired

Sample Issue	Stabilize Existing FFS Delivery System	Possible Delivery System Changes Involving MLTSS
	community-based service array.	community-based service array.

In addition to the detailed systematic issues that need to be addressed in a redesign plan, thoughtful consideration and development of both a communication strategy and training strategy are required. A significant investment by MLTC in stakeholder involvement, communication, and training will allow for better collaboration and understand throughout the implementation process. Many times this component is addressed later in the redesign process, or falls short of the vision established, simply due to the volume of resources needed to keep other elements of the redesign effort and design moving forward. This is one of the most critical elements in a redesign effort. Strategies and materials need to be developed for both internal and external stakeholders and staff dedicated to ensuring ongoing communication and training needs are being met will be critical to stakeholder response to the change.

Mercer recommends an Executive Committee be established for this effort. Each domain area of the redesign plan would have a Champion(s) responsible for assessing and resolving implementation issues. The Executive Committee would be established to ensure all domain leads understand the operational decisions being made and how those decisions may impact the implementation of their domain area. The Executive Committee would also be responsible for reporting key program design decisions and milestones to DHHS, its Divisions, and others impacted.

Mercer will work with MLTC on the "100 first questions," which will continue to evolve to more than 100 questions as decisions are made, new issues raised and processes identified. The documentation of this dialog and resolution of issues that leads to final recommendations will be instrumental for developing the final redesign plan. It will also serve as a collection of information from which stakeholder communications, trainings and FAQ documents may be developed. Our clients have found that our facilitation of this process has helped lead to a deeper understanding of what the redesign plan entails, what operational changes are required, what questions and concerns may be raised by stakeholders through the transition, and why the implementation timeline looks as it does. While our experience allows us to start a framework for this discussion, the direction we go will be heavily depended on MLTC's current delivery system, stakeholder feedback, and vision for the future.

12. Describe how the bidder will ensure that its final recommendations and redesign plan will improve affordability, access to care, individual choice of setting/provider, quality of care, and the State's MITA maturity level.

All of these attributes, affordability, access to care, individual choice of setting/provider, quality of care and the State's MITA maturity level, are at the heart of any Medicaid redesign plan, particularly LTSS where consumers, caregivers/providers and family members have such a close connection. Many people in the Medicaid LTSS system have caregivers that come into their own home/residence to provide care; that is a personal event and an interaction with the health care system unlike any other. Thus, redesigning this system needs to be thoughtful, well-designed, incorporate stakeholder input and not viewed as arbitrary, rushed, or one-sided.

Mercer also knows from experience that it is nearly impossible to please everyone. Compromises will be necessary as the State's resources are finite. Mercer recommends that Nebraska not "let the perfect get in the way of the very good."

The goals of affordability, access to care, individual choice of setting/provider, quality of care and the State's MITA maturity level are not mutually exclusive. Quality care over the long term can be more affordable/cost-effective. Access to the *right* care, at the *right* time in the *right* setting can be affordable and sustainable. Choice of good providers that contribute to better health outcomes improves quality and supports access by avoiding unnecessary costs and utilization associated with a low-performing health care system. This is essentially what the Triple Aim is all about.

Effective use of data to support policy making, performance improvement, reporting, and monitoring evolves over time with the State's information technology resources and the ability to transform data into actionable information. If a piece of paper or data element is not used, why ask for it? If one process can be applied uniformly, why have multiple processes? Data is critical to sustainability. Good/credible data allows a platform for states to evaluate the impact of programmatic policies, individual outcomes, provider performance, accessibility, all of which drive financial results. The importance of developing appropriate tools to collect the data and processes for evaluating and monitoring the results against programmatic goals is often overlooked. The bottom line of any program is impacted by the program operations and policies so these elements and the important role of data cannot be overlooked. An efficient health care ecosystem uses resources more effectively, reduces waste, streamlines administrative processes, eliminates or at least reduces duplication, and encourages more provider participation which translates into more choices. Even successive, little changes in multiple areas can have a compounding effect and pay dividends to all aspects of the health care system. When it comes to LTSS, Mercer recommends that MLTC take a long-term view to long-term care.

Our recommendations in the redesign plan will be based on sound principles, derived from the unique knowledge and experience of our subject matter experts, other states' experience that our team has acquired, and knowledge that is available in the public domain. Additionally, the stakeholder input process, coupled with the experience of MLTC staff, will ensure that recommendations are intended to work for Nebraska given your health care climate, culture, and baseline starting point. Every state is unique. The Mercer team brings a wealth of experience and other state experience, but we have to work together to find a plan that works for Nebraska. For example, Mercer collaborated with Delaware to expand its existing physical/behavioral managed care program into LTSS through an 1115 amendment. This was a solution for Delaware whose Medicaid population and expenditure levels are not terribly dissimilar from Nebraska, yet geographically, Nebraska is much different. This strategy may not work as well for you. Conversely, Mercer completed a robust operational review of a large Medicaid program's HCBS intake system and particularly the individual service plan (ISP) assessment process to identify bottlenecks, squeeze points, duplication of efforts and administrative complexities with the goal to simplify and expedite the process for the benefit of consumers, families, and providers. While this type of LTSS operational review was specific to

that state, it is quite possible that Nebraska may have challenges in the existing delivery system in many of the same areas[1] as we found such as:

- ISP standards varied based on the State staff person.
- Approval time for ISPs varied, but not necessarily related to complexity or priority.
- Policy changes can be sudden and unclear.
- Existing consumer information is required to be entered in multiple areas.
- Inconsistent assessment tools.

The redesign plan will layout tactics, steps, and initiatives to improve your LTSS delivery system. How that plan is then executed and subsequently modified/updated based on real-time operational experience and changing market dynamics will ultimately determine how cost, quality, and access are impacted. This plan cannot be totally static, but instead has to "live and breathe" to some degree. LTSS represents over 40% of the State's $1.8 billion Medicaid/CHIP vendor expenditures[2], so even small, incremental improvements can have a significant impact on fiscal expenditures, but this also means there are many stakeholders whose level of concern will be raised by a fresh approach to redesigning the LTSS delivery system.

Mercer can perform baseline analyses and cost projections to model how costs may be impacted, Mercer can assist MLTC in inventorying providers that do and do not participate in Medicaid, Mercer can recommend quality/outcome metrics to be monitored over time to demonstrate how the program is evolving and we can work together to build incentives into the redesign to encourage positive change, as defined by MLTC's vision. There may be some initial investment cost to the State, and it is difficult to ascertain how much can be changed how quickly without causing a backlash of anti-support. Perhaps enhanced federal funding can mitigate some costs through potential program initiatives such as health homes or Community First Choice. The good news for Nebraska is that now more than ever there are options and choices to improve the Medicaid LTSS system. As your partner, Mercer will help you take a fresh look at delivery system options, assess stakeholder suggestions, and provide objective, independent recommendations from a well-known, reputable public health care consulting firm. Mercer's corporate mission statement is to assist state entities in becoming more efficient sponsors of health and welfare programs. This is what Mercer does.

13. Describe how the bidder will ensure that its final recommendations and redesign plan will improve integration of care for dually-eligible individuals.

Integration of care for the approximately 40,000 dual eligibles in Nebraska[3] (of which about 10% are partial duals) can occur on different levels. First, there is the integration across the spectrum

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[1] In May 2015, ACCESSNebraska began operating with a cross-divisional team focused on addressing operational improvement through a series of process initiatives. Legislative Report LB 657.

[2] Nebraska Medicaid Reform Annual Report, December 1, 2015, downloaded March 29, 2016 from: http://www.nebraskalegislature.gov/FloorDocs/104/PDF/Agencies/Health_and_Human_Services__Department_of/107_20151228-101834.pdf

[3] January 2015 MedPAC data book http://www.medpac.gov/documents/data-book/january-2015-medpac-and-macpac-data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid.pdf

of Medicaid covered behavioral health, physical health and LTSS. Granted, although dual eligibles have a majority of physical health and behavioral health services covered by the Medicare program, there are still services primarily covered by Medicaid, particularly LTSS, that MLTC staff have direct influence on and can more readily impact. Recommendations and activities that can address this integration include, but are not limited to data sharing (perhaps between the state and MCOs/management entities), involvement of the consumer/family support in the care planning process, identification/stratification of needs and protocols/best practice plans based on those needs, creation of multi-disciplinary care management teams that include social and medical resources, requirement that contracting health plans also be a Medicare Advantage organization, contract language that requires management entities to integrate care across settings and utilize evidence-based care models, promote electronic health records, development of outcome/quality measures that do more than just measure the number of events but endeavors to get at improved outcomes, and/or align financial incentives, sanctions or bonus that relate health outcomes/activities across the spectrum of services (e.g., sharing gains/losses across all services). This is a topic area where stakeholders can provide insight into current barriers that can be tackled in the redesign plan.

Second, there is integration of medical and social support services. Dual eligibles are commonly considered an "at-risk" population (e.g., aged, disabled, complex medical needs, complex system of care to navigate), so if MLTC seeks to achieve "whole-person" care and move beyond a medical model, the social support needs of your population has to be considered. Housing, nutrition/SNAP, employment, utilities (e.g., electricity, water) and transportation are examples of how a person's total care needs are evaluated. A key to addressing these care needs is to actively go to the person, not require the person to come to you. Therefore, the redesign plan should include a strong role for community-based care and involvement, outreach/education and mobile support systems to support this at-risk population and increase the level of integration. Otherwise, if the burden is on the person to integrate their care themselves, the challenges of life can preclude improvement in health, living, and outcomes. This is a key topic area where stakeholder input can be extremely valuable in crafting the redesign plan. Consumers, advocates and family members have first-hand experience, good or bad, with the present day system and their experience can guide MLTC staff in reducing or eliminating barriers that are preventing care integration and create a redesign plan that makes a better system, not just rearrange the existing puzzle pieces.

Third, for duals a discussion around Medicare's role is unavoidable when discussing integration. This is a larger challenge because MLTC does not have direct control over Medicare's policies, decision-making, and coverage rules and Nebraska is not one of the CMS Dual Demonstration states. But because of initiatives like the Duals Demonstrations and the presence of Medicare Advantage Special Needs Plans (MA-SNPs) there are more options for "door openers" and discussions with CMS, health plans and providers. Recognizing that there is only 1 MA-SNP in Nebraska for chronic/disabled conditions[4], the existing infrastructure within Nebraska may not be as conducive to fostering more integration with Medicare as in some other states, which means there is an opportunity to tackle this area through the redesign plan. Integration with Medicare may be a later stage in the process, but the goal can be documented within the

[4] Kaiser Family Foundation http://kff.org/medicare/state-indicator/special-needs-plan-offerings/ accessed March 29, 2016

redesign plan to establish the expectation and promote the idea through ongoing discussion. This is a key area where the State's Medicaid MCOs can provide strategic input, perspective, and considerations. Based on the status of the Heritage Health procurement at this time, MLTC is looking to contract with three MCOs, two of which are very large, national health plans, United and WellCare, which can provide MLTC a perspective of Medicare/Medicaid integration in other markets. Mercer's experience with Dual Demonstration states (e.g. Ohio, New York), PACE programs (e.g., California, Delaware, Pennsylvania), Medicaid managed LTSS programs (e.g., Delaware, Massachusetts, New Jersey, New Mexico, Pennsylvania) is available to MLTC if Mercer is selected to be your partner.

Just as important to creating the redesign plan is the ongoing monitoring of the plan. While not necessarily in this direct scope of work, the depth and breadth of the Mercer team offers MLTC the option to continue working with Mercer to provide ongoing monitoring, evaluation and adjustments to the plan based on actual implementation experience. Our clinical sector includes registered nurses, social workers, behavioral health specialists, and registered pharmacists. Our financial sector includes actuaries, analysts, accountants, and consultants. Our Informatics data management sector includes programmers and analysts. This illustrates the uniqueness of Mercer in that all skills sets that Nebraska may need to design, implement, and monitor/evaluate your LTSS redesign plan can be supported through a consistent, independent, and objective partner.

Mercer looks forward to teaming with MLTC to address these challenges and create a redesign plan that is flexible enough to evolve over time, yet has enough impact to effectuate change that the State wants to see happen.

14. Describe the bidder's proposed plan to involve MLTC's contracted MCOs and all other stakeholders in the development of its redesign plan.

Stakeholders in Nebraska have a vital role in contributing to the future course MLTC will pursue regarding the delivery, integration and financing of Medicaid LTSS. The redesign plan itself will be the result of the input stakeholders offer during the stakeholder engagement sessions. Therefore, stakeholders should see elements of their own contribution being built into the redesign plan which should engender a level of buy-in. In Mercer's experience, there are two primary strategies for further involving stakeholders in a major new initiative beyond the basic stakeholder "listening tour." There are pros/cons to each strategy (e.g., time, resources, coordination effort, managing expectations) and ultimately only MLTC can decide what is best:

1. Convene a group of representative stakeholders who will participate in and contribute to the actual development of the redesign plan. The group can be convened by invitation only or open to key stakeholders nominating a representative(s). The size and composition of the group can be at the State's discretion, but Mercer recommends considering a minimum of 10 non-MLTC individuals that includes a cross-section of individuals to cover varying opinions, perspectives and experiences (e.g., providers, caregivers, consumers, MCOs, advocacy groups, current contracted partners). If this option is selected, MLTC will also have a major decision as to what level of input/decision-making responsibility the group will have. This can also come down to two primary options with pros/cons to each:

a. Advisory Role: In this capacity, the stakeholder group advises the State, but does not have final decision-making responsibility which remains with MLTC. Thus this would have similarities to the State's previous Advisory Council.
b. Decision-making Role: In this capacity, the stakeholder group has direct input and decision-making authority on the redesign plan and can override what MLTC/State staff desire (assuming what the group wants is permissible under federal and/or state regulation).

Or

2. The State creates the initial working draft of the redesign plan and then submits the draft for public review and comment. This would be similar to how Medicaid state pan amendments and waiver applications are shared with the public. Based on stakeholder feedback, the draft plan is revised/edited as needed. To the extent that any comments/feedback is more substantial, additional meetings can be held with specific stakeholders to more fully understand the nature of the concern and path to resolution. The final redesign plan is then made publicly available with an acknowledgement and appreciation of the valued input from all stakeholders.

Mercer has worked with other states to have smaller, separate meetings targeted with key stakeholder groups to facilitate further discussions. If this path is pursued with discretion, it can enable some entities, like your existing MCOs, to express concerns or offer suggestions that they may otherwise be reticent to share in a more public forum. However, Mercer recommends that the State do this sparingly as the stakeholder process is better if it is transparent and open to the public. Non-public meetings can sometimes create an air of distrust which is very detrimental to transforming the Medicaid LTSS delivery system.

In addition to the stakeholder meetings, Mercer advises our clients to establish a dedicated internet project site on a familiar and commonly used main website (e.g., DHHS home page) where documents are posted, information, frequently asked questions (FAQs) and other updates are shared and there is a means for the public to submit general comments and questions. Either Mercer or MLTC staff will be tasked with monitoring the site and triaging incoming requests/questions. Our budget proposal assumes that MLTC staff will have primary responsibility for these activities as the State already has taken this step at: http://dhhs.ne.gov/medicaid/Pages/medicaid_LTSS.aspx, but the Mercer team can provide additional peer support.

It is unlikely that all stakeholder input will be adopted by the State either for political, policy or practicality reasons, but the involvement of stakeholders will be clearly evident in the redesign plan. Otherwise, if stakeholder input is rejected and the redesign plan appears foreign, the State can expect significant push-back, delays, negative headlines/publicity, and other reactions that will be detrimental to the process.

Prior to DHHS changing the scope of work for this RFP, Mercer was strongly advising, as a best practice, that MLTC *at a minimum* post the draft redesign plan to a public website and give a period of time (e.g., 15 business days or more) for public reaction and comments. With the change in scope, Mercer is supportive of conducting another series of stakeholder meetings to

present, discuss, and seek feedback on the redesign plan. This will ensure that MCOs and other stakeholders have another opportunity to provide input to the State to consider before finalizing the LTSS redesign plan.

15. Describe how the bidder proposes to train MLTC staff about the redesign plan and resources that will be involved.

Because Mercer is not going to sell MLTC on a specific solution, training will be customized to the needs of the State and highly dependent on the specifics of the redesign plan. For example, if an LTSS expansion of the existing Heritage Health program is adopted, MLTC staff is quite familiar with the operational aspects of a risk-based managed care program already. Thus training would focus on the aspects of LTSS that are particularly sensitive, challenging or have given other states difficulty such as care management transitions, continuity of care plans and/or provider continuity/provider networks. However, if MLTC opts to choose other changes such as adopting Health Homes, Accountable Care Organizations (ACOs) or a hybrid solution, the training may involve all aspects from program implementation, contractual responsibilities, consumer role versus provider role versus caregiver role, and so on.

In our experience of working with many state Medicaid clients across the country, Mercer has found five best practices when it comes to training/collaborating with our state partners:

- **Involve State Staff Early**: This is a process not a single event that occurs over one day. The redesign of your LTSS delivery system will evolve over time; therefore, to the extent practical, Mercer recommends the State be involved early and throughout the process. Decisions are often cumulative and inter-dependent, so training effectively begins on day 1 with the kick-off meeting.

- **Documentation**: Maintaining written documentation, decision-logs, and/or issues with resolution lists provides a means to document the process, establish lines of responsibility and a reference tool when questions are subsequently asked.

- **Leverage Technology**: Conference calls, in-person meetings, webinars, and so forth are all used by the Mercer team to train/collaborate with our state clients. Some topics are better suited to in-person meetings, while many other issues can be addressed remotely. Large group training sessions to smaller working sessions will be used as mutually agreed to.

- **Ask, Don't Assume**: It is better to ask an additional question than to assume everyone is on the same page. Unless MLTC has already decided on a managed care expansion for LTSS, the path to redesign will evolve and the outcome is uncertain. As a result, training MLTC staff requires that everyone is forthcoming about what each other understands, doesn't understand, roles, responsibilities, reporting structure and so forth. This understanding can only be achieved through open dialogue. Mercer is your partner in this, but we can't read minds. Many involved in the process will gain insight into issues and processes for which they have no visibility or perspective on today.

- **Plan, Do and Review**: Training is a process. Mercer's approach is to plan with you what works best (i.e., agenda), do the training, review how it went and improve the process each

time. Perhaps we need more 1 on 1 time, less focus on policy and more on operational issues or perhaps MLTC staff would benefit from an opportunity to talk to your counterparts in other Mercer client states and Mercer can facilitate a three-way conference call where MLTC staff can learn from other states that have been through a similar experience.

In terms of resources, from the Mercer team, the training will involve our subject matter experts/key team members responsible for the given topic area that work on this engagement. As noted previously, the depth and breadth of the Mercer team can be a tremendous asset to the State. Through mutual agreement, Mercer can augment your team in areas such as clinical performance measures, care management policies, managed care contracting/procurement, actuarial/financial analyses, data analytics or pharmacy management programs.

But more importantly, the State resources that will be needed are best summed up by one word: Champions. Our experience has shown repeatedly that states that identify project Champions early on that are responsible for specific domains/topics have much greater success, a smoother implementation curve, and better team continuity. The Champion areas typically include:

- Overall Program Design/Strategy.
- Communication/Stakeholders (external *and* internal).
- Information Systems.
- CMS/Federal Authority.
- Procurement/Contracting.
- Quality/Outcomes.
- Financial.

The selected State Champions will need to have enough seniority, empowerment, and experience to take ownership responsibility to learn, apply, and guide others as they themselves learn, and become trained on the new redesign plan. These individuals will also need a resource that often poses a challenge for many state agencies: Time. Time to spend on the project, time to think through the ramifications of policy options and make informed decisions, time to respond and react to stakeholder input, time to ensure it is done right and time to perform their current job responsibilities if major tasks/responsibilities are not able to be re-assigned to others. Redesigning the Medicaid LTSS delivery system is a major undertaking; over $780 million dollars of program expenditures and provider revenue will be involved with thousands of Medicaid members and perhaps even the culture of how care is delivered, evaluated, and paid for can be impacted by this endeavor. The Mercer team can do much of the heavy lifting, but ultimately, MLTC is the single state agency responsible for the long-term success and sustainability of the redesign. The current administrative design and processes may be completely different under the new system.

Section IV.C. 4
Implementation of a Redesign Plan

16. Describe the bidder's proposed approach to the implementation of its LTSS redesign plan. Describe any potential risks to plan implementation and how they will be mitigated.

Once the redesign plan is complete, Mercer will work together with MLTC to develop a list of suggested implementation tasks as requested in the RFP. The implementation task list will be dependent on what specifically the redesign plan includes, but potential tasks could include:

- Obtaining federal waiver authority.
- LTSS contracting process including a request for proposal if necessary.
- Level of care determination and redeterminations.
- Stakeholder and MCO involvement.
- Care management structure/strategy.
- Quality management structure/strategy.
- Systems/IT requirements.
- Payment reform/value-based payments.
- Organization oversight.

Our approach to implementation will be collaborative in nature. We have to set realistic dates together, have useable work plans, establish clear roles, responsibilities and lines of communication and manage expectations to avoid some of the risk areas described below. We also need to be prepared for and avoid the traps of "paralysis by analysis" or "information request overload" by being judicious in work planning. Implementation will require State Champions, ideally many of the same individuals that championed the redesign effort so that the vision and knowledge is maintained. We will need to create and manage implementation workgroups for key areas noted previously, monitor their progress and ensure that all groups are meeting their milestones through regular status meetings and reports to the Executive/ Steering Advisory Committee.

Strong project management is a necessity for implementation, and this may involve a significant on-site Mercer presence if desired by MLTC. Mercer is prepared for this level of engagement and support but can also be used to a lesser degree to augment State resources. Implementation will proceed at the speed and pace in which you can make the myriad of decisions that will be required. We will offer advice, suggestions, and issues to consider, but ultimately, this is your program. Our approach to implementation will be a positive, can-do attitude; we've done this before with other states and thus the Mercer team can help you make this happen.

Mercer can develop work plans for each of the required areas to implement the LTSS redesign plan. The resources (e.g., time, staffing, and cost) that will be required for completing the steps in the implementation plan will be mutually agreed to between Mercer and MLTC once the LTSS redesign plan and implementation plan is complete. There is simply too much uncertainty and too much variability in potential new LTSS delivery system options to know what level of resources may be required to support the next phase of this work. For example, implementing

an integrated Medicaid/Medicare ACO model with Triple Aim Gain Sharing (TAGS) coupled with consolidated HCBS waiver service definitions and provider qualifications is very different than adding existing LTSS services to the existing Heritage Health MCOs.

There are many potential risks related to plan implementation that will have to be managed. Depending on what the redesign plan covers will directly impact that level of and types of risk the State can expect. Therefore, the specific risks are unknown at this time. However, based on our experience with similar redesign efforts and subsequent implementations, we can group potential risks into the following domains:

- **Change in Strategic Direction**: The redesign plan will take several months to complete as indicated in the RFP. Implementation, done the right way, takes much longer. Unforeseen events, market place changes, leadership changes, and/or external influences are examples of factors that have the potential to delay or distract implementation. It is not practical to mitigate all of these potential events, but the best way to mitigate changes in strategic direction is to get buy-in and support from leadership for the redesign plan. In this context leadership can include the Governor's Office, key legislative leaders, budget office, and prominent stakeholders.

- **Fiscal Challenges**: Redesigning over 40% of Medicaid program expenditures is a big undertaking. Small improvements can have a significant return on investment over a period of time; new, comprehensive innovations can perhaps move the needle stronger and swifter. But sometimes change require upfront costs related to alternative provider payments, systems/IT changes, redeployment of State staff and other expenditures. A risk is that the cost of change may be difficult to balance with other competing priorities for the State's finite resources and line-item budgets may be impacted. This risk can be mitigated by establishing realistic short and long term expectations, keeping key constituents informed of progress, and looking for some "quick wins" as well as larger, systemic changes.

- ***Loss of Momentum***: MLTC has accurately described this redesign and subsequent implementation as a "process." A Medicaid LTSS system does not change overnight. Therefore, there is a risk that the process itself will lose momentum due to things such as State staff turnover, conflicting priorities (e.g., Mental Health Parity compliance, HCBS Transition Plan, Medicaid Managed Care Final Rule compliance) or a LTSS redesign plan that is simply too complicated and gets bogged down by its own weight. This can be mitigated by strong State leadership, a well-designed plan with realistic short-term and long-term activities/milestones, celebrating successes, a good communication campaign, and effective management of internal and external stakeholders.

- **Federal Oversight/Compliance**: Depending on what the redesign specifically calls for, CMS involvement will likely be required in some form or fashion. The more "traditional" the redesign plan is, probably less risk of CMS causing delays or distractions. A more innovative and comprehensive redesign will lead to more CMS involvement, questions, oversight and compliance requirements. This can be mitigated by having a well-constructed redesign plan that addresses the federal authority/federal regulatory issues proactively so implementation goes smoother. Moreover, in our work with other state Medicaid programs,

Mercer has a strategy for when and how to engage CMS depending on the authorities utilized in the redesign plan. Mercer employs several former CMS staff and thus the insight that Mercer can offer on how to navigate the CMS world is a direct benefit to Nebraska.

- **Stakeholder Push-back**: As noted elsewhere, stakeholders can be a force in support of change or a force against change (and perhaps a little of both). A potential risk is that some stakeholder(s) creates enough push-back that implementation is delayed or even derailed. This risk should be mitigated through an effective and ongoing stakeholder engagement process, but even a well-designed stakeholder engagement process cannot ameliorate personal agendas or political motives that sometimes creep into a redesign of this magnitude.

- **IT/Systems Support**: Mercer has seen situations where implementation of an initiative like this can be delayed due to a lack of IT support. Much of Medicaid's day-to-day operations are dependent on IT systems working effectively in areas such as eligibility/enrollment, claims processing/payment, CMS reporting/claiming, program integrity and so on. A redesign plan is just a plan until it is effectuated through actual changes which typically require some level of IT/system changes (e.g., new program eligibility codes, revised provider fees/payment structures) and the risk is that technology cannot be changed/revised within the timeframes envisioned. To mitigate this will require involvement and Champions from the IT/Systems area within DHHS and advanced planning/communication to enable scheduling of required system changes. Depending on the specifics of the redesign plan, Mercer advises MLTC to not under-estimate the role and importance of IT/Systems during the implementation phase.

- **Human Resources**: Adequate resources, specifically State staff, to maintain the current delivery system and transition to a new delivery system, or even implementing enhancements to the current delivery system, takes time. The times we are in are fraught with challenges – State staff tends to be wearing multiple hats and CMS continues to release new regulations and rule requiring compliance. Sufficient time to balance all competing priorities tends to fall on too few shoulders. To mitigate the risk of not having staff resources to ensure day-to-day operations on the current delivery system and progress on the implementation plan toward a new LTSS system, a key first step once the redesign plan is complete will be to assess the resources needed and determine how any identified gaps will be filled.

The above list represents challenges typically faced in the implementation of a redesign effort. Once the redesign plan is complete, a more robust analysis of potential risks and mitigation strategies can be explored to ensure the potential disruptions are minimized.

17. Describe bidder's proposed plan to involve MLTC's contracted MCOs and all other stakeholders in the implementation process.

Mercer believes it is important to get input from stakeholders and MLTC's contracted MCOs (especially if some type of MCO managed delivery system is ultimately chosen) for the LTSS redesign implementation to be successful and sustainable. Indeed, if implementation requires state plan amendments or a waiver, stakeholder feedback will be required by CMS.

Stakeholders, whether internal or external, will want to be informed in a timely manner on the progress the State is making towards the goal of increasing community-based alternatives for LTSS. Moreover, stakeholders will want to know how implementation is tracking compared to the redesign plan, where and why the State may be making significant deviations from the plan and how their input was put into action.

The State will need to have a communications strategy to not only provide this information to stakeholders in practical and appropriate forums, but also to manage and coordinate the input and questions from stakeholders. To that end, Mercer recommends the State empower a Champion with sufficient seniority to serve as a change-manager and move those involved in a coordinated action. Mercer can augment this process by helping the State strategize over how, when and to what extent to involve MCOs and other stakeholders during the implementation phase, assisting with responses to questions, preparing meeting materials in collaboration with MLTC staff and co-presenting if needed.

The process of involving MCOs and other stakeholders in the implementation phase is similar to involving these entities in the redesign plan. However, one major difference is that implementation requires many real-time decisions to effectuate change and these decisions may have financial, policy, political, staffing, systems, and/or quality of care ramifications. This is another area where the Mercer team can be of great value to MLTC in that Mercer brings an objective, independent and un-biased point-of-view to the process. We have no agenda except to support the State of Nebraska in achieving your goals.

As noted in response to involving stakeholders in the redesign plan development, there are two primary strategies for further involving stakeholders in the implementation phase. There are pros/cons to each strategy (e.g., time, resources, coordination effort, managing expectations) and ultimately only MLTC can decide what is best:

1. Convene a group of representative stakeholders who will participate in and contribute to the implementation phase. The group can be convened by invitation only or open to key stakeholders nominating a representative(s). If this option is selected, MLTC will also have a major decision as to what level of input/decision-making responsibility the group will have. This can also come down to two primary options with pros/cons to each:

    a. Advisory Role: In this capacity, the stakeholder group advises the State, but does not have final decision-making responsibility which remains with MLTC. Thus this would have similarities to the State's previous Advisory Council.

    b. Decision-making Role: In this capacity, the stakeholder group has direct input and decision-making authority on implementation and can override what MLTC/State staff desire (assuming what the group wants is permissible under federal and/or state regulation).

Or

2. MLTC leads the implementation process and periodically provides stakeholder groups "progress report updates." This can be done via the Medical Assistance Advisory Committee

meetings and/or through periodic stakeholder status meetings, webinars, or conference calls at major milestone points in the process. Posting information publicly to a website and having an ongoing comments/questions submission process can enable stakeholders to stay involved and informed.

For the implementation phase, because of the complexity of issues that may arise, Mercer recommends that MLTC choose some form of Option 1a or Option 2 where the State leads the implementation phase. There needs to be a balance between involving stakeholders during implementation, but not having the process become so bogged down that progress slows to a crawl and every decision point has to be vetted through multiple channels.

If a redesign plan is pursued that involves managed care contracting, managed care entities will want to know specific details about the program including contractual responsibilities, performance/quality measurers, financial arrangements, and operational issues. The State should expect detailed and technical questions from this group. For example, the PACE Organization and PACE supporters may be concerned about whether or not PACE will still be part of the Nebraska landscape going forward. Mercer can work with the State to discuss and develop appropriate training/education programs for these identified groups. We've done this many times with many different states and we can anticipate the types of questions, issues and concerns MCOs and other stakeholders are likely to voice during the implementation phase.

18. Describe how the bidder proposes to train and work with MLTC staff for plan implementation and resources that would be involved. Describe other potential audiences for training and resources that would be involved.

Implementing the State's LTSS redesign plan will require a significant amount of resources, management, and expertise to achieve all the desired goals. Mercer's staff has the breadth of expertise to assist Nebraska with all facets of implementation. Using the implementation plan discussed above, Mercer would work with the State to identify areas where Mercer resources could be utilized to assist with the implementation process. Many of the implementation steps may require specific training for MLTC staff to be most effective. Mercer would utilize the staff resources assigned to this project including the subject matter experts to provide training to the MLTC staff. Since Mercer has significant expertise in LTSS programs, we can also enlist additional Mercer resources that have specific expertise that may be outside the Nebraska team to provide additional training.

There are a lot of similarities between training (see question #15) on the redesign plan and subsequent implementation of that plan. Mercer would take similar action regarding the implementation as follows:

- **Involve State Staff Early***:* This is a process not a single event that occurs over one day. Implementation takes time to plan, do, adjust, and evaluate. Mercer recommends the State be involved early and throughout the process. Decisions are often cumulative and inter-dependent and State staff needs to be involved in the decisions regarding implementation to know how to effectively oversee the program after implementation.

- **Documentation**: Maintaining written documentation, decision-logs, and/or issues with resolution lists provides a means to document the process, establish lines of responsibility and a reference tool when questions are subsequently asked.

- **Leverage Technology**: Conference calls, in-person meetings, webinars, and so forth are all used by the Mercer team to train/collaborate with our state clients. Some topics are better suited to in-person meetings, while many other issues can be addressed remotely. Large group training sessions to smaller working sessions will be used as mutually agreed to.

- **Ask, Don't Assume**: It is better to ask an additional question than to assume everyone is on the same page. As a result, training MLTC staff requires that everyone is forthcoming about what each other understands, doesn't understand, roles, responsibilities, reporting structure and so forth. This understanding can only be achieved through open communication.

- **Plan, Do and Review**: Training is a process. Mercer's approach is to plan with you what works best (i.e., agenda), do the training, review how it went and improve the process each time. Perhaps MLTC staff would benefit from an opportunity to talk to your counterparts in other Mercer client states and Mercer can facilitate a three-way conference call where MLTC staff can learn from other states.

There are several other potential audiences for training not previously discussed specifically in response to other questions. In this context, training may be more akin to program updates and education. Depending on what strategic direction MLTC takes, there could be specific training related to new billing processes, new benefit options, new program choices and so on. Therefore, other potential audiences may include:

- Consumers and family members.
- Caregivers/Providers (e.g., Nebraska Healthcare Association, Nebraska Home Care Association).
- Advocacy/Support groups (e.g., ADRCs, CILs).
- Area Agencies on Aging (AAAs).
- The Medical Assistance Advisory Committee.
- MLTC's enrollment broker.
- MLTC's EQRO.
- MLTC's MMIS vendor.
- MLTC's PACE organization.
- Legislative bodies.
- Other DHHS divisions/units and LTC Ombudsmen Program.
- Criminal justice system/courts (depending on what the redesign entails).

Resources needed to complete these trainings are similar to other trainings/public outreach efforts. The State will need to have representatives to present information, respond to questions, and be able to articulate the State's position, goals, and activities. Mercer can support MLTC the State in doing this and perhaps co-present as needed. In our experience, often these audiences want to hear first from a State leader, not a consultant. These State representatives may be some of the Champions or other individuals with sufficient knowledge,

presentation skills, and maturity to address each audience effectively. Meeting times, locations, and presentation materials will be needed. Time will also be a needed resource to complete the trainings/education. Mercer can support MLTC with these activities as well as using Mercer's webinar technology.

APPENDIX A

Appendix A – Annual Report

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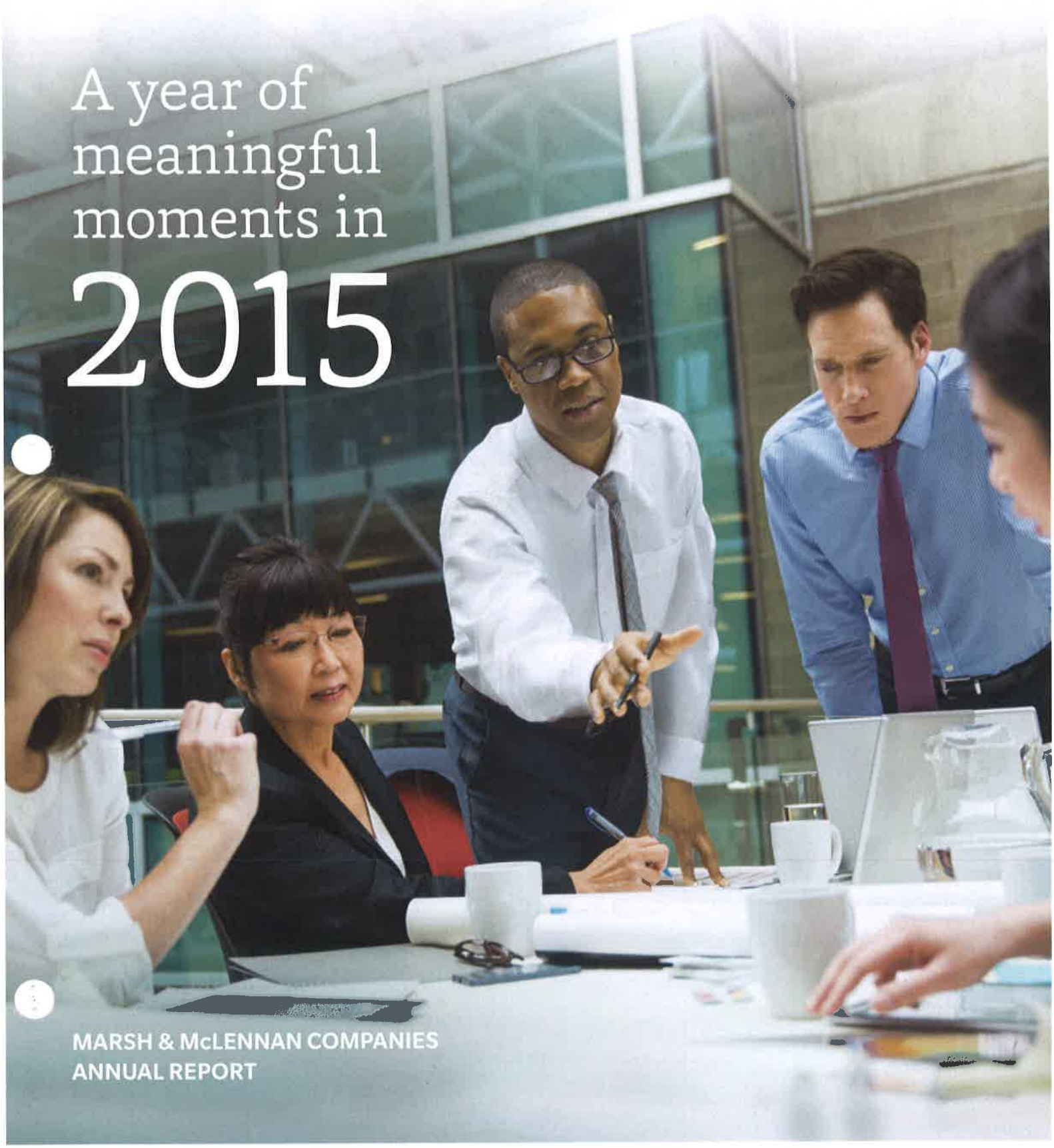
MARSH & McLENNAN COMPANIES

A year of meaningful moments in 2015



MARSH & McLENNAN COMPANIES
ANNUAL REPORT

"We exist to serve clients. If we do so effectively, we will achieve our revenue and profit objectives."

DAN GLASER
PRESIDENT AND CHIEF EXECUTIVE OFFICER
MARSH & McLENNAN COMPANIES

We are Marsh & McLennan Companies: a global professional services firm offering clients advice and solutions in risk, strategy and people.

OUR FOUR OPERATING COMPANIES ARE:

MARSH
A leader in insurance broking and risk management.

GUY CARPENTER
A leader in reinsurance and intermediary advisory services.

MERCER
A leader in talent, health, retirement and investment consulting.

OLIVER WYMAN
A leader in management, economic and brand strategy consulting.

WE ARE COMMITTED TO:

ENABLING CLIENT SUCCESS
We anticipate the needs of our clients and act as their trusted advisors.

FINDING THE SMARTER WAY
We never stop searching for a better solution.

WORKING SIDE BY SIDE
We collaborate to harness our collective intelligence.

LIVING THE GREATER GOOD
We act with integrity and strive to improve our communities around the world.

This annual report contains "forward-looking statements," as defined in the Private Securities Litigation Reform Act of 1995. Please see "Information Concerning Forward-Looking Statements" on page (i) in the Form 10-K included in this annual report.

To our shareholders,

Throughout our 145-year history, we have helped our clients grapple with complex challenges. 2015 was a case in point. Financial markets tumbled, foreign exchange rates fluctuated dramatically and geopolitical turmoil swept through continents. These volatile and uncertain conditions contributed to a dynamic environment full of threats and opportunities for our clients. Our areas of strength — risk, strategy and people — have never been more relevant or important.

145-year

HISTORY OF LEADERSHIP AND INNOVATION

Clients sought our deep expertise, our understanding of their businesses, our creativity and our unwavering commitment to client service.

Our company has considerable advantages that enable us to grow in varied market conditions. Most importantly, we have great people. We are, after all, a professional services firm. The intellectual capacity and creativity of our colleagues is our product. As I visit our offices around the world, I am always impressed by the intelligence, ingenuity and dedication of our colleagues and our leaders.

We make a positive impact on the businesses, people and societies we serve by providing guidance and support during critical moments... that is a powerful purpose that unites us all. Our 60,000 colleagues — actuaries, brokers, consultants, subject-matter experts and other professionals — advise clients on many of the most complex issues of our time: responding to natural catastrophes, providing for retirement security, attracting and retaining the best people and enhancing cyber resilience — to name a few.

We manage our company with three specific constituencies in mind: our clients, our colleagues and our shareholders. We have sought to strike the appropriate balance between rigorous execution in the short term and strategic investment for the long term. These twin objectives are reflected in our return of a record amount of capital to shareholders in 2015 coupled with our substantial investments to grow our business.

Though we live in challenging times, I am confident that our inherent strengths — extraordinary people, a cohesive culture and a restless commitment to finding a better way — will fuel our firm's long-term growth.

6 years

OF CONSECUTIVE OPERATING MARGIN GROWTH IN BOTH SEGMENTS

ANOTHER YEAR OF STRONG FINANCIAL PERFORMANCE

Building on six consecutive years of strong performance, Marsh & McLennan delivered another year of robust financial results in 2015.

We generated 4% underlying revenue growth with healthy increases at all four operating companies. In each of the last six years, we have grown consolidated underlying revenue in the 3% to 5% range. Acquisitions have added an additional two percentage points on average over that same time period.

Adjusted operating income[1] rose 5% to $2.5 billion. We continued our track record of operational excellence by increasing adjusted operating margins. In 2015, our consolidated margin accelerated 100 basis points, to 19.1%, our highest level in more than a decade.

Our earnings per share increased 12%, and adjusted EPS grew 8% to a record $3.05. We achieved these results despite $0.18 of negative impact from the effects of foreign exchange. On a constant currency basis, our adjusted EPS growth was an impressive 14.5%. Since 2009, our adjusted EPS has grown at a CAGR of 13.5%, in line with the 13% long-term target we established in 2010. We delivered this outstanding record of performance while overcoming approximately $200 million of foreign exchange headwinds during this six-year period, representing a yearly average of $.04 per share.

Risk and Insurance Services revenue of $6.9 billion reflected an increase of 3% on an underlying basis. Adjusted operating income rose 3% to $1.6 billion, with the adjusted margin expanding 90 basis points to 23.3%, the highest in more than a decade. Adjusted operating margins in RIS have improved every year since 2007.

Marsh's underlying revenue growth of 3% reflected increases across all major geographies. This was Marsh's fifth straight year of underlying revenue growth of at least 3%.

Guy Carpenter's underlying revenue growth of 2% was a solid result given the dynamics in the reinsurance industry.

1 For a reconciliation of non-GAAP results to GAAP results, as related to all non-GAAP references presented in this letter, please refer to the Company's Form 8-K, dated February 4, 2016, available on the Company's website at mmc.com.

Consulting produced revenue of $6.1 billion, an increase of 5% on an underlying basis. Adjusted operating income rose 4%, exceeding $1 billion for the first time in our history. Consulting's track record of higher adjusted operating margins continued in 2015, expanding 80 basis points to 17.3%. Since 2010, the adjusted margin has improved by 600 basis points.

Mercer's underlying revenue growth of 4% was strong and marked the fifth consecutive year of growth of 3% or higher.

Oliver Wyman's underlying revenue growth of 7% in 2015 came on top of 2014's outstanding growth of 15%.

"Since 2009, our adjusted EPS has grown at a CAGR of 13.5%, consistent with our long-term target set at Investor Day in 2010 and reaffirmed in March 2014."

OUR COMMITMENTS TO SHAREHOLDERS

In 2015, we returned a record level of cash — over $2 billion — to our shareholders.

At our Investor Day in March 2014, we made three commitments to shareholders:

1) Grow adjusted EPS at a long-term CAGR of 13%;
2) Increase our dividend per share by double-digits every year; and
3) Reduce our share count every year.

We continue to deliver on these commitments. Since 2009, our adjusted EPS has grown at a CAGR of 13.5%, consistent with our long-term target set at Investor Day in 2010 and reaffirmed in March 2014. In 2015, we increased our annual dividend by 11.3%, exceeding even the 10.4% increase in 2014. And our share count declined for the second straight year.

Bottom line, Marsh & McLennan delivered another strong year of financial performance in 2015.

OUR VIEW OF THE MARKETS

I am proud to have spent the past 30 years working in the insurance industry, both as a broker and as an underwriter. In my view, the insurance industry plays a crucial role in spurring economic growth, the taking of risk and promoting innovation. On the upside, insurance enables commerce to thrive. Satellites are launched. Skyscrapers are built. Medicines are invented. On the downside, insurance is a vital buffer enabling lives and livelihoods to be rebuilt following loss.

"Today, we are stronger strategically, operationally and financially than at any time in the last decade."

Clients in more than **130 countries**

Investments for growth and efficiencies since 2009 of nearly
$7 billion

$1.2 billion
For 27 acquisitions and investments in 2015

$13 billion
Annual revenue

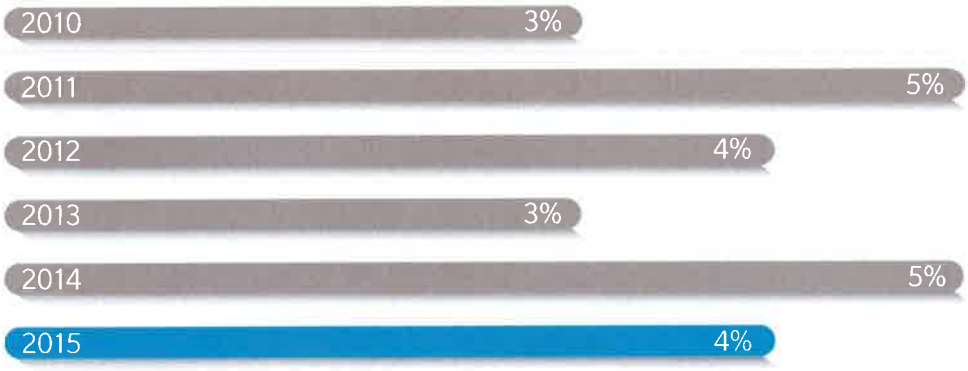
60,000
Colleagues around the world making a difference for clients in critical moments

11.3% Dividend growth

Continuing our commitment to double-digit dividend growth

6 years

Of consecutive underlying revenue growth in the 3% to 5% range



$2 billion

RETURNED TO SHAREHOLDERS THROUGH DIVIDEND AND SHARE REPURCHASE

Like the broader market, these are dynamic times in the insurance industry.

Insurance companies are dealing with significant structural change. We have seen large-scale M&A, senior management changes, a reduction in the underwriting appetite at several companies, an infusion of alternative capital and a willingness at some firms to reconsider reinsurance as a way to reduce volatility.

Intense competition and excess capacity coupled with challenging returns have led to orderly pricing declines. This trend has played out for several years and is fundamentally good for our clients. As insurance markets evolve and consolidate, we believe that the advice of a broker will be all the more important to clients trying to make sense of industry change. Advisors with the deepest experience and broadest capabilities stand to benefit from a flight to quality as clients seek trusted advisors with the right skills to help them navigate through the uncertainty.

Dynamic change also creates exciting opportunities for our consulting businesses. The ongoing development of economies around the world and the impact of key socioeconomic trends should accelerate the need for our advice and solutions.

In mature markets with aging workforces, both companies and individuals wrestle with uncertainty as increasing amounts of responsibility shift to individuals for their retirement, health and investment decisions. Mercer is well-positioned to assist people, companies and governments in developing innovative solutions to adapt to the change wrought by powerful demographic and economic trends.

Global volatility provides significant opportunity for Oliver Wyman, a leading provider of strategic advice and solutions to the C-suite. With deep industry expertise, Oliver Wyman has demonstrated its ability to help clients navigate the changing strategic and regulatory environment in sectors as diverse as financial services, healthcare, aviation and energy.

We remain optimistic about our ability to help clients face the significant challenges of our time.

OUR LONG-TERM GROWTH PHILOSOPHY

Our goal is to become one of the very best companies — not simply in our industry segments — but in the world. To get there, we must demonstrate our ability to generate sustained growth in revenues and profit, drive innovation and make Marsh & McLennan a great place to work.

Each of our operating companies is a global leader, helping clients address the issues of the day. By enabling our clients to succeed, we expect to produce strong

growth in our revenues, earnings and cash flows over the long term. We also expect to deliver, over time, significantly higher earnings growth than the S&P 500, with lower capital requirements and reduced risk.

Our revenue growth is driven by the investments we make. We have invested organically and through acquisition to enter new segments, broaden our geographic footprint and deepen our capabilities.

Since 2009, we have invested nearly $7 billion for growth and efficiency. This includes:

- 115 acquisitions and investments totaling approximately $4.6 billion; and
- Capital investments of $2.2 billion.

"Our goal is to become one of the very best companies — not simply in our industry segments — but in the world. To get there, we must demonstrate our ability to generate sustained growth in revenues and profit, drive innovation and make Marsh & McLennan a great place to work."

In 2015, we completed more acquisitions than in any year in our history. A good example of our acquisition-led growth strategy is the build-out of Marsh & McLennan Agency (MMA). Since 2009, MMA has closed 51 transactions and invested over $2 billion. In 2015, MMA acquired six agencies across the United States, including the highly regarded MHBT in Texas. MMA now has a business approaching $1 billion of annualized revenue, which represents a top-10 independent agency in its own right. We believe we can replicate this success in overseas markets, including the United Kingdom. To strengthen our platform in the UK, we acquired the publicly-traded Jelf Group, a leading UK retail broker, in 2015.

On the organic investment front, the build-out of our Mercer Marketplace Healthcare exchange (MMx) is another developing success story. MMx provides access for approximately 1.5 million lives and helps our clients control costs while offering their employees choice, flexibility and an engaging user experience.

These are just three of many examples of how we are constantly looking forward and investing to position ourselves for sustainable, long-term growth while also producing strong annual performance.

The diversity of our geographic footprint is a particular strength of our company and an important driver of our long-term growth.

Marsh & McLennan is well-established in most large diversified economies that are particularly important to our long-term success. Moreover, our vast global network positions us well in virtually all emerging markets and growth economies. While volatile in 2015, these markets remain a long-term driver of growth because of the under-penetration of insurance and consulting services.

An important part of our strategy is to preserve flexibility and maintain balance. We are managing the business to consistently deliver excellent results while continuing to invest for the long term. In this uncertain global environment, we have preserved the capacity to invest opportunistically during periods of stress. This is the principal reason we have maintained financial leverage at lower levels than our peers and the overall market.

"Each of our operating companies is a global leader, helping clients address the issues of the day."

Lastly, we want to be relentless in our execution. Rigorous execution is every bit as important as strategic vision. We are perpetually dissatisfied with the status quo: We never stop searching for a better solution, whether it is a new insurance product to address an emerging risk, a more streamlined digital solution to optimize healthcare choices or a more refined set of analytics to deliver insights to clients. We have a mantra at the company that there is always a smarter way. Every day, every week, every month, we need to find it.

Our dual focus on short-term execution and long-term investment should increase the distance between us and our competitive set.

OUR COMMITMENT TO INNOVATION

We have a storied history of innovation. In the early 20th century, our founder, Henry Marsh, revolutionized the insurance industry by creating the concept of an insurance broker who acted on behalf of the client rather than the insurer. In the 1920s, Guy Carpenter (yes, there was a man named Guy Carpenter) introduced the novel idea of insurance for insurers — or reinsurance. After World War II, William M. Mercer invented the notion of a defined benefit plan. In the 1980s, Alex Oliver and Bill Wyman created the idea of a management consulting firm built on industry verticals.

Thanks to the pioneering spirit of our colleagues, Marsh & McLennan has been at the forefront of innovation for over a century. The next frontier will almost certainly revolve around technological innovation. Marsh and Guy Carpenter have made substantial investments in technology platforms to benefit their clients. For example, Marsh acquired Dovetail, a technology provider with an advanced cloud-based platform that enables agents to trade with multiple insurers and bind policies in real time. Guy Carpenter recently launched GC ReBid, a proprietary real-time, online reinsurance auction platform where markets can openly bid for participation on reinsurance placements.

Similarly, Mercer has launched an array of digital and mobile solutions that include: Mercer Match, a mobile application that utilizes gamification and neuroscience to match individuals with job opportunities; Mercer Harmonise, a UK mobile application that enables individuals to track critical information about their wealth and health in a single place; and Mercer Pension Risk Exchange, an online platform that allows pension plan sponsors to monitor buy-out capacity and execute transactions swiftly. In a similar vein, Oliver Wyman has launched "OW Labs," which applies advanced algorithms to large data sets to deliver insights to clients through customized dashboard applications.

OUR CULTURE

The diversity of our people contributes to our success and the richness of our lives. After all, we are a brains business. We manufacture ideas and solutions. We harness our collective intelligence, collaborating across teams, business units and global offices to create a value proposition greater than the sum of its individual parts. Our colleagues choose to give us their time, their commitment and their careers. We understand the importance of creating an environment where we look at issues from multiple perspectives and where our people feel comfortable expressing themselves and sharing their ideas.

As I travel around the world, I meet with our colleagues in town hall discussions. I urge them to live fully, reminding them that, at Marsh & McLennan, our people come first. Their family lives are essential, and their personal growth is as important as their professional development. We want Marsh & McLennan to be a vibrant place to work; our commitment to working side by side in a respectful, professional environment is an important value of our firm.

LOOKING FORWARD

I am privileged to serve as the CEO of this great company. I feel fortunate to lead an accomplished executive team that is diverse in thought and cohesive in action. It is a team that keeps its promises. And it is a team that has delivered year after year.

160,000

VOLUNTEER HOURS CONTRIBUTED BY OUR 60,000 COLLEAGUES AROUND THE WORLD TO IMPROVE SOCIETY

I am also fortunate to work with a talented and engaged Board of Directors. Under Lord Ian Lang's leadership as Chairman, the Board has struck an excellent balance between challenge and support. The Board has been actively involved in the development of management's long-term strategic plans. As part of our efforts to expand our global operations, we were particularly pleased to add Maria Silvia Bastos Marques, one of Brazil's leading executives, to our Board in March of 2015.

Having reached our mandatory retirement age, Ian Lang will step down as Chairman at our upcoming annual meeting in May. Ian has brought a global perspective, a keen intellect and a politician's wit to our deliberations. Ian has also sought to make the Board accessible to our colleagues by participating in numerous town halls in Bermuda, London, New York, Paris, San Francisco and Shanghai. On behalf of our entire organization, I want to express our profound gratitude to this elegant man for his almost two decades of service to this company, including five years as Chairman of the Board.

Edward Hanway, a member of our Board since 2010, will become Chairman this May. Before joining our Board, Ed enjoyed a remarkable tenure as the CEO of Cigna Corporation for nearly a decade. I look forward to Ed's leadership of our Board for years to come.

In closing, I want to thank our 60,000 colleagues whose professionalism and hard work are at the heart of this enterprise, our clients who put their trust in us and our investors. I try to manage our business with a keen awareness that I have been trusted by the owners of our company to look after their investment and make it grow. We are always in the market for investors who support our balanced approach of delivering strong financial performance today and investing for the future.

Today, we are stronger strategically, operationally and financially than at any time in the last decade. I am optimistic about the future of Marsh & McLennan. The best is yet to come.

Best regards,

DAN GLASER
PRESIDENT AND CHIEF EXECUTIVE OFFICER
MARSH & McLENNAN COMPANIES
FEBRUARY 24, 2016

Top, from left: Morton O. Schapiro, H. Edward Hanway, Steven A. Mills, Bruce P. Nolop, Daniel S. Glaser, Marc D. Oken, Lloyd M. Yates, Oscar Fanjul
Bottom, from left: R. David Yost, Elaine La Roche, Lord Lang of Monkton, Maria Silvia Bastos Marques

OUR BOARD OF DIRECTORS

OSCAR FANJUL
Vice Chairman, Omega Capital
Former Chairman and
Chief Executive Officer, Repsol

DANIEL S. GLASER
President and Chief Executive Officer,
Marsh & McLennan Companies

H. EDWARD HANWAY
Former Chairman and
Chief Executive Officer,
Cigna Corporation

LORD LANG OF MONKTON
Independent Chairman,
Marsh & McLennan Companies
Former Member of British Parliament
Former British Secretary of State for
Trade and Industry

ELAINE LA ROCHE
Senior Advisor,
China International Capital Corporation US
Former Chief Executive Officer, China
International Capital Corporation, Beijing

MARIA SILVIA BASTOS MARQUES
Special Advisor to the Mayor for the
Rio de Janeiro 2016 Olympic Games
Former Chief Executive Officer,
Icatu Hartford Seguros

STEVEN A. MILLS
Former Executive Vice President,
Software & Systems,
International Business Machines
Corporation (IBM)

BRUCE P. NOLOP
Former Chief Financial Officer,
E*TRADE Financial Corporation

MARC D. OKEN
Managing Partner,
Falfurrias Capital Partners
Former Chief Financial Officer,
Bank of America Corporation

MORTON O. SCHAPIRO
President, Northwestern University

LLOYD M. YATES
Executive Vice President, Market Solutions &
President, Carolinas—Duke Energy

R. DAVID YOST
Former President and
Chief Executive Officer,
AmerisourceBergen Corporation

Top, from left: Scott McDonald, Mark McGivney, Peter J. Beshar, E. Scott Gilbert, Alexander S. Moczarski
Bottom, from left: Peter Zaffino, Daniel S. Glaser, Laurie Ledford, Julio A. Portalatin

OUR EXECUTIVE COMMITTEE

PETER J. BESHAR
Executive Vice President and
General Counsel,
Marsh & McLennan Companies

E. SCOTT GILBERT
Senior Vice President and
Chief Information Officer,
Marsh & McLennan Companies

DANIEL S. GLASER
President and Chief Executive Officer,
Marsh & McLennan Companies

LAURIE LEDFORD
Senior Vice President and
Chief Human Resources Officer,
Marsh & McLennan Companies

SCOTT McDONALD
President and Chief Executive Officer,
Oliver Wyman Group

MARK McGIVNEY
Chief Financial Officer,
Marsh & McLennan Companies

ALEXANDER S. MOCZARSKI
President and Chief Executive Officer,
Guy Carpenter

JULIO A. PORTALATIN
President and Chief Executive Officer,
Mercer

PETER ZAFFINO
Chairman, Risk and
Insurance Services Segment
President and Chief Executive Officer,
Marsh

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2015
Commission File No. 1-5998

Marsh & McLennan Companies, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**36-2668272**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

1166 Avenue of the Americas
New York, New York 10036-2774
(Address of principal executive offices; Zip Code)
(212) 345-5000
Registrant's telephone number, including area code
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, par value $1.00 per share	New York Stock Exchange Chicago Stock Exchange London Stock Exchange

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.
Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting Company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting Company" in Rule 12b-2 of the Exchange Act. (Check one):

Large Accelerated Filer ☒	Accelerated Filer ☐
Non-Accelerated Filer ☐ (Do not check if a smaller reporting company)	Smaller Reporting Company ☐

Indicate by check mark whether the registrant is a shell Company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 30, 2015, the aggregate market value of the registrant's common stock held by non-affiliates of the registrant was approximately $30,066,092,147 computed by reference to the closing price of such stock as reported on the New York Stock Exchange on June 30, 2015.

As of February 18, 2016, there were outstanding 521,227,085 shares of common stock, par value $1.00 per share, of the registrant.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of Marsh & McLennan Companies, Inc.'s Notice of Annual Meeting and Proxy Statement for the 2016 Annual Meeting of Stockholders (the "2016 Proxy Statement") are incorporated by reference in Part III of this Form 10-K.

INFORMATION CONCERNING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains "forward-looking statements," as defined in the Private Securities Litigation Reform Act of 1995. These statements, which express management's current views concerning future events or results, use words like "anticipate," "assume," "believe," "continue," "estimate," "expect," "intend," "plan," "project" and similar terms, and future or conditional tense verbs like "could," "may," "might," "should," "will" and "would." Forward-looking statements are subject to inherent risks and uncertainties that could cause actual results to differ materially from those expressed or implied in our forward-looking statements.

Factors that could materially affect our future results include, among other things: our ability to maintain adequate safeguards to protect the security of confidential, personal or proprietary information; our ability to compete effectively and adapt to changes in the competitive environment, including to technological and other types of innovation; the impact of economic, political and market conditions on us and our clients; our ability to successfully recover should we experience a business continuity problem due to cyberattack, natural disaster or otherwise; our exposure to potential civil remedies or criminal penalties if we fail to comply with U.S. and non-U.S. laws and regulations applicable in the jurisdictions in which we operate; the financial and operational impact of complying with laws and regulations in the jurisdictions in which we operate; our exposure to potential losses and liabilities, including reputational impact, arising from errors and omissions, breach of fiduciary duty and similar claims against us; the impact of fluctuations in exchange and interest rates on our results; the impact of our corporate tax rate relative to our competitors; the effect of our global pension obligations on our financial position, earnings and cash flows; our ability to make acquisitions and dispositions and successfully integrate the businesses we acquire; our ability to incentivize and retain key employees; and the impact of changes in accounting rules or in our accounting estimates or assumptions.

The factors identified above are not exhaustive. Marsh & McLennan Companies and its subsidiaries operate in a dynamic business environment in which new risks emerge frequently. Accordingly, we caution readers not to place reliance on any forward-looking statements, which are based only on information currently available to us and speak only as of the dates on which they are made. The Company undertakes no obligation to update or revise any forward-looking statement to reflect events or circumstances arising after the date on which it is made.

Further information concerning Marsh & McLennan Companies and its businesses, including information about factors that could materially affect our results of operations and financial condition, is contained in the Company's filings with the Securities and Exchange Commission, including the "Risk Factors" section in Part I, Item 1A of this report and the "Management's Discussion and Analysis of Financial Condition and Results of Operations" section in Part II, Item 7 of this report.

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PART I

ITEM 1. BUSINESS.

References in this report to "we", "us" and "our" are to Marsh & McLennan Companies, Inc. and one or more of its subsidiaries (the "Company"), as the context requires.

GENERAL

The Company is a global professional services firm offering clients advice and solutions in risk, strategy and people. It is the parent company of a number of leading risk experts and specialty consultants, including: Marsh, the insurance broker, intermediary and risk advisor; Guy Carpenter, the risk and reinsurance specialist; Mercer, the provider of HR and related financial advice and services; and Oliver Wyman Group, the management, economic and brand consultancy. With approximately 60,000 employees worldwide and annual revenue of approximately $13 billion, the Company provides analysis, advice and transactional capabilities to clients in more than 130 countries.

The Company conducts business through two segments:

- **Risk and Insurance Services** includes risk management activities (risk advice, risk transfer and risk control and mitigation solutions) as well as insurance and reinsurance broking and services. We conduct business in this segment through Marsh and Guy Carpenter.
- **Consulting** includes Health, Retirement, Talent and Investments consulting services and products, and specialized management, economic and brand consulting services. We conduct business in this segment through Mercer and Oliver Wyman Group.

We describe our current segments in further detail below. We provide financial information about our segments in our consolidated financial statements included under Part II, Item 8 of this report.

OUR BUSINESSES

RISK AND INSURANCE SERVICES

The Risk and Insurance Services segment generated approximately 53% of the Company's total revenue in 2015 and employs approximately 32,600 colleagues worldwide. The Company conducts business in this segment through **Marsh** and **Guy Carpenter**.

MARSH

Marsh is a world leader in delivering risk advisory and insurance solutions to companies, institutions and individuals around the world. From its founding in 1871 to the present day, Marsh has provided thought leadership and innovation to clients and the insurance industry, introducing and promoting the concept and practice of client representation through brokerage, the discipline of risk management, the globalization of insurance and risk management services and many other innovative capabilities and service platforms.

Marsh's clients vary by size, industry, geography and risk exposures. Marsh is structured to serve clients effectively and efficiently, delivering solutions tailored to each client's level of complexity of risk, geographic footprint and buying preferences.

Marsh generated approximately 44% of the Company's total revenue in 2015. Approximately 30,200 Marsh colleagues provide risk management, insurance broking, insurance program management services, risk consulting, analytical modeling and alternative risk financing to a wide range of businesses, government entities, professional service organizations and individuals in more than 130 countries.

Insurance Broking and Risk Consulting

In its main insurance broking and risk consulting business, Marsh employs a team approach to address clients' risk management and insurance needs. Each client relationship is coordinated by a client executive or client manager who accesses the many industry and risk specialties within Marsh to coordinate the resources needed to assist clients in analyzing, measuring and managing their various risks. Product and service offerings include risk analysis, program design and placement, post-placement program support and administration, claims support and advocacy, alternative risk strategies and a wide

array of risk analysis and risk management consulting services. Marsh's clients benefit from advanced analytics, deep technical expertise, a collaborative global culture and a track record of innovative product development. Marsh services clients of all sizes, including multi-national companies, middle-market businesses, small commercial enterprises and private clients.

Risk, Specialty and Industry Practices provides consultative advice, brokerage and claims advocacy services for our corporate and institutional clients around the world through dedicated practices in the areas listed below. For both large and mid-size organizations, colleagues in these practices apply their experience and deep knowledge of clients' industry sectors, and of the unique environments in which they operate, to facilitate the requisite breadth of coverage and to reduce the cost of risk.

Risk & Specialty Practices	***Industry Practices***
• Aviation & Aerospace	• Aviation
• Casualty	• Chemicals
• Claims	• Communications, Media and Technology
• Cyber	• Construction
• Employee Benefits	• Education
• Energy	• Energy
• Environmental	• Financial Institutions
• Financial and Professional (FINPRO)	• Forestry Products
• Marine	• Healthcare
• Political Risk	• Hospitality & Gaming
• Premium Finance	• Life Sciences
• Private Equity and Mergers & Acquisitions (PEMA)	• Manufacturing and Automotive
• Product Recall	• Marine
• Project Risk	• Mining, Metals & Minerals
• Property	• Power & Utilities
• Surety	• Public Entities
• Trade Credit	• Rail
• Workers' Compensation	• Real Estate
	• Retail / Wholesale
	• Sports, Entertainment & Events
	• Transportation

Multinational Client Service (MCS) is focused on delivering service excellence and insurance solutions to the largest and most globally active set of our major corporate clients. MCS provides risk management programs with a service platform that comprises a combination of proprietary tools and technology and specialized resources. MCS provides global expertise and an intimate knowledge of local markets, helping clients navigate local regulatory environments to address the worldwide risk issues that confront them.

Marsh & McLennan Agency (MMA) offers a broad range of commercial property and casualty products and services, as well as industry-leading solutions for employee health and benefits, retirement and administration needs and personal lines for our middle-market, small commercial and personal lines clients in the United States and Canada. Since its first acquisition in 2009, MMA has grown to include 49 agencies. MMA provides advice on insurance program structure, market dynamics, industry expertise and transactional capability.

Private Client Services (PCS) provides insurance and risk advisory services to high net worth individuals, families and their advisors and family offices, with a focus on delivery of property and casualty risk management solutions. PCS operates from 27 locations across the United States, is licensed in all 50 states and has more than 300 insurance professionals.

Additional Services and Adjacent Businesses

In addition to commercial insurance broking, Marsh provides clients with certain other specialist advisory or placement services, including:

Marsh Captive Solutions serves more than 1,250 captive facilities, including single-parent captives, reinsurance pools and risk retention groups, among others. The Captive Solutions practice operates in 42 captive domiciles and leverages the consulting expertise within Marsh's brokerage offices worldwide. The practice includes the Captive Advisory group, a consulting arm that performs captive feasibility studies and helps to structure and implement captive solutions; Captive Management, an industry leader in managing captive facilities and in providing administrative, consultative and insurance-related services; and the Actuarial Services group, which is comprised of credentialed actuaries and supporting actuarial analysts.

Schinnerer Group is comprised of Victor O. Schinnerer & Co. in the U.S. and ENCON Group Inc. in Canada. As one of the largest underwriting managers of professional liability and specialty insurance programs in the United States, Victor O. Schinnerer & Co. provides risk management and insurance solutions to insureds through a national third-party distribution network of licensed brokers. ENCON Group Inc., a leading managing general agent in Canada, offers professional liability and construction insurance, as well as group and retiree benefits programs and claims handling for individuals, professionals, organizations and businesses, through a national third-party distribution network of licensed insurance brokers and through benefit plan advisors.

Marsh Risk Consulting (MRC) is a global practice comprised of specialists dedicated to helping clients identify exposures, extract value out of data, assess critical business functions and evaluate existing risk treatment practices and strategies. MRC provides client services in five main areas of exposure: Property Risk Consulting, Workforce Strategies, Claims Consulting and Financial Advisory, Cybersecurity Consulting and Advisory and Strategic Risk Consulting.

Marsh Global Analytics helps organizations use data and analytical tools to better understand risks, make more informed decisions, support the implementation of innovative solutions and strategies, and ultimately, reduce costs. The principal tools employed include data from Marsh's extensive Global Benchmarking Portal, statistical and financial analyses, decision modeling, catastrophic loss modeling and the Marsh Analytical Platform.

Torrent Technologies is a leading service provider to Write Your Own (WYO) insurers participating in the National Flood Insurance Program (NFIP). Recently acquired by Marsh and with its headquarters remaining in Kalispell, Montana, Torrent's employees have combined with Marsh's existing flood insurance specialists to create a Flood Center of Excellence, offering a comprehensive suite of flood insurance products and services. Torrent and Marsh together also have demonstrated capabilities in the non-NFIP retail flood space and in providing other non-NFIP flood insurance administration services to mortgage lenders and other businesses.

Marsh ClearSight (formerly branded CS STARS) is a cloud-based software application that serves the needs of risk management professionals, as well as insurance carriers and third-party administrators, through integrated technology, analytics and data services solutions across risk, safety and claims management. Marsh ClearSight enables its customers to analyze trends, gain industry insights, optimize decision-making and reduce costs across the entire risk lifecycle.

Bowring Marsh is an international placement broker for property and casualty risks. Bowring Marsh uses placement expertise in major international insurance market hubs, including Bermuda, Brazil, China, Dubai, Dublin, Hong Kong, London, Madrid, Miami, Singapore, South Korea, Tokyo and Zurich, and an integrated global network to secure advantageous terms and conditions for its clients throughout the world.

Services for Insurers

Insurer Consulting Group provides services to insurance carriers. Through Marsh's patented electronic platform, MarketConnect, and through sophisticated data analysis, Marsh provides insurers with individualized preference setting and risk identification capabilities, as well as detailed performance data and metrics. Insurer consulting teams review performance metrics and preferences with insurers. Marsh's Insurer Consulting services are designed to improve the product offerings available to Marsh's clients, assist insurers in identifying new opportunities and enhance insurers' operational efficiency. The scope and nature of the services vary by insurer and by geography.

GUY CARPENTER

Guy Carpenter generated approximately 9% of the Company's total revenue in 2015. Approximately 2,400 Guy Carpenter professionals help clients with a combination of specialized reinsurance broking expertise, strategic advisory services and analytics. Guy Carpenter teams create and execute reinsurance and risk management solutions for clients worldwide, by providing risk assessment analytics, actuarial services, highly specialized product knowledge and trading relationships with reinsurance markets. Client services also include contract and claims management and fiduciary accounting.

Acting as a broker or intermediary on all classes of reinsurance, Guy Carpenter places two main types of property and casualty reinsurance: treaty reinsurance, which involves the transfer of a portfolio of risks; and facultative reinsurance, which entails the transfer of part or all of the coverage provided by a single insurance policy.

Guy Carpenter provides reinsurance services in a broad range of specialty practice areas, including: agriculture; alternative risk transfer (such as group-based captives and insurance pools); aviation & aerospace; casualty clash (losses involving multiple policies or insureds); construction and engineering; credit, bond & political risk; excess & umbrella; general casualty; life, accident & health; marine and energy; medical professional liability; professional liability; program manager solutions; property; retrocessional reinsurance (reinsurance between reinsurers); surety (reinsurance of surety bonds and other financial guarantees); terror risk and workers compensation.

Guy Carpenter also offers clients alternatives to traditional reinsurance, including industry loss warranties and, through its licensed affiliates, capital markets alternatives such as transferring catastrophe risk through the issuance of risk-linked securities. GC Securities, the Guy Carpenter division of MMC Securities LLC (formerly MMC Securities Corp.) and MMC Securities (Europe) Limited, offers corporate finance solutions, including mergers & acquisitions and private debt and equity capital raising, and capital markets-based risk transfer solutions that complement Guy Carpenter's strong industry relationships, analytical capabilities and reinsurance expertise.

In addition, Guy Carpenter provides its clients with numerous reinsurance-related services, such as actuarial, enterprise risk management, financial and regulatory consulting, portfolio analysis and advice on the efficient use of capital. Guy Carpenter's GC Analytics® unit serves as a local resource that helps clients better understand and quantify the uncertainties inherent in their businesses. Working in close partnership with Guy Carpenter account executives, GC Analytics specialists help support clients' critical decisions in numerous areas, including reinsurance utilization, catastrophe exposure portfolio management, new product and market development, rating agency, regulatory and account impacts, loss reserve risk, capital adequacy and return on capital.

Compensation for Services in Risk and Insurance Services

Marsh and Guy Carpenter are compensated for brokerage and consulting services through commissions and fees. Commission rates and fees vary in amount and can depend upon a number of factors, including the type of insurance or reinsurance coverage provided, the particular insurer or reinsurer selected, the capacity in which the broker acts and negotiations with clients. In addition to compensation from its

clients, Marsh also receives compensation from insurance companies. This compensation includes, among other things, payments for consulting and analytics services provided to insurers; fees for administrative and other services provided to or on behalf of insurers (including services relating to the administration and management of quota shares, panels and other facilities in which insurers participate); and contingent commissions, which are paid by insurers based on the attainment of specified goals relating to Marsh's placements, particularly at Marsh & McLennan Agency and in parts of Marsh's international operations.

Marsh and Guy Carpenter receive interest income on certain funds (such as premiums and claims proceeds) held in a fiduciary capacity for others. For a more detailed discussion of revenue sources and factors affecting revenue in our Risk and Insurance Services segment, see Part II, Item 7 ("Management's Discussion and Analysis of Financial Condition and Results of Operations") of this report.

CONSULTING

The Company's Consulting segment generated approximately 47% of the Company's total revenue in 2015 and employs approximately 25,300 colleagues worldwide. The Company conducts business in this segment through **Mercer** and **Oliver Wyman Group**.

MERCER

Mercer is a global consulting leader in Health, Retirement, Investments and Talent. Mercer helps clients around the world advance the health, wealth and performance of their most vital asset - their people. Mercer's approximately 21,200 employees are based in more than 40 countries. Clients include a majority of the companies in the Fortune 1000 and FTSE 100, as well as medium- and small-market organizations. Mercer generated approximately 33% of the Company's total revenue in 2015.

Mercer operates in the following areas:

Health. In its Health & Benefits business, Mercer assists public and private sector employers in the design, management and administration of employee health care programs; compliance with local benefits-related regulations; and the establishment of health and welfare benefits coverage for employees. Mercer provides a range of advice and solutions to clients, which, depending on the engagement, may include: total health management strategies; global health brokerage solutions; vendor performance and audit; life and disability management; and measurement of healthcare provider performance. These services are provided through traditional fee-based consulting as well as commission-based brokerage services in connection with the selection of insurance companies and healthcare providers. Mercer also provides products and solutions for private active and retiree exchanges in the United States, including its Mercer Marketplace℠ private exchange.

Retirement. Mercer provides a wide range of strategic and compliance-related retirement services and solutions to corporate, governmental and institutional clients. Mercer assists clients worldwide in the design, governance and risk management of defined benefit, defined contribution and hybrid retirement plans. Mercer's approach to retirement services enables clients to consider the benefits, accounting, funding and investment aspects of plan design and management in the context of business objectives and governance requirements.

Investments. Mercer's investments business provides clients with investment consulting and investment management services. In its investment consulting business, Mercer provides investment advice and related services to the sponsors of pension funds, foundations, endowments, insurance companies, wealth management firms and other investors in more than 40 countries. Mercer's services cover all stages of the institutional investment process, from strategy, structure and implementation to ongoing portfolio management.

Mercer provides investment management services - also referred to as delegated solutions or fiduciary management - to institutional investors including retirement plans (defined benefit and defined contribution), endowments and foundations and wealth managers, primarily through investment in manager of manager funds sponsored and managed by Mercer. Mercer offers a diverse range of solutions to meet a full spectrum of risk/return preferences and manages investment vehicles across a range of investment strategies for clients globally. As of December 31, 2015, Mercer had assets under management of approximately $135 billion worldwide.

Benefits Administration. Mercer also provides benefits administration services to clients globally as part of its Retirement, Health and Investments businesses. Mercer's administration offerings include total benefits outsourcing; total retirement outsourcing, including administration and delivery for retirement benefits; and stand-alone services for defined benefit administration, defined contribution administration, health benefits administration and flexible benefits programs.

Talent. Mercer's talent businesses advise organizations on the engagement, management and rewarding of employees; the design of executive remuneration programs; and improvement of human resource (HR) effectiveness. Through proprietary survey data and decision support tools, Mercer's Information Products Solutions business provides clients with human capital information and analytical capabilities to improve strategic human capital decision making. Mercer's Communications business helps clients plan and implement HR programs and other organizational changes designed to maximize employee engagement, drive desired employee behaviors and achieve improvements in business performance.

OLIVER WYMAN GROUP

With approximately 4,000 professionals and offices in 26 countries, Oliver Wyman Group delivers advisory services to clients through three operating units, each of which is a leader in its field: Oliver Wyman, Lippincott and NERA Economic Consulting. Oliver Wyman Group generated approximately 14% of the Company's total revenue in 2015.

Oliver Wyman is a leading global management consulting firm. Oliver Wyman's consultants specialize by industry and functional area, allowing clients to benefit from both deep sector knowledge and specialized expertise in strategy, operations, risk management and organization transformation. Industry groups include:

- Automotive
- Aviation, Aerospace & Defense
- Business Services
- Communications, Media & Technology
- Distribution & Wholesale
- Energy
- Financial services (including corporate and institutional banking, insurance, wealth and asset management, public policy, and retail and business banking)
- Health & Life Sciences
- Industrial products
- Public Sector
- Retail & consumer products
- Surface transportation
- Travel & Leisure

Oliver Wyman overlays its industry knowledge with expertise in the following functional specializations:

- *Actuarial.* Oliver Wyman offers actuarial consulting services to public and private enterprises, self-insured group organizations, insurance companies, government entities, insurance regulatory agencies and other organizations.
- *Business & Organization Transformation.* Oliver Wyman advises organizations undergoing or anticipating profound change or facing strategic discontinuities or risks by providing guidance on leading the institution, structuring its operations, improving its performance and building its organizational capabilities.
- *Corporate Finance & Restructuring.* Oliver Wyman provides an array of capabilities to support investment decision making by private equity funds, hedge funds, sovereign wealth funds, investment banks, commercial banks, arrangers, strategic investors and insurers.
- *Digital.* Oliver Wyman has a dedicated cross-industry team helping clients to capitalize on the opportunities created by digital technology and address the strategic threats.

- *Marketing & Sales.* Oliver Wyman advises leading firms in the areas of offer/pricing optimization; product/service portfolio management; product innovation; marketing spend optimization; value-based customer management; and sales and distribution model transformation.
- *Oliver Wyman Labs.* Oliver Wyman applies innovative approaches to technology to drive business impact for its clients. The mission of OW Labs is to help clients to unleash the power of the information they already have or could capture - essentially to become knowledge-powered businesses - and through that to drive competitive advantage and sustained impact.
- *Operations & Technology.* Oliver Wyman offers market-leading IT organization design, IT economics management, Lean Six Sigma principles and methodologies, and sourcing expertise to clients across a broad range of industries.
- *Risk Management.* Oliver Wyman works with chief financial officers, chief risk officers, and other senior finance and risk management executives of corporations and financial institutions. Oliver Wyman provides a range of services that provide effective, customized solutions to the challenges presented by the evolving roles, needs and priorities of these individuals and organizations.
- *Strategy.* Oliver Wyman is a leading provider of corporate strategy advice and solutions in the areas of growth strategy and corporate portfolio; non-organic growth and M&A; performance improvement; business design and innovation; corporate center and shared services; and strategic planning.
- *Sustainability Center.* The Sustainability Center at Oliver Wyman supports leading companies and governments around the world in their efforts to foster economic growth while encouraging more responsible use of natural resources and environmental protection.
- *Value Sourcing.* Oliver Wyman helps organizations with optimization of purchasing processes or organization; cost monitoring; low-cost country sourcing; supply chain management; strategic sourcing; sequenced supply; part kitting; and with transforming procurement into a strong competitive advantage, delivering sustained value.

Lippincott is a brand strategy and design consulting firm that advises corporations around the world in a variety of industries on corporate branding, identity and image. Lippincott has helped create some of the world's most recognized brands.

NERA Economic Consulting provides economic analysis and advice to public and private entities to achieve practical solutions to highly complex business and legal issues arising from competition, regulation, public policy, strategy, finance and litigation. NERA professionals operate worldwide assisting clients including corporations, governments, law firms, regulatory agencies, trade associations, and international agencies. NERA's specialized practice areas include: antitrust; securities; complex commercial litigation; energy; environmental economics; network industries; intellectual property; product liability and mass torts; and transfer pricing.

Compensation for Services in Consulting

Mercer and the Oliver Wyman Group businesses are compensated for advice and services primarily through fees paid by clients. Mercer's Health & Benefits business is compensated through commissions for the placement of insurance contracts (comprising more than half of the revenue in the Health & Benefits business) and consulting fees. Mercer's delegated solutions business and certain of Mercer's defined contribution administration services are compensated typically through fees based on assets under administration or management. For a majority of the Mercer-managed investment funds, revenue received from Mercer's investment management clients as sub-advisor fees is reported in accordance with U.S. GAAP, on a gross basis rather than a net basis. For a more detailed discussion of revenue sources and factors affecting revenue in the Consulting segment, see Part II, Item 7 ("Management's Discussion and Analysis of Financial Condition and Results of Operations") of this report.

REGULATION

The Company's activities are subject to licensing requirements and extensive regulation under U.S. federal and state laws, as well as laws of other countries in which the Company's subsidiaries operate.

See Part I, Item 1A ("Risk Factors") below for a discussion of how actions by regulatory authorities or changes in legislation and regulation in the jurisdictions in which we operate may have an adverse effect on our businesses.

Risk and Insurance Services. While laws and regulations vary from location to location, every state of the United States and most foreign jurisdictions require insurance market intermediaries and related service providers (such as insurance brokers, agents and consultants, reinsurance brokers and managing general agents) to hold an individual or company license from a government agency or self-regulatory organization. Some jurisdictions issue licenses only to individual residents or locally-owned business entities; in those instances, if the Company has no licensed subsidiary, it may maintain arrangements with residents or business entities licensed to act in such jurisdiction. Such arrangements are subject to an internal review and approval process. Licensing of reinsurance intermediaries is generally less rigorous compared to that of insurance brokers, and most jurisdictions require only corporate reinsurance intermediary licenses.

The Insurance Mediation Directive was adopted by the United Kingdom and 26 other European Union Member States in 2005. Its implementation gave powers to the Financial Services Authority ("FSA"), the United Kingdom regulator at the time, to expand their responsibilities in line with the Financial Services and Markets Act, the result of which was the regulation of insurance and reinsurance intermediaries. The enhanced regulatory regime effected a licensing system based on an assessment of factors which included professional competence, financial capacity and the requirement to hold professional indemnity insurance. In April 2013, the FSA was superseded by the Financial Conduct Authority ("FCA"). In April 2014, the FCA's responsibilities were expanded further to include the regulation of credit activities for consumers. This included the broking of premium finance to consumers who wished to spread the cost of their insurance. In April 2015, the FCA obtained their concurrent competition powers enabling them to enforce the prohibitions on anti-competitive behavior in relation to financial services.

Insurance authorities in the United States and certain other jurisdictions in which the Company's subsidiaries do business, including the FCA in the United Kingdom, also have enacted laws and regulations governing the investment of funds, such as premiums and claims proceeds, held in a fiduciary capacity for others. These laws and regulations typically provide for segregation of these fiduciary funds and limit the types of investments that may be made with them, and generally apply to both the insurance and reinsurance business. The FCA is currently reviewing its rules drafted to protect client assets and client money. If deemed appropriate, the FCA will implement changes intended to provide enhanced protection to client funds.

Certain of the Company's Risk and Insurance Services activities are governed by other regulatory bodies, such as investment, securities and futures licensing authorities. In the United States, Marsh and Guy Carpenter use the services of MMC Securities LLC (formerly MMC Securities Corp.), a broker-dealer, investment adviser and introducing broker. MMC Securities LLC is registered in the United States with the SEC and is a member of the Financial Industry Regulatory Authority ("FINRA"), the National Futures Association and the Securities Investor Protection Corporation ("SIPC"), primarily in connection with capital markets and other investment banking-related services relating to insurance-linked and alternative risk financing transactions. Also in the United States, Marsh uses the services of MMA Securities LLC (formerly NIA Securities, LLC), a U.S. registered broker-dealer and member of FINRA, SIPC and the Municipal Securities Rulemaking Board. In the United Kingdom, Marsh and Guy Carpenter use the expertise of MMC Securities (Europe) Limited, which is authorized and regulated by the FCA to provide advice on securities and investments, including mergers & acquisitions in the European Union. MMC Securities LLC, MMC Securities (Europe) Limited, MMA Securities LLC and Marsh Investment Services Limited are indirect, wholly-owned subsidiaries of Marsh & McLennan Companies, Inc.

Consulting. Certain of Mercer's retirement-related consulting and investment services are subject to pension law and financial regulation in many countries. In addition, the trustee services, investment services (including advice to persons, institutions and other entities on the investment of pension assets and assumption of discretionary investment management responsibilities) and retirement and employee benefit program administrative services provided by Mercer and its subsidiaries and affiliates are also subject to investment and securities regulations in various jurisdictions, including regulations imposed or enforced by the SEC and the Department of Labor in the United States, the FCA in the United Kingdom,

the Central Bank of Ireland and the Australian Prudential Regulation Authority and the Australian Securities and Investments Commission. In the United States, Mercer provides investment services through Mercer Investment Management, Inc. and Mercer Investment Consulting LLC, each an SEC-registered investment adviser. Mercer Trust Company, a New Hampshire chartered trust bank, provides services for Mercer's benefits administration and investment management business in the United States. The benefits insurance consulting and brokerage services provided by Mercer and its subsidiaries and affiliates are subject to the same licensing requirements and regulatory oversight as the insurance market intermediaries described above regarding our Risk and Insurance Services businesses. Mercer uses the services of MMC Securities LLC in connection with the provision of certain retirement and employee benefit services. Oliver Wyman Group uses the services of MMC Securities LLC in the United States and MMC Securities (Europe) Limited in the European Union, primarily in connection with corporate finance advisory services.

FATCA. Regulations promulgated by the U.S. Treasury Department pursuant to the Foreign Account Tax Compliance Act and related legislation (FATCA) require the Company to take various measures relating to non-U.S. funds, transactions and accounts. The regulations impose on Mercer certain client financial account tracking and disclosure obligations with respect to non-U.S. financial institution and insurance clients, and require Marsh and Guy Carpenter (and Mercer, in limited circumstances) to collect, validate and maintain certain documentation from each foreign insurance entity that insures a risk that is subject to the regulations. The Company has adopted processes to substantially address FATCA's requirements. Barring U.S. Treasury action to scale back FATCA in 2016, FATCA's application is due to expand as of January 1, 2017 to regulate a broader set of insurance and reinsurance placements, known as "foreign-to-foreign" transactions. Though this expansion of FATCA's reach may be delayed or permanently suspended, the Company has begun to undertake measures to also achieve timely compliance with FATCA's foreign-to-foreign requirements.

COMPETITIVE CONDITIONS

The Company faces strong competition in all of its businesses from providers of similar products and services, including competition with regard to identifying and pursuing acquisition candidates. The Company also encounters strong competition throughout its businesses from both public corporations and private firms in attracting and retaining qualified employees. In addition to the discussion below, see "Risks Relating to the Company Generally-Competitive Risks," in Part I, Item 1A of this report.

Risk and Insurance Services. The Company's combined insurance and reinsurance services businesses are global in scope. The principal bases upon which our insurance and reinsurance businesses compete include the complexity, range, quality and cost of the services and products offered to clients. The Company encounters strong competition from other insurance and reinsurance brokerage firms that operate on a nationwide or worldwide basis, from a large number of regional and local firms in the United States, the European Union and elsewhere, from insurance and reinsurance companies that market, distribute and service their insurance and reinsurance products without the assistance of brokers or agents and from other businesses, including commercial and investment banks, accounting firms, consultants and web search engines, that provide risk-related services and products or alternatives to traditional brokerage services.

Certain insureds and groups of insureds have established programs of self insurance (including captive insurance companies) as a supplement or alternative to third-party insurance, thereby reducing in some cases their need for insurance placements. Certain insureds also obtain coverage directly from insurance providers. There are also many other providers of managing general agency, affinity programs and private client services, including specialized firms, insurance companies and other institutions.

Consulting. The Company's consulting and HR outsourcing businesses face strong competition from other privately and publicly held worldwide and national companies, as well as regional and local firms. These businesses compete generally on the basis of the range, quality and cost of the services and products provided to clients. Competitors include independent consulting and outsourcing firms, as well as consulting and outsourcing operations affiliated with accounting, information systems, technology and financial services firms.

Mercer's investments business faces competition from many sources, including investment consulting firms (many of which offer delegated services) and other financial institutions. In some cases, clients have the option of handling the services provided by Mercer and Oliver Wyman Group internally, without assistance from outside advisors.

Segmentation of Activity by Type of Service and Geographic Area of Operation.

Financial information relating to the types of services provided by the Company and the geographic areas of its operations is incorporated herein by reference to Note 16 to the consolidated financial statements included under Part II, Item 8 of this report.

Employees

As of December 31, 2015, the Company and its consolidated subsidiaries employed approximately 60,000 people worldwide, including approximately 32,600 in risk and insurance services, 25,300 in consulting and 1,700 individuals at the parent-company level.

EXECUTIVE OFFICERS OF THE COMPANY

The executive officers of the Company are appointed annually by the Company's Board of Directors. The following individuals are the executive officers of the Company:

Peter J. Beshar, age 54, is Executive Vice President and General Counsel of Marsh & McLennan Companies. In addition to managing the Company's Legal, Compliance & Public Affairs function, Mr. Beshar also oversees the Company's Government Relations and Risk Management groups. Before joining Marsh & McLennan Companies in November 2004, Mr. Beshar was a Litigation Partner in the law firm of Gibson, Dunn & Crutcher LLP. Mr. Beshar joined Gibson, Dunn & Crutcher in 1995 after serving as an Assistant Attorney General in the New York Attorney General's office and as the Special Assistant to Cyrus Vance in connection with the peace negotiations in the former Yugoslavia.

E. Scott Gilbert, age 60, is Senior Vice President and Chief Information Officer of Marsh & McLennan Companies. Mr. Gilbert leads the Company's firm-wide efforts to improve the experience of clients and colleagues through the development and implementation of innovative and cost-effective technologies. In his role, he has responsibility for the Global Technology Infrastructure group and the Marsh & McLennan Innovation Centre, and he chairs the Company's Information Technology Council. In addition, Mr. Gilbert oversees the Company's global Business Resiliency and Security operations. Prior to joining Marsh & McLennan Companies in January 2005, he had been the Chief Compliance Counsel of the General Electric Company since September 2004. Prior thereto, he was Counsel, Litigation and Legal Policy at GE. Between 1986 and 1992, when he joined GE, he served as an Assistant United States Attorney in the Southern District of New York.

Daniel S. Glaser, age 55, is President and Chief Executive Officer of Marsh & McLennan Companies. Prior to assuming this role in January 2013, Mr. Glaser served as Group President and Chief Operating Officer of Marsh & McLennan Companies from April 2011 through December 2012, with strategic and operational oversight of both the Risk and Insurance Services and the Consulting segments of the Company. Mr. Glaser rejoined Marsh in December 2007 as Chairman and Chief Executive Officer of Marsh Inc. after serving in senior positions in commercial insurance and insurance brokerage in the United States, Europe, and the Middle East. He began his career at Marsh more than 30 years ago. Mr. Glaser was named Chairman of the Federal Advisory Committee on Insurance (FACI) in August 2014. Mr. Glaser also serves on the International Advisory Board of BritishAmerican Business and is a member of the Board of Trustees for The Institutes (American Institute for Chartered Property Casualty Underwriters), the Insurance Information Institute and Ohio Wesleyan University.

Laurie Ledford, age 58, is the Company's Senior Vice President and Chief Human Resources Officer. Ms. Ledford is responsible for Marsh & McLennan Companies' overall human capital and talent strategy and the delivery of human resources services to all our colleagues worldwide. Prior to her current role, Ms. Ledford served as Chief Human Resources Officer (CHRO) for Marsh Inc. Ms. Ledford joined Marsh in 2000 and was named CHRO in 2006, after having served as Senior Human Resources Director for Marsh's International Specialty Operations. Her prior experience was with Citibank and NationsBank.

Scott McDonald, age 49, is President and Chief Executive Officer of Oliver Wyman Group. Prior to assuming this role in January 2014, Mr. McDonald was President of Oliver Wyman. Before becoming President of Oliver Wyman in 2012, Mr. McDonald was the Managing Partner of Oliver Wyman's Financial Services practice and has held a number of senior positions, including the Global head of the Corporate & Institutional Banking practice. Before joining Oliver Wyman in 1995, he was an M&A investment banker with RBC Dominion Securities in Toronto.

Mark McGivney, age 48, is the Company's Chief Financial Officer. Mr. McGivney has held a number of senior financial management positions since joining the Company in 2007, including Chief Financial Officer of Marsh and Chief Financial Officer and Chief Operating Officer of Mercer. In his most recent role as Senior Vice President, Corporate Finance of Marsh & McLennan Companies, Mr. McGivney was responsible for leading and directing the Company's Corporate Development, Treasury and Investor Relations functions. His prior experience includes senior positions at The Hanover Insurance Group, including serving as Senior Vice President of Finance, Treasurer and Chief Financial Officer of the Property & Casualty business, and investment banking positions at Merrill Lynch and Salomon Brothers.

Alexander S. Moczarski, age 60, is President and Chief Executive Officer of Guy Carpenter. In addition, Mr. Moczarski is Chairman of Marsh & McLennan Companies International. In this role, Mr. Moczarski oversees the Company's international strategy, as well as its group of Country Corporate Officers located in regions around the world. Prior to being named Guy Carpenter CEO in April 2011, Mr. Moczarski was President and CEO of the International Division of Marsh. Previously, he was CEO of Marsh Inc.'s Europe, Middle East and Africa region. While at Marsh, Mr. Moczarski held several other roles, including President and CEO of the firm's International Specialty Operations and Region Head for the Latin America and Caribbean Region. Before joining Marsh in 1993, Mr. Moczarski worked for AIG for nearly 15 years, including as CEO of the firm's operations in Argentina and Chile.

Julio A. Portalatin, age 56, is President and Chief Executive Officer of Mercer. Prior to joining Mercer in February 2012, Mr. Portalatin was the President and CEO of Chartis Growth Economies, and Senior Vice President, American International Group (AIG). In that role, he had responsibility for operations in Asia Pacific, South Asia, Latin America, Africa, the Middle East and Central Europe. Mr. Portalatin began his career with AIG in 1993 and thereafter held a number of key leadership roles, including President of the Worldwide Accident & Health Division at American International Underwriters (AIU) from 2002-2007. From 2007-2010, he served as President and CEO of Chartis Europe S.A. and Continental European Region, based in Paris, before becoming President and CEO of Chartis Emerging Markets. Prior to joining AIG/ Chartis, Mr. Portalatin spent 12 years with Allstate Insurance Company in various executive product underwriting, distribution and marketing positions.

Peter Zaffino, age 49, is Chairman of the Risk and Insurance Services segment and President and Chief Executive Officer of Marsh. Mr. Zaffino was named Chairman of the Risk and Insurance Services segment of the Company in May 2015. Prior to being named Marsh CEO in 2011, Mr. Zaffino was President and CEO of Guy Carpenter, a position he assumed in early 2008. Previously, he was an Executive Vice President of Guy Carpenter and had held a number of senior positions, including Head of Guy Carpenter's U.S. Treaty Operations and Head of the firm's Global Specialty Practices. Mr. Zaffino has over 25 years of experience in the Insurance and Reinsurance industry. Prior to joining Guy Carpenter in 2001, he held several senior positions, including serving in an executive role with a GE Capital portfolio company.

AVAILABLE INFORMATION

The Company is subject to the information reporting requirements of the Securities Exchange Act of 1934. In accordance with the Exchange Act, the Company files with, or furnishes to, the SEC annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K. The Company makes these reports and any amendments to these reports available free of charge through its website, www.mmc.com, as soon as reasonably practicable after they are filed with, or furnished to, the SEC. The SEC also maintains an Internet site at www.sec.gov that contains reports, proxy and information statements and other information regarding issuers, like the Company, that file electronically with the SEC.

The Company also posts on its website the following documents with respect to corporate governance:

- Guidelines for Corporate Governance;
- Code of Conduct, *The Greater Good*;
- Procedures for Reporting Complaints and Concerns Regarding Accounting Matters; and
- the charters of the Audit Committee, Compensation Committee, Corporate Responsibility Committee and Directors and Governance Committee of the Company's Board of Directors.

All of the above documents are available in printed form to any Company stockholder upon request. The information on our website is not a part of, or incorporated by reference into, this report.

Item 1A. Risk Factors

You should consider the risks described below in conjunction with the other information presented in this report. These risks have the potential to materially adversely affect the Company's business, results of operations or financial condition.

RISKS RELATING TO THE COMPANY GENERALLY

Legal and Regulatory Issues

We are subject to significant uninsured exposures arising from errors and omissions, breach of fiduciary duty and similar claims.

Our operating companies provide numerous professional services, including the placement of insurance and the provision of consulting, investment advisory, actuarial and other services, to clients around the world. As a result of these activities, the Company and its subsidiaries are subject to a significant number of errors and omissions, breach of fiduciary duty and similar claims, which we refer to collectively as "E&O claims." In our Risk and Insurance Services segment, such claims include allegations of damages arising from our failure to adequately place coverage or notify insurers of potential claims on behalf of clients. In our Consulting segment, such claims include allegations of damages arising from the provision of consulting, investments, actuarial, pension administration and other services. These services frequently involve complex calculations and other analysis, including (i) assumptions and estimates concerning contingent future events, (ii) drafting and interpretation of complex documentation governing pension plans, (iii) calculating benefits within complex pension structures and (iv) the provision of investment advice, including regarding asset allocation and investment strategy, and management of client assets, including the selection of investment managers. Given the long-tail nature of many of these types of claims, these matters often relate to services provided by the Company dating back many years. Such claims may subject us to significant liability for monetary damages, including punitive and treble damages, negative publicity and reputational harm and may divert personnel and management resources. We may be unable to effectively limit our potential liability in certain jurisdictions or in connection with certain types of claims, particularly including those concerning claims of a breach of fiduciary duty.

In establishing liabilities for E&O claims in accordance with FASB ASC Subtopic No. 450-20 (Contingencies - Loss Contingencies), the Company uses case level reviews by inside and outside counsel, an internal actuarial analysis and other analysis to estimate potential losses. A liability is established when a loss is both probable and reasonably estimable. The liability is reviewed quarterly and adjusted as developments warrant. In many cases, the Company has not recorded a liability, other than for legal fees to defend the claim, because we are unable, at the present time, to make a determination that a loss is both probable and reasonably estimable. Nevertheless, given the challenges inherent in establishing liabilities in accordance with FASB ASC Subtopic No. 450-20, as well as the unpredictability of E&O claims and the litigation that can flow from them, it is possible that an adverse outcome in a particular matter could have a material adverse effect on the Company's business, results of operations, financial condition or cash flow in a given quarterly or annual period.

Further, and as more fully described in Note 15 to our consolidated financial statements included under Part II, Item 8 of this report, we are subject to legal proceedings, regulatory investigations and other contingencies other than E&O claims which, if determined unfavorably to us, could have a material adverse effect on our business, results of operations or financial condition.

We cannot guarantee that we are or will be in compliance with all current and potentially applicable U.S. federal and state or foreign laws and regulations, and actions by regulatory authorities or changes in legislation and regulation in the jurisdictions in which we operate could have a material adverse effect on our business.

Our activities are subject to extensive regulation under the laws of the United States and its various states, the European Union and its member states and the other jurisdictions in which we operate. For example, we are subject to regulation by agencies such as the SEC in the United States and the FCA in the United Kingdom, state insurance regulators in the United States and self-regulatory organizations such as FINRA, as further described above under Part I, Item 1 - Business (Regulation) of this report. We are also subject to trade sanctions laws relating to countries such as Cuba, Iran, Russia, Sudan and Syria, and anti-corruption laws such as the U.S. Foreign Corrupt Practices Act and the U.K. Bribery Act 2010. We are subject to numerous other laws on matters as diverse as internal and disclosure controls and procedures, securities regulation, data privacy and protection, taxation, anti-trust, immigration, wage-and-hour standards and employment and labor relations.

The U.S. and foreign laws and regulations that apply to our operations are complex, and our efforts to comply with these myriad laws and regulations require significant resources. In some cases, these laws and regulations may impose operational limitations on our business, including on the products and services we may offer or on the rates we may charge for our products and services. While we attempt to comply with all applicable laws and regulations, there can be no assurance that we, our employees, our consultants and our contractors and other agents are in full compliance with such laws and regulations or interpretations at all times, or that we will be able to comply with any future laws or regulations. If we fail to comply with applicable laws and regulations, including those referred to above, we may be subject to investigations, criminal penalties or civil remedies, including fines, injunctions, loss of an operating license or approval, increased scrutiny or oversight by regulatory authorities, the suspension of individual employees, limitations on engaging in a particular business or redress to clients. The cost of compliance and the consequences of non-compliance could have a material adverse effect on our business, results of operations and financial condition. In addition, a failure to comply with applicable laws and regulations could have a material adverse effect on the Company by exposing us to negative publicity and reputational damage or by harming our client or employee relationships.

In most jurisdictions, government regulatory authorities have the power to interpret and amend applicable laws and regulations, and have discretion to grant, renew and revoke the various licenses and approvals we need to conduct our activities. Such authorities may require the Company to incur substantial costs in order to comply with such laws and regulations. In some areas of our businesses, we act on the basis of our own or the industry's interpretations of applicable laws or regulations, which may conflict from state to state or country to country. In the event those interpretations eventually prove different from the interpretations of regulatory authorities, we may be penalized or precluded from carrying on our previous activities. Moreover, the laws and regulations to which we are subject may conflict among the various jurisdictions and countries in which we operate, which increases the likelihood of our businesses being non-compliant in one or more jurisdictions.

We could incur significant liability or our reputation could be damaged if our information systems are breached or we otherwise fail to protect client or Company data or information systems.

We rely on the efficient, uninterrupted and secure operation of complex information technology systems and networks to operate our business and securely process, transmit and store electronic information. Information technology systems are potentially vulnerable to damage or interruption from a variety of sources, including cyber-attacks, computer viruses and other malware, ransomware and other types of security breaches. Our systems are also subject to compromise from improper action by employees, vendors and other third parties with otherwise legitimate access to our systems. We could experience significant harm if our information systems are breached, or sensitive client or Company data are compromised.

We are at risk of attack by a growing list of adversaries, be it state-sponsored organizations, organized crime, hackers or "hactivists" (activist hackers), through use of increasingly sophisticated methods of attack, including long-term, persistent attacks referred to as advanced persistent threats. Because the

techniques used to obtain unauthorized access or sabotage systems change frequently and generally are not identified until they are launched against a target, we may be unable to anticipate these techniques or implement adequate preventative measures, resulting in potential data loss or other damage to information technology systems.

As the breadth and complexity of our infrastructure continues to grow, including as a result of the use of mobile technologies, cloud services, social media and the increased reliance on devices connected to the Internet (known as the "Internet of Things"), the potential risk of security breaches and cyberattacks also increases. Although encryption is growing in use as a means to protect data from theft, we may not be able to encrypt the data across our diverse systems. Should an attacker gain access to our network using compromised credentials of an authorized user, we are at risk that the attacker might successfully leverage that access to compromise additional systems and data. Certain measures that could increase the security of our infrastructure, such as data encryption or deployment of multi-factor authentication, take significant time and resources to deploy broadly. The inability to implement, maintain and upgrade adequate safeguards could have a material adverse effect on our business.

Due to the large number of systems and platforms that we operate, the increased frequency at which vendors issue security patches to their products and the need to test patches and, in some cases coordinate with clients and vendors, before they can be deployed, we are at risk that we cannot deploy patches in a timely manner. We are also dependent on third party vendors like cloud service providers to keep their systems patched in order to protect our data. If we, our clients and our vendors are unable to keep our systems patched in a timely manner, our systems may be breached, which could have a material adverse effect on our business.

We have numerous vendors and other third parties who receive personal information from us in connection with the services we offer our clients. A small percentage of them have direct access to our systems. We are at risk of a cyber-attack involving a vendor or other third party, which could result in a breakdown of its data protection processes or the cyber-attackers gaining access to our infrastructure through the third party. To the extent that a vendor or third party suffers a cyberattack that compromises their operations, we could incur significant costs and possible service interruption, which could have an adverse effect on our business.

We have a history of making acquisitions, including 92 acquisitions in the period from 2009-2015. The process of integrating the information systems of the businesses we acquire is complex and exposes us to additional risk. For instance, we may not adequately identify weaknesses in the target's information systems, either before or after the acquisition, which could affect the value we are able to derive from the acquisition, expose us to unexpected liabilities or make our own systems more vulnerable to a cyber-attack. We may also be unable to integrate the systems of the businesses we acquire into our environment in a timely manner, which could further increase these risks until such integration takes place.

Our policies, procedures and technical safeguards may be insufficient to prevent or detect improper access to confidential, personal or proprietary information by employees, vendors or other third parties with otherwise legitimate access to our systems. Improper access to or disclosure of sensitive client or Company information could harm our reputation and subject us to liability under our contracts, as well as under existing or future laws, rules and regulations, resulting in increased legal and other costs and harm to our reputation and our business.

We have from time to time experienced data incidents and cybersecurity breaches, such as malware incursions (including computer viruses and ransomware), users exceeding their data access authorization, employee misconduct, and incidents resulting from human error, such as loss of portable and other data storage devices. Like many companies, we are subject to regular phishing email campaigns directed at our employees that can result in malware infections and data losses. Although these incidents have resulted in data loss and other damages, to date, they have not had a material adverse effect on our business or operations. In the future, these types of incidents could result in confidential, personal or proprietary information being lost or stolen, including client, employee or company data, which could have a material adverse effect on our business. We also may be unable to detect an incident, assess its severity or impact, or appropriately respond in a timely manner.

Privacy laws are proliferating and changing frequently, at times in a manner that creates conflicting demands. We may not be in compliance with all applicable U.S. federal and state or foreign privacy and data protection laws and regulations in the jurisdictions in which we operate.

In providing services and solutions to clients, we store sensitive client or Company data, including personal data, in multiple jurisdictions. We leverage systems and applications that are spread all over the world requiring us to regularly move data across national borders. We expect these activities to increase in scope and complexity. As a result, we are subject to numerous laws and regulations designed to protect personal data, such as the national laws implementing the European Union's Data Protection Directive and various U.S. federal and state laws governing the protection of health or other personally identifiable information. These laws and regulations are frequently changing and are becoming increasingly complex and sometimes conflict among the various jurisdictions and countries in which we provide services. For example, the European Union has just reached an agreement on a new General Data Protection Regulation (the GDPR) that greatly increases the jurisdictional reach of its laws and adds a broad array of requirements for handling personal data, such as privacy impact assessments, data portability and the appointment of data protection officers in some cases. Other countries are passing data localization laws that require data to stay within their borders. All of these evolving compliance and operational requirements impose significant costs that are likely to increase over time.

Unauthorized disclosure of sensitive or confidential client or Company data, whether through systems failure, employee negligence, fraud or misappropriation, could subject us to significant litigation, monetary damages, regulatory enforcement actions, fines and criminal prosecution in one or more jurisdictions. Under the GDPR, certain violations may trigger a fine of up to 4% of a corporation's global annual revenue. Such events could also result in negative publicity and damage to our reputation, and cause us to lose clients, and could therefore have a material adverse effect on our results of operations. Our liability insurance, which includes cyber insurance, may not be sufficient in type or amount to cover us against claims related to security breaches, cyberattacks and other related breaches.

Financial Risks

Our pension obligations could cause the Company's financial position, earnings and cash flows to fluctuate.

The Company has significant pension obligations to its current and former employees, totaling approximately $14.8 billion, and related plan assets of approximately $14.0 billion, at December 31, 2015. The Company's policy for funding its tax-qualified defined benefit retirement plans is to contribute amounts at least sufficient to meet the funding requirements set forth by U.S. law and the laws of the non-U.S. jurisdictions in which the Company offers defined benefit plans. In the United States, contributions to the tax-qualified defined benefit plans are based on ERISA guidelines. Contribution rates for non-U.S. plans are generally based on local funding practices and statutory requirements, which may differ from measurements under U.S. GAAP. In the United Kingdom, for example, contributions to defined benefit pension plans are based on statutory requirements and are determined through a negotiation process between the Company and the plans' trustee. This negotiation process is governed by U.K. pension regulations. Certain of the assumptions that result from the funding negotiations are different from those used for U.S. GAAP and currently result in a lower funded status than under U.S. GAAP.

During 2015, the Company contributed $29 million to its U.S. pension plans and $166 million to its non-U.S. pension plans. The calculations relating to our defined benefit pension plans are complex. As indicated in Note 8 to our consolidated financial statements, pension plan assets and liabilities, periodic pension expense and future funding amounts are affected by future asset performance, the assumed interest rates we use to discount our pension liabilities, rates of inflation, mortality assumptions and other variables. Given the magnitude of our worldwide pension plans, variations in or reassessment of the preceding factors or potential miscalculations relating to our defined benefit pension plans could cause significant fluctuation from year to year in our earnings and cash flow, as well as our pension plan assets, liabilities and equity, and may result in increased levels of contributions to our pension plans.

Our results of operations could be adversely affected by macroeconomic conditions and political events around the world and the effects of these conditions and events on our clients' businesses and levels of business activity.

Macroeconomic conditions and political events around the world affect our clients' businesses and the markets they serve. These conditions may reduce demand for our services or depress pricing for those services, which could have a material adverse effect on our results of operations. Changes in macroeconomic and political conditions could also shift demand to services for which we do not have a competitive advantage, and this could negatively affect the amount of business that we are able to obtain. If the demand for our products and services declines as a result of macroeconomic conditions, political events or other factors, we may be required to restructure our business, which could adversely affect our ability to execute our business strategy.

Our investments, including our minority investments in other companies as well as our cash investments and those held in a fiduciary capacity, are subject to general credit, liquidity, counterparty, market and interest rate risks. These may be exacerbated by global macroeconomic conditions, market volatility and regulatory, financial and other difficulties affecting the companies in which we have invested or that may be faced by financial institution counterparties. During times of stress in the banking industry, counterparty risk can quickly escalate, potentially resulting in substantial trading and investment losses for corporate and other investors. In addition, we may incur investment losses as a result of unusual and unpredictable market developments, and we may continue to experience reduced investment earnings if the yields on investments deemed to be low risk remain at or near their current low levels. If the banking system or the fixed income, interest rate, credit or equity markets deteriorate, the value and liquidity of our investments could be adversely affected.

Our significant non-U.S. operations expose us to exchange rate fluctuations and various risks that could impact our business.

We are subject to exchange rate movement because some of our subsidiaries receive revenue other than in their functional currencies and because we must translate the financial results of our foreign subsidiaries into U.S. dollars. Our U.S. operations earn revenue and incur expenses primarily in U.S. dollars. In certain jurisdictions, however, our Risk and Insurance Services operations generate revenue in a number of different currencies, but expenses are almost entirely incurred in local currency. Due to fluctuations in foreign exchange rates, we are subject to economic exposure as well as currency translation exposure on the profits of our operations. Because the non-U.S. based revenue that is exposed to foreign exchange fluctuations is approximately 51% of total revenue, exchange rate movement can have a significant impact on our business, financial condition, results of operations and cash flow. For additional discussion, see "Market Risk and Credit Risk-Foreign Currency Risk" in Part II, Item 7A ("Quantitative and Qualitative Disclosures about Market Risk") of this report.

We may not be able to receive dividends or other distributions in needed amounts from our subsidiaries.

The Company is organized as a legal entity separate and distinct from our operating subsidiaries. Because we do not have significant operations of our own, we are dependent upon dividends and other payments from our operating subsidiaries to meet our obligations for paying principal and interest on outstanding debt obligations, paying dividends to stockholders, repurchasing our common stock under our share repurchase program and paying corporate expenses. In the event our operating subsidiaries are unable to pay sufficient dividends and make other payments to the Company, we may not be able to service our debt, pay dividends on or repurchase our common stock or meet our other obligations.

Further, the Company derives a significant portion of its revenue and operating profit from operating subsidiaries located outside the United States. Funds from current year's earnings of the Company's non-U.S. operating subsidiaries are regularly repatriated to the United States. A number of factors could arise that could limit our ability to repatriate funds or could make repatriation cost-prohibitive, including, but not limited to, the imposition of currency controls and other government restrictions on repatriation in the jurisdictions in which our subsidiaries operate, fluctuations in foreign exchange rates, the imposition of withholding and other taxes on such payments and our ability to repatriate earnings in a tax-efficient manner.

In the event we are unable to generate or repatriate cash from our operating subsidiaries for any of the reasons discussed above, our overall liquidity could deteriorate and our ability to finance our obligations, including to pay dividends on or repurchase our common stock, could be adversely affected.

Credit rating downgrades would increase our financing costs and could subject us to operational risk.

Currently, the Company's senior debt is rated A- by S&P and Baa1 by Moody's. The ratings from both S&P and Moody's currently carry a Stable outlook.

If we need to raise capital in the future (for example, in order to fund maturing debt obligations or finance acquisitions or other initiatives), credit rating downgrades would increase our financing costs, and could limit our access to financing sources. Further, we believe that a downgrade to a rating below investment-grade could result in greater operational risks through increased operating costs and increased competitive pressures.

Our quarterly revenues and profitability may fluctuate significantly.

Quarterly variations in revenues and operating results may occur due to several factors. These include:

- the significance of client engagements commenced and completed during a quarter;
- the possibility that clients may decide to delay or terminate a current or anticipated project as a result of factors unrelated to our work product or progress;
- fluctuations in hiring and utilization rates and clients' ability to terminate engagements without penalty;
- seasonality due to the impact of regulatory deadlines, policy renewals and other timing factors to which our clients are subject;
- the success of our acquisitions or investments;
- macroeconomic factors such as changes in foreign exchange rates, interest rates and global securities markets, particularly in the case of Mercer, where fees in its investments business and certain other business lines are derived from the value of assets under management or administration; and
- general economic conditions, since results of operations are directly affected by the levels of business activity of our clients, which in turn are affected by the level of economic activity in the industries and markets that they serve.

A significant portion of our total operating expenses is relatively fixed in the short term. Therefore, a variation in the number of client assignments or in the timing of the initiation or the completion of client assignments can cause significant variations in quarterly operating results for these businesses.

If we are unable to collect our receivables, our results of operations and cash flows could be adversely affected.

Our business depends on our ability to successfully obtain payment from our clients of the amounts they owe us for the work we perform. Accounts receivable typically total about one-quarter of our total annual revenues. In most cases, we bill and collect on relatively short cycles. There is no guarantee that we will accurately assess the creditworthiness of our clients. Macroeconomic conditions could result in financial difficulties for our clients, which could cause clients to delay payments to us, request modifications to their payment arrangements that could increase our receivables balance or default on their payment obligations to us. Timely collection of client balances also depends on our ability to complete our contractual commitments and bill and collect our contracted revenues. If we are unable to meet our contractual requirements, we might experience delays in collection of, or be unable to collect, our client balances, and if this occurs, our results of operations and cash flows could be adversely affected. In addition, if we experience an increase in the time it takes to bill and collect for our services, our cash flows could be adversely affected.

Market perceptions concerning the instability of the Euro could adversely affect the Company's operating results as well as the value of the Company's Euro-denominated assets.

Concerns persist regarding the ability of certain Eurozone countries to service their debt obligations. As a result, a number of these countries have undertaken a variety of actions, such as cutting spending and raising taxes, designed to ease their future debt burdens. A potential consequence may be stagnant growth, or even recession, in the Eurozone economies and beyond. Any of these developments could lead to further contraction in the Eurozone economies, adversely affecting our operating results in the region. The Company may also face increased credit risk as our clients and financial institution counterparties in the region find themselves with reduced resources to meet their obligations. Finally, the value of the Company's assets held in the Eurozone, including cash holdings, will decline if the currency devalues.

Global Operations

We are exposed to multiple risks associated with the global nature of our operations.

We do business worldwide. In 2015, 51% of the Company's total revenue was generated from operations outside the United States, and over one-half of our employees were located outside the United States. We expect to expand our non-U.S. operations further.

The geographic breadth of our activities subjects us to significant legal, economic, operational, market, compliance and reputational risks. These include, among others, risks relating to:

- economic and political conditions in the countries in which we operate;
- unexpected increases in taxes or changes in U.S. or foreign tax laws or rulings;
- withholding or other taxes that foreign governments may impose on the payment of dividends or other remittances to us from our non-U.S. subsidiaries;
- potential transfer pricing-related tax exposures that may result from the allocation of U.S.-based costs that benefit our non-U.S. businesses;
- potential conflicts of interest that may arise as we expand the scope of our businesses and our client base;
- international hostilities, terrorist activities, natural disasters and infrastructure disruptions;
- local investment or other financial restrictions that foreign governments may impose;
- potential costs and difficulties in complying with a wide variety of foreign laws and regulations (including tax systems) administered by foreign government agencies, some of which may conflict with U.S. or other sources of law;
- potential costs and difficulties in complying, or monitoring compliance, with foreign and U.S. laws and regulations that are applicable to our operations abroad, including trade sanctions laws relating to countries such as Cuba, Iran, Russia, Sudan and Syria and anti-corruption laws such as the U.S. Foreign Corrupt Practices Act and the U.K. Bribery Act 2010;
- limitations or restrictions that foreign or U.S. governments and regulators may impose on the products or services we sell or the methods by which we sell our products and services;
- limitations that foreign governments may impose on the conversion of currency or the payment of dividends or other remittances to us from our non-U.S. subsidiaries;
- the length of payment cycles and potential difficulties in collecting accounts receivable;
- engaging and relying on third parties to perform services on behalf of the Company; and
- potential difficulties in monitoring employees in geographically dispersed locations.

Our inability to successfully recover should we experience a disaster or other business continuity problem could cause material financial loss, loss of human capital, regulatory actions, reputational harm or legal liability.

Should we experience a local or regional disaster or other business continuity problem, such as an earthquake, hurricane, flood, terrorist attack, pandemic, security breach, cyber attack, power loss, telecommunications failure or other natural or man-made disaster, our ability to continue to operate will depend, in part, on the availability of our personnel, our office facilities and the proper functioning of our computer, telecommunication and other related systems and operations. In such an event, we could experience operational challenges that could have a material adverse effect on our business.

Our operations depend upon our ability to protect our technology infrastructure against damage from events that could have a significant disruptive effect. We could potentially lose client or Company data or experience material adverse interruptions to our operations or delivery of services to our clients in a disaster recovery scenario. In particular, a cyber-attack on us or a key vendor or supplier could result in a significant and extended disruption in the functioning of our information technology systems or operations, requiring us to incur significant expense to address and remediate or otherwise resolve such issues. An extended service outage may result in the loss of clients and a decline in our revenues.

We regularly assess and take steps to improve our existing business continuity plans and key management succession. However, a disaster or other continuity event on a significant scale or affecting certain of our key operating areas within or across regions, or our inability to successfully recover from such an event, could materially interrupt our business operations and result in material financial loss, loss of human capital, regulatory actions, reputational harm, damaged client relationships and legal liability.

Competitive Risks

Each of the Company's businesses operates in a highly competitive environment. If we fail to compete effectively against our competitors, some of which have lower effective tax rates, our business, results of operations and financial condition will be impacted adversely.

As a global professional services firm, the Company faces acute and continuous competition in each of its operating segments. Our ability to compete successfully depends on a variety of factors, including the quality and expertise of our colleagues, our geographic reach, the sophistication and quality of our services, our pricing relative to competitors, our customers' ability to self-insure or use internal resources instead of consultants and our ability to respond to changes in client demand and industry conditions. Some of our competitors may have greater financial resources, or may be better positioned to respond to technological and other changes in the industries we serve, and they may be able to compete more effectively. If we are unable to respond successfully to the competition we face, our business, results of operations and financial condition will be adversely impacted.

In addition, given the global breadth of our operations, the Company derives a significant portion of its revenue and operating profit from operating subsidiaries located outside the United States. Funds from the Company's non-U.S. operating subsidiaries are regularly repatriated to the United States out of annual earnings to pay dividends to stockholders, fund share repurchases and for other corporate purposes. The Company's consolidated tax rate is higher than a number of its key competitors that are domiciled outside the United States where corporate tax rates are lower than the U.S. statutory tax rate. The higher consolidated tax rate at which our earnings are taxed could have an adverse impact on our ability to compete with a number of our competitors.

In our Risk and Insurance Services segment, in addition to the challenges posed by capital market alternatives to traditional insurance and reinsurance, we compete intensely against a wide range of other insurance and reinsurance brokerage firms that operate on a global, regional, national or local scale for both client business and employee talent. We compete as well with insurance and reinsurance companies that market and service their insurance products without the assistance of brokers or other market intermediaries, and with various other companies that provide risk-related services or alternatives to traditional brokerage services. This competition is intensified by an industry trend toward a "syndicated" or "distributed" approach to the purchase of insurance and reinsurance brokerage services, whereby a client engages multiple brokers to service different portions of the client's account.

In our Consulting segment, we compete for business and employee talent with numerous consulting firms and organizations affiliated with accounting, information systems, technology and financial services firms around the world. Through these affiliations, such competitors may be able to offer more comprehensive products and services to potential clients, which may give them a competitive advantage.

The loss of key professionals could hurt our ability to retain existing client revenues and generate revenues from new business.

Across all of our businesses, our colleagues are critical to developing and retaining the client relationships performing the service on which our revenues depend. It is therefore important for us to retain significant revenue-producing employees and the key managerial and other professionals who support them. We face numerous challenges in this regard, including the intense competition for talent in all of our businesses and the general mobility of professionals in our businesses.

Losing employees who manage or support substantial client relationships or possess substantial experience or expertise could adversely affect our ability to secure and complete client engagements, which could adversely affect our results of operations. And, subject to applicable restrictive covenants, if any of our key professionals were to join an existing competitor or form a competing company, some of our clients could choose to use the services of that competitor instead of our services.

Our businesses face rapid technological changes and our failure to adequately anticipate or respond to these changes or to successfully implement strategic initiatives to address them could adversely affect our business and results of operations.

To remain competitive in many of our business areas, we must anticipate and respond effectively to the threat of digital disruption and other technological change. We must also identify relevant technologies and methodologies and integrate them into our product and service offerings. We may not be able to do this effectively. We have a number of strategic initiatives involving investments in technology systems and infrastructure to support our growth strategy. In addition to new platforms and systems, we are deploying new processes and many of our colleagues across the business are changing the way they perform certain roles to capture efficiencies. In some cases, we depend on key vendors and partners to provide technology and other support for our strategic initiatives. If these vendors or partners fail to perform their obligations or otherwise cease to work with us, our ability to execute on our strategic initiatives could be adversely affected. If we do not keep up with technological changes or execute well on our strategic initiatives, our business and results of operations could be adversely impacted.

Consolidation in the industries we serve could adversely affect our business.

Companies in the industries that we serve may seek to achieve economies of scale and other synergies by combining with or acquiring other companies. If two or more of our current clients merge or consolidate and combine their operations, it may decrease the amount of work that we perform for these clients. If one of our current clients merges or consolidates with a company that relies on another provider for its services, we may lose work from that client or lose the opportunity to gain additional work. Any of these or similar possible results of industry consolidation could adversely affect our business. Guy Carpenter is especially susceptible to this risk given the limited number of insurance company clients and reinsurers in the marketplace.

Acquisitions and Dispositions

We face risks when we acquire and dispose of businesses.

We have a history of making acquisitions, including a total of 92 acquisitions in the period 2009-2015 for aggregate purchase consideration of $4.2 billion. We expect that acquisitions will continue to be a key part of our business strategy. Our success in this regard will depend on our ability to identify and compete for appropriate acquisition candidates and to complete with favorable results the transactions we decide to pursue.

While we intend that our acquisitions will improve our competitiveness and profitability, we cannot be certain that our past or future acquisitions will be accretive to earnings or otherwise meet our operational or strategic expectations. Acquisitions involve special risks, including accounting, regulatory, compliance, information technology or human resources issues that could arise in connection with, or as a result of,

the acquisition of the acquired company; the assumption of unanticipated liabilities and contingencies; difficulties in integrating acquired businesses; and the inability of acquired businesses to achieve the levels of revenue, profit or productivity we anticipate or otherwise perform as we expect. In addition, if in the future, the performance of our reporting units or an acquired business varies from our projections or assumptions, or estimates about future profitability of our reporting units or an acquired business change, the estimated fair value of our reporting units or an acquired business could change materially and could result in an impairment of goodwill and other acquisition-related intangible assets recorded on our balance sheet or in adjustments in contingent payment amounts. As of December 31, 2015, the Company's consolidated balance sheet reflected $8.9 billion of goodwill and intangible assets, representing approximately 49% of the Company's total consolidated assets and allocated by reporting segment as follows: Risk and Insurance Services, $6.5 billion and Consulting, $2.4 billion. Given the significant size of the Company's goodwill and intangible assets, an impairment could have a material adverse effect on our results of operations in any given period.

When we dispose of businesses, we are subject to the risk, contractually agreed or otherwise, that we will continue to be subject to the liabilities of that business after its disposition. For example, as described in Note 15 to our consolidated financial statements included under Part II, Item 8 of this report, we have retained certain contingent litigation liabilities relating to our disposition of Kroll.

RISKS RELATING TO OUR RISK AND INSURANCE SERVICES SEGMENT

Our Risk and Insurance Services segment, conducted through Marsh and Guy Carpenter, represented 53% of the Company's total revenue in 2015. Our business in this segment is subject to particular risks.

Results in our Risk and Insurance Services segment may be adversely affected by a general decline in economic activity.

Demand for many types of insurance and reinsurance generally rises or falls as economic growth expands or slows. This dynamic affects the level of commissions and fees generated by Marsh and Guy Carpenter. To the extent our clients become adversely affected by declining business conditions, they may choose to limit their purchases of insurance and reinsurance coverage, as applicable, which would inhibit our ability to generate commission revenue. Also, the insurance they seek to obtain through us may be impacted by changes in their assets, property values, sales or number of employees, which may reduce our commission revenue, and they may decide not to purchase our risk advisory services, which would inhibit our ability to generate fee revenue. Moreover, insolvencies and combinations associated with an economic downturn, especially insolvencies and combinations in the insurance industry, could adversely affect our brokerage business through the loss of clients or by hampering our ability to place insurance and reinsurance business. Guy Carpenter is especially susceptible to this risk given the limited number of insurance company clients and reinsurers in the market place.

Allegations of conflicts of interest, adverse legal developments and future regulations concerning compensation we receive from insurers could have a material adverse effect on Marsh's business, results of operations and financial condition.

The method by which insurance intermediaries are compensated has received substantial scrutiny from regulators in the past because of the potential for conflicts of interest. The potential for conflicts of interest arises when an intermediary is compensated by two parties in connection with the same or similar transactions. The vast majority of the compensation that Marsh receives is in the form of retail commissions and fees that are paid by the client or paid from premium that is paid by the client. The amount of compensation that we receive from insurance companies, separate from retail commissions and fees, has increased significantly in the last several years, both organically and through acquisition. This compensation includes payment for, among other things (i) consulting and analytics services provided to insurers and (ii) administrative and other services provided to or on behalf of insurers (including services relating to the administration and management of quota shares, panels and other facilities in which insurers participate). It also takes the form of contingent commission, which is paid by insurers based on the attainment of specified goals relating to Marsh's placements, particularly at Marsh & McLennan Agency and in parts of Marsh's international operations. Future changes in the regulatory environment may impact our ability to collect these revenue streams. In addition, these revenues present potential regulatory, litigation and reputational risks that may arise from alleged conflicts of interest or

allegations under antitrust, competition and other laws. Adverse regulatory, legal or other developments regarding these revenues could have a material adverse effect on our business, results of operations or financial condition, expose us to negative publicity and reputational damage and harm our client, insurer or other relationships.

Volatility or declines in premiums and other market trends may significantly impede our ability to improve revenues and profitability.

A significant portion of our Risk and Insurance Services revenue consists of commissions paid to us out of the premiums that insurers and reinsurers charge our clients for coverage. Our revenues and profitability are subject to change to the extent that premium rates fluctuate or trend in a particular direction. The potential for changes in premium rates is significant, due to the general phenomenon of pricing cyclicality in the commercial insurance and reinsurance markets.

In addition to movements in premium rates, our ability to generate premium-based commission revenue may be challenged by the growing availability of alternative methods for clients to meet their risk-protection needs. This trend includes a greater willingness on the part of corporations to "self-insure," the use of so-called "captive" insurers, and the advent of capital markets-based solutions to traditional insurance and reinsurance needs. Further, the profitability of our Risk and Insurances Services segment depends in part on our ability to be compensated, not only for insurance and reinsurance transactions, but also for the increasing analytical services and advice that we provide. If we are unable to achieve and maintain adequate billing rates for all of our services, our margins and profitability could decline.

RISKS RELATING TO OUR CONSULTING SEGMENT

Our Consulting segment, conducted through Mercer and Oliver Wyman Group, represented 47% of our total revenue in 2015. Our businesses in this segment are subject to particular risks.

Revenues for our services may decline for various reasons, including as a result of changes in economic conditions, the value of equity, debt and other asset markets, our clients' or an industry's financial condition or government regulation.

Global economic conditions over the past several years have negatively affected businesses and financial institutions. Many of our clients, including financial institutions, corporations, government entities and pension plans, have been reducing expenses, including amounts spent on consulting services. The evolving needs and financial circumstances of our clients may reduce demand for our services and our revenues and profitability. If the economy or markets in which we operate experience continued weakness at current levels or deteriorate further, our business, financial condition and results of operations could be materially and adversely affected.

In addition, some segments of Mercer's investments business generate fees based upon the value of the clients' assets under management or advisement. Changes in the value of equity, debt, currency, real estate, commodities or other asset classes could cause the value of assets under management or advisement, and the fees received by Mercer, to decline. Such changes could also cause clients to withdraw funds from Mercer's investment business in favor of other asset management strategies. In either case, our business, financial condition and results of operations could be materially and adversely affected.

Demand for many of Mercer's benefits services is affected by government regulation and tax rules, which drive our clients' needs for benefits-related services. Significant changes in government regulations affecting the value, use or delivery of benefits and human resources programs, including changes in regulations relating to health and welfare plans, defined contribution plans or defined benefit plans, may adversely affect the demand for or profitability of Mercer's services.

Factors affecting defined benefit pension plans and the services we provide relating to those plans could adversely affect Mercer.

Mercer currently provides corporate, multi-employer and public clients with actuarial, consulting and administration services relating to defined benefit pension plans. The nature of our work is complex. Our actuarial services involve numerous assumptions and estimates regarding future events, including interest rates used to discount future liabilities, estimated rates of return for a plan's assets, healthcare cost trends, salary projections and participants' life expectancies. Our consulting services involve the

drafting and interpretation of trust deeds and other complex documentation governing pension plans. Our administration services include calculating benefits within complicated pension plan structures. Clients dissatisfied with our services have brought, and may bring, significant claims against us, particularly in the United States and the United Kingdom. In addition, a number of Mercer's clients have frozen or curtailed their defined benefit plans and have moved to defined contribution plans resulting in reduced revenue for Mercer's retirement business. These developments could adversely affect Mercer's business and operating results.

Mercer's investment business is subject to a number of risks, including risks related to third-party investment managers, operational risk, conflicts of interest, asset performance and regulatory compliance, that, if realized, could result in significant damage to our business.

Mercer's investment business provides clients with investment consulting and investment management (referred to as "delegated solutions") services. In the investment consulting business, clients make and implement their own investment policy decisions based upon advice provided by Mercer. In its delegated solutions business, Mercer implements the client's investment policy by engaging and overseeing independent investment managers who determine which securities to buy and sell (typically through the client's investment in Mercer's "manager of managers" funds).

Mercer's investment business is subject to a number of risks, including risks related to third-parties, our operations, conflicts of interest, asset performance and regulatory compliance, which could arise in connection with these offerings. For example, Mercer's due diligence on an investment manager may fail to uncover material deficiencies or fraud that could result in investment losses to a client. There is a risk that Mercer will fail to properly implement a client's investment policy, which could cause an incorrect or untimely allocation of client assets among investment managers or strategies. Mercer may also be perceived as recommending certain investment managers to clients, or offering delegated solutions to an investment consulting client, solely to enhance its own compensation. Asset classes may perform poorly, or investment managers may underperform their benchmarks, due to poor market performance, negligence or other reasons, resulting in poor returns or loss of client capital. These risks, if realized, could result in significant liability and damage our business.

Our profitability may decline if we are unable to achieve or maintain adequate utilization and pricing rates for our consultants.

The profitability of our Consulting businesses depends in part on ensuring that our consultants maintain adequate utilization rates (i.e., the percentage of our consultants' working hours devoted to billable activities). Our utilization rates are affected by a number of factors, including:

- our ability to transition consultants promptly from completed projects to new assignments, and to engage newly-hired consultants quickly in revenue-generating activities;
- our ability to continually secure new business engagements, particularly because a portion of our work is project-based rather than recurring in nature;
- our ability to forecast demand for our services and thereby maintain appropriate headcount in each of our geographies and workforces;
- our ability to manage attrition;
- unanticipated changes in the scope of client engagements;
- the potential for conflicts of interest that might require us to decline client engagements that we otherwise would have accepted;
- our need to devote time and resources to sales, training, professional development and other non-billable activities;
- the potential disruptive impact of acquisitions and dispositions; and
- general economic conditions.

If the utilization rate for our consulting professionals declines, our profit margin and profitability could decline.

In addition, the profitability of our Consulting businesses depends in part on the prices we are able to charge for our services. The prices we charge are affected by a number of factors, including:

- clients' perception of our ability to add value through our services;
- market demand for the services we provide;
- our ability to develop new services and the introduction of new services by competitors;
- the pricing policies of our competitors;
- the extent to which our clients develop in-house or other capabilities to perform the services that they might otherwise purchase from us; and
- general economic conditions.

If we are unable to achieve and maintain adequate billing rates for our services, our profit margin and profitability could decline.

Item 1B. Unresolved Staff Comments.

There are no unresolved comments to be reported pursuant to Item 1B.

Item 2. Properties.

Marsh & McLennan Companies maintains its corporate headquarters in New York City. We also maintain other offices around the world, primarily in leased space. In certain circumstances we may have space that we sublet to third parties, depending upon our needs in particular locations.

Marsh & McLennan Companies and certain of its subsidiaries own, directly and indirectly through special purpose subsidiaries, a 58% condominium interest covering approximately 900,000 square feet of office space in a 44-story building in New York City. This real estate serves as the Company's headquarters and is occupied primarily by the Company and its subsidiaries for general corporate use. The remaining condominium interests in this property are owned by unaffiliated third parties. The Company's owned interest is financed by a 30-year loan that is non-recourse to the Company (except in the event of certain prohibited actions) and secured by a first mortgage lien on the condominium interest and a first priority assignment of leases and rents. In the event (1) the Company is downgraded below B (stable outlook) by S&P or Fitch or B2 (stable outlook) by Moody's or (2) an event of default under the loan has occurred and is continuing, the Company would be obligated to pay rent for the entire occupancy of the mortgaged property, which would, in effect, pay the mortgage.

Item 3. Legal Proceedings.

Information regarding legal proceedings is set forth in Note 15 to the consolidated financial statements appearing under Part II, Item 8 ("Financial Statements and Supplementary Data") of this report.

Item 4. Mine Safety Disclosures.

Not applicable.

PART II

Item 5. Market for the Company's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

For information regarding dividends paid and the number of holders of the Company's common stock, see the table entitled "Selected Quarterly Financial Data and Supplemental Information (Unaudited)" below on the last page of Part II, Item 8 ("Financial Statements and Other Supplementary Data") of this report.

The Company's common stock is listed on the New York, Chicago and London Stock Exchanges. The following table indicates the high and low prices (NYSE composite quotations) of the Company's common stock during 2015 and 2014 and each quarterly period thereof:

	2015 Stock Price Range		2014 Stock Price Range	
	High	Low	High	Low
First Quarter	$58.11	$53.50	$50.48	$44.25
Second Quarter	$59.99	$55.79	$52.39	$46.78
Third Quarter	$58.83	$50.90	$53.64	$50.09
Fourth Quarter	$57.46	$51.05	$58.74	$48.66
Full Year	$59.99	$50.90	$58.74	$44.25

On February 19, 2016, the closing price of the Company's common stock on the NYSE was $57.31.

In May 2015, the Board of Directors of the Company authorized share repurchases up to a dollar value of $2 billion of the Company's common stock. The Company repurchased 1.4 million shares of its common stock for $75 million during the fourth quarter of 2015, resulting in full year 2015 repurchases of 24.8 million shares for $1.4 billion. As of December 31, 2015, the Company remained authorized to repurchase shares of its common stock up to a dollar value of approximately $1.2 billion. There is no time limit on the authorization.

Period	(a) Total Number of Shares (or Units) Purchased	(b) Average Price Paid per Share (or Unit)	(c) Total Number of Shares (or Units) Purchased as Part of Publicly Announced Plans or Programs	(d) Maximum Number (or Approximate Dollar Value) of Shares (or Units) that May Yet Be Purchased Under the Plans or Programs
Oct 1-31, 2015	1,393,738	$ 53.8118	1,393,738	$ 1,155,471,664
Nov 1-30, 2015	—	$ —	—	$ 1,155,471,664
Dec 1-31, 2015	—	$ —	—	$ 1,155,471,664
Total	1,393,738	$ 53.8118	1,393,738	$ 1,155,471,664

Item 6. Selected Financial Data.

Marsh & McLennan Companies, Inc. and Subsidiaries
FIVE-YEAR STATISTICAL SUMMARY OF OPERATIONS

For the Years Ended December 31, *(In millions, except per share figures)*	2015	2014	2013	2012	2011
Revenue	$ 12,893	$ 12,951	$ 12,261	$ 11,924	$ 11,526
Expense:					
Compensation and Benefits	7,334	7,515	7,226	7,134	6,969
Other Operating Expenses	3,140	3,135	2,958	2,961	2,919
Operating Expenses	10,474	10,650	10,184	10,095	9,888
Operating Income [a]	2,419	2,301	2,077	1,829	1,638
Interest Income	13	21	18	24	28
Interest Expense	(163)	(165)	(167)	(181)	(199)
Cost of Extinguishment of Debt	—	(137)	(24)	—	(72)
Investment Income	38	37	69	24	9
Income Before Income Taxes	2,307	2,057	1,973	1,696	1,404
Income Tax Expense	671	586	594	492	422
Income From Continuing Operations	1,636	1,471	1,379	1,204	982
Discontinued Operations, Net of Tax	—	26	6	(3)	33
Net Income Before Non-Controlling Interests	1,636	1,497	1,385	1,201	1,015
Less: Net Income Attributable to Non-Controlling Interests	37	32	28	25	22
Net Income Attributable to the Company	$ 1,599	$ 1,465	$ 1,357	$ 1,176	$ 993
Basic Net Income Per Share Information:					
Income From Continuing Operations	$ 3.01	$ 2.64	$ 2.46	$ 2.16	$ 1.76
Income From Discontinued Operations	—	0.05	0.01	—	0.06
Net Income Attributable to the Company	$ 3.01	$ 2.69	$ 2.47	$ 2.16	$ 1.82
Average Number of Shares Outstanding	531	545	549	544	542
Diluted Income Per Share Information:					
Income From Continuing Operations	$ 2.98	$ 2.61	$ 2.42	$ 2.13	$ 1.73
Discontinued Operations, net of tax per share	—	0.04	0.01	—	0.06
Net Income Attributable to the Company	$ 2.98	$ 2.65	$ 2.43	$ 2.13	$ 1.79
Average Number of Shares Outstanding	536	553	558	552	551
Dividends Paid Per Share	$ 1.18	$ 1.06	$ 0.96	$ 0.90	$ 0.86
Return on Average Equity	23 %	19 %	19 %	19 %	16 %
Year-end Financial Position:					
Working capital [b]	$ 1,336	$ 1,856	$ 2,027	$ 2,007	$ 1,545
Total assets [b]	$ 18,216	$ 17,793	$ 16,960	$ 16,274	$ 15,449
Long-term debt [b]	$ 4,402	$ 3,368	$ 2,619	$ 2,657	$ 2,667
Total equity	$ 6,602	$ 7,133	$ 7,975	$ 6,606	$ 5,940
Total shares outstanding (net of treasury shares)	522	540	547	545	539
Other Information:					
Number of employees	60,000	57,000	55,000	54,000	52,000
Stock price ranges—					
U.S. exchanges — High	$ 59.99	$ 58.74	$ 48.56	$ 35.78	$ 32.00
— Low	$ 50.90	$ 44.25	$ 34.43	$ 30.69	$ 25.29

(a) Includes the impact of net restructuring costs of $28 million, $12 million, $22 million, $78 million, and $51 million in 2015, 2014, 2013, 2012 and 2011, respectively.

(b) In 2015, the Company adopted new Financial Accounting Standards Board guidance related to the presentation of deferred tax assets and liabilities and debt issuance costs. The 2011-2014 amounts have been amended to reflect the adoption of the new guidance. See Footnote 1 in the consolidated financial statements for a discussion of the changes.

See Management's Discussion and Analysis of Financial Condition and Results of Operations, appearing under Part II, Item 7 of this report, for discussion of significant items affecting the results of operations in 2015, 2014 and 2013.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

General

Marsh & McLennan Companies, Inc. and subsidiaries (the "Company") is a global professional services firm offering clients advice and solutions in risk, strategy and people. It is the parent company of a number of leading risk experts and specialty consultants, including: Marsh, the insurance broker, intermediary and risk advisor; Guy Carpenter, the risk and reinsurance specialist; Mercer, the provider of HR and related financial advice and services; and Oliver Wyman Group, the management, economic and brand consultancy. With approximately 60,000 employees worldwide and annual revenue of nearly $13 billion, the Company provides analysis, advice and transactional capabilities to clients in more than 130 countries.

The Company conducts business through two segments:

- **Risk and Insurance Services** includes risk management activities (risk advice, risk transfer and risk control and mitigation solutions) as well as insurance and reinsurance broking and services. We conduct business in this segment through Marsh and Guy Carpenter.
- **Consulting** includes Health, Retirement, Talent and Investments consulting services and products, and specialized management, economic and brand consulting services. We conduct business in this segment through Mercer and Oliver Wyman Group.

We describe the primary sources of revenue and categories of expense for each segment below, in our discussion of segment financial results. A reconciliation of segment operating income to total operating income is included in Note 16 to the consolidated financial statements included in Part II, Item 8 in this report. The accounting policies used for each segment are the same as those used for the consolidated financial statements.

This Management's Discussion & Analysis ("MD&A") contains forward-looking statements as that term is defined in the Private Securities Litigation Reform Act of 1995. See "Information Concerning Forward-Looking Statements" at the outset of this report.

Consolidated Results of Operations

For the Years Ended December 31, *(In millions, except per share figures)*	**2015**	2014	2013
Revenue	**$ 12,893**	$ 12,951	$ 12,261
Expense			
Compensation and Benefits	**7,334**	7,515	7,226
Other Operating Expenses	**3,140**	3,135	2,958
Operating Expenses	**10,474**	10,650	10,184
Operating Income	**$ 2,419**	$ 2,301	$ 2,077
Income from Continuing Operations	**$ 1,636**	$ 1,471	$ 1,379
Discontinued Operations, Net of Tax	**—**	26	6
Net Income Before Non-Controlling Interests	**$ 1,636**	$ 1,497	$ 1,385
Net Income Attributable to the Company	**$ 1,599**	$ 1,465	$ 1,357
Net Income from Continuing Operations Per Share:			
Basic	**$ 3.01**	$ 2.64	$ 2.46
Diluted	**$ 2.98**	$ 2.61	$ 2.42
Net Income Per Share Attributable to the Company:			
Basic	**$ 3.01**	$ 2.69	$ 2.47
Diluted	**$ 2.98**	$ 2.65	$ 2.43
Average number of shares outstanding:			
Basic	**531**	545	549
Diluted	**536**	553	558
Shares outstanding at December 31,	**522**	540	547

Consolidated operating income increased 5% to $2.4 billion in 2015 compared with $2.3 billion in 2014, reflecting the combined impact of a slight decrease in revenue and a 2% decrease in expenses as compared to the prior year. The Company achieved this growth despite significant foreign exchange headwinds, caused by the strengthened U.S. dollar, which had the effect of reducing the translated value of the Company's foreign earnings.

Diluted net income per share from continuing operations was $2.98, compared to $2.61 last year, reflecting a $160 million increase in net income as well as a 3% decrease in the average number of diluted shares outstanding as compared to the same period last year. Shares issued related to the vesting of share awards and exercise of employee stock options were more than offset by share repurchases over the past four quarters.

Risk and Insurance Services operating income increased $30 million or 2% in 2015 compared with 2014. Revenue decreased 1%, but increased 3% on an underlying basis, to $6.9 billion in 2015, reflecting underlying revenue growth of 3% at Marsh and 2% at Guy Carpenter, while expenses decreased 2%, but increased 2% on an underlying basis.

Consulting operating income increased $80 million or 8% to $1.1 billion in 2015 compared with 2014, reflecting flat revenue, but an increase of 5% on an underlying basis. Expense decreased 1%, but increased 4% on an underlying basis. Mercer and Oliver Wyman recorded underlying revenue growth of 4% and 7%, respectively, in 2015 as compared to 2014. The operating income and revenue in 2015 include a pre-tax gain of $37 million from the sale of Mercer's U.S. defined contribution recordkeeping business.

Consolidated operating income increased 11% to $2.3 billion in 2014 compared with $2.1 billion in 2013. This reflects the combined impact of a 6% increase in revenue and a 5% increase in expense.

Risk and Insurance Services operating income increased $88 million or 6% in 2014 compared with 2013. Revenue increased 5%, or 3% on an underlying basis, to $6.9 billion in 2014, reflecting underlying revenue growth of 4% at Marsh and 2% at Guy Carpenter, while expenses increased 5%, or 3% on an underlying basis.

Consulting operating income increased $151 million or 18% to $996 million in 2014 compared with 2013, reflecting a 6% increase in revenue and a 4% increase in expense. Mercer and Oliver Wyman recorded underlying revenue growth of 3% and 15%, respectively, in 2014 as compared to 2013.

The Company recorded expenses related to the early extinguishment of debt of $137 million in 2014 and $24 million in 2013.

Consolidated net income attributable to the Company was $1.6 billion in 2015, compared with $1.5 billion in 2014 and $1.4 billion in 2013.

Consolidated Revenue and Expense

Because the Company conducts business in many countries, foreign exchange rate movements may impact period-to-period comparisons of revenue. Similarly, the revenue impact of acquisitions and dispositions may affect period-to-period comparisons of revenue. Underlying revenue measures the change in revenue from one period to another by isolating these impacts. The impact of foreign currency exchange fluctuations, acquisitions and dispositions, including transfers among businesses and other items, on the Company's operating revenues is as follows:

	Year Ended December 31,		Components of Revenue Change*			
(In millions, except percentage figures)	**2015**	2014	% Change GAAP Revenue	Currency Impact	Acquisitions/ Dispositions Impact	Underlying Revenue
Risk and Insurance Services						
Marsh	**$ 5,727**	$ 5,753	—	(7)%	3 %	3%
Guy Carpenter	**1,121**	1,154	(3)%	(4)%	(1)%	2%
Subtotal	**6,848**	6,907	(1)%	(6)%	2 %	3%
Fiduciary Interest Income	**21**	24				
Total Risk and Insurance Services	**6,869**	6,931	(1)%	(6)%	2 %	3%
Consulting						
Mercer	**4,313**	4,350	(1)%	(7)%	2 %	4%
Oliver Wyman Group	**1,751**	1,709	3 %	(6)%	2 %	7%
Total Consulting	**6,064**	6,059	—	(7)%	2 %	5%
Corporate/Eliminations	**(40)**	(39)				
Total Revenue	**$ 12,893**	$ 12,951	—	(6)%	2 %	4%

* Components of revenue change may not add due to rounding.

The following table provides more detailed revenue information for certain of the components presented above:

	Year Ended December 31,		Components of Revenue Change*			
(In millions, except percentage figures)	**2015**	2014	% Change GAAP Revenue	Currency Impact	Acquisitions/ Dispositions Impact	Underlying Revenue
Marsh:						
EMEA	**$ 1,848**	$ 1,980	(7)%	(10)%	1 %	2%
Asia Pacific	**636**	683	(7)%	(10)%	1 %	2%
Latin America	**380**	413	(8)%	(18)%	2 %	8%
Total International	**2,864**	3,076	(7)%	(11)%	1 %	3%
U.S. / Canada	**2,863**	2,677	7 %	(1)%	5 %	3%
Total Marsh	**$ 5,727**	$ 5,753	—	(7)%	3 %	3%
Mercer:						
Health	**$ 1,558**	$ 1,553	—	(3)%	(2)%	6%
Retirement	**1,345**	1,375	(2)%	(7)%	5 %	—
Investments	**818**	836	(2)%	(12)%	2 %	7%
Talent	**592**	586	1 %	(7)%	3 %	5%
Total Mercer	**$ 4,313**	$ 4,350	(1)%	(7)%	2 %	4%

Underlying revenue measures the change in revenue using consistent currency exchange rates, excluding the impact of certain items that affect comparability such as: acquisitions, dispositions and transfers among businesses. The impact of a $37 million gain in 2015 from the disposal of Mercer's U.S. defined contribution recordkeeping business is included in acquisitions/dispositions in Mercer's Retirement business.

* Components of revenue change may not add due to rounding.

(In millions, except percentage figures)	Year Ended December 31, 2014	2013	% Change GAAP Revenue	Components of Revenue Change* Currency Impact	Acquisitions/ Dispositions Impact	Underlying Revenue
Risk and Insurance Services						
Marsh	$ 5,753	$ 5,438	6%	(1)%	3%	4%
Guy Carpenter	1,154	1,131	2%	—	1%	2%
Subtotal	6,907	6,569	5%	(1)%	3%	4%
Fiduciary Interest Income	24	27				
Total Risk and Insurance Services	6,931	6,596	5%	(1)%	3%	3%
Consulting						
Mercer	4,350	4,241	3%	(1)%	—	3%
Oliver Wyman Group	1,709	1,460	17%	—	2%	15%
Total Consulting	6,059	5,701	6%	(1)%	—	6%
Corporate /Eliminations	(39)	(36)				
Total Revenue	$ 12,951	$ 12,261	6%	(1)%	2%	5%

* Components of revenue change may not add due to rounding.

The following table provides more detailed revenue information for certain of the components presented above:

(In millions, except percentage figures)	Year Ended December 31, 2014	2013	% Change GAAP Revenue	Components of Revenue Change* Currency Impact	Acquisitions/ Dispositions Impact	Underlying Revenue
Marsh:						
EMEA	$ 1,980	$ 1,902	4 %	—	1%	3 %
Asia Pacific	683	659	4 %	(4)%	—	7 %
Latin America	413	392	5 %	(10)%	6%	10 %
Total International	3,076	2,953	4 %	(2)%	1%	5 %
U.S. / Canada	2,677	2,485	8 %	(1)%	6%	3 %
Total Marsh	$ 5,753	$ 5,438	6 %	(1)%	3%	4 %
Mercer:						
Health	$ 1,553	$ 1,511	3 %	(1)%	—	3 %
Retirement	1,375	1,344	2 %	—	—	2 %
Investments	836	780	7 %	(3)%	1%	9 %
Talent	586	606	(3)%	(2)%	—	(1)%
Total Mercer	$ 4,350	$ 4,241	3 %	(1)%	—	3 %

Underlying revenue measures the change in revenue using consistent currency exchange rates, excluding the impact of certain items that affect comparability such as: acquisitions, dispositions and transfers among businesses.

* Components of revenue change may not add due to rounding.

Revenue

Consolidated revenue was $12.9 billion in 2015, a slight decrease from last year, but an increase of 4% on an underlying basis. Revenue in the Risk and Insurance Services segment decreased 1% in 2015 compared with 2014, but increased 3% on an underlying basis. Revenue increased 3% and 2% on an underlying basis at Marsh and Guy Carpenter, respectively, as compared to 2014. The Consulting

segment's revenue was flat compared to 2014, but increased 5% on an underlying basis. Mercer and Oliver Wyman's revenue increased 4% and 7% on an underlying basis, respectively, compared to 2014.

Consolidated revenue of $13 billion in 2014 increased 6%, or 5% on an underlying basis, compared with $12.3 billion in 2013. Revenue in the Risk and Insurance Services segment increased 5% in 2014 compared with 2013, or 3% on an underlying basis, with underlying revenue growth of 4% at Marsh and 2% at Guy Carpenter. The Consulting segment's revenue increased 6% on both a reported and underlying basis. On an underlying basis, Mercer's revenue was up 3% in 2014 compared with 2013, while revenue of the Oliver Wyman Group increased 15%.

Operating Expense

Consolidated operating expenses decreased 2% in 2015 compared with the same period in 2014, but increased 3% on an underlying basis. The increase in underlying expenses primarily reflects higher base salary, bonus, and higher defined benefit and defined contribution plan costs ("retirement benefit costs"), partly offset by the impact of the net benefit from the termination of the Company's post-65 retiree medical reimbursement plan in the U.S. (the "RRA Plan").

Consolidated operating expenses increased 5% in 2014 compared with the same period in 2013 and 4% on an underlying basis. The increase in underlying expenses primarily reflects higher incentive compensation, facilities and software amortization costs, partly offset by lower pension costs.

Risk and Insurance Services

In the Risk and Insurance Services segment, the Company's subsidiaries and other affiliated entities act as brokers, agents or consultants for insureds, insurance underwriters and other brokers in the areas of risk management, insurance broking and insurance program management services, primarily under the name of Marsh; and engage in reinsurance broking, catastrophe and financial modeling services and related advisory functions, primarily under the name of Guy Carpenter.

Marsh and Guy Carpenter are compensated for brokerage and consulting services primarily through fees paid by clients and/or commissions paid out of premiums charged by insurance and reinsurance companies. Commission rates vary in amount depending upon the type of insurance or reinsurance coverage provided, the particular insurer or reinsurer, the capacity in which the broker acts and negotiations with clients. Revenues can be affected by premium rate levels in the insurance/reinsurance markets, the amount of risk retained by insurance and reinsurance clients themselves and by the value of the risks that have been insured since commission-based compensation is frequently related to the premiums paid by insureds/reinsureds. In many cases, fee compensation may be negotiated in advance, based on the type of risk, coverage required, and service provided by the Company and ultimately placed into the insurance market or retained by the client. The trends and comparisons of revenue from one period to the next can be affected by changes in premium rate levels, fluctuations in client risk retention, and increases or decreases in the value of risks that have been insured, as well as new and lost business, and the volume of business from new and existing clients.

Marsh also receives compensation from insurance companies. This compensation includes, among other things, payment for consulting and analytics services provided to insurers; administrative and other services provided to or on behalf of insurers (including services relating to the administration and management of quota share, panels and other facilities in which insurers participate); and contingent commissions. Marsh and Guy Carpenter receive interest income on certain funds (such as premiums and claims proceeds) held in a fiduciary capacity for others. The investment of fiduciary funds is regulated by state and other insurance authorities. These regulations typically require segregation of fiduciary funds and limit the types of investments that may be made with them. Interest income from these investments varies depending on the amount of funds invested and applicable interest rates, both of which vary from time to time. For presentation purposes, fiduciary interest is segregated from the other revenues of Marsh and Guy Carpenter and separately presented within the segment, as shown in the revenue by segments charts earlier in this MD&A.

The results of operations for the Risk and Insurance Services segment are presented below:

(In millions of dollars)	**2015**	2014	2013
Revenue	**$ 6,869**	$ 6,931	$ 6,596
Compensation and Benefits	**3,629**	3,781	3,618
Other Operating Expenses	**1,701**	1,641	1,557
Operating Expenses	**5,330**	5,422	5,175
Operating Income	**$ 1,539**	$ 1,509	$ 1,421
Operating Income Margin	**22.4%**	21.8%	21.5%

Revenue

Revenue in the Risk and Insurance Services segment decreased 1%, but increased 3% on an underlying basis, in 2015 compared with 2014.

In Marsh, revenue of $5.7 billion, was essentially flat on a reported basis in 2015 as compared to 2014, reflecting a 3% increase on an underlying basis and a 3% increase from acquisitions, offset by a 7% decrease resulting from the impact of foreign currency translation. The underlying revenue increase reflects growth in all major geographies. International operations had underlying revenue growth of 3% reflecting increases of 8% in Latin America, 2% in Asia Pacific and 2% in EMEA, while U.S./Canada increased 3%.

Guy Carpenter's revenue decreased 3% to $1.1 billion in 2015 compared with 2014, but increased 2% on an underlying basis.

Fiduciary interest income was $21 million in 2015 compared to $24 million in 2014 due to lower average invested funds combined with lower interest rates.

The Risk and Insurance Services segment completed thirteen acquisitions during 2015. Acquisition details can be found in Note 4 to the consolidated financial statements.

Revenue in the Risk and Insurance Services segment increased 5%, or 3% on an underlying basis, in 2014 compared with 2013.

In Marsh, revenue grew to $5.8 billion or 6% in 2014 as compared to 2013, reflecting a 4% increase on an underlying basis and a 3% increase from acquisitions, partly offset by a 1% decrease resulting from the impact of foreign currency translation. The underlying revenue increase reflects growth in all major geographies driven by strong new business, particularly in countries such as the U.S., Canada, and the U.K., as well as in Africa. International operations had underlying revenue growth of 5% reflecting increases of 10% in Latin America, 7% in Asia Pacific and 3% in EMEA, while U.S./Canada increased 3%.

Guy Carpenter's revenue increased 2% to $1.2 billion in 2014 compared with 2013 on both a reported and an underlying basis, reflecting growth across the U.S., U.K. Facultative, Asia and Global Specialties such as Aviation and Marine.

Fiduciary interest income was $24 million in 2014 compared to $27 million in 2013 due to lower average invested funds combined with lower interest rates.

The Risk and Insurance segment completed fifteen acquisitions during 2014.

Expense

Expenses in the Risk and Insurance Services segment decreased 2% on a reported basis, but increased 2% on an underlying basis, in 2015 compared with 2014. The impact of foreign currency translation reduced expenses by 7%, partly offset by a 3% increase related to acquisitions. The increase in underlying expenses reflects higher base salaries, incentive compensation and retirement benefit costs, higher amortization of intangible assets and charges for adjustments to acquisition-related contingent consideration liabilities, partly offset by the impact of the net benefit from the termination of the RRA plan.

Expenses in the Risk and Insurance Services segment increased 5% on a reported basis and 3% on an underlying basis in 2014 compared with 2013. The increase in expenses on an underlying basis is

primarily due to higher base salaries, incentive compensation, facilities and intangible asset amortization expenses, partly offset by lower defined benefit pension costs.

Consulting

The Company conducts business in its Consulting segment through two main business groups. Mercer provides consulting expertise, advice, services and solutions in the areas of health, retirement, talent and investments. Oliver Wyman Group provides specialized management, economic and brand consulting services.

The major component of revenue in the Consulting business is fees paid by clients for advice and services. Mercer, principally through its health line of business, also earns revenue in the form of commissions received from insurance companies for the placement of group (and occasionally individual) insurance contracts, primarily life, health and accident coverages. Revenue for Mercer's investment management business and certain of Mercer's defined contribution administration services consists principally of fees based on assets under management and/or administration.

Revenue in the Consulting segment is affected by, among other things, global economic conditions, including changes in clients' particular industries and markets. Revenue is also affected by competition due to the introduction of new products and services, broad trends in employee demographics, including levels of employment, the effect of government policies and regulations, and fluctuations in interest and foreign exchange rates. Revenues from the provision of investment management services and retirement trust and administrative services are significantly affected by the level of assets under management and securities market performance.

Reimbursable expenses incurred by professional staff in the generation of revenue and sub-advisory fees incurred by the majority of funds are included on a gross basis in the investment management business in revenue and the related expenses are included in other operating expenses.

The results of operations for the Consulting segment are presented below:

(In millions of dollars)	**2015**	2014	2013
Revenue	**$ 6,064**	$ 6,059	$ 5,701
Compensation and Benefits	**3,354**	3,398	3,269
Other Operating Expenses	**1,635**	1,665	1,587
Operating Expenses	**4,989**	5,063	4,856
Operating Income	**$ 1,075**	$ 996	$ 845
Operating Income Margin	**17.7%**	16.4%	14.8%

Revenue

Consulting revenue in 2015, was essentially flat compared to 2014, reflecting a 5% increase on an underlying basis and a 2% increase related to acquisitions, offset by a 7% decrease from the impact of foreign currency translation. Mercer's revenue was $4.3 billion in 2015, a decrease of 1%, but an increase of 4% on an underlying basis. The year over year revenue change also reflects an increase of 2% from acquisitions/dispositions, offset by a decrease of 7% from the impact of foreign currency translation. Mercer's revenue includes a $37 million gain from the disposal of its U.S. defined contribution recordkeeping business, and is reflected in the 2% impact from acquisitions/dispositions. The underlying revenue growth reflects an increase in Investments of 7%, Health of 6% and Talent of 5%, while Retirement remained flat. Oliver Wyman's revenue increased 3% in 2015 compared to 2014, reflecting an increase of 7% on an underlying basis and a 2% increase from acquisitions, partly offset by a decrease of 6% from the impact of foreign currency translation.

The Consulting segment completed eight acquisitions during 2015. Acquisition details can be found in Note 4 to the consolidated financial statements.

Consulting revenue in 2014 increased 6% on both a reported and underlying basis as compared to 2013. Mercer's revenue was $4.4 billion in 2014, an increase of 3% on both a reported and underlying basis, partly offset by a 1% decrease due to the impact of foreign currency translation. The underlying revenue growth reflects an increase in Investments of 9%, Health of 3% and Retirement of 2%, partly offset by a

decrease in Talent of 1%. Oliver Wyman's revenue increased 17% in 2014 compared to 2013, or 15% on an underlying basis, as all industry sectors contributed to this growth. On a geographic basis, the revenue growth was attributable to both North America and Europe.

The Consulting segment completed six acquisitions during 2014.

During 2014, Mercer acquired a 34% stake in South Africa-based Alexander Forbes Group Holding Limited ("Alexander Forbes"). The Company's investment in Alexander Forbes is accounted for using the equity method of accounting and is included in other assets in the consolidated balance sheets.

Expense

Consulting expenses in 2015 decreased 1%, reflecting increases of 4% in underlying expenses and 1% related to acquisitions, partly offset by a 6% decrease from the impact of foreign currency translation. The increase in underlying expenses reflects the impact of higher base salaries and incentive compensation costs and higher retirement benefit costs, partly offset by the impact of the net benefit from the termination of the RRA plan.

Consulting expenses in 2014 increased 4% on both a reported and underlying basis compared to 2013. This increase reflects the impact of higher incentive compensation costs, partly offset by lower defined benefit pension costs.

Corporate and Other

Corporate expenses in 2015 were $195 million compared to $204 million in 2014. The lower expenses in 2015 were primarily due to the cost of non-recurring corporate initiatives which occurred in 2014, discussed in more detail below.

Corporate expenses in 2014 were $204 million compared to $190 million in 2013. The increase is primarily due to corporate initiatives, which include strengthening cyber security protections, expenses related to strategic investments and corporate transformation efforts, primarily within the HR and Finance functions.

Discontinued Operations

As part of the disposal transactions for Putnam and Kroll, the Company provided certain indemnities, primarily related to pre-transaction tax uncertainties and legal contingencies. In accordance with applicable accounting guidance, liabilities were established related to these indemnities at the time of the sales and reflected as a reduction of the gain on disposal. Discontinued operations includes charges or credits resulting from the settlement or resolution of the indemnified matters, as well as adjustments to the liabilities related to such matters.

On December 31, 2014, an agreement was reached between Putnam and the Massachusetts Department of Revenue ("DOR") regarding a tax dispute, which was covered under the indemnity agreement discussed above. The December 2014 agreement was subject to certain approvals, which included the State Attorney General and the Commissioner of the DOR. In January 2015, all necessary approvals were received, the agreement was executed and the tax was paid. Concurrently, Putnam and the Company executed a settlement agreement to resolve all remaining matters under the indemnity agreement. The Company recorded a gain, net of federal tax, of approximately $28 million in 2014 related to the settlement with Putnam.

Discontinued operations in 2013 includes estimated costs covered under the indemnity related to the Kroll sale as well as tax indemnities related to the Putnam sale.

Summarized Statements of Income data for discontinued operations are as follows:

For the Years Ended December 31, *(In millions of dollars, except per share figures)*	**2015**	2014	2013
Income (loss) from discontinued operations, net of tax	$ —	$ —	$ —
Disposals of discontinued operations	**(5)**	42	(4)
Income tax (credit) expense	**(5)**	16	(10)
Disposals of discontinued operations, net of tax	—	26	6
Discontinued operations, net of tax	$ —	$ 26	$ 6
Discontinued operations, net of tax per share			
—Basic	$ —	$ 0.05	$ 0.01
—Diluted	$ —	$ 0.04	$ 0.01

Other Corporate Items

Interest

Interest income earned on corporate funds amounted to $13 million in 2015 compared with $21 million in 2014, primarily due to a lower level of invested funds in 2015. Interest expense was $163 million in 2015 compared with $165 million in 2014, due to lower average interest rates in 2015 compared with the prior year, partly offset by higher average debt outstanding during 2015.

Interest income earned on corporate funds amounted to $21 million in 2014 compared with $18 million in 2013. The increase in interest income is due to a higher level of invested funds, partly offset by lower effective interest rates. Interest expense was $165 million in 2014 compared with $167 million in 2013.

Cost of Extinguishment of Debt

In October 2014, the Company redeemed $230 million of its 2015 notes and $400 million of its 2019 notes. The Company acquired the notes at market value plus a make-whole premium based on the terms of the original indenture, which exceeded the carrying value of the notes and resulted in a cost of $137 million in the fourth quarter of 2014.

In October 2013, the Company redeemed $250 million of its 2015 notes. The Company acquired the notes at market value plus a make-whole premium based on the terms of the original indenture, which exceeded the carrying value of the notes and resulted in a cost of approximately $24 million in the fourth quarter of 2013.

Investment Income

The caption "Investment income (loss)" in the consolidated statements of income comprises realized and unrealized gains and losses from investments recognized in current earnings. It includes, when applicable, other-than-temporary declines in the value of debt and available-for-sale securities and equity method gains or losses on its investment in private equity funds. The Company's investments may include direct investments in insurance or consulting companies and investments in private equity funds. The Company recorded net investment income of $38 million and $37 million in 2015 and 2014, respectively, primarily related to the general partner carried interest from Trident III. Stonepoint Capital, the investment manager of Trident III, harvested the remaining two investments of Trident III during the third quarter of 2015, which resulted in the Company recognizing its remaining deferred performance fees.

Income Taxes

The Company's consolidated effective tax rate was 29.1%, 28.5% and 30.1% in 2015, 2014 and 2013, respectively. The tax rate in each year reflects foreign operations which are taxed at rates lower than the U.S. statutory tax rate. The lower effective tax rate attributed to the Company's foreign operations primarily reflects lower corporate tax rates that prevail outside of the U.S., net of the U.S. tax impact from repatriating foreign earnings. In 2015, pre-tax income in the U.K., Canada, Australia, Germany, Bermuda and Ireland accounted for approximately 60% of the Company's total non-U.S. pre-tax income, with effective rates in those countries of 22% (excluding the non-cash deferred tax impact of U.K. tax

legislation enacted in 2015), 27%, 30%, 31%, 1% and 12%, respectively. Under current U.S. tax law, the Company anticipates its non-U.S. operations will continue to incur taxes at rates below the U.S. federal tax rate of 35%. The Company's U.S. revenue over the past three years has been approximately 46% of total revenue, while over that period the pre-tax income from U.S. locations varied from 15% to 30% of total pre-tax income.

As a U.S.-domiciled parent holding company, Marsh & McLennan Companies, Inc. is the issuer of essentially all of the Company's external indebtedness, and incurs the related interest expense in the U.S. Further, most senior executive and oversight functions are conducted in the U.S. and the associated costs are incurred primarily in the United States.

The effective tax rate may vary significantly from period to period for the foreseeable future. It is sensitive to the geographic mix and repatriation of the Company's earnings, which may result in higher or lower tax rates. A proportional increase in U.S. pre-tax income will tend to increase the effective tax rate because U.S. federal and state corporate tax rates exceed tax rates applicable outside the U.S. Losses in certain jurisdictions cannot be offset by earnings from other operations, and may require valuation allowances that affect the rate, depending on estimates of the realizability of associated deferred tax assets. The effective tax rate is also sensitive to changes in unrecognized tax benefits, including the impact of settled tax audits and expired statutes of limitation.

The realization of deferred tax assets depends on generating future taxable income during the periods in which the tax benefits are deductible or creditable. Tax liabilities are determined and assessed jurisdictionally by legal entity or filing group. Certain taxing jurisdictions allow or require combined or consolidated tax filings. The Company assessed the realizability of its deferred tax assets and considered all available evidence, including the existence of a recent history of losses, placing particular weight on evidence that could be objectively verified. A valuation allowance was recorded to reduce deferred tax assets to the amount that the Company believes is more likely than not to be realized.

Changes in tax laws or tax rulings in any of the jurisdictions in which we operate could have a significant adverse impact on our effective tax rate.

Liquidity and Capital Resources

The Company is organized as a holding company, a legal entity separate and distinct from its operating subsidiaries. As a holding company without significant operations of its own, the Company is dependent upon dividends and other payments from its operating subsidiaries to meet its obligations for paying principal and interest on outstanding debt obligations, for paying dividends to stockholders, for share repurchases and for corporate expenses. We also provide financial support to our operating subsidiaries for acquisitions, investments and certain parts of their business that require liquidity, such as the capital markets raising business of Guy Carpenter. Other sources of liquidity include borrowing facilities discussed below in financing cash flows.

The Company derives a significant portion of its revenue and operating profit from operating subsidiaries located outside of the United States. Funds from the Company's operating subsidiaries located outside of the United States are regularly repatriated to the United States out of annual earnings. At December 31, 2015, the Company had approximately $800 million of cash and cash equivalents in its foreign operations, substantially all of which is considered to be permanently invested in those operations to fund foreign investments and working capital needs. At the current time, the Company does not intend to repatriate any of this cash. The non-U.S. cash and cash equivalents considered permanently reinvested includes $191 million of operating funds required to be maintained for regulatory requirements or as collateral under certain captive insurance arrangements. The Company expects to continue its practice of repatriating foreign funds out of current annual earnings. While management does not foresee a need to repatriate the funds which are currently deemed permanently invested, if facts or circumstances change, management could elect to repatriate them, if necessary, which could result in higher effective tax rates in the future. During 2015, the Company recorded foreign currency translation adjustments which reduced net equity by $643 million. Continued strengthening of the U.S. dollar against foreign currencies would further reduce the translated U.S. dollar value of the Company's net investments in its non-U.S. subsidiaries, as well as the translated U.S. dollar value of cash repatriations from those subsidiaries.

Cash on our consolidated balance sheets includes funds available for general corporate purposes. Funds held on behalf of clients in a fiduciary capacity are segregated and shown separately in the consolidated balance sheets as an offset to fiduciary liabilities. Fiduciary funds cannot be used for general corporate purposes, and should not be considered as a source of liquidity for the Company.

Operating Cash Flows

The Company generated $1.9 billion of cash from operations in 2015, compared with $2.1 billion in 2014. These amounts reflect the net income reported by the Company during those periods, excluding gains or losses from investments, cost of extinguishment of debt and the disposition of businesses, adjusted for non-cash charges such as depreciation and amortization and changes in working capital which relate, primarily, to the timing of payments for accrued liabilities or receipts of assets.

Pension-Related Items

During 2015, the Company contributed $29 million to its U.S. pension plans and $166 million to non-U.S. pension plans. In 2014, the Company contributed $25 million to U.S. plans and $156 million to non-U.S. plans.

In the U.S., contributions to the tax-qualified defined benefit plans are based on ERISA guidelines and the Company generally expects to maintain a funded status of 80% or more of the liability determined under the ERISA guidelines. The pension stabilization provisions included in the "Moving Ahead for Progress in the 21st Century Act", enacted on July 6, 2012, changed the methodology for determining the discount rate used for calculating plan liabilities under ERISA, which determines, in part, the funding requirements. After considering the impact of the pension funding stabilization provisions discussed above, there was no ERISA funding requirement for the U.S. qualified plan in 2015. The Company made a $0.2 million contribution to its tax-qualified U.S. pension plan in the first quarter of 2014. There currently is no ERISA funding requirement for the U.S. qualified plan for 2016. The Company expects to fund approximately $26 million to its non-qualified U.S. pension plans in 2016.

The Company continues to manage the cost and assess the competitiveness of its benefits programs, and also to manage the risks related to its defined benefit pension plan liabilities. Effective September 1, 2015, the Company divided its U.S. qualified defined benefit plan. The existing plan was amended to cover only the retirees currently receiving benefits and terminated vested participants as of August 1, 2015. The Company's active participants as of that date were transferred into a newly established, legally separate qualified defined benefit plan. The benefits provided to the plans' participants were unchanged. As a result of the plan amendment and establishment of the new plan, the Company re-measured the assets and liabilities of the two plans, as required under U.S. GAAP, based on assumptions and market conditions at the amendment date. Net periodic pension expense in 2015 includes the weighted average costs of the December 31, 2014 measurement and the September 1, 2015 re-measurement.

Effective August 1, 2015, the Company amended its Ireland defined benefit pension plans to close those plans to future benefit accruals and replaced those plans with a defined contribution arrangement. The Company re-measured the assets and liabilities of the plans, based on assumptions and market conditions on the amendment date.

The Company has a large number of non-U.S. defined benefit pension plans, the largest of which are in the U.K., which comprise approximately 83% of non-U.S. plan assets. Contribution rates for non-U.S. plans are generally based on local funding practices and statutory requirements, which may differ significantly from measurements under U.S. GAAP. In the U.K., contributions to defined benefit pension plans are determined through a negotiation process between the Company and the plans' trustee that typically occurs every three years in conjunction with the actuarial valuation of the plans. This process is governed by U.K. pension regulations. The assumptions that result from the funding negotiations are different from those used for U.S. GAAP and currently result in a lower funded status than under U.S. GAAP. In March 2014, the Company and the Trustee of the U.K. Defined Benefits Plans agreed to a funding deficit recovery plan for the U.K. defined benefit pension plans. The current agreement with the Trustee sets out the annual deficit contributions which would be due based on the deficit at December 31, 2012. The funding level is subject to re-assessment, in most cases on November 1st of each year. If the funding level on November 1st is sufficient, no deficit funding contributions will be required in the following year, and the contribution amount will be deferred. As part of a long-term strategy, which depends on

having greater influence over asset allocation and overall investment decisions, the Company has agreed to support annual deficit contributions by the U.K. operating companies under certain circumstances, up to GBP 450 million over a seven-year period ("contingent guarantee agreement").

The Company contributed $51 million to the U.K. plans in 2015. The U.K. employers also contribute an expense allowance each year of approximately $9 million. Based on the funding test carried out at November 1, 2015, the Company contributions to the U.K. plans in 2016 are expected to be approximately $100 million, including the expense allowance.

In the aggregate, the Company expects to contribute approximately $191 million to its non-U.S. defined benefit plans in 2016, comprising approximately $91 million to plans outside of the U.K. and $100 million to the U.K. plans.

Funding amounts may be influenced by future asset performance, the level of discount rates and other variables impacting the funded status of the plan.

After completion of a consultation period with affected colleagues, in January 2014, the Company amended its U.K. defined benefit pension plans to close those plans to future benefit accruals effective August 1, 2014 and replaced those plans, along with its existing defined contribution plans, with a new, comprehensive defined contribution arrangement. This change resulted in a curtailment of the U.K. defined benefit plans, and as required under GAAP, the Company re-measured the defined benefit plans' assets and liabilities at the amendment date, based on assumptions and market conditions at that date. The Company recognized a curtailment gain of $65 million in the first quarter of 2014, primarily resulting from the recognition of the remaining unamortized prior service credit related to a plan amendment made in December 2012. This gain was mostly offset by the cost of a transition benefit to certain employees most impacted by the amendment.

The year-over-year change in the funded status of the Company's pension plans is impacted by the difference between actual and assumed results, particularly with regard to return on assets, and changes in the discount rate, as well as the amount of Company contributions, if any. Unrecognized actuarial losses were approximately $1.8 billion and $2.9 billion at December 31, 2015 for the U.S. plans and non-U.S. plans, respectively, compared with $1.7 billion and $3.2 billion at December 31, 2014. The increase in the U.S. was due to the increase in the discount rate, partially offset by negative returns on plan assets. The decrease in the non-U.S. plans was primarily due to the impact of increases in the discount rates and actual returns on plan assets in 2015 that were lower than the estimated long-term rate of return on plan assets. In the past several years, the amount of actuarial losses has been significantly impacted, both positively and negatively, by actual asset performance and changes in discount rates. The discount rate used to measure plan liabilities increased in both the U.S. and the U.K. (the Company's largest plans) in 2015 after decreasing in 2014. The discount rate increased in 2013 following decreases in each of the four years from 2009 to 2012. An increase in the discount rate decreases the measured plan benefit obligation, resulting in actuarial gains, while a decrease in the discount rate increases the measured plan obligation, resulting in actuarial losses. During 2015, the Company's defined benefit pension plan assets had a loss of 3.9% in the U.S. and gain of 1.2% in the U.K. During 2014, the Company's defined benefit pension plan assets had actual returns of 9.8% and 19.4% in the U.S. and U.K., respectively, and in 2013, actual returns of 12.6%, and 8.6% in the U.S. and U.K., respectively.

Overall, based on the measurement at December 31, 2015, expenses related to the Company's defined benefit pension plans are expected to decrease in 2016 by approximately $165 million from the 2015 expenses of $82 million. This is driven by expense decreases of approximately $80 million in U.S. plans and $85 million in non-U.S. plans. The expense decrease in the U.S. plans results primarily from an increase in the discount rates used to measure plan liabilities and costs and the impact of an increase in the length of the period over which actuarial gains and losses are amortized, moving to average life expectancy for a U.S. plan that has substantially all inactive members. The decrease in the Company's non-U.S. defined benefit plans is due to generally higher discount rates used to measure plan liabilities and costs, the impact of the amortization period for actuarial gains and losses moving to average life expectancy for plans in Ireland that were frozen and have substantially all inactive members, and a change in how the Company estimates the service and interest cost components of net periodic benefit costs (described in more detail below), partly offset by lower estimated returns to be earned on plan assets.

Historically, service and interest costs were estimated using a single weighted average discount rate derived from the yield curves used to measure the benefit obligations at the beginning of the period. For 2016, the Company has changed the approach used to estimate the service and interest cost components of net periodic benefit cost for its significant non-U.S. plans. This change in approach was made to improve the correlation between the projected benefit cash flows and the corresponding yield curve spot rates and to provide a more precise measurement of service and interest costs. The change does not impact the measurement of the plans' total projected benefit obligation. The Company has accounted for this change as a change in estimate, that will be applied prospectively beginning in 2016. As a result of this change, service and interest cost in 2016 are expected to be approximately $45 million lower than if the prior approach were used in 2016. This amount is included in the $85 million decrease for non-U.S. plans described above.

The Company's accounting policies for its defined benefit pension plans, including the selection of and sensitivity to assumptions, are discussed below under Management's Discussion of Critical Accounting Policies. For additional information regarding the Company's retirement plans, see Note 8 to the consolidated financial statements.

In March 2015, the Company amended its U.S. Post-65 retiree medical reimbursement plan (the "RRA plan"), resulting in its termination, with benefits to certain participants to be paid through December 31, 2016. As a result of the termination of the RRA plan, the Company recognized a net credit of approximately $125 million in the first quarter of 2015.

Financing Cash Flows

Net cash used for financing activities was $906 million in 2015 compared with $968 million used in 2014.

Debt

The Company increased outstanding debt by approximately $1.0 billion in 2015 and $426 million in 2014.

In September 2015, the Company issued $600 million of 3.75% 10.5-year senior notes. The Company used the net proceeds for general corporate purposes.

In March 2015, the Company issued $500 million of 2.35% five-year senior notes. The Company used the net proceeds for general corporate purposes.

In September 2014, the Company issued $300 million of 2.35% five-year senior notes and $500 million of 3.50% 10.5-year senior notes. In October 2014, a significant portion of the net proceeds of this offering was used to redeem $630 million of debt, including $230 million of 5.75% senior notes due in September 2015 and $400 million of 9.25% senior notes due in 2019. Total cash outflow related to this transaction was approximately $765 million, including a $137 million cost for early redemption, which was reflected as a charge in the consolidated statements of income in the fourth quarter of 2014.

During the second quarter of 2014, the Company issued $600 million of 3.5% ten-year senior notes. The net proceeds of this offering were used for general corporate purposes, including the repayment of $320 million of 5.375% senior notes that matured in July 2014.

In September 2013, the Company issued $250 million of 2.55% five-year senior notes and $250 million of 4.05% ten-year senior notes. The net proceeds of this offering were used for general corporate purposes, which included a partial redemption of $250 million of the outstanding principal amount of the existing 5.75% senior notes due 2015. The redemption settled in October 2013 with a total cash outflow of approximately $275 million, including a $24 million cost for early redemption.

Acquisitions

During 2015, the Company paid $47 million of contingent payments related to acquisitions made in prior years. These payments are split between financing and operating cash flows in the consolidated statements of cash flows. The portion of these payments that is reflected as a financing activity is $13 million, which represents payments related to the contingent consideration liability that was recorded on the date of acquisition. Payments related to increases in the contingent consideration liability subsequent to the date of acquisition, which were $34 million in 2015, are reflected as operating cash flows. Remaining estimated future contingent consideration payments of $309 million for acquisitions completed

in 2015 and in prior years are included in accounts payable and accrued liabilities or other liabilities in the consolidated balance sheet at December 31, 2015. The Company paid deferred purchase consideration related to prior years' acquisitions of $36 million, $25 million and $15 million for the years ended December 31, 2015, 2014 and 2013, respectively. Remaining deferred cash payments of approximately $143 million are included in accounts payable and accrued liabilities or other liabilities in the consolidated balance sheet at December 31, 2015.

In 2014, the Company paid $42 million of contingent payments related to acquisitions made in prior periods, of which $30 million was reported as financing cash flows and $12 million as operating cash flows. In 2013, the Company made $17 million of contingent payments related to acquisitions made in prior periods.

Credit Facilities

On November 24, 2015, the Company and certain of its subsidiaries amended its $1.2 billion facility, discussed below, into a new $1.5 billion multi-currency five-year unsecured revolving credit facility. The interest rate on this facility is based on LIBOR plus a fixed margin which varies with the Company's credit ratings. This facility expires in November 2020 and requires the Company to maintain certain coverage and leverage ratios which are tested quarterly. There were no borrowings outstanding under this facility at December 31, 2015.

The Company and certain of its subsidiaries previously maintained a $1.2 billion multi-currency five-year revolving credit facility. The facility was previously due to expire in March 2019 and was in effect until November 2015. There were no borrowings outstanding under this facility at the time it was amended.

The Company has a $150 million uncommitted bank credit line. There were no borrowings under this facility at December 31, 2015.

In December 2012, the Company closed on a $50 million, three-year delayed draw term loan facility. The interest rate on this facility was based on LIBOR plus an agreed fixed margin which varied with the Company's credit ratings. The loan was repaid and the facility was terminated on October 30, 2015.

The Company's senior debt is currently rated A- by Standard & Poor's and Baa1 by Moody's. The Company's short-term debt is currently rated A-2 by Standard & Poor's and P-2 by Moody's. The Company carries a stable outlook from both firms.

The Company also maintains other credit facilities, guarantees and letters of credit with various banks, primarily related to operations located outside the United States, aggregating $229 million at December 31, 2015 and $260 million at December 31, 2014. There was $0.4 million outstanding borrowings under these facilities at December 31, 2015 and $0.6 million outstanding borrowings under these facilities at December 31, 2014.

Share Repurchases

In May 2015, the Board of Directors renewed the Company's share repurchase program, allowing management to buy back up to $2 billion of shares going forward. During 2015, the Company repurchased 24.8 million shares of its common stock for total consideration of $1.4 billion at an average price per share of $56.46. As of December 31, 2015, the Company remained authorized to purchase additional shares of its common stock up to a value of approximately $1.2 billion. There is no time limit on this authorization. During 2014, the Company repurchased 15.5 million shares of its common stock for total consideration of $800 million at an average price per share of $51.44.

Dividends

The Company paid total dividends of $632 million in 2015 ($1.18 per share), $582 million in 2014 ($1.06 per share) and $533 million in 2013 ($0.96 per share).

Investing Cash Flows

Net cash used for investing activities amounted to $1.3 billion in 2015 compared with $1.2 billion used for investing activities in 2014.

The Company made 21 acquisitions in 2015. Cash used for these acquisitions, net of cash acquired, was $952 million.

On June 23, 2014, Mercer acquired 34% of the common shares of South Africa-based Alexander Forbes Group Holdings Limited ("Alexander Forbes"). Mercer purchased its stake in Alexander Forbes in two tranches at 7.50 South African Rand per share at an aggregate purchase price of approximately $300 million. The investment in Alexander Forbes is accounted for using the equity method and is included in other assets in the consolidated balance sheets.

The Company made 21 acquisitions in 2014. Cash used for these acquisitions, net of cash acquired, was $554 million.

The Company received proceeds from distributions on its Investment in Trident II of $100 million in 2013. Trident II fully harvested all its portfolio investments and made final distributions to partners during the fourth quarter of 2013.

The Company's additions to fixed assets and capitalized software, which amounted to $325 million in 2015 and $368 million in 2014, primarily relate to computer equipment purchases, the refurbishing and modernizing of office facilities and software development costs.

On February 24, 2015, Mercer purchased shares of common stock of Benefitfocus (NASDAQ:BNFT) constituting approximately 9.9% of BNFT's outstanding capital stock as of the acquisition date. The purchase price for the BNFT shares and certain other rights and other consideration was approximately $75 million.

The Company has commitments for potential future investments of approximately $54 million in four private equity funds that invest primarily in financial services companies.

Commitments and Obligations

The following sets forth the Company's future contractual obligations by the types identified in the table below as of December 31, 2015:

	Payment due by Period				
Contractual Obligations *(In millions of dollars)*	Total	Within 1 Year	1-3 Years	4-5 Years	After 5 Years
Current portion of long-term debt	$ 12	$ 12	$ —	$ —	$ —
Long-term debt	4,433	—	525	827	3,081
Interest on long-term debt	1,496	166	321	289	720
Net operating leases	2,149	325	566	416	842
Service agreements	284	172	101	9	2
Other long-term obligations	508	143	310	50	5
Purchase commitments	13	13	—	—	—
Total	$ 8,895	$ 831	$ 1,823	$ 1,591	$ 4,650

The above does not include the liability for unrecognized tax benefits of $74 million as the Company is unable to reasonably predict the timing of settlement of these liabilities, other than approximately $3 million that may become payable during 2016. The above does not include the indemnified liabilities discussed in Note 15 as the Company is unable to reasonably predict the timing of settlement of these liabilities. The above does not include net pension liabilities of approximately $1.9 billion because the timing and amount of ultimate payment of such liability is dependent upon future events, including, but not limited to, future returns on plan assets and changes in the discount rate used to measure the liabilities. The amounts of estimated future benefits payments to be made from pension plan assets are disclosed in Note 8 to the consolidated financial statements. In 2016, the Company expects to contribute approximately $26 million and $191 million to its U.S. and non-U.S. pension plans, respectively.

Management's Discussion of Critical Accounting Policies

The preparation of financial statements in conformity with accounting principles generally accepted in the United States ("GAAP") requires management to make estimates and judgments that affect reported amounts of assets, liabilities, revenue and expenses, and disclosure of contingent assets and liabilities. Management considers the policies discussed below to be critical to understanding the Company's financial statements because their application places the most significant demands on management's judgment, and requires management to make estimates about the effect of matters that are inherently uncertain. Actual results may differ from those estimates.

Legal and Other Loss Contingencies

The Company and its subsidiaries are subject to numerous claims, lawsuits and proceedings including claims for errors and omissions ("E&O"). GAAP requires that a liability be recorded when a loss is both probable and reasonably estimable. Significant management judgment is required to apply this guidance. The Company utilizes case level reviews by inside and outside counsel, an internal actuarial analysis and other analyses to estimate potential losses. The liability is reviewed quarterly and adjusted as developments warrant. In many cases, the Company has not recorded a liability, other than for legal fees to defend the claim, because we are unable, at the present time, to make a determination that a loss is both probable and reasonably estimable. Given the unpredictability of E&O claims and of litigation that could flow from them, it is possible that an adverse outcome in a particular matter could have a material adverse effect on the Company's businesses, results of operations, financial condition or cash flow in a given quarterly or annual period.

In addition, to the extent that insurance coverage is available, significant management judgment is required to determine the amount of recoveries that are probable of collection under the Company's various insurance programs.

Retirement Benefits

The Company maintains qualified and non-qualified defined benefit pension and defined contribution plans for its eligible U.S. employees and a variety of defined benefit and defined contribution plans for its eligible non-U.S. employees. The Company's policy for funding its tax-qualified defined benefit retirement plans is to contribute amounts at least sufficient to meet the funding requirements set forth in U.S. and applicable foreign laws.

The Company recognizes the funded status of its over-funded defined benefit pension and retiree medical plans as a net benefit plan asset and its unfunded and underfunded plans as a net benefit plan liability. The gains or losses and prior service costs or credits that have not been recognized as components of net periodic costs are recorded as a component of Accumulated Other Comprehensive Income ("AOCI"), net of tax, in the Company's consolidated balance sheets. The gains and losses that exceed specified corridors are amortized prospectively out of AOCI over a period that approximates the average remaining service period of active employees, or for plans in which substantially all the participants are inactive, over the remaining life expectancy of the inactive employees.

The determination of net periodic pension cost is based on a number of assumptions, including an expected long-term rate of return on plan assets, the discount rate, mortality and assumed rate of salary increase. Significant assumptions used in the calculation of net periodic pension costs and pension liabilities are disclosed in Note 8 to the consolidated financial statements. The Company believes the assumptions for each plan are reasonable and appropriate and will continue to evaluate assumptions at least annually and adjust them as appropriate.

Future pension expense or credits will depend on plan provisions, future investment performance, future assumptions and various other factors related to the populations participating in the pension plans. Holding all other assumptions constant, a half-percentage point change in the rate of return on plan assets and discount rate assumptions would affect net periodic pension cost for the U.S. and U.K. plans, which together comprise approximately 86% of total pension plan liabilities, as follows:

	0.5 Percentage Point Increase		0.5 Percentage Point Decrease	
(In millions of dollars)	U.S.	U.K.	U.S.	U.K.
Assumed Rate of Return on Plan Assets	$ (22)	$ (40)	$ 22	$ 40
Discount Rate	$ (26)	$ (7)	$ 29	$ 6

Changing the discount rate and leaving the other assumptions constant may not be representative of the impact on expense, because the long-term rates of inflation and salary increases are often correlated with the discount rate. Changes in these assumptions will not necessarily have a linear impact on the net periodic pension cost.

The Company contributes to certain health care and life insurance benefits provided to its retired employees. The cost of these post-retirement benefits for employees in the U.S. is accrued during the period up to the date employees are eligible to retire, but is funded by the Company as incurred. The key assumptions and sensitivity to changes in the assumed health care cost trend rate are discussed in Note 8 to the consolidated financial statements.

Income Taxes

The Company's tax rate reflects its income, statutory tax rates and tax planning in the various jurisdictions in which it operates. Significant judgment is required in determining the annual effective tax rate and in evaluating uncertain tax positions. The Company reports a liability for unrecognized tax benefits resulting from uncertain tax positions taken or expected to be taken in a tax return. The evaluation of a tax position is a two-step process. The first step involves recognition. The Company determines whether it is more likely than not that a tax position will be sustained upon tax examination, including resolution of any related appeals or litigation, based on only the technical merits of the position. The technical merits of a tax position derive from both statutory and judicial authority (legislation and statutes, legislative intent, regulations, rulings, and case law) and their applicability to the facts and circumstances of the tax position. If a tax position does not meet the more likely than not recognition threshold, the benefit of that position is not recognized in the financial statements. The second step is measurement. A tax position that meets the more likely than not recognition threshold is measured to determine the amount of benefit to recognize in the financial statements. The tax position is measured as the largest amount of benefit that is greater than 50 percent likely of being realized upon ultimate resolution with a taxing authority.

Uncertain tax positions are evaluated based upon the facts and circumstances that exist at each reporting period and involve significant management judgment. Subsequent changes in judgment based upon new information may lead to changes in recognition, derecognition, and measurement. Adjustments may result, for example, upon resolution of an issue with the taxing authorities, or expiration of a statute of limitations barring an assessment for an issue.

Tax law requires items be included in the Company's tax returns at different times than the items are reflected in the financial statements. As a result, the annual tax expense reflected in the consolidated statements of income is different than that reported in the tax returns. Some of these differences are permanent, such as expenses that are not deductible in the returns, and some differences are temporary and reverse over time, such as depreciation expense. Temporary differences create deferred tax assets and liabilities. Deferred tax liabilities generally represent tax expense recognized in the financial statements for which payment has been deferred, or expense for which a deduction has been taken already in the tax return but the expense has not yet been recognized in the financial statements. Deferred tax assets generally represent items that can be used as a tax deduction or credit in tax returns in future years for which a benefit has already been recorded in the financial statements. In assessing the need for and amount of a valuation allowance for deferred tax assets, the Company considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized and adjusts

the valuation allowance accordingly. The Company evaluates all significant available positive and negative evidence, including the existence of losses in recent years and its forecast of future taxable income by jurisdiction, in assessing the need for a valuation allowance. The Company also considers tax planning strategies that would result in realization of deferred tax assets, and the presence of taxable income in prior period tax filings in jurisdictions that allow for the carryback of tax attributes pursuant to the applicable tax law. The underlying assumptions the Company uses in forecasting future taxable income require significant judgment and take into account the Company's recent performance. The ultimate realization of deferred tax assets is dependent on the generation of future taxable income during the periods in which temporary differences or carry-forwards are deductible or creditable. Valuation allowances are established for deferred tax assets when it is estimated that it is more likely than not that future taxable income will be insufficient to fully use a deduction or credit in that jurisdiction.

Fair Value Determinations

Goodwill Impairment Testing—The Company is required to assess goodwill and any indefinite-lived intangible assets for impairment annually, or more frequently if circumstances indicate impairment may have occurred. The Company performs the annual impairment test for each of its reporting units during the third quarter of each year. In accordance with applicable accounting guidance, the Company assesses qualitative factors to determine whether it is necessary to perform the two-step goodwill impairment test. The Company considered numerous factors, which included that the fair value of each reporting unit exceeded its carrying value by a substantial margin in its most recent estimate of reporting unit fair values, whether significant acquisitions or dispositions occurred which might alter the fair value of its reporting units, macroeconomic conditions and their potential impact on reporting unit fair values, actual performance compared with budget and prior projections used in its estimation of reporting unit fair values, industry and market conditions, and the year-over-year change in the Company's share price.

The Company completed its qualitative assessment in the third quarter of 2015 and concluded that a two-step goodwill impairment test was not required in 2015 and that goodwill was not impaired.

Share-based Payment

The guidance for accounting for share-based payments requires, among other things, that the estimated fair value of stock options be charged to earnings. Significant management judgment is required to determine the appropriate assumptions for inputs such as volatility and expected term necessary to estimate option values. In addition, management judgment is required to analyze the terms of the plans and awards granted thereunder to determine if awards will be treated as equity awards or liability awards, as defined by the accounting guidance.

As of December 31, 2015, there was $11.8 million of unrecognized compensation cost related to stock option awards. The weighted-average period over which the costs are expected to be recognized is 1.16 years. Also as of December 31, 2015, there was $94.5 million of unrecognized compensation cost related to the Company's restricted stock, restricted stock unit and performance stock unit awards. The weighted-average period over which that cost is expected to be recognized is approximately 1.1 years.

See Note 9 to the consolidated financial statements for additional information regarding accounting for share-based payments.

New Accounting Pronouncements

Note 1 to the consolidated financial statements contains a summary of the Company's significant accounting policies, including a discussion of recently issued accounting pronouncements and their impact or potential future impact on the Company's financial results, if determinable, under the sub-heading "New Accounting Pronouncements".

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Market Risk and Credit Risk

Certain of the Company's revenues, expenses, assets and liabilities are exposed to the impact of interest rate changes and fluctuations in foreign currency exchange rates and equity markets.

Interest Rate Risk and Credit Risk

Interest income generated from the Company's cash investments as well as invested fiduciary funds will vary with the general level of interest rates.

The Company had the following investments subject to variable interest rates:

(In millions of dollars)		December 31, 2015
Cash and cash equivalents invested in money market funds, certificates of deposit and time deposits	$	1,374
Fiduciary cash and investments	$	4,146

Based on the above balances, if short-term interest rates increased or decreased by 10%, or 6 basis points, over the course of the year, annual interest income, including interest earned on fiduciary funds, would increase or decrease by approximately $2 million.

In addition to interest rate risk, our cash investments and fiduciary fund investments are subject to potential loss of value due to counter-party credit risk. To minimize this risk, the Company and its subsidiaries invest pursuant to a Board approved investment policy. The policy mandates the preservation of principal and liquidity and requires broad diversification with counter-party limits assigned based primarily on credit rating and type of investment. The Company carefully monitors its cash and fiduciary fund investments and will further restrict the portfolio as appropriate to market conditions. The majority of cash and fiduciary fund investments are invested in short-term bank deposits and liquid money market funds.

Foreign Currency Risk

The translated values of revenue and expense from the Company's international operations are subject to fluctuations due to changes in currency exchange rates. The non-U.S. based revenue that is exposed to foreign exchange fluctuations is approximately 51% of total revenue. We periodically use forward contracts and options to limit foreign currency exchange rate exposure on net income and cash flows for specific, clearly defined transactions arising in the ordinary course of business. Although the Company has significant revenue generated in foreign locations which is subject to foreign exchange rate fluctuations, in most cases both the foreign currency revenue and expenses are in the functional currency of the foreign location. As such, under normal circumstances, the U.S. dollar translation of both the revenues and expenses, as well as the potentially offsetting movements of various currencies against the U.S. dollar, generally tends to mitigate the impact on net operating income of foreign currency risk. If foreign exchange rates of major currencies (Euro, Sterling, Australian dollar and Canadian dollar) moved 10% in the same direction against the U.S. dollar compared with the foreign exchange rates in 2015, the Company estimates net operating income would increase or decrease by approximately $50 million. The Company has exposure to approximately 80 foreign currencies overall. Starting at the end of 2014 and continuing through 2015, the U.S. dollar strengthened significantly against most currencies, which had a significant impact on net operating income in 2015. If exchange rates at January 31, 2016 hold constant throughout 2016, the Company estimates the year-over-year impact from conversion of foreign currency earnings will reduce full year income by approximately $50 million. In Continental Europe, the largest amount of revenue from renewals for the Risk & Insurance segment occurs in the first quarter. Consequently, a significant portion of the year-over-year foreign exchange impact is expected to occur in the first quarter.

Equity Price Risk

The Company holds investments in both public and private companies as well as private equity funds that invest primarily in financial services companies. Investments of approximately $20 million are classified as available for sale, approximately $76 million are accounted for using the cost method, which includes the Company's investment in Benefitfocus, and $347 million are accounted for using the equity method, which includes the Company's investments in Alexander Forbes. The investments are subject to risk of changes in market value, which, if determined to be other than temporary, could result in realized impairment losses. The Company periodically reviews the carrying value of such investments to determine if any valuation adjustments are appropriate under the applicable accounting pronouncements.

At December 31, 2015, the carrying value of the Company's investment in Alexander Forbes, purchased at 7.50 South African Rand per share, was approximately $230 million. The market value of the Company's shares, based on the closing share price of 5.78 Rand per share, was approximately $166 million. During 2015, the share price of Alexander Forbes ranged from 10.38 Rand to 5.32 Rand. The trading price first dropped below MMC's purchase price at the end of November 2015. The Company considered several factors related to its investment in Alexander Forbes, including its financial position, the near- and long-term prospects of Alexander Forbes and the broader South African economy and capital markets, the length of time and extent to which the market value was below cost, and the Company's intent and ability to retain the investment for a sufficient period of time to allow for anticipated recovery in market value. As a result, the Company determined the investment was not impaired.

Other

A number of lawsuits and regulatory proceedings are pending. See Note 15 to the consolidated financial statements included in this report.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

MARSH & McLENNAN COMPANIES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF INCOME

For the Years Ended December 31, *(In millions, except per share figures)*	**2015**	2014	2013
Revenue	**$ 12,893**	$ 12,951	$ 12,261
Expense:			
Compensation and benefits	**7,334**	7,515	7,226
Other operating expenses	**3,140**	3,135	2,958
Operating expenses	**10,474**	10,650	10,184
Operating income	**2,419**	2,301	2,077
Interest income	**13**	21	18
Interest expense	**(163)**	(165)	(167)
Cost of extinguishment of debt	**—**	(137)	(24)
Investment income	**38**	37	69
Income before income taxes	**2,307**	2,057	1,973
Income tax expense	**671**	586	594
Income from continuing operations	**1,636**	1,471	1,379
Discontinued operations, net of tax	**—**	26	6
Net income before non-controlling interests	**1,636**	1,497	1,385
Less: Net income attributable to non-controlling interests	**37**	32	28
Net income attributable to the Company	**$ 1,599**	$ 1,465	$ 1,357
Basic net income per share – Continuing operations	**$ 3.01**	$ 2.64	$ 2.46
– Net income attributable to the Company	**$ 3.01**	$ 2.69	$ 2.47
Diluted net income per share – Continuing operations	**$ 2.98**	$ 2.61	$ 2.42
– Net income attributable to the Company	**$ 2.98**	$ 2.65	$ 2.43
Average number of shares outstanding – Basic	**531**	545	549
– Diluted	**536**	553	558
Shares outstanding at December 31,	**522**	540	547

The accompanying notes are an integral part of these consolidated statements.

MARSH & McLENNAN COMPANIES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

For the Years Ended December 31, (In millions)	**2015**	2014	2013
Net income before non-controlling interests	**$ 1,636**	$ 1,497	$ 1,385
Other comprehensive income (loss), before tax:			
Foreign currency translation adjustments	**(639)**	(527)	(86)
Unrealized investment income	**1**	—	1
Gain (loss) related to pension/post-retirement plans	**337**	(1,085)	1,213
Other comprehensive (loss) income, before tax	**(301)**	(1,612)	1,128
Income tax expense (credit) on other comprehensive (loss) income	**72**	(386)	442
Other comprehensive (loss) income, net of tax	**(373)**	(1,226)	686
Comprehensive income	**1,263**	271	2,071
Less: Comprehensive income attributable to non-controlling interests	**37**	32	28
Comprehensive income attributable to the Company	**$ 1,226**	$ 239	$ 2,043

The accompanying notes are an integral part of these consolidated statements.

MARSH & McLENNAN COMPANIES, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

December 31, *(In millions, except share figures)*	2015	2014
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,374	$ 1,958
Receivables		
Commissions and fees	3,198	3,142
Advanced premiums and claims	51	50
Other	309	280
	3,558	3,472
Less-allowance for doubtful accounts and cancellations	(87)	(95)
Net receivables	3,471	3,377
Other current assets	199	198
Total current assets	5,044	5,533
Goodwill	7,889	7,241
Other intangible assets	1,036	692
Fixed assets, net	773	809
Pension related assets	1,159	967
Deferred tax assets	1,138	1,358
Other assets	1,177	1,193
	$ 18,216	$ 17,793
LIABILITIES AND EQUITY		
Current liabilities:		
Short-term debt	$ 12	$ 11
Accounts payable and accrued liabilities	1,886	1,883
Accrued compensation and employee benefits	1,656	1,633
Accrued income taxes	154	150
Total current liabilities	3,708	3,677
Fiduciary liabilities	4,146	4,552
Less – cash and investments held in a fiduciary capacity	(4,146)	(4,552)
	—	—
Long-term debt	4,402	3,368
Pension, postretirement and postemployment benefits	2,058	2,244
Liability for errors and omissions	318	341
Other liabilities	1,128	1,030
Commitments and contingencies	—	—
Equity:		
Preferred stock, $1 par value, authorized 6,000,000 shares, none issued	—	—
Common stock, $1 par value, authorized 1,600,000,000 shares, issued 560,641,640 shares at December 31, 2015 and December 31, 2014	561	561
Additional paid-in capital	861	930
Retained earnings	11,302	10,335
Accumulated other comprehensive loss	(4,220)	(3,847)
Non-controlling interests	89	79
	8,593	8,058
Less – treasury shares, at cost, 38,743,686 shares at December 31, 2015 and 20,499,596 shares at December 31, 2014	(1,991)	(925)
Total equity	6,602	7,133
	$ 18,216	$ 17,793

The accompanying notes are an integral part of these consolidated statements.

MARSH & McLENNAN COMPANIES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS

For the Years Ended December 31, *(In millions)*	**2015**	2014	2013
Operating cash flows:			
Net income before non-controlling interests	**$ 1,636**	$ 1,497	$ 1,385
Adjustments to reconcile net income to cash provided by operations:			
Depreciation and amortization of fixed assets and capitalized software	**314**	302	286
Amortization of intangible assets	**109**	86	72
Intangible asset impairment	**—**	—	5
Adjustments and payments related to contingent consideration liability	**11**	19	24
Cost of early extinguishment of debt	**—**	137	24
Provision for deferred income taxes	**178**	127	184
Gain on investments	**(38)**	(37)	(69)
(Gain) Loss on disposition of assets	**(13)**	(38)	1
Share-based compensation expense	**88**	93	129
Changes in assets and liabilities:			
Net receivables	**(52)**	(58)	(245)
Other current assets	**3**	8	1
Other assets	**(10)**	13	(141)
Accounts payable and accrued liabilities	**(125)**	45	106
Accrued compensation and employee benefits	**23**	167	(8)
Accrued income taxes	**(15)**	33	43
Contributions to pension and other benefit plans in excess of current year expense/credit	**(231)**	(152)	(432)
Other liabilities	**(60)**	(196)	8
Effect of exchange rate changes	**70**	73	(32)
Net cash provided by operations	**1,888**	2,119	1,341
Financing cash flows:			
Purchase of treasury shares	**(1,400)**	(800)	(550)
Proceeds from debt	**1,091**	1,386	547
Repayments of debt	**(61)**	(331)	(260)
Payments for early extinguishment of debt	**—**	(765)	(274)
Shares withheld for taxes on vested units – treasury shares	**(49)**	(64)	(79)
Issuance of common stock from treasury shares	**224**	263	352
Payments of deferred and contingent consideration for acquisitions	**(49)**	(55)	(9)
Distributions of non-controlling interests	**(30)**	(20)	(28)
Dividends paid	**(632)**	(582)	(533)
Net cash used for financing activities	**(906)**	(968)	(834)
Investing cash flows:			
Capital expenditures	**(325)**	(368)	(401)
Net (purchases) sales of long-term investments	**(65)**	6	93
Purchase of equity investment	**—**	(304)	—
Proceeds from sales of fixed assets	**2**	3	5
Dispositions	**71**	—	5
Acquisitions	**(952)**	(554)	(142)
Other, net	**4**	(5)	(6)
Net cash used for investing activities	**(1,265)**	(1,222)	(446)
Effect of exchange rate changes on cash and cash equivalents	**(301)**	(274)	(59)
(Decrease) increase in cash and cash equivalents	**(584)**	(345)	2
Cash and cash equivalents at beginning of period	**1,958**	2,303	2,301
Cash and cash equivalents at end of period	**$ 1,374**	$ 1,958	$ 2,303

The accompanying notes are an integral part of these consolidated statements.

MARSH & McLENNAN COMPANIES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF EQUITY

For the Years Ended December 31, *(In millions, except per share figures)*	**2015**	2014	2013
COMMON STOCK			
Balance, beginning and end of year	**$ 561**	$ 561	$ 561
ADDITIONAL PAID-IN CAPITAL			
Balance, beginning of year	**$ 930**	$ 1,028	$ 1,107
Change in accrued stock compensation costs	**16**	(15)	(22)
Issuance of shares under stock compensation plans and employee stock purchase plans and related tax impact	**(85)**	(83)	(57)
Balance, end of period	**$ 861**	$ 930	$ 1,028
RETAINED EARNINGS			
Balance, beginning of year	**$ 10,335**	$ 9,452	$ 8,628
Net income attributable to the Company	**1,599**	1,465	1,357
Dividend equivalents declared - (per share amounts: $1.18 in 2015, $1.06 in 2014, and $0.96 in 2013)	**(4)**	(3)	(6)
Dividends declared – (per share amounts: $1.18 in 2015, $1.06 in 2014, and $0.96 in 2013)	**(628)**	(579)	(527)
Balance, end of period	**$ 11,302**	$ 10,335	$ 9,452
ACCUMULATED OTHER COMPREHENSIVE LOSS			
Balance, beginning of year	**$ (3,847)**	$ (2,621)	$ (3,307)
Other comprehensive (loss) income, net of tax	**(373)**	(1,226)	686
Balance, end of period	**$ (4,220)**	$ (3,847)	$ (2,621)
TREASURY SHARES			
Balance, beginning of year	**$ (925)**	$ (515)	$ (447)
Issuance of shares under stock compensation plans and employee stock purchase plans	**334**	387	481
Issuance of shares for acquisitions	**—**	3	1
Purchase of treasury shares	**(1,400)**	(800)	(550)
Balance, end of period	**$ (1,991)**	$ (925)	$ (515)
NON-CONTROLLING INTERESTS			
Balance, beginning of year	**$ 79**	$ 70	$ 64
Net income attributable to non-controlling interests	**37**	32	28
Distributions	**(30)**	(20)	(28)
Other changes	**3**	(3)	6
Balance, end of period	**$ 89**	$ 79	$ 70
TOTAL EQUITY	**$ 6,602**	$ 7,133	$ 7,975

The accompanying notes are an integral part of these consolidated statements.

1. Summary of Significant Accounting Policies

Nature of Operations: Marsh & McLennan Companies, Inc. (the "Company"), a global professional services firm, is organized based on the different services that it offers. Under this organizational structure, the Company's two business segments are Risk and Insurance Services and Consulting.

The Risk and Insurance Services segment provides risk management activities and insurance broking, reinsurance broking and insurance program management services for businesses, public entities, insurance companies, associations, professional services organizations, and private clients. The Company conducts business in this segment through Marsh and Guy Carpenter.

The Company conducts business in its Consulting segment through two main business groups. Mercer provides consulting expertise, advice, services and solutions in the areas of health, retirement, talent and investments. Oliver Wyman Group provides specialized management and economic and brand consulting services.

Acquisitions impacting the Risk and Insurance Services and Consulting segments are discussed in Note 4 below.

Principles of Consolidation: The accompanying consolidated financial statements include all wholly-owned and majority-owned subsidiaries. All significant inter-company transactions and balances have been eliminated.

Fiduciary Assets and Liabilities: In its capacity as an insurance broker or agent, the Company generally collects premiums from insureds and, after deducting its commissions, remits the premiums to the respective insurance underwriters. The Company also collects claims or refunds from underwriters on behalf of insureds. Unremitted insurance premiums and claims proceeds are held by the Company in a fiduciary capacity. Risk and Insurance Services revenue includes interest on fiduciary funds of $21 million, $24 million and $27 million in 2015, 2014 and 2013, respectively. The Consulting segment recorded fiduciary interest income of $4 million, $6 million and $5 million in 2015, 2014 and 2013, respectively. Since fiduciary assets are not available for corporate use, they are shown in the consolidated balance sheets as an offset to fiduciary liabilities.

Net uncollected premiums and claims and the related payables were $6.9 billion and $7.3 billion at December 31, 2015 and 2014, respectively. The Company is not a principal to the contracts under which the right to receive premiums or the right to receive reimbursement of insured losses arises. Net uncollected premiums and claims and the related payables are, therefore, not assets and liabilities of the Company and are not included in the accompanying consolidated balance sheets.

In certain instances, the Company advances premiums, refunds or claims to insurance underwriters or insureds prior to collection. These advances are made from corporate funds and are reflected in the accompanying consolidated balance sheets as receivables.

Mercer manages approximately $21 billion of assets in trusts or funds for which Mercer's management or trustee fee is considered a variable interest. Mercer is not the primary beneficiary of these trusts or funds. Mercer's only variable interest in any of these trusts or funds is its unpaid fees, if any. Mercer's maximum exposure to loss of its interests is, therefore, limited to collection of its fees.

Revenue: Risk and Insurance Services revenue includes insurance commissions, fees for services rendered and interest income on certain fiduciary funds. Insurance commissions and fees for risk transfer services generally are recorded as of the effective date of the applicable policies or, in certain cases (primarily in the Company's reinsurance broking operations), as of the effective date or billing date, whichever is later. A reserve for policy cancellation is provided based on historic and current data on cancellations. Consideration for fee arrangements covering multiple insurance placements, the provision of risk management and/or other services are allocated to all deliverables on the basis of their relative selling prices. Fees for non-risk transfer services provided to clients are recognized over the period in which the services are provided, using a proportional performance model. Fees resulting from

achievement of certain performance thresholds are recorded when such levels are attained and such fees are not subject to forfeiture.

Consulting revenue includes fees paid by clients for advice and services and commissions from insurance companies for the placement of individual and group contracts. Fee revenue for engagements where remuneration is based on time plus out-of-pocket expenses is recognized based on the amount of time consulting professionals expend on the engagement. For fixed fee engagements, revenue is recognized using a proportional performance model. Revenue from insurance commissions not subject to a fee arrangement is recorded over the effective period of the applicable policies. Revenue for asset based fees is recognized on an accrual basis by applying the daily/monthly rate as contractually agreed with the client to the applicable net asset value. On a limited number of engagements, performance fees may also be earned for achieving certain prescribed performance criteria. Such fees are recognized when the performance criteria have been achieved and, when required, agreed to by the client. Reimbursable expenses incurred by professional staff in the generation of revenue and sub-advisory fees related to the majority of funds in the investment management business are included in revenue and the related expenses are included in other operating expenses.

Cash and Cash Equivalents: Cash and cash equivalents primarily consist of certificates of deposit and time deposits, with original maturities of three months or less, and money market funds. The estimated fair value of the Company's cash and cash equivalents approximates their carrying value. The Company is required to maintain operating funds primarily related to regulatory requirements outside the U.S. or as collateral under captive insurance arrangements. At December 31, 2015, the Company maintained $209 million related to these regulatory requirements.

Fixed Assets: Fixed assets are stated at cost less accumulated depreciation and amortization. Expenditures for improvements are capitalized. Upon sale or retirement, the cost and related accumulated depreciation and amortization are removed from the accounts and any gain or loss is reflected in income. Expenditures for maintenance and repairs are charged to operations as incurred.

Depreciation of buildings, building improvements, furniture, and equipment is provided on a straight-line basis over the estimated useful lives of these assets. Furniture and equipment is depreciated over periods ranging from three to ten years. Leasehold improvements are amortized on a straight-line basis over the periods covered by the applicable leases or the estimated useful life of the improvement, whichever is less. Buildings are depreciated over periods ranging from thirty to forty years. The Company periodically reviews long-lived assets for impairment whenever events or changes indicate that the carrying value of assets may not be recoverable.

The components of fixed assets are as follows:

December 31, *(In millions of dollars)*	**2015**	2014
Furniture and equipment	**$ 1,133**	$ 1,193
Land and buildings	**396**	401
Leasehold and building improvements	**865**	854
	2,394	2,448
Less-accumulated depreciation and amortization	**(1,621)**	(1,639)
	$ 773	$ 809

Investments: The Company holds investments in private companies and private equity funds.

Investments in private equity funds are accounted for under the equity method of accounting using a consistently applied three-month lag period adjusted for any known significant changes from the lag period to the reporting date of the Company. The underlying private equity funds follow investment company accounting, where investments within the fund are carried at fair value. The Company records in earnings, investment gains/losses for its proportionate share of the change in fair value of the funds. Investments using the equity method of accounting are included in other assets in the consolidated balance sheets.

As part of the sale of MMC Capital in 2005, the Company retained the rights to receive certain performance fees related to the Trident II and Trident III private equity partnerships. The Company recognizes performance fee income when such fees are no longer subject to forfeiture, which may take a number of years to resolve. This income is based on the investment performance over the life of each investment in the private equity fund, and future declines in the fund performance from current levels may result in forfeiture of such revenue. Since Trident II fully harvested all its portfolio investments and made final distributions to its partners in 2013, the Company no longer holds any rights to Trident II performance fees. In 2015, the Company recorded investment income of $38 million compared to $37 million in 2014 and $69 million in 2013. The Company recorded investment income related to its general partner carried interest from Trident III no longer subject to clawback of $29 million, $31 million and $41 million in 2015, 2014 and 2013, respectively. In 2013, the Company recorded $15 million of general partner carried interest from Trident II. Stonepoint Capital, the investment manager of Trident III, harvested its remaining two investments in Trident III in the third quarter of 2015, which resulted in the Company recognizing its remaining deferred performance fees.

Goodwill and Other Intangible Assets: Goodwill represents acquisition costs in excess of the fair value of net assets acquired. Goodwill is reviewed at least annually for impairment. The Company performs an annual impairment test for each of its reporting units during the third quarter of each year. When a step 1 test is performed, fair values of the reporting units are estimated using either a market approach or a discounted cash flow model. Carrying values for the reporting units are based on balances at the prior quarter end and include directly identified assets and liabilities as well as an allocation of those assets and liabilities not recorded at the reporting unit level. As discussed in Note 6, the Company may elect to assess qualitative factors to determine if a step 1 test is necessary. Other intangible assets, which primarily consist of customer lists that are not deemed to have an indefinite life, are amortized over their estimated lives, typically ranging from 10 to 15 years, and reviewed for impairment upon the occurrence of certain triggering events in accordance with applicable accounting literature. The Company had no indefinite lived identified intangible assets at December 31, 2015 and 2014.

Capitalized Software Costs: The Company capitalizes certain costs to develop, purchase or modify software for the internal use of the Company. These costs are amortized on a straight-line basis over periods ranging from 3 to 10 years. Costs incurred during the preliminary project stage and post implementation stage, are expensed as incurred. Costs incurred during the application development stage are capitalized. Costs related to updates and enhancements are only capitalized if they will result in additional functionality. Capitalized computer software costs of $498 million and $501 million, net of accumulated amortization of $958 million and $837 million at December 31, 2015 and 2014, respectively, are included in other assets in the consolidated balance sheets.

Legal and Other Loss Contingencies: The Company and its subsidiaries are subject to a significant number of claims, lawsuits and proceedings including claims for errors and omissions ("E&O"). The preparation of financial statements in conformity with accounting principles generally accepted in the United States ("GAAP") requires that a liability be recorded when a loss is both probable and reasonably estimable. Significant management judgment is required to apply this guidance. The Company utilizes case level reviews by inside and outside counsel, an internal actuarial analysis and other analysis to estimate potential losses. The liability is reviewed quarterly and adjusted as developments warrant. In many cases, the Company has not recorded a liability, other than for legal fees to defend the claim, because we are unable, at the present time, to make a determination that a loss is both probable and reasonably estimable. Given the unpredictability of E&O claims and of litigation that could flow from them, it is possible that an adverse outcome in a particular matter could have a material adverse effect on the Company's businesses, results of operations, financial condition or cash flow in a given quarterly or annual period.

In addition, to the extent that insurance coverage is available, significant management judgment is required to determine the amount of recoveries that are probable of collection under the Company's various insurance programs.

The legal and other contingent liabilities described above are not discounted.

Income Taxes: The Company's effective tax rate reflects its income, statutory tax rates and tax planning in the various jurisdictions in which it operates. Significant judgment is required in determining the annual effective tax rate and in evaluating uncertain tax positions and the ability to realize deferred tax assets.

The Company records a liability for unrecognized tax benefits resulting from uncertain tax positions taken or expected to be taken in a tax return. The evaluation of a tax position is a two-step process. The first step involves recognition. The Company determines whether it is more likely than not that a tax position will be sustained upon tax examination, including resolution of any related appeals or litigation, based on only the technical merits of the position. The technical merits of a tax position derive from both statutory and judicial authority (legislation and statutes, legislative intent, regulations, rulings, and case law) and their applicability to the facts and circumstances of the tax position. If a tax position does not meet the more likely than not recognition threshold, the benefit of that position is not recognized in the financial statements. The second step is measurement. A tax position that meets the more likely than not recognition threshold is measured to determine the amount of benefit to recognize in the financial statements. The tax position is measured as the largest amount of benefit that is greater than 50 percent likely to be realized upon ultimate resolution with a taxing authority. Uncertain tax positions are evaluated based upon the facts and circumstances that exist at each reporting period. Subsequent changes in judgment based upon new information may lead to changes in recognition, de-recognition, and measurement. Adjustments may result, for example, upon resolution of an issue with the taxing authorities, or expiration of a statute of limitations barring an assessment for an issue. The Company recognizes interest and penalties, if any, related to unrecognized tax benefits in income tax expense.

Tax law requires items to be included in the Company's tax returns at different times than the items are reflected in the financial statements. As a result, the annual tax expense reflected in the consolidated statements of income is different than that reported in the income tax returns. Some of these differences are permanent, such as expenses that are not deductible in the returns, and some differences are temporary and reverse over time, such as depreciation expense. Temporary differences create deferred tax assets and liabilities. Deferred tax assets generally represent items that can be used as a tax deduction or credit in tax returns in future years for which benefit has already been recorded in the financial statements. Valuation allowances are established for deferred tax assets when it is estimated that future taxable income will be insufficient to use a deduction or credit in that jurisdiction. Deferred tax liabilities generally represent tax expense recognized in the financial statements for which payment has been deferred, or expense for which a deduction has been taken already in the tax return but the expense has not yet been recognized in the financial statements.

Derivative Instruments: All derivatives, whether designated in hedging relationships or not, are recorded on the balance sheet at fair value. If the derivative is designated as a fair value hedge, the changes in the fair value of the derivative and of the hedged item attributable to the hedged risk are recognized in earnings. The fair value of the derivative is recorded in the consolidated balance sheet in other receivables or accounts payable and accrued liabilities. The change in the fair value of a derivative is recorded in the consolidated statement of income in other operating expenses. If the derivative is designated as a cash flow hedge, the effective portions of changes in the fair value of the derivative are recorded in other comprehensive income and are recognized in the income statement when the hedged item affects earnings. Changes in the fair value attributable to the ineffective portion of cash flow hedges are recognized in earnings.

Concentrations of Credit Risk: Financial instruments which potentially subject the Company to concentrations of credit risk consist primarily of cash and cash equivalents, commissions and fees receivable and insurance recoverable. The Company maintains a policy providing for the diversification of cash and cash equivalent investments and places its investments in a large number of high quality financial institutions to limit the amount of credit risk exposure. Concentrations of credit risk with respect to receivables are generally limited due to the large number of clients and markets in which the Company does business, as well as the dispersion across many geographic areas.

Per Share Data: Basic net income per share attributable to the Company and income from continuing operations per share are calculated by dividing the respective after-tax income attributable to common shares by the weighted average number of outstanding shares of the Company's common stock.

Diluted net income per share attributable to the Company and income from continuing operations per share are calculated by dividing the respective after-tax income attributable to common shares by the weighted average number of outstanding shares of the Company's common stock, which have been adjusted for the dilutive effect of potentially issuable common shares. Reconciliations of the applicable income components used for diluted EPS - Continuing Operations and basic weighted average common shares outstanding to diluted weighted average common shares outstanding are presented below. The reconciling items related to the calculation of diluted weighted average common shares outstanding are the same for net income attributable to the Company.

Basic and Diluted EPS Calculation - *Continuing Operations*

(In millions, except per share figures)	**2015**	2014	2013
Net income from continuing operations	**$ 1,636**	$ 1,471	$ 1,379
Less: Net income attributable to non-controlling interests	**37**	32	28
	$ 1,599	$ 1,439	$ 1,351
Basic weighted average common shares outstanding	**531**	545	549
Dilutive effect of potentially issuable common shares	**5**	8	9
Diluted weighted average common shares outstanding	**536**	553	558
Average stock price used to calculate common stock equivalents	**$ 56.27**	$ 51.15	$ 40.97

There were 14.8 million, 18.0 million and 22.6 million stock options outstanding as of December 31, 2015, 2014 and 2013, respectively.

Estimates: GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results may vary from those estimates.

New Accounting Pronouncements: In September 2015, the Financial Accounting Standards Board (the "FASB") issued new guidance intended to simplify the accounting for adjustments made to provisional amounts recognized in business combinations. The guidance requires the acquirer to recognize adjustments to estimated amounts that are identified during the measurement period in the reporting period in which the adjustments are determined, and to record, in the same period's financial statements, the effect on earnings of changes in depreciation, amortization, or other income effects, if any, as a result of the change to the estimated amounts, calculated as if the accounting had been completed as of the acquisition date. The guidance also includes additional disclosures required for the amounts recorded in current period earnings arising from such adjustments. The guidance is effective for fiscal years beginning after December 15, 2015, including interim periods within those fiscal years. The guidance should be applied prospectively for adjustments to provisional amounts after the effective date, with earlier application permitted for financial statements that have not been issued. The adoption of this new guidance is not expected to have a material impact on the Company's financial statements.

In May 2015, the FASB issued new guidance which removes the requirement to present certain investments for which the practical expedient is used to measure fair value at net asset value within the fair value hierarchy table. Instead, an entity would be required to include those investments as a reconciling item so that the total fair value amount of investments in the disclosure is consistent with the fair value investment balance on the statement of net assets. This guidance is effective for fiscal years beginning after December 15, 2015. The adoption of this new guidance will affect footnote disclosure and is not expected to have a material impact on the Company's financial statements.

In February 2015, the FASB issued new accounting guidance intended to improve targeted areas of consolidation guidance for legal entities such as limited partnerships, limited liability corporations and securitization structures. The guidance focuses on the consolidation evaluation for reporting organizations that are required to evaluate whether they should consolidate certain legal entities. The guidance is effective for periods beginning after December 15, 2015. Early adoption is permitted, including adoption in

an interim period. The adoption of this guidance is not expected to have a material impact on the Company's financial statements.

In January 2015, the FASB issued new accounting guidance that eliminated the concept of extraordinary items. The guidance is effective for annual periods beginning after December 15, 2015. The guidance may be adopted prospectively, or retrospectively to all prior periods presented in the financial statements. Early adoption is permitted provided the guidance is applied from the beginning of the fiscal year of adoption. Adoption of the guidance is not expected to materially affect the Company's financial condition, results of operations or cash flows.

In June 2014, the FASB issued new accounting guidance to clarify the treatment of share-based payment awards that require a specific performance target to be achieved in order for employees to be eligible to vest in the awards which include terms that may provide that the performance conditions could be achieved after an employee completes the requisite service period. The guidance requires that a performance target that affects vesting and that could be achieved after the requisite service period be treated as a performance condition. As such, a reporting entity should apply the existing guidance as it relates to awards with performance conditions that affect vesting. The guidance is effective for annual periods beginning after December 15, 2015. Earlier adoption is permitted. Adoption of the guidance is not expected to materially affect the Company's financial condition, results of operations or cash flows.

In May 2014, the FASB issued new accounting guidance to clarify the principles for revenue recognition. The core principle of the guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. To achieve that principle, the entity should apply the following steps: identify the contract(s) with the customer, identify the performance obligations in the contract(s), determine the transaction price, allocate the transaction price to the performance obligations in the contract and recognize revenue when (or as) the entity satisfies a performance obligation. The guidance is effective for fiscal years beginning after December 15, 2017, including interim periods within that reporting period. Early application is not permitted. Entities are permitted to adopt the guidance under one of the following methods: retrospectively to each prior reporting period presented (with certain practical expedients allowed) or retrospectively with the cumulative effect of initially applying the guidance recognized at the date of initial application. If an entity elects this transition method, it must provide disclosures in reporting periods that include the date of initial application of the amount by which each financial statement line item is affected in the current reporting period by application of the guidance as compared to guidance that was in effect before the change, and an explanation for the reasons for significant changes. The Company is currently evaluating the impact of the adoption of the guidance on its financial condition and results of operations.

New Accounting Pronouncements Recently Adopted

In November 2015, the FASB issued a new standard related to the balance sheet classification of deferred taxes ("deferred tax standard"), which simplifies the presentation of deferred income taxes. The deferred tax standard requires companies to classify deferred tax assets and liabilities as noncurrent in the consolidated balance sheet. The previous standard required companies to classify deferred tax assets and liabilities as current and noncurrent. The deferred tax standard is effective for fiscal years beginning after December 15, 2016, including interim periods within that reporting period. Early adoption is permitted for any interim and annual financial statements that have not yet been issued. Effective December 31, 2015, the Company early adopted the deferred tax standard retrospectively, as a change in accounting principle. The impact of this change on the Company's prior years Consolidated Balance Sheets and Consolidated Statements of Cash Flows is shown in the table below. The adoption of this standard had no impact on our results of operations.

In April 2015, the FASB issued a new standard related to the presentation of debt issuance costs ("debt issuance costs standard"). The debt issuance cost standard requires debt issuance costs related to recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. The previous standard required these debt issuance costs be classified as an asset and amortized ratably over the life of the debt. The debt issuance cost standard is effective for fiscal years beginning after December 15, 2015, including interim periods within that reporting period. Early adoption is permitted for any interim and annual financial statements that have

not yet been issued. The Company has elected to early adopt the debt issuance costs standard, effective December 31, 2015. The adoption of the debt issuance costs standard had no impact on our results of operations. This guidance is effective on a retrospective basis, as a change in accounting principle. The impact of this change on the Company's prior years Consolidated Balance Sheets and Consolidated Statements of Cash Flows is shown in the table below.

	2014			
Consolidated Balance Sheet	As Previously Reported	Change in Deferred Tax Presentation	Change in Prepaid Debt Fees Presentation	As Amended
Current deferred tax asset	$ 521	$ (521)	$ —	$ —
Other current assets	199	—	(1)	198
Total current assets	6,055	(521)	(1)	5,533
Deferred tax assets	876	482	—	1,358
Other assets	1,200	—	(7)	1,193
Total assets	**17,840**	**(39)**	**(8)**	**17,793**
Accrued income taxes	178	(28)	—	150
Total current liabilities	3,705	(28)	—	3,677
Long-term debt	3,376	—	(8)	3,368
Other liabilities	1,041	(11)	—	1,030
Total liabilities and equity	**$ 17,840**	**$ (39)**	**$ (8)**	**$ 17,793**
Consolidated Statement of Cash Flows				
Changes in assets and liabilities:				
Other current assets	$ (32)	$ 39	$ 1	$ 8
Other assets	25	(18)	6	13
Accrued income taxes	43	(10)	—	33
Other liabilities	(185)	(11)	—	(196)
Net cash provided by operations	**2,112**	**—**	**7**	**2,119**
Proceeds from debt	1,393	—	(7)	1,386
Net cash used for financing activities	**$ (961)**	**$ —**	**$ (7)**	**$ (968)**

	2013		
	As Previously Reported	Change in Deferred Tax Presentation	As Amended
Consolidated Statement of Cash Flows			
Changes in assets and liabilities:			
Other current assets	$ (70)	$ 71	$ 1
Other assets	(75)	(66)	(141)
Accrued income taxes	43	—	43
Other liabilities	13	(5)	8
Net cash provided by operations	**1,341**	**—**	**1,341**
Proceeds from debt	547	—	547
Net cash used for financing activities	**$ (834)**	**$ —**	**$ (834)**

In April 2014, the FASB issued new accounting guidance which changes the criteria for reporting discontinued operations and enhances disclosures in this area. Under the new guidance, only disposals representing a strategic shift in operations, such as disposal of a major geographic area or a major line of business, should be presented as discontinued operations. Those strategic shifts should have a major impact on the organization's operations and financial results. In addition, the new guidance requires expanded disclosures about discontinued operations. The guidance is effective for fiscal years beginning on or after December 15, 2014. Adoption of the guidance did not have a material affect on the Company's financial condition, results of operations or cash flows.

Reclassifications

In addition to the above changes, reclassifications have been made to prior period amounts to conform with current year separate presentation of goodwill and other intangible assets in the consolidated balance sheets.

2. Supplemental Disclosures

The following schedule provides additional information concerning acquisitions, interest and income taxes paid:

(In millions of dollars)	**2015**	2014	2013
Assets acquired, excluding cash	**$ 1,327**	$ 815	$ 217
Liabilities assumed	**(199)**	(64)	(53)
Contingent/deferred purchase consideration	**(176)**	(197)	(39)
Net cash outflow for current year acquisitions	**952**	554	125
Purchase of other intangibles	**—**	—	2
Net cash outflow for acquisitions	**$ 952**	$ 554	$ 127

(In millions of dollars)	**2015**	2014	2013
Interest paid	**$ 146**	$ 172	$ 170
Income taxes paid, net of refunds	**$ 433**	$ 426	$ 360

The Company paid deferred purchase consideration related to prior years' acquisitions of $36 million, $25 million and $15 million for the years ended December 31, 2015, 2014 and 2013, respectively.

The Company had non-cash issuances of common stock under its share-based payment plan of $72 million, $108 million and $150 million for the years ended December 31, 2015, 2014 and 2013, respectively. The Company recorded stock-based compensation expense related to equity awards of $67 million, $75 million and $110 million for the years ended December 31, 2015, 2014 and 2013, respectively.

The consolidated statement of cash flows includes the cash flow impact of discontinued operations related to indemnification payments from the Putnam disposition that reduced the net cash flow provided by operations by $82 million in 2015.

An analysis of the allowance for doubtful accounts is as follows:

For the Years Ended December 31, *(In millions of dollars)*	**2015**	2014	2013
Balance at beginning of year	**$ 95**	$ 98	$ 106
Provision charged to operations	**14**	20	16
Accounts written-off, net of recoveries	**(18)**	(17)	(19)
Effect of exchange rate changes and other	**(4)**	(6)	(5)
Balance at end of year	**$ 87**	$ 95	$ 98

3. Other Comprehensive Income (Loss)

The changes in the balances of each component of Accumulated Other Comprehensive Income ("AOCI") for the years ended December 31, 2015 and 2014, including amounts reclassified out of AOCI, are as follows:

(In millions of dollars)	Unrealized Investment Gains	Pension/Post-Retirement Plans Gains (Losses)	Foreign Currency Translation Adjustments	Total
Balance as of January 1, 2015	$ 5	$ (3,393)	$ (459)	$ (3,847)
Other comprehensive income (loss) before reclassifications	1	101	(643)	(541)
Amounts reclassified from accumulated other comprehensive loss	—	168	—	168
Net current period other comprehensive income (loss)	1	269	(643)	(373)
Balance as of December 31, 2015	$ 6	$ (3,124)	$ (1,102)	$ (4,220)

(In millions of dollars)	Unrealized Investment Gains	Pension/Post-Retirement Plans Gains (Losses)	Foreign Currency Translation Adjustments	Total
Balance as of January 1, 2014	$ 5	$ (2,682)	$ 56	$ (2,621)
Other comprehensive loss before reclassifications	—	(816)	(515)	(1,331)
Amounts reclassified from accumulated other comprehensive loss	—	105	—	105
Net current period other comprehensive loss	—	(711)	(515)	(1,226)
Balance as of December 31, 2014	$ 5	$ (3,393)	$ (459)	$ (3,847)

The components of other comprehensive income (loss) are as follows:

For the Year Ended December 31,	2015		
(In millions of dollars)	Pre-Tax	Tax (Credit)	Net of Tax
Foreign currency translation adjustments	$ (639)	$ 4	$ (643)
Unrealized investment gains	1	—	1
Pension/post-retirement plans:			
Amortization of losses (gains) included in net periodic pension cost:			
Prior service credits (a)	(1)	—	(1)
Net actuarial losses (a)	271	96	175
Subtotal	270	96	174
Effect of curtailment	(3)	—	(3)
Plan Termination	(6)	(3)	(3)
Net losses arising during period	(125)	(62)	(63)
Foreign currency translation adjustments	214	43	171
Other	(13)	(6)	(7)
Pension/post-retirement plans gains	337	68	269
Other comprehensive (loss) income	$ (301)	$ 72	$ (373)

(a) Components of net periodic pension cost are included in compensation and benefits in the Consolidated Statements of Income. Tax on prior service gains and net actuarial losses is included in income tax expense.

For the Year Ended December 31,	2014		
(In millions of dollars)	Pre-Tax	Tax (Credit)	Net of Tax
Foreign currency translation adjustments	$ (527)	$ (12)	$ (515)
Pension/post-retirement plans:			
Amortization of losses (gains) included in net periodic pension cost:			
Prior service credits (a)	(16)	(5)	(11)
Net actuarial losses (a)	242	74	168
Subtotal	226	69	157
Effect of curtailment	(65)	(13)	(52)
Net losses arising during period	(1,418)	(466)	(952)
Foreign currency translation adjustments	180	39	141
Other adjustments	(8)	(3)	(5)
Pension/post-retirement plans losses	(1,085)	(374)	(711)
Other comprehensive loss	$ (1,612)	$ (386)	$ (1,226)

(a) Components of net periodic pension cost are included in compensation and benefits in the Consolidated Statements of Income. Tax on prior service gains and net actuarial losses is included in income tax expense.

For the Year Ended December 31,	2013		
(In millions of dollars)	Pre-Tax	Tax (Credit)	Net of Tax
Foreign currency translation adjustments	$ (86)	$ (2)	$ (84)
Unrealized investment gains	1	—	1
Pension/post-retirement plans:			
Amortization of losses (gains) included in net periodic pension cost:			
Prior service credits (a)	(22)	(8)	(14)
Net actuarial losses (a)	317	108	209
Subtotal	295	100	195
Net gains arising during period	898	339	559
Foreign currency translation adjustments	27	8	19
Other	(7)	(3)	(4)
Pension/post-retirement plans gains	1,213	444	769
Other comprehensive income	$ 1,128	$ 442	$ 686

(a) Components of net periodic pension cost are included in compensation and benefits in the Consolidated Statements of Income. Tax on prior service gains and net actuarial losses is included in income tax expense.

The components of accumulated other comprehensive income (loss) are as follows:

(In millions of dollars)	**December 31, 2015**	December 31, 2014
Foreign currency translation adjustments (net of deferred tax asset of $8 and $5 in 2015 and 2014, respectively)	**$ (1,102)**	$ (459)
Net unrealized investment gains (net of deferred tax liability of $2 in both 2015 and 2014)	**6**	5
Net charges related to pension / post-retirement plans (net of deferred tax asset of $1,519 and $1,587 in 2015 and 2014, respectively)	**(3,124)**	(3,393)
	$ (4,220)	$ (3,847)

4. Acquisitions / Dispositions

The Company's acquisitions have been accounted for as business combinations. Net assets and results of operations are included in the Company's consolidated financial statements commencing at the respective purchase closing dates. In connection with acquisitions, the Company records the estimated value of the net tangible assets purchased and the value of the identifiable intangible assets purchased, which typically consist of purchased customer lists, trademarks and non-compete agreements. The valuation of purchased intangible assets involves significant estimates and assumptions. Any change in assumptions could affect the carrying value of such intangible assets.

The Risk and Insurance Services segment completed thirteen acquisitions during 2015.

- January – Marsh acquired INGESEG S.A., an insurance brokerage located in Argentina.
- May – Marsh acquired Sylvite Financial Services, Inc., a Canada-based insurance consulting firm and Sumitomo Life Insurance Agency America, Inc., an employee benefits brokerage and consulting firm providing employee benefit and other services to U.S.-based subsidiaries of Japanese companies.
- June – Marsh & McLennan Agency ("MMA") acquired MHBT, Inc., a Texas-based insurance broker and Marsh acquired SIS Co. Ltd, a Korea-based insurance broker and advisor.
- July – MMA acquired Vezina, a Canada-based independent insurance brokerage firm, Tequesta Insurance Advisors, an employee benefits insurance provider based in Florida, Cline Wood Agency, a Kansas City-based independent specialty insurance agency and J.W. Terrill, a Missouri-based independent insurance agency. Marsh acquired SMEI Group Ltd., a U.K.-based insurance broker providing specialist commercial insurance to small and medium-sized firms.
- August – Marsh acquired Dovetail Insurance, a leading provider of insurance technology services to the U.S. small commercial market.
- October – MMA acquired Dawson Insurance Agency, a North Dakota-based agency providing commercial and personal insurance, surety bonds, safety and loss control programs, and employee benefits services.
- December – Marsh acquired Jelf Group, PLC, a U.K.-based insurance broking and financial consulting firm.

The Consulting segment completed eight acquisitions during 2015.

- February – Oliver Wyman acquired TeamSAI, a Georgia-based provider of consulting and technical services to the transportation industry, and Mercer acquired Strategic Capital Management AG, a Switzerland-based institutional investment advisor.
- June – Mercer acquired Kepler Associates, a U.K.-based executive remuneration specialist.
- August – OWG acquired the Hong Kong and Shanghai franchises of OC&C Strategy Consultants.
- September – Mercer acquired Comptryx, a global pay and workforce metrics business specializing in the technology sector.
- November – Mercer acquired HR Business Solutions (Asia) Limited, a Hong Kong-based compensation and employee benefits consulting firm, and Gama Consultores Associados Ltda, a Brazil-based retirement consulting firm.
- December – Mercer acquired CPSG Partners, a Workday Services partner assisting clients worldwide to maximize the value of Workday Financial Management and Human Capital Management.

Total purchase consideration for acquisitions made during 2015 was approximately $1.2 billion, which consisted of cash paid of $1.0 billion and deferred purchase and estimated contingent consideration of $176 million. Contingent consideration arrangements are based primarily on EBITDA and revenue targets over periods of two to four years. The fair value of the contingent consideration was based on projected revenue and earnings of the acquired entities. Estimated fair values of assets acquired and liabilities assumed are subject to adjustment when purchase accounting is finalized. During 2015, the Company also paid $36 million of deferred purchase consideration and $47 million of contingent consideration related to acquisitions made in prior years. In addition, the Company purchased other intangible assets in the amount of $2 million.

The following table presents the preliminary allocation of the acquisition cost to the assets acquired and liabilities assumed, based on their fair values:

(In millions)	2015
Cash	$ 1,004
Estimated fair value of deferred/contingent consideration	176
Total consideration	$ 1,180
Allocation of purchase price:	
Cash and cash equivalents	$ 52
Accounts receivable, net	39
Other current assets	5
Property, plant, and equipment	11
Other intangible assets	486
Goodwill	783
Other assets	3
Total assets acquired	1,379
Current liabilities	106
Other liabilities	93
Total liabilities assumed	199
Net assets acquired	$ 1,180

Other intangible assets acquired are based on initial estimates and subject to change based on final valuations during the measurement period post acquisition date. The following chart provides information of other intangible assets acquired during 2015:

	Amount	Weighted Average Amortization Period
Client relationships	$ 433	13 years
Other (a)	53	4.8 years
	$ 486	

(a) Primarily non-compete agreements, trade names and developed technology

Prior Year Acquisitions

During 2014, the Risk and Insurance Services segment completed the following fifteen acquisitions:

- January – MMA acquired Barney & Barney, LLC, a San Diego-based insurance broking firm that provides insurance, risk management and employee benefits solutions to businesses and individuals throughout the U.S. and abroad, Great Lakes Employee Benefits Services, Inc., an employee group benefits consulting and brokerage firm based in Michigan, and Bond Network, Inc., a surety bonding agency based in North Carolina.
- February – Marsh acquired Central Insurance Services, an independent insurance broker in Scotland that provides insurance broking and risk advisory services to companies of all sizes across industry sectors.
- March – MMA acquired Capstone Insurance Services, LLC, an agency that provides property-casualty insurance and risk management solutions to businesses and individuals throughout South Carolina.
- May – MMA acquired Kinker-Eveleigh Insurance Agency, an Ohio-based agency specializing in property-casualty and employee benefits solutions, VISICOR, a full-service employee benefits brokerage and consulting firm based in Texas, and Senn Dunn Insurance, a full-service insurance brokerage located in North Carolina.

- August – Marsh acquired Seguros Morrice y Urrutia S.A., an insurance broker based in Panama City, Panama.
- September – Marsh acquired Kocisko Insurance Brokers, Inc., a full-service commercial insurance brokerage located in Montreal, Quebec.
- October – MMA acquired NuWest Insurance Services, Inc., a California-based property-casualty agency.
- November – Marsh acquired Torrent Technologies, Inc., a Montana-based flood insurance specialist.
- December – Marsh acquired Seafire Insurance Services, LLC, a Kansas-based managing general underwriter, and Trade Insure NV, a leading distributor of credit insurance policies in Belgium, and MMA acquired The Benefit Planning Group, Inc., a North Carolina-based employee benefit consulting firm.

During 2014, the Consulting segment completed the following six acquisitions:

- February – Mercer acquired Transition Assist, a retiree exchange specializing in helping retirees in employer-sponsored plans select Medicare supplemental health care insurance.
- September – Oliver Wyman acquired Bonfire Communications, an agency specializing in employee engagement and internal communications based in San Francisco, California.
- November – Mercer acquired AUSREM, a remuneration research and workforce consulting specialist based in Australia, and Jeitosa Group International, a global HR business consultancy and IT systems integration firm.
- December – Mercer acquired Denarius, a compensation and benefits survey and information products consulting firm based in Chile, and Oliver Wyman acquired OC&C Strategy Consultants (Boston) LLC (part of the OC&C network), a Boston-based consulting firm specializing in the business media, information services and education sectors.

Total purchase consideration for acquisitions made during 2014 was $772 million, which consisted of cash paid of $575 million and deferred purchase and estimated contingent consideration of $197 million. Contingent consideration arrangements are primarily based on EBITDA and revenue targets over two to four years. The fair value of the contingent consideration was based on projected revenue and earnings of the acquired entities. Estimated fair values of assets acquired and liabilities assumed are subject to adjustment when purchase accounting is finalized. During 2014, the Company also paid $25 million of deferred purchase consideration and $42 million of contingent consideration related to acquisitions made in prior years.

Pro-Forma Information

While the Company does not believe its acquisitions in the aggregate are material, the following unaudited pro-forma financial data gives effect to the acquisitions made by the Company during 2015 and 2014. In accordance with accounting guidance related to pro-forma disclosures, the information presented for current year acquisitions is as if they occurred on January 1, 2014 and reflects acquisitions made in 2014 as if they occurred on January 1, 2013. The pro-forma information adjusts for the effects of amortization of acquired intangibles. The unaudited pro-forma financial data is presented for illustrative purposes only and is not necessarily indicative of the operating results that would have been achieved if such acquisitions had occurred on the dates indicated, nor is it necessarily indicative of future consolidated results.

	Years Ended December 31,		
(In millions, except per share data)	**2015**	2014	2013
Revenue	**$ 13,185**	$ 13,395	$ 12,550
Income from continuing operations	**$ 1,676**	$ 1,475	$ 1,395
Net income attributable to the Company	**$ 1,639**	$ 1,469	$ 1,373
Basic net income per share:			
– Continuing operations	**$ 3.09**	$ 2.65	$ 2.49
– Net income attributable to the Company	**$ 3.09**	$ 2.69	$ 2.50
Diluted net income per share:			
– Continuing operations	**$ 3.05**	$ 2.61	$ 2.45
– Net income attributable to the Company	**$ 3.05**	$ 2.66	$ 2.46

The consolidated statement of income for 2015 includes approximately $124 million of revenue and $7 million of operating income related to acquisitions made during 2015.

Dispositions

In December 2015, Mercer sold its U.S. defined contribution recordkeeping business, recognizing a pre-tax gain of $37 million, which is included in revenue in the consolidated statements of income. The sale agreement includes contingent consideration based on retention and renewal of the client contracts by the acquirer. Additional consideration, if any, will be recognized when all conditions precedent to its receipt have been satisfied.

5. Discontinued Operations

As part of the disposal transactions for Putnam and Kroll, the Company provided certain indemnities, primarily related to pre-transaction tax uncertainties and legal contingencies. In accordance with applicable accounting guidance, liabilities were established related to these indemnities at the time of the sales and reflected as a reduction of the gain on disposal. Discontinued operations includes charges or credits resulting from the settlement or resolution of the indemnified matters, as well as adjustments to the liabilities related to such matters.

On December 31, 2014, an agreement was reached between Putnam and the Massachusetts Department of Revenue ("DOR") regarding a tax dispute, which was covered under the indemnity agreement discussed above. The December 2014 agreement was subject to certain approvals, which included the State Attorney General and the Commissioner of the DOR. In January 2015, all necessary approvals were received, the agreement was executed and the tax was paid. Concurrently, Putnam and the Company executed a settlement agreement to resolve all remaining matters under the indemnity agreement. The Company recorded a gain, net of federal income taxes, of approximately $28 million in 2014 related to the settlement with Putnam.

Discontinued operations in 2013 includes estimated costs covered under the indemnity related to the Kroll sale as well as tax indemnities related to the Putnam sale.

Summarized Statements of Income data for discontinued operations is as follows:

For the Years Ended December 31,			
(In millions of dollars)	**2015**	2014	2013
Income (loss) from discontinued operations, net of tax	**$ —**	$ —	$ —
Disposals of discontinued operations	**(5)**	42	(4)
Income tax (credit) expense	**(5)**	16	(10)
Disposals of discontinued operations, net of tax	**—**	26	6
Discontinued operations, net of tax	**$ —**	$ 26	$ 6
Discontinued operations, net of tax per share			
– Basic	**$ —**	$ 0.05	$ 0.01
– Diluted	**$ —**	$ 0.04	$ 0.01

6. Goodwill and Other Intangibles

The Company is required to assess goodwill and any indefinite-lived intangible assets for impairment annually, or more frequently if circumstances indicate impairment may have occurred. The Company performs the annual impairment assessment for each of its reporting units during the third quarter of each year. In accordance with applicable accounting guidance, the Company assesses qualitative factors to determine whether it is necessary to perform the two-step goodwill impairment test. The Company considered numerous factors, which included that the fair value of each reporting unit exceeded its carrying value by a substantial margin in its most recent estimate of reporting unit fair values, whether significant acquisitions or dispositions occurred which might alter the fair value of its reporting units, macroeconomic conditions and their potential impact on reporting unit fair values, actual performance compared with budget and prior projections used in its estimation of reporting unit fair values, industry and market conditions, and the year-over-year change in the Company's share price. The Company completed its qualitative assessment in the third quarter of 2015 and concluded that a two-step goodwill impairment test was not required in 2015 and that goodwill was not impaired.

Other intangible assets that are not deemed to have an indefinite life are amortized over their estimated lives and reviewed for impairment upon the occurrence of certain triggering events in accordance with applicable accounting literature.

Changes in the carrying amount of goodwill are as follows:

(In millions of dollars)	**2015**	2014
Balance as of January 1, as reported	**$ 7,241**	$ 6,893
Goodwill acquired	**783**	472
Other adjustments[(a)]	**(135)**	(124)
Balance at December 31,	**$ 7,889**	$ 7,241

(a) Primarily due to the impact of foreign exchange in both years.

The goodwill acquired of $783 million in 2015 (approximately $387 million of which is deductible for tax purposes) is comprised of $639 million related to the Risk and Insurance Services segment and $144 million related to the Consulting segment.

Goodwill allocable to the Company's reportable segments is as follows: Risk and Insurance Services, $5.6 billion and Consulting, $2.3 billion.

The gross cost and accumulated amortization at December 31, 2015 and 2014 are as follows:

(In millions of dollars)	**2015**			2014		
	Gross Cost	**Accumulated Amortization**	**Net Carrying Amount**	Gross Cost	Accumulated Amortization	Net Carrying Amount
Client relationships	**$ 1,281**	**$ 347**	**$ 934**	$ 1,000	$ 391	$ 609
Other (a)	**176**	**74**	**102**	177	94	83
Amortized intangibles	**$ 1,457**	**$ 421**	**$ 1,036**	$ 1,177	$ 485	$ 692

(a) Primarily non-compete agreements, trade names and developed technology

Aggregate amortization expense was $109 million for the year ended December 31, 2015, $86 million for the year ended December 31, 2014 and $72 million for the year ended December 31, 2013. The estimated future aggregate amortization expense is as follows:

For the Years Ending December 31, *(In millions of dollars)*	
2016	$ 128
2017	120
2018	118
2019	112
2020	105
Subsequent years	453
	$ 1,036

7. Income Taxes

For financial reporting purposes, income before income taxes includes the following components:

For the Years Ended December 31, *(In millions of dollars)*	**2015**	2014	2013
Income before income taxes:			
U.S.	**$ 702**	$ 313	$ 407
Other	**1,605**	1,744	1,566
	$ 2,307	$ 2,057	$ 1,973
The expense for income taxes is comprised of:			
Income taxes:			
Current–			
U.S. Federal	**$ 90**	$ 80	$ 102
Other national governments	**385**	369	264
U.S. state and local	**52**	26	45
	527	475	411
Deferred–			
U.S. Federal	**125**	27	12
Other national governments	**15**	62	149
U.S. state and local	**4**	22	22
	144	111	183
Total income taxes	**$ 671**	$ 586	$ 594

The significant components of deferred income tax assets and liabilities and their balance sheet classifications are as follows:

December 31, *(In millions of dollars)*	**2015**	2014
Deferred tax assets:		
Accrued expenses not currently deductible	**$ 586**	$ 572
Differences related to non-U.S. operations [(a)]	**120**	119
Accrued retirement benefits U.S.	**630**	638
Net operating losses [(b)]	**70**	57
Income currently recognized for tax	**70**	75
Foreign tax credit carryforwards	**20**	109
Other	**49**	84
	$ 1,545	$ 1,654
Deferred tax liabilities:		
Differences related to non-U.S. operations	**$ 176**	$ 131
Depreciation and amortization	**368**	307
Accrued retirement & postretirement benefits - non-U.S. operations	**94**	41
Other	**6**	5
	$ 644	$ 484

(a) Net of valuation allowances of $9 million in 2015 and $15 million in 2014.
(b) Net of valuation allowances of $19 million in 2015 and $82 million in 2014.

December 31, *(In millions of dollars)*	**2015**	2014
Balance sheet classifications:		
Deferred tax assets	**$ 1,138**	$ 1,358
Other liabilities	**$ 237**	$ 188

U.S. Federal income taxes are not provided on the excess of the amount for financial reporting over the tax basis of investments in foreign subsidiaries that are essentially permanent in duration, which at December 31, 2015, the Company estimates, amounted to approximately $3.4 billion. The determination of the unrecognized deferred tax liability with respect to these investments is not practicable.

A reconciliation from the U.S. Federal statutory income tax rate to the Company's effective income tax rate is shown below:

For the Years Ended December 31,	**2015**	2014	2013
U.S. Federal statutory rate	**35.0%**	35.0%	35.0%
U.S. state and local income taxes—net of U.S. Federal income tax benefit	**1.6**	1.7	2.1
Differences related to non-U.S. operations	**(8.0)**	(7.5)	(6.0)
Other	**0.5**	(0.7)	(1.0)
Effective tax rate	**29.1%**	28.5%	30.1%

The Company's consolidated tax rate was 29.1%, 28.5% and 30.1% in 2015, 2014 and 2013, respectively. The tax rate in each year reflects foreign operations, which are generally taxed at rates lower than the U.S. statutory tax rate.

Valuation allowances had a net decrease of $69 million in 2015, and net increases of $15 million and $10 million in 2014 and 2013, respectively. During the respective years, adjustments of the beginning of the year balances of valuation allowances decreased income tax expense by $14 million, $9 million and $3 million in 2015, 2014 and 2013, respectively. The decrease in the valuation allowance in 2015 also reflects the write down of a deferred tax asset along with its full valuation allowance because the Company cannot utilize a net operating loss. Approximately 80% of the Company's net operating loss carryforwards expire from 2016 through 2035, and others are unlimited. The potential tax benefit from net operating loss carryforwards at the end of 2015 comprised federal, state and local, and non-U.S. tax benefits of $10 million, $55 million and $36 million, respectively, before reduction for valuation allowances. Foreign tax credit carryforwards expire in 2021 and 2022.

The realization of deferred tax assets depends on generating future taxable income during the periods in which the tax benefits are deductible or creditable. Tax liabilities are determined and assessed jurisdictionally by legal entity or filing group. Certain taxing jurisdictions allow or require combined or consolidated tax filings. The Company assessed the realizability of its deferred tax assets and considered all available evidence, including the existence of a recent history of losses, placing particular weight on evidence that could be objectively verified. A valuation allowance was recorded to reduce deferred tax assets to the amount that the Company believes is more likely than not to be realized.

Following is a reconciliation of the Company's total gross unrecognized tax benefits for the years ended December 31, 2015, 2014 and 2013:

(In millions of dollars)	**2015**	2014	2013
Balance at January 1,	**$ 97**	$ 128	$ 117
Additions, based on tax positions related to current year	**3**	13	16
Additions for tax positions of prior years	**22**	3	35
Reductions for tax positions of prior years	**(10)**	(29)	(7)
Settlements	**(20)**	(4)	(3)
Lapses in statutes of limitation	**(18)**	(14)	(30)
Balance at December 31,	**$ 74**	$ 97	$ 128

Of the total unrecognized tax benefits at December 31, 2015, 2014 and 2013, $53 million, $51 million and $71 million, respectively, represent the amount that, if recognized, would favorably affect the effective tax rate in any future periods. The total gross amount of accrued interest and penalties at December 31, 2015, 2014 and 2013, before any applicable federal benefit, was $8 million, $7 million and $10 million, respectively.

As discussed in Note 5, the Company has provided certain indemnities related to contingent tax liabilities as part of the disposals of Putnam and Kroll. At December 31, 2015, 2014 and 2013, $1 million, $2 million and $2 million, respectively, included in the table above, relates to Putnam and Kroll positions included in consolidated Company tax returns. Since the Company remains primarily liable to the taxing authorities for resolution of uncertain tax positions related to consolidated returns, these balances will remain as part of the Company's consolidated liability for uncertain tax positions. Any future charges or credits related to these matters, including interest accrued, will be recorded in discontinued operations as incurred.

The Company is routinely examined by the jurisdictions in which it has significant operations. In the U.S. federal jurisdiction the Company participates in the Internal Revenue Service's (IRS) Compliance Assurance Process (CAP), which is structured to conduct real-time compliance reviews. The IRS is currently examining the Company's 2014 tax return and performing a pre-filing review of 2015. During 2015 the Company settled its federal tax audit with the IRS for the year 2013. In 2014, the Company settled its federal tax audit for the year 2012, and in 2013 settled the years 2007, and 2009 through 2011. The tax year 2008 was settled in a prior period. New York State and New York City have examinations underway for various entities covering the years 2007 through 2014. During 2015, Illinois completed its audit of years 2009 through 2010. Outside the United States, during calendar year 2015 examinations commenced in Germany for the years 2009 through 2012. There are ongoing examinations of certain subsidiaries in France for years 2011 to 2014, in Canada for years 2012 and 2013 and in the United Kingdom for years 2011 and 2012, as well as in other smaller jurisdictions. The Company regularly considers the likelihood of assessments in each of the taxing jurisdictions resulting from examinations. The Company has established liabilities for uncertain tax positions in relation to the potential assessments. The Company believes the resolution of tax matters will not have a material effect on the consolidated financial position of the Company, although a resolution of tax matters could have a material impact on the Company's net income or cash flows and on its effective tax rate in a particular future period. It is reasonably possible that the total amount of unrecognized tax benefits will decrease between zero and approximately $8 million within the next twelve months due to the settlement of audits and the expiration of statutes of limitation.

8. Retirement Benefits

The Company maintains qualified and non-qualified defined benefit pension plans for its U.S. and non-U.S. eligible employees. The Company's policy for funding its tax qualified defined benefit retirement plans is to contribute amounts at least sufficient to meet the funding requirements set forth by U.S. law and the laws of the non-U.S. jurisdictions in which the Company offers defined benefit plans.

Combined U.S. and non-U.S. Plans

The weighted average actuarial assumptions utilized for the U.S. and significant non-U.S. defined benefit plans and postretirement benefit plans are as follows:

	Pension Benefits		Postretirement Benefits	
	2015	2014	**2015**	2014
Weighted average assumptions:				
Discount rate (for expense)	**3.83%**	4.82%	**3.87%**	4.92%
Expected return on plan assets	**7.23%**	7.52%	—	—
Rate of compensation increase (for expense)	**2.42%**	2.64%	—	—
Discount rate (for benefit obligation)	**4.11%**	3.79%	**4.12%**	4.08%
Rate of compensation increase (for benefit obligation)	**2.44%**	2.42%	—	—

The Company uses actuaries from Mercer, a subsidiary of the Company, to perform valuations of its pension plans. The long-term rate of return on plan assets assumption is determined for each plan based on the facts and circumstances that exist as of the measurement date, and the specific portfolio mix of each plan's assets. The Company utilizes a model developed by the Mercer actuaries to assist in the determination of this assumption. The model takes into account several factors, including: actual and target portfolio allocation; investment, administrative and trading expenses incurred directly by the plan trust; historical portfolio performance; relevant forward-looking economic analysis; and expected returns, variances and correlations for different asset classes. These measures are used to determine probabilities using standard statistical techniques to calculate a range of expected returns on the portfolio. The Company generally does not adjust the rate of return assumption from year to year if, at the measurement date, it is within the range between the 25th and 75th percentile of the expected long-term annual returns. Historical long-term average asset returns of each plan are also reviewed to determine whether they are consistent and reasonable compared with the rate selected. The expected return on plan assets is determined by applying the assumed long-term rate of return to the market-related value of plan assets. This market-related value recognizes investment gains or losses over a five-year period from the year in which they occur. Investment gains or losses for this purpose are the difference between the expected return calculated using the market-related value of assets and the actual return based on the market value of assets. Since the market-related value of assets recognizes gains or losses over a five-year period, the future market-related value of the assets will be impacted as previously deferred gains or losses are reflected.

The target asset allocation for the U.S. Plans is 64% equities and equity alternatives and 36% fixed income. At the end of 2015, the actual allocation for the U.S. Plans was 63% equities and equity alternatives and 37% fixed income. The target asset allocation for the U.K. Plans, which comprise approximately 83% of non-U.S. Plan assets, is 48% equities and equity alternatives and 52% fixed income. At the end of 2015, the actual allocation for the U.K. Plans was 47% equities and equity alternatives and 53% fixed income. The assets of the Company's defined benefit plans are diversified and are managed in accordance with applicable laws and with the goal of maximizing the plans' real return within acceptable risk parameters. The Company uses threshold-based portfolio re-balancing to ensure the actual portfolio remains consistent with target asset allocation ranges.

The discount rate selected for each U.S. plan is based on a model bond portfolio with coupons and redemptions that closely match the expected liability cash flows from the plan. Discount rates for non-U.S. plans are based on appropriate bond indices adjusted for duration; in the U.K., the plan duration is reflected using the Mercer yield curve.

The components of the net periodic benefit cost for defined benefit and other postretirement plans are as follows:

Combined U.S. and significant non-U.S. Plans	Pension			Postretirement		
For the Years Ended December 31,	Benefits			Benefits		
(In millions of dollars)	**2015**	2014	2013	**2015**	2014	2013
Service cost	**$ 196**	$ 213	$ 252	**$ 3**	$ 4	$ 5
Interest cost	**587**	641	581	**5**	11	11
Expected return on plan assets	**(977)**	(990)	(911)	**—**	—	—
Amortization of prior service (credit) cost	**(1)**	(16)	(22)	**3**	—	—
Recognized actuarial loss (gain)	**271**	243	315	**(1)**	(1)	2
Net periodic benefit cost	**$ 76**	$ 91	$ 215	**$ 10**	$ 14	$ 18
Curtailment (loss) gain	**5**	(65)	—	**—**	—	—
Plan termination	**—**	—	—	**(128)**	—	—
Settlement loss	**1**	—	—	**—**	—	—
Total cost	**$ 82**	$ 26	$ 215	**$ (118)**	$ 14	$ 18

Plan Assets

For the U.S. Plans, investment allocation decisions are made by a fiduciary committee composed of senior executives appointed by the Company's Chief Executive Officer. For the non-U.S. plans, investment allocation decisions are made by local fiduciaries, in consultation with the Company for the larger plans. Plan assets are invested in a manner consistent with the fiduciary standards set forth in all relevant laws relating to pensions and trusts in each country. Primary investment objectives are (1) to achieve an investment return that, in combination with current and future contributions, will provide sufficient funds to pay benefits as they become due, and (2) to minimize the risk of large losses. The investment allocations are designed to meet these objectives by broadly diversifying plan assets among numerous asset classes with differing expected returns, volatilities, and correlations.

The major categories of plan assets include equity securities, equity alternative investments, and fixed income securities. For the U.S. qualified plans, the category ranges are 59-69% for equities and equity alternatives, and 31-41% for fixed income. For the U.K. Plan, the category ranges are 45-51% for equities and equity alternatives, and 49-55% for fixed income. Asset allocation is monitored frequently and re-balancing actions are taken as appropriate. Re-balancing in the U.K. Plan was suspended in 2014 while a contingent guarantee agreement was put in place and the investment strategy of the plan was finalized. After the contingent guarantee agreement was executed in January 2015, re-balancing resumed in February 2015 with target asset allocation of 48% equities and equity alternatives and 52% fixed income.

Plan investments are exposed to stock market, interest rate, and credit risk. Concentrations of these risks are generally limited due to diversification by investment style within each asset class, diversification by investment manager, diversification by industry sectors and issuers, and the dispersion of investments across many geographic areas.

Unrecognized Actuarial Gains/Losses

In accordance with applicable accounting guidance, the funded status of the Company's pension plans is recorded in the consolidated balance sheets and provides for a delayed recognition of actuarial gains or losses arising from changes in the projected benefit obligation due to changes in the assumed discount rates, differences between the actual and expected value of plan assets and other assumption changes. The unrecognized pension plan actuarial gains or losses and prior service costs not yet recognized in net periodic pension cost are recognized in Accumulated Other Comprehensive Income ("AOCI"), net of tax. These gains and losses are amortized prospectively out of AOCI over a period that approximates the average remaining service period of active employees, or for plans in which substantially all the participants are inactive, over the remaining life expectancy of the inactive employees.

Interest and Service Cost

In 2016, the Company changed the approach used to estimate the service and interest cost components of net periodic benefit cost for its significant non-U.S. plans. Historically, service and interest costs were estimated using a single weighted average discount rate derived from the yield curves used to measure the benefit obligations at the beginning of the period. This change in approach was made to improve the correlation between the projected benefit cash flows and the corresponding yield curve spot rates and to provide a more precise measurement of service and interest costs. The change does not impact the measurement of the plans' total Projected Benefit Obligation. The Company has accounted for this change as a change in estimate, that will be applied prospectively beginning in 2016. As a result of this change, service and interest cost in 2016 are expected to be approximately $45 million lower than if the prior methodology were used in 2016.

U.S. Plans

The following schedules provide information concerning the Company's U.S. defined benefit pension plans and postretirement benefit plans:

	U.S. Pension Benefits		U.S. Postretirement Benefits	
(In millions of dollars)	**2015**	2014	**2015**	2014
Change in benefit obligation:				
Benefit obligation at beginning of year	**$ 5,924**	$ 4,827	**$ 177**	$ 158
Service cost	**114**	91	**1**	2
Interest cost	**254**	253	**2**	7
Employee contributions	**—**	—	**3**	13
Plan amendments	**—**	—	**—**	(4)
Plan termination	**—**	—	**(128)**	—
Actuarial (gain) loss	**(392)**	955	**(5)**	21
Medicare part D subsidy	**—**	—	**—**	1
Benefits paid	**(215)**	(202)	**(10)**	(21)
Benefit obligation, December 31	**$ 5,685**	$ 5,924	**$ 40**	$ 177
Change in plan assets:				
Fair value of plan assets at beginning of year	**$ 4,516**	$ 4,279	**$ 18**	$ —
Plan combination	**—**	—	**—**	—
Actual return on plan assets	**(170)**	414	**—**	—
Employer contributions	**29**	25	**4**	13
Employee contributions	**—**	—	**3**	13
Medicare part D subsidy	**—**	—	**—**	1
Benefits paid	**(215)**	(202)	**(10)**	(21)
Other	**—**	—	**(12)**	12
Fair value of plan assets, December 31	**$ 4,160**	$ 4,516	**$ 3**	$ 18
Net funded status, December 31	**$ (1,525)**	$ (1,408)	**$ (37)**	$ (159)
Amounts recognized in the consolidated balance sheets:				
Current liabilities	**$ (26)**	$ (25)	**$ (2)**	$ (2)
Non-current liabilities	**(1,499)**	(1,383)	**(35)**	(157)
Net liability recognized, December 31	**$ (1,525)**	$ (1,408)	**$ (37)**	$ (159)
Amounts recognized in other comprehensive income (loss):				
Prior service (cost) credit	**$ —**	$ —	**$ (7)**	$ 4
Net actuarial (loss) gain	**(1,754)**	(1,749)	**13**	2
Total recognized accumulated other comprehensive (loss) income, December 31	**$ (1,754)**	$ (1,749)	**$ 6**	$ 6
Cumulative employer contributions in excess (less than) net periodic cost	**229**	341	**(43)**	(165)
Net amount recognized in consolidated balance sheet	**$ (1,525)**	$ (1,408)	**$ (37)**	$ (159)
Accumulated benefit obligation at December 31	**$ 5,600**	$ 5,825	**$ —**	$ —

	U.S. Pension Benefits		U.S. Postretirement Benefits	
(In millions of dollars)	**2015**	2014	**2015**	2014
Reconciliation of prior service credit (cost) recognized in accumulated other comprehensive income (loss):				
Beginning balance	**$ —**	$ 7	**$ 4**	$ —
Recognized as component of net periodic benefit cost	**—**	(7)	**3**	—
Plan termination	**—**	—	**(14)**	—
Plan amendment	**—**	—	**—**	4
Prior service (cost) credit, December 31	**$ —**	$ —	**$ (7)**	$ 4

	U.S. Pension Benefits		U.S. Postretirement Benefits	
(In millions of dollars)	**2015**	2014	**2015**	2014
Reconciliation of net actuarial (loss) gain recognized in accumulated other comprehensive income (loss):				
Beginning balance	**$ (1,749)**	$ (974)	**$ 2**	$ 13
Recognized as component of net periodic benefit cost (credit)	**146**	112	**(2)**	(2)
Changes in plan assets and benefit obligations recognized in other comprehensive income (loss):				
Other	**—**	—	**8**	—
Liability experience	**392**	(955)	**5**	(21)
Asset experience	**(543)**	68	**—**	12
Total (loss) gain recognized as change in plan assets and benefit obligations	**(151)**	(887)	**5**	(9)
Net actuarial (loss) gain, December 31	**$ (1,754)**	$ (1,749)	**$ 13**	$ 2

For the Years Ended December 31,	U.S. Pension Benefits			U.S. Postretirement Benefits		
(In millions of dollars)	**2015**	2014	2013	**2015**	2014	2013
Total recognized in net periodic benefit cost and other comprehensive loss (income)	**$ 146**	$ 885	$ (696)	**$ (138)**	$ 14	$ (5)

Estimated amounts that will be amortized from accumulated other comprehensive loss in the next fiscal year:

	U.S. Pension Benefits	U.S. Postretirement Benefits
(In millions of dollars)	2016	2016
Prior service credit	$ —	$ (4)
Net actuarial loss	71	2
Projected cost (credit)	$ 71	$ (2)

The weighted average actuarial assumptions utilized in determining the above amounts for the U.S. defined benefit and other U.S. postretirement plans as of the end of the year are as follows:

	U.S. Pension Benefits		U.S. Postretirement Benefits	
	2015	2014	**2015**	2014
Weighted average assumptions:				
Discount rate (for expense)	**4.41%**	5.30%	**3.90%**	4.99%
Expected return on plan assets	**8.75%**	8.75%	—	—
Rate of compensation increase (for expense)	**2.00%**	2.00%	—	—
Discount rate (for benefit obligation)	**4.74%**	4.30%	**4.36%**	4.19%
Rate of compensation increase (for benefit obligation)	**2.00%**	2.00%	—	—

In 2014, the Society of Actuaries in the United States issued a new mortality table (RP-2014) and an updated improvement scale. The Company considered the effect of RP-2014, along with other available information on mortality improvement and industry specific mortality studies, to select its assumptions for measurement of the plans' benefit obligations at December 31, 2014 and 2015.

The projected benefit obligation, accumulated benefit obligation and aggregate fair value of plan assets for U.S. pension plans with accumulated benefit obligations in excess of plan assets were $5.7 billion, $5.6 billion and $4.2 billion, respectively, as of December 31, 2015 and $5.9 billion, $5.8 billion and $4.5 billion, respectively, as of December 31, 2014.

The projected benefit obligation and fair value of plans assets for U.S. pension plans with projected benefit obligations in excess of plan assets was $5.7 billion and $4.2 billion, respectively, as of December 31, 2015 and $5.9 billion and $4.5 billion, respectively, as of December 31, 2014.

As of December 31, 2015, the U.S. qualified plans hold 4 million shares of the Company's common stock which were contributed to the Plan by the Company in 2005. This represented approximately 5.3% of those plans' assets as of December 31, 2015. In addition, plan assets may be invested in funds managed by Mercer Investments, a subsidiary of the Company.

The components of the net periodic benefit cost for the U.S. defined benefit and other postretirement benefit plans are as follows:

U.S. Plans only For the Years Ended December 31,	Pension Benefits			Postretirement Benefits		
(In millions of dollars)	**2015**	2014	2013	**2015**	2014	2013
Service cost	**$ 114**	$ 91	$ 104	**$ 1**	$ 2	$ 3
Interest cost	**254**	253	229	**2**	7	7
Expected return on plan assets	**(373)**	(346)	(324)	**—**	—	—
Amortization of prior service (credit) cost	**—**	(7)	(16)	**3**	—	—
Recognized actuarial loss (gain)	**146**	112	207	**(2)**	(2)	—
Net periodic benefit cost (credit)	**$ 141**	$ 103	$ 200	**$ 4**	$ 7	$ 10
Plan termination	**—**	—	—	**(128)**	—	—
Total cost (credit)	**$ 141**	$ 103	$ 200	**$ (124)**	$ 7	$ 10

Effective September 1, 2015, the Company divided its U.S. qualified defined benefit plan to provide enhanced flexibility and better manage the risks. The existing plan was amended to cover only the retirees currently receiving benefits and terminated vested participants as of August 1, 2015. The Company's active participants as of that date were transferred into a newly established, legally separate qualified defined benefit plan. The benefits offered to the plans' participants were unchanged. As a result of the plan amendment and establishment of the new plan, the Company re-measured the assets and liabilities of the two plans as required under U.S. GAAP, based on assumptions and market conditions at the amendment date. The net periodic pension expense recognized in 2015 reflects the weighted average costs of the December 31, 2014 measurement and the September 1, 2015 re-measurement.

In March 2015, the Company amended its U.S. Post-65 retiree medical reimbursement plan (the "RRA plan"), resulting in its termination, with benefits to certain participants paid through December 31, 2016. As a result of the termination of the RRA plan, the Company recognized a net credit of approximately $125 million in the first quarter of 2015.

In December 2003, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 became law. The net periodic benefit cost for all periods shown above includes the related subsidy.

The assumed health care cost trend rate for Medicare eligibles and non-Medicare eligibles is approximately 7.3% in 2015, gradually declining to 4.5% in 2029. Assumed health care cost trend rates have a small effect on the amounts reported for the U.S. health care plans because the Company caps its share of health care trend at 5%. A one percentage point change in assumed health care cost trend rates would have no effect on the total service and interest cost components or the postretirement benefit obligation.

Estimated Future Contributions

The Company expects to fund approximately $26 million for its U.S. non-qualified plans in 2016. The Company's policy for funding its tax-qualified defined benefit retirement plans is to contribute amounts at least sufficient to meet the funding requirements set forth in the U.S. and applicable foreign law. There is currently no ERISA funding requirement for the U.S. qualified plans for 2016.

Non-U.S. Plans

The following schedules provide information concerning the Company's non-U.S. defined benefit pension plans and non-U.S. postretirement benefit plans:

	Non-U.S. Pension Benefits		Non-U.S. Postretirement Benefits	
(In millions of dollars)	**2015**	2014	**2015**	2014
Change in benefit obligation:				
Benefit obligation at beginning of year	**$ 10,018**	$ 8,711	**$ 93**	$ 97
Service cost	**82**	122	**2**	2
Interest cost	**333**	388	**3**	4
Employee contributions	**8**	10	**—**	—
Actuarial loss (gain)	**(432)**	1,619	**(6)**	(1)
Plan amendments	**(5)**	13	**—**	—
Effect of settlement	**(12)**	(11)	**—**	—
Effect of curtailment	**8**	—	**—**	—
Benefits paid	**(337)**	(311)	**(3)**	(3)
Foreign currency changes	**(632)**	(585)	**(10)**	(6)
Other	**45**	62	**—**	—
Benefit obligation December 31	**$ 9,076**	$ 10,018	**$ 79**	$ 93
Change in plan assets:				
Fair value of plan assets at beginning of year	**$ 10,410**	$ 9,351	**$ —**	$ —
Actual return on plan assets	**187**	1,756	**—**	—
Effect of settlement	**(12)**	(11)	**—**	—
Company contributions	**166**	156	**3**	3
Employee contributions	**8**	10	**—**	—
Benefits paid	**(337)**	(311)	**(3)**	(3)
Foreign currency changes	**(620)**	(578)	**—**	—
Other	**24**	37	**—**	—
Fair value of plan assets, December 31	**$ 9,826**	$ 10,410	**$ —**	$ —
Net funded status, December 31	**$ 750**	$ 392	**$ (79)**	$ (93)
Amounts recognized in the consolidated balance sheets:				
Non-current assets	**$ 1,144**	$ 967	**$ —**	$ —
Current liabilities	**(5)**	(6)	**(3)**	(4)
Non-current liabilities	**(389)**	(569)	**(76)**	(89)
Net asset (liability) recognized, December 31	**$ 750**	$ 392	**$ (79)**	$ (93)
Amounts recognized in other comprehensive (loss) income:				
Prior service (cost) credit	**$ (3)**	$ (2)	**$ —**	$ —
Net actuarial loss	**(2,887)**	(3,215)	**(6)**	(14)
Total recognized accumulated other comprehensive (loss) income, December 31	**$ (2,890)**	$ (3,217)	**$ (6)**	$ (14)
Cumulative employer contributions in excess (deficient) of net periodic cost	**3,640**	3,609	**(73)**	(79)
Net asset (liability) recognized in consolidated balance sheet, December 31	**$ 750**	$ 392	**$ (79)**	$ (93)
Accumulated benefit obligation, December 31	**$ 8,830**	$ 9,731	**$ —**	$ —

	Non-U.S. Pension Benefits		Non-U.S. Postretirement Benefits	
(In millions of dollars)	**2015**	2014	**2015**	2014
Reconciliation of prior service credit (cost) recognized in accumulated other comprehensive income (loss):				
Beginning balance	**$ (2)**	$ 85	**$ —**	$ —
Recognized as component of net periodic benefit credit	**(1)**	(9)	**—**	—
Effect of curtailment	**(5)**	(65)	**—**	—
Changes in plan assets and benefit obligations recognized in other comprehensive income:				
Plan amendments	**5**	(13)	**—**	—
Exchange rate adjustments	**—**	—	**—**	—
Prior service (cost) credit, December 31	**$ (3)**	$ (2)	**$ —**	$ —

	Non-U.S. Pension Benefits		Non-U.S. Postretirement Benefits	
(In millions of dollars)	**2015**	2014	**2015**	2014
Reconciliation of net actuarial gain (loss) recognized in accumulated other comprehensive income (loss):				
Beginning balance	**$ (3,215)**	$ (3,010)	**$ (14)**	$ (16)
Recognized as component of net periodic benefit cost	**125**	131	**1**	1
Effect of settlement	**2**	—	**—**	—
Changes in plan assets and benefit obligations recognized in other comprehensive (loss) income:				
Liability experience	**432**	(1,619)	**6**	1
Asset experience	**(417)**	1,112	**—**	—
Other	**(20)**	(14)	**—**	—
Total amount recognized as change in plan assets and benefit obligations	**(5)**	(521)	**6**	1
Exchange rate adjustments	**206**	185	**1**	—
Net actuarial loss, December 31	**$ (2,887)**	$ (3,215)	**$ (6)**	$ (14)

For the Years Ended December 31,	Non-U.S. Pension Benefits			Non-U.S. Postretirement Benefits		
(In millions of dollars)	**2015**	2014	2013	**2015**	2014	2013
Total recognized in net periodic benefit cost and other comprehensive loss (income)	**$ (407)**	$ 201	$ (276)	**$ (2)**	$ 5	$ (2)

Estimated amounts that will be amortized from accumulated other comprehensive income in the next fiscal year:

	Non-U.S. Pension Benefits	Non-U.S. Postretirement Benefits
(In millions of dollars)	**2016**	**2016**
Prior service credit	**$ 1**	**$ —**
Net actuarial loss	**(100)**	**—**
Projected cost	**$ (99)**	**$ —**

The weighted average actuarial assumptions utilized for the non-U.S. defined and postretirement benefit plans as of the end of the year are as follows:

	Non-U.S. Pension Benefits		Non-U.S. Postretirement Benefits	
	2015	2014	**2015**	2014
Weighted average assumptions:				
Discount rate (for expense)	**3.49%**	4.55%	**3.85%**	4.80%
Expected return on plan assets	**6.57%**	6.95%	—	—
Rate of compensation increase (for expense)	**2.67%**	2.99%	—	—
Discount rate (for benefit obligation)	**3.71%**	3.49%	**4.00%**	3.85%
Rate of compensation increase (for benefit obligation)	**2.72%**	2.67%	—	—

The non-U.S. defined benefit plans do not have any direct ownership of the Company's common stock.

The pension plan in the United Kingdom no longer holds an interest in the Trident III private equity fund, since the fund fully harvested all its portfolio investments and made final distributions to its partners in 2015.

The projected benefit obligation, accumulated benefit obligation and fair value of plan assets for the non-U.S. pension plans with accumulated benefit obligations in excess of plan assets were $1.7 billion, $1.6 billion and $1.3 billion, respectively, as of December 31, 2015 and $2.1 billion, $2.0 billion and $1.6 billion, respectively, as of December 31, 2014.

The projected benefit obligation and fair value of plan assets for non-U.S. pension plans with projected benefit obligations in excess of plan assets was $1.9 billion and $1.5 billion, respectively, as of December 31, 2015 and $2.2 billion and $1.6 billion, respectively, as of December 31, 2014.

Non-U.S. Plan Amendments

Effective August 1, 2015, the Company amended its Ireland defined benefit pension plans to close those plans to future benefit accruals and replaced those plans with a defined contribution arrangement. The Company re-measured the assets and liabilities of the plans, based on assumptions and market conditions on the amendment date. The net periodic pension costs recognized in 2015 reflects the weighted average costs of the December 31, 2014 measurement and the August 1, 2015 re-measurement.

After completion of a consultation period with affected colleagues, in January 2014, the Company amended its U.K. defined benefit pension plans to close those plans to future benefit accruals effective August 1, 2014 and replaced those plans, along with its existing defined contribution plans, with a new, comprehensive defined contribution arrangement. This change resulted in a curtailment of the U.K. defined benefit plans and, as required under GAAP, the Company re-measured the defined benefit plans' assets and liabilities at the amendment date, based on assumptions and market conditions at that date. The net periodic benefit costs recognized in 2014 are the weighted average resulting from the December 31, 2013 measurement and the January 2014 re-measurement. The Company recognized a curtailment gain of $65 million in the first quarter of 2014, primarily resulting from the recognition of the remaining unamortized prior service credit related to a plan amendment made in December 2012. This gain was mostly offset by the cost of a transition benefit for certain employees most impacted by the amendment, which is not part of net periodic pension cost.

Components of Net Periodic Benefits Costs

The components of the net periodic benefit cost for the non-U.S. defined benefit and other postretirement benefit plans and the curtailment, settlement and termination expenses are as follows:

For the Years Ended December 31,	Non-U.S. Pension Benefits			Non-U.S. Postretirement Benefits		
(In millions of dollars)	**2015**	2014	2013	**2015**	2014	2013
Service cost	**$ 82**	$ 122	$ 148	**$ 2**	$ 2	$ 2
Interest cost	**333**	388	352	**3**	4	4
Expected return on plan assets	**(604)**	(644)	(587)	**—**	—	—
Amortization of prior service cost	**(1)**	(9)	(6)	**—**	—	—
Recognized actuarial loss	**125**	131	108	**1**	1	2
Net periodic benefit (credit) cost	**(65)**	(12)	15	**6**	7	8
Settlement loss	**1**	—	—	**—**	—	—
Curtailment loss (gain)	**5**	(65)	—	**—**	—	—
Total (credit) cost	**$ (59)**	$ (77)	$ 15	**$ 6**	$ 7	$ 8

The assumed health care cost trend rate was approximately 5.30% in 2015, gradually declining to 4.53% in 2026. Assumed health care cost trend rates can have a significant effect on the amounts reported for the non-U.S. health care plans. A one percentage point change in assumed health care cost trend rates would have the following effects:

(In millions of dollars)	1 Percentage Point Increase	1 Percentage Point Decrease
Effect on total of service and interest cost components	$ 1	$ (1)
Effect on postretirement benefit obligation	$ 7	$ (6)

Estimated Future Contributions

The Company expects to fund approximately $191 million to its non-U.S. pension plans in 2016. Funding requirements for non-U.S. plans vary by country. Contribution rates are generally based on local funding practices and requirements, which may differ significantly from measurements under U.S. GAAP. Funding amounts may be influenced by future asset performance, the level of discount rates and other variables impacting the assets and/or liabilities of the plan. Discretionary contributions may also be affected by alternative uses of the Company's cash flows, including dividends, investments and share repurchases.

In the U.K., contributions to defined benefit pension plans are determined through a negotiation process between the Company and the plans' Trustee that typically occurs every three years in conjunction with the actuarial valuation of the plans. This process is governed by U.K. pension regulations. The assumptions that result from the funding negotiations are different from those used for U.S. GAAP and currently result in a lower funded status than under U.S. GAAP. In March 2014, the Company and the Trustee of the U.K. Defined Benefits Plans agreed to a funding deficit recovery plan for the U.K. defined benefit pension plans. The current agreement with the Trustee sets out the annual deficit contributions which would be due based on the deficit at December 31, 2012. The funding level is subject to re-assessment, in most cases on November 1st of each year. If the funding level on November 1st has sufficiently improved, no deficit funding contributions will be required in the following year, and the contribution amount will be deferred. As part of a long-term strategy, which depends on having greater influence over asset allocation and overall investment decisions, the Company has agreed to support annual deficit contributions by the U.K. operating companies under certain circumstances, up to GBP 450 million over a seven-year period.

Estimated Future Benefit Payments

The Plans' estimated future benefit payments for its pension and postretirement benefits (without reduction for Medicare subsidy receipts) are as follows:

For the Years Ended December 31,	Pension Benefits		Postretirement Benefits	
(In millions of dollars)	U.S.	Non-U.S.	U.S.	Non-U.S.
2016	$ 231	$ 260	$ 4	$ 3
2017	$ 247	$ 274	$ 4	$ 4
2018	$ 264	$ 287	$ 4	$ 4
2019	$ 274	$ 299	$ 4	$ 4
2020	$ 286	$ 314	$ 4	$ 4
2021-2025	$ 1,586	$ 1,837	$ 16	$ 19

Defined Benefit Plans Fair Value Disclosures

In December 2008, the FASB issued guidance for Employers' Disclosures About Pension and Other Post Retirement Benefit Plan Assets. The guidance requires fair value plan asset disclosures for an employer's defined benefit pension and postretirement plans similar to the guidance on Fair Value Measurements as well as (a) how investment allocation decisions are made, (b) the major categories of plan assets, and (c) significant concentrations of risk within plan assets.

The U.S. and non-U.S. plan investments are classified into Level 1, which refers to investments valued using quoted prices from active markets for identical assets; Level 2, which refers to investments not traded on an active market but for which observable market inputs are readily available; and Level 3, which refers to investments valued based on significant unobservable inputs. Assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement.

The following table sets forth, by level within the fair value hierarchy, a summary of the U.S. and non-U.S. plans' investments measured at fair value on a recurring basis at December 31, 2015 and 2014:

	Fair Value Measurements at December 31, 2015			
Assets *(In millions of dollars)*	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Common/collective trusts	**$ 175**	**$ 6,591**	**$ 270**	**$ 7,036**
Corporate obligations	**—**	**2,651**	**1**	**2,652**
Corporate stocks	**1,844**	**6**	**2**	**1,852**
Private equity/partnerships	**—**	**—**	**710**	**710**
Government securities	**10**	**415**	**—**	**425**
Real estate	**—**	**8**	**434**	**442**
Short-term investment funds	**312**	**4**	**—**	**316**
Company common stock	**222**	**—**	**—**	**222**
Other investments	**13**	**47**	**257**	**317**
Total investments	**$ 2,576**	**$ 9,722**	**$ 1,674**	**$ 13,972**

	Fair Value Measurements at December 31, 2014			
Assets *(In millions of dollars)*	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Common/collective trusts	$ 172	$ 6,766	$ 184	$ 7,122
Corporate obligations	—	2,938	3	2,941
Corporate stocks	2,087	6	1	2,094
Private equity/partnerships	—	—	727	727
Government securities	—	371	—	371
Real estate	—	6	375	381
Short-term investment funds	724	12	—	736
Company common stock	229	—	—	229
Other investments	16	23	239	278
Total investments	$ 3,228	$ 10,122	$ 1,529	$ 14,879

The tables below set forth a summary of changes in the fair value of the plans' Level 3 assets for the years ended December 31, 2015 and December 31, 2014:

Assets (In millions)	Fair Value, January 1, 2015	Purchases	Sales	Unrealized Gain/ (Loss)	Realized Gain/ (Loss)	Exchange Rate Impact	Transfers in/(out) and Other	Fair Value, December 31, 2015
Private equity/ Partnerships	**$ 727**	**$ 223**	**$(121)**	**$ (263)**	**$ 159**	**$ (15)**	**$ —**	**$ 710**
Real estate	**375**	**50**	**(1)**	**32**	**1**	**(23)**	**—**	**434**
Other investments	**239**	**47**	**(13)**	**14**	**—**	**(30)**	**—**	**257**
Common/ Collective trusts	**184**	**149**	**(27)**	**(6)**	**—**	**(30)**	**—**	**270**
Corporate stocks	**1**	**—**	**—**	**1**	**—**	**—**	**—**	**2**
Corporate obligations	**3**	**—**	**—**	**—**	**—**	**—**	**(2)**	**1**
Total assets	**$ 1,529**	**$ 469**	**$(162)**	**$ (222)**	**$ 160**	**$ (98)**	**$ (2)**	**$ 1,674**

Assets *(In millions)*	Fair Value, January 1, 2014	Purchases	Sales	Unrealized Gain/ (Loss)	Realized Gain/ (Loss)	Exchange Rate Impact	Transfers in/(out) and Other	Fair Value, December 31, 2014
Private equity/ Partnerships	$ 799	$ 158	$ (185)	$ (173)	$ 137	$ (12)	$ 3	$ 727
Real estate	312	97	(50)	19	16	(19)	—	375
Other investments	238	21	(16)	18	—	(28)	6	239
Common/ Collective trusts	151	—	(1)	50	—	(16)	—	184
Corporate stocks	1	—	—	—	—	—	—	1
Corporate obligations	4	3	(1)	—	—	—	(3)	3
Government securities	2	—	—	—	—	—	(2)	—
Total assets	$ 1,507	$ 279	$ (253)	$ (86)	$ 153	$ (75)	$ 4	$ 1,529

The following is a description of the valuation methodologies used for assets measured at fair value:

Company common stock: Valued at the closing price reported on the New York Stock Exchange.

Common stocks, preferred stocks, convertible equity securities and rights/warrants (included in Corporate stocks): Valued at the closing price reported on the primary exchange.

Corporate bonds (included in Corporate obligations): The fair value of corporate bonds is estimated using recently executed transactions, market price quotations (where observable) and bond spreads. The spread data used are for the same maturity as the bond. If the spread data does not reference the issuer, then data that references a comparable issuer are used. When observable price quotations are not available, fair value is determined based on cash flow models.

Commercial mortgage-backed and asset-backed securities (included in Corporate obligations): Fair value is determined using discounted cash flow models. Observable inputs are based on trade and quote activity of bonds with similar features including issuer vintage, purpose of underlying loan (first or second lien), prepayment speeds and credit ratings. The discount rate is the combination of the appropriate rate from the benchmark yield curve and the discount margin based on quoted prices.

Common/Collective trusts: Valued at the net asset value of units of a bank collective trust. The net asset value as provided by the trustee, is used as a practical expedient to estimate fair value. The net asset value is based on the fair value of the underlying investments held by the fund less its liabilities. This practical expedient is not used when it is determined to be probable that the fund will sell the investment for an amount different than the reported net asset value.

U.S. government bonds (included in Government securities): The fair value of U.S. government bonds is estimated by pricing models that utilize observable market data including quotes, spreads and data points for yield curves.

U.S. agency securities (included in Government securities): U.S. agency securities are comprised of two main categories consisting of agency issued debt and mortgage pass-throughs. Agency issued debt securities are valued by benchmarking market-derived prices to quoted market prices and trade data for identical or comparable securities. Mortgage pass-throughs include certain "To-be-announced" (TBA) securities and mortgage pass-through pools. TBA securities are generally valued using quoted market prices or are benchmarked thereto. Fair value of mortgage pass-through pools are model driven with respect to spreads of the comparable TBA security.

Private equity and real estate partnerships: Investments in private equity and real estate partnerships are valued based on the fair value reported by the manager of the corresponding partnership and reported on a one quarter lag. The managers provide unaudited quarterly financial statements and audited annual financial statements which set forth the value of the fund. The valuations obtained from the managers are based on various analyses on the underlying holdings in each partnership, including financial valuation models and projections, comparable valuations from the public markets, and precedent private market transactions. Investments are valued in the accompanying financial statements based on the Plan's beneficial interest in the underlying net assets of the partnership as determined by the partnership agreement.

Insurance group annuity contracts: The fair values for these investments are based on the current market value of the aggregate accumulated contributions plus interest earned.

Swap assets (included in Other investments): Fair values for interest rate swaps, equity index swaps and inflation swaps are estimated using a discounted cash flow pricing model. These models use observable market data such as contractual fixed rate, broker quotes, spot equity price or index value and dividend data. The fair values of credit default swaps are estimated using an income approach model which determines expected cash flows based on default probabilities from the issuer-specific credit spread curve and credit loss recovery rates, both of which are dependent on market quotes.

Real estate investment trusts (included in Corporate stocks): Valued at the closing price reported on an exchange.

Short-term investment funds: Primarily high-grade money market instruments valued at net asset value at year-end.

Real estate: Valued by investment managers generally using proprietary pricing models.

Registered investment companies: Valued at the closing price reported on the primary exchange.

Defined Contribution Plans

The Company maintains certain defined contribution plans for its employees, including the Marsh & McLennan Companies 401(k) Savings & Investment Plan ("401(k) Plan"), that are qualified under U.S. tax laws. Under these plans, eligible employees may contribute a percentage of their base salary, subject to certain limitations. For the 401(k) Plan, the Company matches a fixed portion of the employees' contributions. The 401(k) Plan contains an Employee Stock Ownership Plan feature under U.S. tax law. Approximately $398 million of the 401(k) Plan's assets at December 31, 2015 and $453 million in December 31, 2014 were invested in the Company's common stock. If a participant does not choose an investment direction for his or her future contributions, they are automatically invested in a BlackRock LifePath Portfolio that most closely matches the participant's expected retirement year. The cost of these defined contribution plans was $51 million in 2015, $49 million in 2014 and $50 million in 2013. In addition, the Company has a significant defined contribution plan in the U.K. As noted above, effective August 1, 2014, a newly formed defined contribution plan replaced the existing defined contribution and defined benefit plans with regard to future service. The cost of the U.K. defined contribution plan was $93 million, $65 million and $23 million in 2015, 2014 and 2013, respectively.

9. Stock Benefit Plans

The Company maintains multiple stock-based payment arrangements under which employees are awarded grants of restricted stock units, stock options and other forms of stock-based payment arrangements.

Marsh & McLennan Companies, Inc. Incentive and Stock Award Plans

On May 19, 2011, the Marsh & McLennan Companies, Inc. 2011 Incentive and Stock Award Plan (the "2011 Plan") was approved by the Company's stockholders. The 2011 Plan replaced the Company's two previous equity incentive plans (the 2000 Senior Executive Incentive and Stock Award Plan and the 2000 Employee Incentive and Stock Award Plan).

The types of awards permitted under the 2011 Plan include stock options, restricted stock and restricted stock units payable in Company common stock or cash, and other stock-based and performance-based awards. The Compensation Committee of the Board of Directors (the "Compensation Committee") determines, at its discretion, which affiliates may participate in the 2011 Plan, which eligible employees will receive awards, the types of awards to be received, and the terms and conditions thereof. The right of an employee to receive an award may be subject to performance conditions as specified by the Compensation Committee. The 2011 Plan contains a provision which, in the event of a change in control of the Company, may accelerate the vesting of the awards. This provision requires both a change in control of the Company and a subsequent specified termination of employment for vesting to be accelerated.

The 2011 Plan retains the remaining share authority of the two previous plans as of the date the 2011 Plan was approved by stockholders. Thus, approximately 23.2 million shares of common stock, plus shares remaining unused under the previous plans, are available for awards over the life of the 2011 Plan.

The current practice is to grant non-qualified stock options, restricted stock units and/or performance stock units ("PSUs") on an annual basis to senior executives and a limited number of other employees as part of their total compensation. Restricted stock units are also granted to new hires or as retention awards for certain employees. Restricted stock has not been granted since 2005.

Stock Options: Options granted under the 2011 Plan may be designated as either incentive stock options or non-qualified stock options. The Compensation Committee determines the terms and conditions of the option, including the time or times at which an option may be exercised, the methods by which such exercise price may be paid, and the form of such payment. Options are generally granted with an exercise price equal to the market value of the Company's common stock on the date of grant. These option awards generally vest 25% per annum and have a contractual term of 10 years.

The estimated fair value of options granted is calculated using the Black-Scholes option pricing valuation model. This model takes into account several factors and assumptions. The risk-free interest rate is based on the yield on U.S. Treasury zero-coupon issues with a remaining term equal to the expected life assumption at the time of grant. The expected life (estimated period of time outstanding) is estimated using the contractual term of the option and the effects of employees' expected exercise and post-vesting employment termination behavior. The Company uses a blended volatility rate based on the following: (i) volatility derived from daily closing price observations for the 10-year period ended on the valuation date, (ii) implied volatility derived from traded options for the period one week before the valuation date and (iii) average volatility for the 10-year periods ended on 15 anniversaries prior to the valuation date, using daily closing price observations. The expected dividend yield is based on expected dividends for the expected term of the stock options.

The assumptions used in the Black-Scholes option pricing valuation model for options granted by the Company in 2015, 2014 and 2013 are as follows:

	2015	2014	2013
Risk-free interest rate	**1.78%**	1.88%	1.03%-1.30%
Expected life (in years)	**6.0**	6.0	6.0
Expected volatility	**23.75%**	24.2%	23.6%-24.1%
Expected dividend yield	**1.97%**	2.08%	2.48%-2.54%

A summary of the status of the Company's stock option awards as of December 31, 2015 and changes during the year then ended is presented below:

	Shares	**Weighted Average Exercise Price**	**Weighted Average Remaining Contractual Term**	**Aggregate Intrinsic Value ($000)**
Balance at January 1, 2015	**17,995,082**	**$ 30.97**		
Granted	**1,574,706**	**$ 56.84**		
Exercised	**(4,607,079)**	**$ 29.24**		
Forfeited	**(131,126)**	**$ 46.43**		
Expired	**(54,779)**	**$ 30.45**		
Balance at December 31, 2015	**14,776,804**	**$ 34.14**	**5.4 years**	**$ 328,225**
Options vested or expected to vest at December 31, 2015	**14,584,291**	**$ 34.04**	**5.4 years**	**$ 325,388**
Options exercisable at December 31, 2015	**10,104,569**	**$ 28.88**	**4.3 years**	**$ 276,975**

In the above table, forfeited options are unvested options whose requisite service period has not been met. Expired options are vested options that were not exercised. The weighted-average grant-date fair value of the Company's option awards granted during the years ended December 31, 2015, 2014 and 2013 was $11.34, $9.66 and $6.21, respectively. The total intrinsic value of options exercised during the same periods was $124.6 million, $174.3 million and $198.1 million, respectively.

As of December 31, 2015, there was $11.8 million of unrecognized compensation cost related to the Company's option awards. The weighted-average period over which that cost is expected to be recognized is approximately 1.16 years. Cash received from the exercise of stock options for the years ended December 31, 2015, 2014 and 2013 was $134.7 million, $178.1 million and $281.1 million, respectively.

The Company's policy is to issue treasury shares upon option exercises or share unit conversion. The Company intends to issue treasury shares as long as an adequate number of those shares is available.

Restricted Stock Units and Performance Stock Units: Restricted stock units may be awarded under the Company's 2011 Incentive and Stock Award Plan. The Compensation Committee determines the restrictions on such units, when the restrictions lapse, when the units vest and are paid, and under what terms the units are forfeited. The cost of these awards is amortized over the vesting period, which is generally three years. Awards to senior executives and other employees may include three-year performance-based restricted stock units and three-year service-based restricted stock units. The payout of performance stock units (payable in shares of the Company's common stock) ranges, generally, from 0-200% of the number of units granted, based on the achievement of objective, pre-determined Company performance measures, generally, over a three-year performance period. The Company accounts for these awards as performance condition restricted stock units. The performance condition is not considered in the determination of grant date fair value of such awards. Compensation cost is recognized over the performance period based on management's estimate of the number of units expected to vest and is adjusted to reflect the actual number of shares paid out at the end of the three-year performance period. Dividend equivalents are not paid out unless and until such time that the award vests.

A summary of the status of the Company's restricted stock units and performance stock units as of December 31, 2015 and changes during the period then ended is presented below:

	Restricted Stock Units		Performance Stock Units	
	Shares	Weighted Average Grant Date Fair Value	Shares	Weighted Average Grant Date Fair Value
Non-vested balance at January 1, 2015	2,097,730	$ 38.74	868,008	$ 37.56
Granted	1,737,354	$ 56.81	210,829	$ 56.84
Vested	(1,264,076)	$ 35.56	(373,449)	$ 31.99
Forfeited	(111,715)	$ 52.67	(27,223)	$ 46.91
Non-vested balance at December 31, 2015	2,459,293	$ 52.51	678,165	$ 46.25

The weighted-average grant-date fair value of the Company's restricted stock units granted during the years ended December 31, 2014 and 2013 was $48.16 and $36.70, respectively. The weighted average grant date fair value of the Company's performance stock units granted during the years ended December 31, 2014 and 2013 was $48.00 and $36.54, respectively. The total fair value of the shares distributed during the years ended December 31, 2015, 2014 and 2013 in connection with the Company's non-option equity awards was $114.3 million, $165.3 million and $205.5 million, respectively.

The payout of shares in respect of PSUs awarded in 2012 that vested in 2015 on the PSU Scheduled Vesting Date was 200% of target. The payout of shares in respect of PSUs awarded in 2013 and 2014 that vested in 2015 (either in full or on a pro-rata basis due to certain types of termination) was 200% and 167% of target, respectively. In aggregate, 746,370 shares became distributable in respect to PSUs vested in 2015.

Restricted Stock: Restricted shares of the Company's common stock may be awarded under the 2011 Plan and are subject to restrictions on transferability and other restrictions, if any, as the Compensation Committee may impose. The Compensation Committee may also determine when and under what circumstances the restrictions may lapse and whether the participant receives the rights of a stockholder, including, without limitation, the right to vote and receive dividends. Unless the Compensation Committee determines otherwise, restricted stock that is still subject to restrictions is forfeited upon termination of employment. There have been no restricted shares granted since 2005.

A summary of the status of the Company's restricted stock awards as of December 31, 2015 and changes during the period then ended is presented below:

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance at January 1, 2015	7,200	$ 46.14
Granted	—	$ —
Vested	(7,200)	$ 46.14
Forfeited	—	$ —
Non-vested balance at December 31, 2015	—	$ —

The total fair value of the Company's restricted stock distributed was $0.4 million during the year ended December 31, 2015 and $1.1 million during the year ended December 31, 2013. There were no restricted stock distributions during 2014.

As of December 31, 2015, there was $94.5 million of unrecognized compensation cost related to the Company's restricted stock, restricted stock units and performance stock unit awards. The weighted-average period over which that cost is expected to be recognized is approximately 1.1 years.

Marsh & McLennan Companies Stock Purchase Plans

In May 1999, the Company's stockholders approved an employee stock purchase plan (the "1999 Plan") to replace the 1994 Employee Stock Purchase Plan (the "1994 Plan"), which terminated on September 30, 1999 following its fifth annual offering. Under the current terms of the Plan, shares are purchased four times during the plan year at a price that is 95% of the average market price on each quarterly purchase date. Under the 1999 Plan, after including the available remaining unused shares in the 1994 Plan and reducing the shares available by 10,000,000 consistent with the Company's Board of Directors' action in March 2007, no more than 35,600,000 shares of the Company's common stock may be sold. Employees purchased 507,411 shares during the year ended December 31, 2015 and at December 31, 2015, 2,271,784 shares were available for issuance under the 1999 Plan. Under the 1995 Company Stock Purchase Plan for International Employees (the "International Plan"), after reflecting the additional 5,000,000 shares of common stock for issuance approved by the Company's Board of Directors in July 2002, and the addition of 4,000,000 shares due to a shareholder action in May 2007, no more than 12,000,000 shares of the Company's common stock may be sold. Employees purchased 145,422 shares during the year ended December 31, 2015 and there were 2,748,564 shares available for issuance at December 31, 2015 under the International Plan. The plans are considered non-compensatory.

10. Fair Value Measurements

Fair Value Hierarchy

The Company has categorized its assets and liabilities that are valued at fair value on a recurring basis into a three-level fair value hierarchy as defined by the accounting literature. The fair value hierarchy gives the highest priority to quoted prices in active markets for identical assets and liabilities (Level 1) and lowest priority to unobservable inputs (Level 3). In some cases, the inputs used to measure fair value might fall into different levels of the fair value hierarchy. In such cases, the level in the fair value hierarchy, for disclosure purposes, is determined based on the lowest level input that is significant to the fair value measurement. Assets and liabilities recorded in the consolidated balance sheets at fair value are categorized based on the inputs in the valuation techniques as follows:

Level 1. Assets and liabilities whose values are based on unadjusted quoted prices for identical assets or liabilities in an active market (examples include active exchange-traded equity securities and money market mutual funds).

Assets and liabilities utilizing Level 1 inputs include exchange-traded mutual funds and money market funds.

Level 2. Assets and liabilities whose values are based on the following:

a) Quoted prices for similar assets or liabilities in active markets;

b) Quoted prices for identical or similar assets or liabilities in non-active markets (examples include corporate and municipal bonds, which trade infrequently);

c) Pricing models whose inputs are observable for substantially the full term of the asset or liability (examples include most over-the-counter derivatives, including interest rate and currency swaps); and

d) Pricing models whose inputs are derived principally from or corroborated by observable market data through correlation or other means for substantially the full asset or liability (for example, certain mortgage loans).

The Company does not have any assets or liabilities that utilize Level 2 inputs.

Level 3. Assets and liabilities whose values are based on prices, or valuation techniques that require inputs that are both unobservable and significant to the overall fair value measurement. These inputs reflect management's own assumptions about the assumptions a market participant would use in pricing the asset or liability (examples include private equity investments, certain commercial mortgage whole loans, and long-dated or complex derivatives including certain foreign exchange options and long-dated options on gas and power).

Liabilities utilizing Level 3 inputs include liabilities for contingent purchase consideration.

Valuation Techniques

Equity Securities and Mutual Funds - Level 1

Investments for which market quotations are readily available are valued at the sale price on their principal exchange, or official closing bid price for certain markets.

Contingent Purchase Consideration Liability - Level 3

Purchase consideration for some acquisitions made by the Company includes contingent consideration arrangements. Contingent consideration arrangements are primarily based on meeting EBITDA and revenue targets over periods from two to four years. The fair value of contingent consideration is estimated as the present value of future cash flows resulting from the projected revenue and earnings of the acquired entities.

The following fair value hierarchy table presents information about the Company's assets and liabilities measured at fair value on a recurring basis as of December 31, 2015 and 2014:

(In millions of dollars)	Identical Assets (Level 1)		Observable Inputs (Level 2)		Unobservable Inputs (Level 3)		Total	
	12/31/15	12/31/14	**12/31/15**	12/31/14	**12/31/15**	12/31/14	**12/31/15**	12/31/14
Assets:								
Financial instruments owned:								
Mutual funds[a]	**$ 142**	$ 150	**$ —**	$ —	**$ —**	$ —	**$ 142**	$ 150
Money market funds[b]	**140**	107	**—**	—	**—**	—	**140**	107
Total assets measured at fair value	**$ 282**	$ 257	**$ —**	$ —	**$ —**	$ —	**$ 282**	$ 257
Fiduciary Assets:								
Money market funds	**$ 48**	$ 57	**$ —**	$ —	**$ —**	$ —	**$ 48**	$ 57
Total fiduciary assets measured at fair value	**$ 48**	$ 57	**$ —**	$ —	**$ —**	$ —	**$ 48**	$ 57
Liabilities:								
Contingent purchase consideration liability[c]	**$ —**	$ —	**$ —**	$ —	**$ 309**	$ 207	**$ 309**	$ 207
Total liabilities measured at fair value	**$ —**	$ —	**$ —**	$ —	**$ 309**	$ 207	**$ 309**	$ 207

(a) Included in other assets in the consolidated balance sheets.
(b) Included in cash and cash equivalents in the consolidated balance sheets.
(c) Included in accounts payable and accrued liabilities and other liabilities in the consolidated balance sheets.

During the year ended December 31, 2015, there were no assets or liabilities that transferred between any of the levels.

The table below sets forth a summary of the changes in fair value of the Company's Level 3 liabilities for the years ended December 31, 2015 and December 31, 2014 that represent contingent purchase consideration related to acquisitions:

(In millions of dollars)		**2015**		2014
Balance at January 1,	**$**	**207**	$	104
Additions		**104**		114
Payments		**(47)**		(42)
Revaluation Impact		**45**		31
Balance at December 31,	**$**	**309**	$	207

The fair value of the contingent purchase consideration liability is based on projections of revenue and earnings for the acquired entities that are reassessed on a quarterly basis. As set forth in the table above, based on the Company's ongoing assessment of the fair value of contingent consideration, the Company recorded a net increase in the estimated fair value of such liabilities for prior period acquisitions of $45 million for the year ended December 31, 2015. A 5% increase in the above mentioned projections would increase the liability by approximately $24 million. A 5% decrease in the above mentioned projections would decrease the liability by approximately $37 million.

Long-Term Investments

The Company holds investments in certain private companies, public companies and certain private equity investments that are accounted for using the equity method of accounting. The carrying value of these investments amounted to $347 million and $388 million at December 31, 2015 and 2014, respectively.

The Company's investments in private equity funds were $76 million and $61 million at December 31, 2015 and December 31, 2014, respectively. The carrying values of these private equity investments approximates fair value. The underlying private equity funds follow investment company accounting, where investments within the fund are carried at fair value. The Company records in earnings, investment gains/losses for its proportionate share of the change in fair value of the funds. These investments would be classified as Level 3 in the fair value hierarchy and are included in other assets in the consolidated balance sheets.

Alexander Forbes: During 2014, the Company acquired a 34% interest in South Africa-based Alexander Forbes Group Holding Limited ("Alexander Forbes") becoming a strategic shareholder after Alexander Forbes successfully launched an initial public offering. Mercer purchased its stake in Alexander Forbes in two tranches at 7.50 South African Rand per share for aggregate purchase consideration of approximately $300 million.

Upon completion of the acquisition, the purchase price of the Alexander Forbes shares exceeded the Company's share of the equity in net assets by approximately $146 million. The majority of this basis difference resulted from the excess of the Company's purchase price for the Alexander Forbes common stock acquired over the book value of Alexander Forbes' net assets. Substantially all of this basis difference was allocated, based on the fair values of Alexander Forbes' assets and liabilities, to the value of investment contracts, customer contracts and relationships acquired and technology related intangible assets, related deferred tax liability and goodwill. The basis difference related to these intangible assets (excluding goodwill) is recorded as additional amortization expense over their estimated lives. The basis difference related to the goodwill will be recognized upon disposition of our investment.

Alexander Forbes principally focuses on employee benefits and investment solutions for institutional clients, and financial wellbeing and retail financial solutions for individual clients. Services include retirement funds and investment consulting, actuarial and administration services, employee risk benefits and health-care consulting, multi-manager investments solutions, and personal lines and business insurance.

As of December 31, 2015, the carrying value of the Company's investment in Alexander Forbes was approximately $230 million. As of December 31, 2015, the market value of the approximately 443 million shares owned by the Company, based on the December 31, 2015 closing share price of 5.78 South

African Rand per share, was approximately $166 million. During 2015, the share price of Alexander Forbes ranged from 5.32 Rand to 10.38 Rand. The trading price first dropped below MMC's purchase price in November 2015. The Company considered several factors related to its investment in Alexander Forbes, including its financial position, the near- and long-term prospects of Alexander Forbes and the broader South African economy and capital markets, the length of time and extent to which the market value was below cost, and the Company's intent and ability to retain the investment for a sufficient period of time to allow for anticipated recovery in market value. As a result, the Company determined the investment was not impaired.

The carrying value of the Company's investment in Alexander Forbes and its other investments in private companies that are accounted for using the equity method of accounting is included in other assets in the consolidated balance sheets and the related results are included in revenue in the consolidated income statements. The Company records its share of income or loss on its equity method investments on a one quarter lag basis.

On February 24, 2015, Mercer purchased shares of common stock of Benefitfocus (NASDAQ:BNFT) constituting approximately 9.9% of BNFT's outstanding capital stock as of the acquisition date. The purchase price for the BNFT shares and certain other rights and other consideration was approximately $75 million. The Company has elected to account for this investment under the cost method of accounting as the shares purchased are categorized as restricted and cannot be sold for more than one year. Effective January 1, 2017, these shares will be be accounted for as available for sale securities and classified as Level 2 in the fair value hierarchy and included in other assets in the consolidated balance sheets. The value of the BNFT shares based on the closing price on the NASDAQ at December 31, 2015 and without regard to the restrictions on sale was approximately $102 million.

The summarized financial information presented below reflects the aggregated financial information of all significant equity method investees as of and for the twelve months ended September 30 of each year (or portion of those twelve months the Company owned its investment), consistent with the Company's recognition of the results of its equity method investments on a one quarter lag. The investment income information presented below reflects the net realized and unrealized gains/losses, net of expenses, related to the Company's investments in several private equity funds. Certain of the Company's equity method investments, including Alexander Forbes, have unclassified balance sheets. Therefore, the asset and liability information presented below are not split between current and non-current.

Below is a summary of the financial information for the Company's significant equity method investees:

For the Twelve Months Ended September 30, *(In millions of dollars)*		**2015**		2014		2013
Revenue	**$**	**1,018**	$	239	$	148
Net investment income (a)	**$**	**1,620**	$	161	$	88
Net income	**$**	**196**	$	216	$	135

As of September 30, *(In millions of dollars)*		**2015**		2014
Total assets	**$**	**21,101**	$	25,497
Total liabilities	**$**	**19,348**	$	24,209
Non-controlling interests	**$**	**12**	$	14

The information above includes twelve months of income statement activity for Alexander Forbes in 2015 and two months of activity in 2014, reflecting the timing of the Company's investment.

(a) Net investment income in 2015 includes approximately $1.5 billion related to Alexander Forbes, substantially all of which is credited to policy holders.

11. Long-term Commitments

The Company leases office facilities, equipment and automobiles under non-cancelable operating leases. These leases expire on varying dates, in some instances contain renewal and expansion options, do not restrict the payment of dividends or the incurrence of debt or additional lease obligations, and contain no significant purchase options. In addition to the base rental costs, occupancy lease agreements generally provide for rent escalations resulting from increased assessments for real estate taxes and other charges. Approximately 98% of the Company's lease obligations are for the use of office space.

The consolidated statements of income include net rental costs of $381 million, $393 million and $403 million for 2015, 2014 and 2013, respectively, after deducting rentals from subleases ($14 million in 2015, $12 million in 2014 and $13 million in 2013). These net rental costs exclude rental costs and sublease income for previously accrued restructuring charges related to vacated space.

At December 31, 2015, the aggregate future minimum rental commitments under all non-cancelable operating lease agreements are as follows:

For the Years Ended December 31, *(In millions of dollars)*	Gross Rental Commitments	Rentals from Subleases	Net Rental Commitments
2016	$ 372	$ 47	$ 325
2017	$ 341	$ 44	$ 297
2018	$ 311	$ 42	$ 269
2019	$ 259	$ 35	$ 224
2020	$ 224	$ 32	$ 192
Subsequent years	$ 847	$ 5	$ 842

The Company has entered into agreements, primarily with various service companies, to outsource certain information systems activities and responsibilities and processing activities. Under these agreements, the Company is required to pay minimum annual service charges. Additional fees may be payable depending upon the volume of transactions processed, with all future payments subject to increases for inflation. At December 31, 2015, the aggregate fixed future minimum commitments under these agreements are as follows:

For the Years Ended December 31, *(In millions of dollars)*	Future Minimum Commitments
2016	$ 172
2017	64
2018	37
Subsequent years	11
	$ 284

12. Debt

The Company's outstanding debt is as follows:

December 31, *(In millions of dollars)*		**2015**		2014 *
Short-term:				
Current portion of long-term debt	$	**12**	$	11
Long-term:				
Senior notes – 2.30% due 2017		**249**		249
Senior notes – 2.55% due 2018		**249**		249
Senior notes – 2.35% due 2019		**298**		298
Senior notes – 2.35% due 2020		**496**		—
Senior notes – 4.80% due 2021		**497**		497
Senior notes – 4.05% due 2023		**248**		247
Senior notes – 3.50% due 2024		**595**		594
Senior notes – 3.50% due 2025		**495**		494
Senior notes – 3.75% due 2026		**595**		—
Senior notes – 5.875% due 2033		**297**		297
Mortgage – 5.70% due 2035		**393**		403
Term Loan Facility		**—**		50
Other		**2**		1
		4,414		3,379
Less current portion		**12**		11
	$	**4,402**	$	3,368

* Amended to reflect the adoption in 2015 of new Financial Accounting Standards Board guidance related to the presentation of debt issuance costs.

The senior notes in the table above are publically registered by the Company with no guarantees attached.

In September 2015, the Company issued $600 million of 3.75% 10.5-year senior notes. The Company used the net proceeds for general corporate purposes.

In March 2015, the Company issued $500 million of 2.35% five-year senior notes. The Company used the net proceeds for general corporate purposes.

In September 2014, the Company issued $300 million of 2.35% five-year senior notes and $500 million of 3.50% 10.5-year senior notes. In October 2014, a significant portion of the net proceeds of this offering were used to redeem $630 million of debt, including $230 million of 5.75% senior notes due in September 2015 and $400 million of 9.25% senior notes due in 2019. Total cash outflow related to this transaction was approximately $765 million, including a $137 million cost for early redemption, which was reflected as a charge in the consolidated statements of income in the fourth quarter of 2014.

In May 2014, the Company issued $600 million of 3.50% ten-year senior notes. The net proceeds of this offering were used for general corporate purposes, which included the repayment of $320 million of the existing 5.375% senior notes, which matured on July 15, 2014.

On November 24, 2015, the Company and certain of its foreign subsidiaries amended a $1.2 billion multi-currency five-year revolving credit facility, that was due to expire in March 2019, into a new $1.5 billion multi-currency five-year unsecured revolving credit facility. The interest rate on this facility is based on LIBOR plus a fixed margin which varies with the Company's credit ratings. This facility expires in November 2020 and requires the Company to maintain certain coverage and leverage ratios which are tested quarterly. There were no borrowings outstanding under this facility at December 31, 2015.

The Company and certain of its foreign subsidiaries previously maintained a $1.2 billion multi-currency five-year revolving credit facility. The facility was previously due to expire in March 2019 and was in effect

until November 2015. There were no borrowings outstanding under this facility at the time it was amended.

The Company has a $150 million uncommitted bank credit line. There were no borrowings under this facility at December 31, 2015.

In December 2012, the Company closed on a $50 million, three-year term loan facility, which was terminated on October 30, 2015.

Additional credit facilities, guarantees and letters of credit are maintained with various banks, primarily related to operations located outside the United States, aggregating $229 million at December 31, 2015 and $260 million at December 31, 2014. There was $0.4 million outstanding borrowings under these facilities at December 31, 2015 and $0.6 million outstanding borrowings under these facilities at December 31, 2014.

Scheduled repayments of long-term debt in 2016 and in the four succeeding years are $12 million, $263 million, $262 million, $313 million and $514 million, respectively.

Fair value of Short-term and Long-term Debt

The estimated fair value of the Company's short-term and long-term debt is provided below. Certain estimates and judgments were required to develop the fair value amounts. The fair value amounts shown below are not necessarily indicative of the amounts that the Company would realize upon disposition, nor do they indicate the Company's intent or need to dispose of the financial instrument.

	December 31, 2015		December 31, 2014	
(In millions of dollars)	**Carrying Amount**	**Fair Value**	Carrying Amount	Fair Value
Short-term debt	**$ 12**	**$ 12**	$ 11	$ 11
Long-term debt	**$ 4,402**	**$ 4,513**	$ 3,376	$ 3,493

The fair value of the Company's short-term debt consists primarily of term debt maturing within the next year and its fair value approximates its carrying value. The estimated fair value of a primary portion of the Company's long-term debt is based on discounted future cash flows using current interest rates available for debt with similar terms and remaining maturities. Short- and long-term debt would be classified as Level 2 in the fair value hierarchy.

13. Integration and Restructuring Costs

In 2015, the Company implemented restructuring actions which resulted in costs totaling $28 million. Restructuring costs consist primarily of severance and benefits, costs for future rent and other real estate costs. These costs were incurred as follows: Risk and Insurance Services—$8 million; Consulting—$8 million; and Corporate—$12 million.

Details of the restructuring liability activity from January 1, 2014 through December 31, 2015, including actions taken prior to 2015, are as follows:

(In millions of dollars)	Balance at 1/1/14	Expense Incurred	Cash Paid	Other	Balance at 12/31/14	Expense Incurred	Cash Paid	Other	**Balance at 12/31/15**
Severance	$ 11	$ 4	$ (8)	$ —	$ 7	$ 17	$ (7)	$ (2)	**$ 15**
Future rent under non-cancelable leases and other costs	113	8	(35)	(1)	85	11	(21)	3	**78**
Total	$ 124	$ 12	$ (43)	$ (1)	$ 92	$ 28	$ (28)	$ 1	**$ 93**

As of January 1, 2013, the liability balance related to restructuring activity was $170 million. In 2013, the Company accrued $22 million and had cash payments and other adjustments of $68 million related to restructuring activities that resulted in the liability balance at January 1, 2014 reported above.

The expenses associated with the above initiatives are included in compensation and benefits and other operating expenses in the consolidated statements of income. The liabilities associated with these initiatives are classified on the consolidated balance sheets as accounts payable and accrued liabilities, other liabilities, or accrued compensation and employee benefits, depending on the nature of the items.

14. Common Stock

During 2015, the Company repurchased 24.8 million shares of its common stock for total consideration of $1.4 billion. In May 2015, the Board of Directors renewed the Company's share repurchase program, allowing management to buy back up to $2 billion of the Company's common stock. The Company remains authorized to purchase additional shares of its common stock up to a value of approximately $1.2 billion. There is no time limit on the authorization. During 2014, the Company purchased 15.5 million shares of its common stock for total consideration of $800 million.

15. Claims, Lawsuits and Other Contingencies

Litigation Matters

The Company and its subsidiaries are subject to a significant number of claims, lawsuits and proceedings in the ordinary course of business. Such claims and lawsuits consist principally of alleged errors and omissions in connection with the performance of professional services, including the placement of insurance, the provision of actuarial services for corporate and public sector clients, the provision of investment advice and investment management services to pension plans, the provision of advice relating to pension buy-out transactions and the provision of consulting services relating to the drafting and interpretation of trust deeds and other documentation governing pension plans. These claims may seek damages, including punitive and treble damages, in amounts that could, if awarded, be significant. In establishing liabilities for errors and omissions claims in accordance with FASB ASC Subtopic No. 450-20 (Contingencies-Loss Contingencies), the Company uses case level reviews by inside and outside counsel, an internal actuarial analysis and other analysis to estimate potential losses. A liability is established when a loss is both probable and reasonably estimable. The liability is reviewed quarterly and adjusted as developments warrant. In many cases, the Company has not recorded a liability, other than for legal fees to defend the claim, because we are unable, at the present time, to make a determination that a loss is both probable and reasonably estimable.

To the extent that expected losses exceed our deductible in any policy year, the Company also records an asset for the amount that we expect to recover under any available third-party insurance programs. The Company has varying levels of third-party insurance coverage, with policy limits and coverage terms varying significantly by policy year.

Governmental Inquiries and Enforcement Matters

Our activities are regulated under the laws of the United States and its various states, the European Union and its member states, and the other jurisdictions in which the Company operates. In the ordinary course of business, the Company is also subject to subpoenas, investigations, lawsuits and other regulatory actions undertaken by governmental authorities.

Other Contingencies-Guarantees

In connection with its acquisition of U.K.-based Sedgwick Group in 1998, the Company acquired several insurance underwriting businesses that were already in run-off, including River Thames Insurance Company Limited ("River Thames"), which the Company sold in 2001. Sedgwick guaranteed payment of claims on certain policies underwritten through the Institute of London Underwriters (the "ILU") by River Thames. The policies covered by this guarantee were reinsured up to £40 million by a related party of River Thames. Payment of claims under the reinsurance agreement is collateralized by segregated assets held in a trust. As of December 31, 2015, the reinsurance coverage exceeded the best estimate of the projected liability of the policies covered by the guarantee. To the extent River Thames or the

reinsurer is unable to meet its obligations under those policies, a claimant may seek to recover from the Company under the guarantee.

From 1980 to 1983, the Company owned indirectly the English & American Insurance Company ("E&A"), which was a member of the ILU. The ILU required the Company to guarantee a portion of E&A's obligations. After E&A became insolvent in 1993, the ILU agreed to discharge the guarantee in exchange for the Company's agreement to post an evergreen letter of credit that is available to pay claims by policyholders on certain E&A policies issued through the ILU and incepting between July 3, 1980 and October 6, 1983. Certain claims have been paid under the letter of credit and the Company anticipates that additional claimants may seek to recover against the letter of credit.

Kroll-related Matters

Under the terms of a stock purchase agreement with Altegrity, Inc. ("Altegrity") related to Altegrity's purchase of Kroll from the Company in August 2010, a copy of which is attached as an exhibit to the Company's Quarterly Report on Form 10-Q for the period ended June 30, 2010, the Company agreed to provide a limited indemnity to Altegrity with respect to certain Kroll-related litigation and regulatory matters.

* * * *

The pending proceedings and other matters described in this Note 15 on Claims, Lawsuits and Other Contingencies may expose the Company or its subsidiaries to liability for significant monetary damages and other forms of relief. Where a loss is both probable and reasonably estimable, the Company establishes liabilities in accordance with FASB ASC Subtopic No. 450-20 (Contingencies-Loss Contingencies). Except as described above, the Company is not able at this time to provide a reasonable estimate of the range of possible loss attributable to these matters or the impact they may have on the Company's consolidated results of operations, financial position or cash flows. This is primarily because these matters are still developing and involve complex issues subject to inherent uncertainty. Adverse determinations in one or more of these matters could have a material impact on the Company's consolidated results of operations, financial condition or cash flows in a future period.

16. Segment Information

The Company is organized based on the types of services provided. Under this organizational structure, the Company's segments are:

- **Risk and Insurance Services**, comprising insurance services (Marsh) and reinsurance services (Guy Carpenter); and
- **Consulting**, comprising Mercer and Oliver Wyman Group

The accounting policies of the segments are the same as those used for the consolidated financial statements described in Note 1. Segment performance is evaluated based on segment operating income, which includes directly related expenses, and charges or credits related to integration and restructuring but not the Company's corporate-level expenses. Revenues are attributed to geographic areas on the basis of where the services are performed.

Selected information about the Company's segments and geographic areas of operation are as follows:

For the Year Ended December 31, *(In millions of dollars)*	Revenue	Operating Income (Loss)	Total Assets (d)	Depreciation and Amortization	Capital Expenditures
2015 –					
Risk and Insurance Services	**$ 6,869 (a)**	**$ 1,539**	**$ 13,290**	**$ 240**	**$ 136**
Consulting	**6,064 (b)**	**1,075**	**6,485**	**120**	**108**
Total Segments	**12,933**	**2,614**	**19,775**	**360**	**244**
Corporate/Eliminations	**(40)**	**(195)**	**(1,559) (c)**	**63**	**81**
Total Consolidated	**$ 12,893**	**$ 2,419**	**$ 18,216**	**$ 423**	**$ 325**
2014 –					
Risk and Insurance Services	$ 6,931 (a)	$ 1,509	$ 12,211	$ 213	$ 173
Consulting	6,059 (b)	996	5,916	119	92
Total Segments	12,990	2,505	18,127	332	265
Corporate/Eliminations	(39)	(204)	(334) (c)	56	103
Total Consolidated	$ 12,951	$ 2,301	$ 17,793	$ 388	$ 368
2013 –					
Risk and Insurance Services	$ 6,596 (a)	$ 1,421	$ 11,365	$ 192	$ 158
Consulting	5,701 (b)	845	5,178	115	155
Total Segments	12,297	2,266	16,543	307	313
Corporate/Eliminations	(36)	(189)	417 (c)	51	88
Total Consolidated	$ 12,261	$ 2,077	$ 16,960	$ 358	$ 401

(a) Includes inter-segment revenue of $6 million in 2015, $4 million in 2014 and $5 million in 2013, interest income on fiduciary funds of $21 million, $24 million and $27 million in 2015, 2014 and 2013, respectively, and equity method income of $6 million, $9 million and $8 million in 2015, 2014 and 2013, respectively.

(b) Includes inter-segment revenue of $34 million, $35 million and $31 million in 2015, 2014 and 2013, respectively, interest income on fiduciary funds of $4 million in 2015, $6 million in 2014 and $5 million in 2013 and equity method income of $21 million in 2015, $2 million in 2014 and $0 million in 2013.

(c) Corporate assets primarily include insurance recoverables, pension related assets, the owned portion of the Company headquarters building and intercompany eliminations.

(d) Amended to reflect the adoption in 2015 of new Financial Accounting Standards Board guidance related to the presentation of deferred taxes and debt issuance costs.

Details of operating segment revenue are as follows:

For the Years Ended December 31, *(In millions of dollars)*	**2015**	2014	2013
Risk and Insurance Services			
Marsh	**$ 5,745**	$ 5,774	$ 5,461
Guy Carpenter	**1,124**	1,157	1,135
Total Risk and Insurance Services	**6,869**	6,931	6,596
Consulting			
Mercer	**4,313**	4,350	4,241
Oliver Wyman Group	**1,751**	1,709	1,460
Total Consulting	**6,064**	6,059	5,701
Total Segments	**12,933**	12,990	12,297
Corporate/Eliminations	**(40)**	(39)	(36)
Total	**$ 12,893**	$ 12,951	$ 12,261

Information by geographic area is as follows:

For the Years Ended December 31, *(In millions of dollars)*	**2015**	2014	2013
Revenue			
United States	**$ 6,316**	$ 5,865	$ 5,485
United Kingdom	**2,036**	2,111	1,979
Continental Europe	**1,902**	2,077	1,943
Asia Pacific	**1,333**	1,420	1,396
Other	**1,346**	1,517	1,494
	12,933	12,990	12,297
Corporate/Eliminations	**(40)**	(39)	(36)
	$ 12,893	$ 12,951	$ 12,261

For the Years Ended December 31, *(In millions of dollars)*	**2015**	2014	2013
Fixed Assets, Net			
United States	**$ 460**	$ 483	$ 494
United Kingdom	**115**	120	121
Continental Europe	**57**	60	64
Asia Pacific	**49**	62	72
Other	**92**	84	77
	$ 773	$ 809	$ 828

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Marsh & McLennan Companies, Inc.
New York, New York

We have audited the accompanying consolidated balance sheets of Marsh & McLennan Companies, Inc. and subsidiaries (the "Company") as of December 31, 2015 and 2014, and the related consolidated statements of income, comprehensive income, cash flows and equity for each of the three years in the period ended December 31, 2015. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Marsh & McLennan Companies, Inc. and subsidiaries as of December 31, 2015 and 2014, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2015, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2015, based on the criteria established in *Internal Control-Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 24, 2016 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ Deloitte & Touche LLP

New York, New York
February 24, 2016

Marsh & McLennan Companies, Inc. and Subsidiaries
SELECTED QUARTERLY FINANCIAL DATA AND SUPPLEMENTAL INFORMATION (UNAUDITED)

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
(In millions, except per share figures)				
2015:				
Revenue	**$ 3,215**	**$ 3,225**	**$ 3,115**	**$ 3,338**
Operating income	**$ 735**	**$ 629**	**$ 461**	**$ 594**
Income from continuing operations	**$ 498**	**$ 429**	**$ 329**	**$ 380**
Discontinued operations, net of tax	**$ (3)**	**$ —**	**$ 2**	**$ 1**
Net income attributable to the Company	**$ 482**	**$ 419**	**$ 323**	**$ 375**
Basic Per Share Data:				
Continuing operations	**$ 0.90**	**$ 0.78**	**$ 0.61**	**$ 0.72**
Discontinued operations, net of tax	**$ (0.01)**	**$ —**	**$ —**	**$ —**
Net income attributable to the Company	**$ 0.89**	**$ 0.78**	**$ 0.61**	**$ 0.72**
Diluted Per Share Data:				
Continuing operations	**$ 0.89**	**$ 0.77**	**$ 0.60**	**$ 0.71**
Discontinued operations, net of tax	**$ (0.01)**	**$ —**	**$ 0.01**	**$ —**
Net income attributable to the Company	**$ 0.88**	**$ 0.77**	**$ 0.61**	**$ 0.71**
Dividends Paid Per Share	**$ 0.28**	**$ 0.28**	**$ 0.31**	**$ 0.31**
2014:				
Revenue	$ 3,264	$ 3,300	$ 3,141	$ 3,246
Operating income	$ 673	$ 647	$ 445	$ 536
Income from continuing operations	$ 457	$ 440	$ 305	$ 269
Discontinued operations, net of tax	$ (1)	$ (2)	$ (1)	$ 30
Net income attributable to the Company	$ 443	$ 431	$ 297	$ 294
Basic Per Share Data:				
Continuing operations	$ 0.81	$ 0.79	$ 0.55	$ 0.49
Discontinued operations, net of tax	$ —	$ (0.01)	$ —	$ 0.05
Net income attributable to the Company	$ 0.81	$ 0.78	$ 0.55	$ 0.54
Diluted Per Share Data:				
Continuing operations	$ 0.80	$ 0.78	$ 0.54	$ 0.48
Discontinued operations, net of tax	$ —	$ (0.01)	$ —	$ 0.06
Net income attributable to the Company	$ 0.80	$ 0.77	$ 0.54	$ 0.54
Dividends Paid Per Share	$ 0.25	$ 0.25	$ 0.28	$ 0.28

As of February 18th, 2016, there were 5,927 stockholders of record.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

Disclosure Controls and Procedures. Based on their evaluation, as of the end of the period covered by this annual report on Form 10-K, the Company's chief executive officer and chief financial officer have concluded that the Company's disclosure controls and procedures (as defined in Rules 13a-15(e) or 15d-15(e) under the Securities Exchange Act of 1934) are effective.

Internal Control over Financial Reporting.

(a) *Management's Annual Report on Internal Control Over Financial Reporting*

MANAGEMENT'S ANNUAL REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

The management of Marsh & McLennan Companies, Inc. is responsible for establishing and maintaining adequate internal control over financial reporting for the Company. The Company's internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles.

The Company's internal control over financial reporting includes those policies and procedures relating to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; the recording of all necessary transactions to permit the preparation of the Company's consolidated financial statements in accordance with generally accepted accounting principles; the proper authorization of receipts and expenditures in accordance with authorizations of the Company's management and directors; and the prevention or timely detection of the unauthorized acquisition, use or disposition of assets that could have a material effect on the Company's consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management evaluated the effectiveness of the Company's internal control over financial reporting as of December 31, 2015 under the supervision and with the participation of the Company's principal executive and principal financial officers. In making this evaluation, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in Internal Control—Integrated Framework issued in 2013. Based on its evaluation, management determined that the Company maintained effective internal control over financial reporting as of December 31, 2015.

Deloitte & Touche LLP, the Independent Registered Public Accounting Firm that audited and reported on the Company's consolidated financial statements included in this annual report on Form 10-K, also issued an audit report on the effectiveness of the Company's internal control over financial reporting as of December 31, 2015.

(b) *Audit Report of the Registered Public Accounting Firm.*

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Marsh & McLennan Companies, Inc.
New York, New York

We have audited the internal control over financial reporting of Marsh & McLennan Companies, Inc. and subsidiaries (the "Company") as of December 31, 2015, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Annual Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, based on the criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2015 of the Company and our report dated February 24, 2016 expressed an unqualified opinion on those financial statements.

/s/ Deloitte & Touche LLP

New York, New York
February 24, 2016

(c) *Changes in Internal Control Over Financial Reporting*

There were no changes in the Company's internal control over financial reporting identified in connection with the evaluation required by Rules 13a-15(d) or 15d-15(d) under the Securities Exchange Act of 1934 that occurred during the quarter ended December 31, 2015 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information.

In light of the impact of foreign exchange globally, the Compensation Committee (the "Committee") of the Board of Directors of the Company granted performance stock unit awards on February 22, 2016 with a three-year adjusted earnings per share ("EPS") growth performance measure that excludes the impact of currency exchange rate fluctuations.

With respect to the performance stock unit awards granted in 2015 ("2015 PSUs"), the three-year adjusted EPS growth performance measure selected by the Committee did not expressly reference the impact of currency exchange rate fluctuations. On February 22, 2016, the Committee amended the adjusted EPS performance measure for the outstanding 2015 PSUs, including awards held by the Company's executive officers, to exclude the impact of currency exchange rate fluctuations.

Accordingly, the relevant definition for "adjusted EPS growth" for outstanding performance stock unit awards granted in 2016 and 2015 is: earnings per share from continuing operations calculated in accordance with accounting principles generally accepted in the U.S. ("GAAP"), adjusted for the impact of "noteworthy items" (adjusted diluted EPS), and adjusted further to exclude the impact of currency exchange rate fluctuations, for the variation between actual and budgeted results for Marsh & McLennan Risk Capital Holdings, Ltd. (MMRCH), the legal entity through which the Company owns interests in private equity funds and other investments, and for the costs related to the early extinguishment of debt.

Also on February 22, 2016, the Committee increased the annual long-term incentive award target grant date fair value for the Company's CEO, Dan Glaser, from $8,000,000 to $9,500,000.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Information as to the directors and nominees for the board of directors of the Company is incorporated herein by reference to the material set forth under the heading "Item 1: Election of Directors" in the 2016 Proxy Statement.

The executive officers of the Company are Peter J. Beshar, E. Scott Gilbert, Daniel S. Glaser, Laurie Ledford, Scott McDonald, Mark C. McGivney, Alexander S. Moczarski, Julio A. Portalatin and Peter Zaffino. Information with respect to these individuals is provided in Part I, Item 1 above under the heading "Executive Officers of the Company".

The information set forth in the 2016 Proxy Statement in the sections "Corporate Governance—Codes of Conduct", "Board of Directors and Committees—Committees—Audit Committee", "Additional Information—Transactions with Management and Others" and "Additional Information—Section 16(a) Beneficial Ownership Reporting Compliance" is incorporated herein by reference.

Item 11. Executive Compensation.

The information set forth in the sections "Board of Directors and Committees—Director Compensation" and "Executive Compensation—Compensation of Executive Officers" in the 2016 Proxy Statement is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The information set forth in the sections "Additional Information—Stock Ownership of Directors, Management and Certain Beneficial Owners" and "Additional Information—Equity Compensation Plan Information" in the 2016 Proxy Statement is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

The information set forth in the sections "Corporate Governance—Director Independence", "Corporate Governance—Review of Related-Person Transactions" and "Additional Information—Transactions with Management and Others" in the 2016 Proxy Statement is incorporated herein by reference.

Item 14. Principal Accountant Fees and Services.

The information set forth under the heading "Item 3: Ratification of Selection of Independent Registered Public Accounting Firm—Fees of Independent Registered Public Accounting Firm" in the 2016 Proxy Statement is incorporated herein by reference.

PART IV

Item 15. Exhibits and Financial Statement Schedules. †

The following documents are filed as a part of this report:

(1) Consolidated Financial Statements:

Consolidated Statements of Income for each of the three years in the period ended December 31, 2015

Consolidated Statements of Comprehensive Income for each of the three years in the period ended December 31, 2015

Consolidated Balance Sheets as of December 31, 2015 and 2014

Consolidated Statements of Cash Flows for each of the three years in the period ended December 31, 2015

Consolidated Statements of Stockholders' Equity for each of the three years in the period ended December 31, 2015

Notes to Consolidated Financial Statements

Report of Independent Registered Public Accounting Firm

Other:

Selected Quarterly Financial Data and Supplemental Information (Unaudited) for fiscal years 2015 and 2014

Five-Year Statistical Summary of Operations

(2) All required Financial Statement Schedules are included in the Consolidated Financial Statements or the Notes to Consolidated Financial Statements.

(3) The following exhibits are filed as a part of this report:

(2.1) Stock Purchase Agreement, dated as of June 6, 2010, by and between Marsh & McLennan Companies, Inc. and Altegrity, Inc. (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2010)

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†As permitted by Item 601(b)(4)(iii)(A) of Regulation S-K, the Company has not filed with this Form 10-K certain instruments defining the rights of holders of long-term debt of the Company and its subsidiaries because the total amount of securities authorized under any of such instruments does not exceed 10% of the total assets of the Company and its subsidiaries on a consolidated basis. The Company agrees to furnish a copy of any such agreement to the Commission upon request.

(3.1) Restated Certificate of Incorporation of Marsh & McLennan Companies, Inc. (incorporated by reference to the Company's Current Report on Form 8-K dated July 17, 2008)

(3.2) Amended and Restated By-Laws of Marsh & McLennan Companies, Inc. (incorporated by reference to the Company's Current Report on Form 8-K dated September 17, 2009)

(4.1) Indenture dated as of June 14, 1999 between Marsh & McLennan Companies, Inc. and State Street Bank and Trust Company, as trustee (incorporated by reference to the Company's Registration Statement on Form S-3, Registration No. 333-108566)

(4.2) Third Supplemental Indenture dated as of July 30, 2003 between Marsh & McLennan Companies, Inc. and U.S. Bank National Association (as successor to State Street Bank and Trust Company), as trustee (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2003)

(4.3) Indenture dated as of March 19, 2002 between Marsh & McLennan Companies, Inc. and State Street Bank and Trust Company, as trustee (incorporated by reference to the Company's Registration Statement on Form S-4, Registration No. 333-87510)

(4.4) Indenture, dated as of July 15, 2011, between Marsh & McLennan Companies, Inc. and The Bank of New York Mellon, as trustee (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2011)

(4.5) First Supplemental Indenture, dated as of July 15, 2011, between Marsh & McLennan Companies, Inc. and The Bank of New York Mellon, as trustee (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2011)

(4.6) Form of Second Supplemental Indenture between Marsh & McLennan Companies, Inc. and The Bank of New York Mellon, as trustee (incorporated by reference to the Company's Current Report on Form 8-K dated March 7, 2012)

(4.7) Form of Third Supplemental Indenture between Marsh & McLennan Companies, Inc. and The Bank of New York Mellon, as trustee (incorporated by reference to the Company's Current Report on Form 8-K dated September 24, 2013)

(4.8) Form of Fourth Supplemental Indenture between Marsh & McLennan Companies, Inc. and The Bank of New York Mellon, as trustee (incorporated by reference to the Company's Current Report on Form 8-K dated May 27, 2014)

(4.9) Form of Fifth Supplemental Indenture between Marsh & McLennan Companies, Inc. and The Bank of New York Mellon, as trustee (incorporated by reference to the Company's Current Report on Form 8-K dated September 10, 2014)

(4.10) Sixth Supplemental Indenture, dated as of March 6, 2015, between Marsh & McLennan Companies, Inc. and The Bank of New York Mellon, as trustee (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)

(4.11) Seventh Supplemental Indenture, dated as of September 14, 2015, between Marsh & McLennan Companies, Inc. and The Bank of New York Mellon, as trustee (incorporated by reference to the Company's Current Report on Form 8-K filed on September 14, 2015)

(10.1) *Marsh & McLennan Companies, Inc. U.S. Employee 1996 Cash Bonus Award Voluntary Deferral Plan (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 1996)

(10.2) *Marsh & McLennan Companies, Inc. U.S. Employee 1997 Cash Bonus Award Voluntary Deferral Plan (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 1997)

(10.3) *Marsh & McLennan Companies, Inc. U.S. Employee 1998 Cash Bonus Award Voluntary Deferral Plan (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 1998)

(10.4) *Marsh & McLennan Companies, Inc. 2000 Senior Executive Incentive and Stock Award Plan (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 1999)

(10.5) *Amendments to Marsh & McLennan Companies, Inc. 2000 Senior Executive Incentive and Stock Award Plan and the Marsh & McLennan Companies, Inc. 2000 Employee Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2005)

(10.6) *Form of Awards under the Marsh & McLennan Companies, Inc. 2000 Senior Executive Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2004)

(10.7) *Additional Forms of Awards under the Marsh & McLennan Companies, Inc. 2000 Senior Executive Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2005)

(10.8) *Marsh & McLennan Companies, Inc. 2000 Employee Incentive and Stock Award Plan (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2001)

(10.9) *Form of Awards under the Marsh & McLennan Companies, Inc. 2000 Employee Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2004)

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*Management contract or compensatory plan or arrangement required to be filed as an exhibit pursuant to Item 15(b) of Form 10-K.

(10.10) *Additional Forms of Awards under the Marsh & McLennan Companies, Inc. 2000 Employee Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2005)

(10.11) *Form of Long-term Incentive Award under the Marsh & McLennan Companies, Inc. 2000 Senior Executive Incentive and Stock Award Plan and the Marsh & McLennan Companies, Inc. 2000 Employee Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2006)

(10.12) *Form of 2007 Long-term Incentive Award under the Marsh & McLennan Companies, Inc. 2000 Senior Executive Incentive and Stock Award Plan and the Marsh & McLennan Companies, Inc. 2000 Employee Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2007)

(10.13) *Form of 2008 Long-term Incentive Award under the Marsh & McLennan Companies, Inc. 2000 Senior Executive Incentive and Stock Award Plan and the Marsh & McLennan Companies, Inc. 2000 Employee Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008)

(10.14) *Form of 2009 Long-term Incentive Award under the Marsh & McLennan Companies, Inc. 2000 Senior Executive Incentive and Stock Award Plan and the Marsh & McLennan Companies, Inc. 2000 Employee Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2009)

(10.15) *Form of 2010 Long-term Incentive Award under the Marsh & McLennan Companies, Inc. 2000 Senior Executive Incentive and Stock Award Plan and the Marsh & McLennan Companies, Inc. 2000 Employee Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2010)

(10.16) *Form of 2011 Long-term Incentive Award under the Marsh & McLennan Companies, Inc. 2000 Senior Executive Incentive and Stock Award Plan and the Marsh & McLennan Companies, Inc. 2000 Employee Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2011)

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*Management contract or compensatory plan or arrangement required to be filed as an exhibit pursuant to Item 15(b) of Form 10-K.

(10.17) *Form of 2011 Long-term Incentive Award dated as of June 1, 2011 under the Marsh & McLennan Companies, Inc. 2011 Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011)

(10.18) *Form of 2012 Long-term Incentive Award under the Marsh & McLennan Companies, Inc. 2011 Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2012)

(10.19) *Form of 2013 Long-term Incentive Award under the Marsh & McLennan Companies, Inc. 2011 Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013)

(10.20) *Form of 2014 Long-term Incentive Award under the Marsh & McLennan Companies, Inc. 2011 Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014)

(10.21) *Form of 2015 Long-term Incentive Award under the Marsh & McLennan Companies, Inc. 2011 Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)

(10.22) *Form of Deferred Stock Unit Award, dated as of February 24, 2012, under the Marsh & McLennan Companies, Inc. 2011 Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2012)

(10.23) *Form of Deferred Stock Unit Award, dated as of March 1, 2013, under the Marsh & McLennan Companies, Inc. 2011 Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013)

(10.24) *Form of Deferred Stock Unit Award, dated as of March 1, 2014, under the Marsh & McLennan Companies, Inc. 2011 Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014)

(10.25) *Form of Deferred Stock Unit Award, dated as of March 1, 2015, under the Marsh & McLennan Companies, Inc. 2011 Incentive and Stock Award Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)

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*Management contract or compensatory plan or arrangement required to be filed as an exhibit pursuant to Item 15(b) of Form 10-K.

(10.26) *Marsh & McLennan Companies, Inc. 2011 Incentive and Stock Award Plan (incorporated by reference to the Company's Registration Statement on Form S-8 dated August 5, 2011, Registration No. 333-176084)

(10.27) *Amendments to Certain Marsh & McLennan Companies Equity-Based Awards Due to U.S. Tax Law Changes Affecting Equity-Based Awards granted under the Marsh & McLennan Companies, Inc. 2000 Senior Executive Incentive and Stock Award Plan and the Marsh & McLennan Companies, Inc. 2000 Employee Incentive and Stock Award Plan, effective January 1, 2009 (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)

(10.28) *Section 409A Amendment Document, effective as of January 1, 2009 (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)

(10.29) *Section 409A Amendment Regarding Payments Conditioned Upon Employment-Related Action to Any and All Plans or Arrangements Entered into by the Marsh & McLennan Companies, Inc., or any of its Direct or Indirect Subsidiaries, that Provide for the Payment of Section 409A Nonqualified Deferred Compensation, effective December 21, 2012 (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2012)

(10.30) *Marsh & McLennan Companies Supplemental Savings & Investment Plan (formerly the Marsh & McLennan Companies Stock Investment Supplemental Plan) Restatement, effective January 1, 2012 (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2012)

(10.31) *Marsh & McLennan Companies, Inc. Special Severance Pay Plan (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 1996)

(10.32) *Marsh & McLennan Companies Benefit Equalization Plan and Marsh & McLennan Companies Supplemental Retirement Plan as Restated, effective January 1, 2012 (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2012)

(10.33) *Marsh & McLennan Companies, Inc. Senior Executive Severance Pay Plan (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the Quarter ended March 31, 2008)

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*Management contract or compensatory plan or arrangement required to be filed as an exhibit pursuant to Item 15(b) of Form 10-K.

(10.34) *Amendment to the Marsh & McLennan Companies, Inc. Senior Executive Severance Pay Plan, effective December 31, 2009 (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2009)

(10.35) *Marsh & McLennan Companies, Inc. Senior Management Incentive Compensation Plan (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 1994)

(10.36) *Marsh & McLennan Companies, Inc. Directors' Stock Compensation Plan - May 31, 2009 Restatement (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009)

(10.37) *Marsh & McLennan Companies International Retirement Plan As Amended and Restated Effective January 1, 2009 (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014)

(10.38) *Description of compensation arrangements for independent directors of Marsh & McLennan Companies, Inc. effective June 1, 2014 (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014)

(10.39) *Letter Agreement, effective as of March 20, 2013, between Marsh & McLennan Companies, Inc. and Daniel S. Glaser (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013)

(10.40) *Non-Competition and Non-Solicitation Agreement, effective as of September 18, 2013, between Marsh & McLennan Companies, Inc. and Daniel S. Glaser (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013)

(10.41) *Letter Agreement, effective as of May 14, 2014, between Marsh & McLennan Companies, Inc. and Daniel S. Glaser (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014)

(10.42) *Letter Agreement, effective as of March 20, 2013, between Marsh & McLennan Companies, Inc. and J. Michael Bischoff (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2013)

(10.43) *Non-Competition and Non-Solicitation Agreement, effective as of November 21, 2013, between Marsh & McLennan Companies, Inc. and J. Michael Bischoff (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2013)

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*Management contract or compensatory plan or arrangement required to be filed as an exhibit pursuant to Item 15(b) of Form 10-K.

(10.44) *Letter Agreement, effective as of May 14, 2014, between Marsh & McLennan Companies, Inc. and J. Michael Bischoff (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014)

(10.45) *Letter Agreement, effective as of March 20, 2013, between Marsh & McLennan Companies, Inc. and Peter Zaffino (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2013)

(10.46) *Non-Competition and Non-Solicitation Agreement, effective as of November 21, 2013, between Marsh & McLennan Companies, Inc. and Peter Zaffino (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2013)

(10.47) *Letter Agreement, effective as of May 14, 2014, between Marsh & McLennan Companies, Inc. and Peter Zaffino (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014)

(10.48) *Letter Agreement, effective as of March 20, 2013, between Marsh & McLennan Companies, Inc. and Julio A. Portalatin (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2013)

(10.49) *Non-Competition and Non-Solicitation Agreement, effective as of November 21, 2013, between Marsh & McLennan Companies, Inc. and Julio A. Portalatin (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2013)

(10.50) *Letter Agreement, effective as of May 14, 2014, between Marsh & McLennan Companies, Inc. and Julio A. Portalatin (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014)

(10.51) *Letter Agreement, effective as of March 20, 2013, between Marsh & McLennan Companies, Inc. and Alexander S. Moczarski (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014)

(10.52) *Non-Competition and Non-Solicitation Agreement, effective as of November 21, 2013, between Marsh & McLennan Companies, Inc. and Alexander S. Moczarski (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014)

(10.53) *Letter Agreement, effective as of May 14, 2014, between Marsh & McLennan Companies, Inc. and Alexander S. Moczarski (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014)

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*Management contract or compensatory plan or arrangement required to be filed as an exhibit pursuant to Item 15(b) of Form 10-K.

(10.54)	*Letter Agreement, effective as of March 20, 2013, between Marsh & McLennan Companies, Inc. and Peter J. Beshar (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
(10.55)	*Non-Competition and Non-Solicitation Agreement, effective as of November 21, 2013, between Marsh & McLennan Companies, Inc. and Peter J. Beshar (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
(10.56)	*Letter Agreement, effective as of January 1, 2016, between Marsh & McLennan Companies, Inc. and Mark C. McGivney (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
(10.57)	*Non-Competition and Non-Solicitation Agreement, effective as of January 1, 2016, between Marsh & McLennan Companies, Inc. and Mark C. McGivney (incorporated by reference to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
(12.1)	Statement Re: Computation of Ratio of Earnings to Fixed Charges
(14.1)	Code of Ethics for Chief Executive and Senior Financial Officers (incorporated by reference to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
(21.1)	List of Subsidiaries of Marsh & McLennan Companies, Inc. (as of February 19, 2016)
(23.1)	Consent of Independent Registered Public Accounting Firm
(24.1)	Power of Attorney (included on signature page)
(31.1)	Rule 13a-14(a)/15d-14(a) Certification of Chief Executive Officer
(31.2)	Rule 13a-14(a)/15d-14(a) Certification of Chief Financial Officer
(32.1)	Section 1350 Certifications
101.INS	XBRL Instance Document
101.SCH	XBRL Taxonomy Extension Schema
101.CAL	XBRL Taxonomy Extension Calculation Linkbase
101.DEF	XBRL Taxonomy Extension Definition Linkbase
101.LAB	XBRL Taxonomy Extension Label Linkbase
101.PRE	XBRL Taxonomy Extension Presentation Linkbase

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*Management contract or compensatory plan or arrangement required to be filed as an exhibit pursuant to Item 15(b) of Form 10-K.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

MARSH & McLENNAN COMPANIES, INC.

Dated: February 24, 2016

By /s/ DANIEL S. GLASER

Daniel S. Glaser
President and Chief Executive Officer

Each person whose signature appears below hereby constitutes and appoints Carey S. Roberts and Tiffany D. Wooley, and each of them singly, such person's lawful attorneys-in-fact and agents, with full power to them and each of them to sign for such person, in the capacity indicated below, any and all amendments to this Annual Report on Form 10-K filed with the Securities and Exchange Commission.

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities indicated this 24th day of February, 2016.

Name	Title	Date
/s/ DANIEL S. GLASER Daniel S. Glaser	Director, President & Chief Executive Officer	February 24, 2016
/s/ MARK C. MCGIVNEY Mark C. McGivney	Chief Financial Officer	February 24, 2016
/s/ ROBERT J. RAPPORT Robert J. Rapport	Senior Vice President & Controller (Chief Accounting Officer)	February 24, 2016
/s/ OSCAR FANJUL Oscar Fanjul	Director	February 24, 2016
/s/ H. EDWARD HANWAY H. Edward Hanway	Director	February 24, 2016
/s/ LORD LANG OF MONKTON Lord Lang of Monkton	Director	February 24, 2016
/s/ ELAINE LA ROCHE Elaine La Roche	Director	February 24, 2016
/s/ MARIA SILVIA BASTOS MARQUES Maria Silvia Bastos Marques	Director	February 24, 2016
/s/ STEVEN A. MILLS Steven A. Mills	Director	February 24, 2016

Name	Title	Date
/s/ BRUCE P. NOLOP Bruce P. Nolop	Director	February 24, 2016
/s/ MARC D. OKEN Marc D. Oken	Director	February 24, 2016
/s/ MORTON O. SCHAPIRO Morton O. Schapiro	Director	February 24, 2016
/s/ LLOYD YATES Lloyd Yates	Director	February 24, 2016
/s/ R. DAVID YOST R. David Yost	Director	February 24, 2016

Exhibit 31.1

CERTIFICATIONS

I, Daniel S. Glaser, certify that:

1. I have reviewed this Annual Report on Form 10-K of Marsh & McLennan Companies, Inc. (the "registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 24, 2016

/s/ Daniel S. Glaser
Daniel S. Glaser
President and Chief Executive Officer

Exhibit 31.2

CERTIFICATIONS

I, Mark C. McGivney, certify that:

1. I have reviewed this Annual Report on Form 10-K of Marsh & McLennan Companies, Inc. (the "registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 24, 2016

/s/ Mark C. McGivney

Mark C. McGivney
Chief Financial Officer

Exhibit 32.1

Certification of Chief Executive Officer and Chief Financial Officer

The certification set forth below is being submitted in connection with the Annual Report on Form 10-K for the year ended December 31, 2015 of Marsh & McLennan Companies, Inc. (the "Report") for the purpose of complying with Rule 13a-14(b) or Rule 15d-14(b) under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and Section 1350 of Chapter 63 of Title 18 of the United States Code.

Daniel S. Glaser, the President and Chief Executive Officer, and Mark C. McGivney, the Chief Financial Officer, of Marsh & McLennan Companies, Inc. each certifies that, to the best of his knowledge:

1. the Report fully complies with the requirements of Section 13(a) or 15(d) of the Exchange Act; and
2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Marsh & McLennan Companies, Inc.

Date: February 24, 2016

/s/ Daniel S. Glaser
Daniel S. Glaser
President and Chief Executive Officer

Date: February 24, 2016

/s/ Mark C. McGivney
Mark C. McGivney
Chief Financial Officer

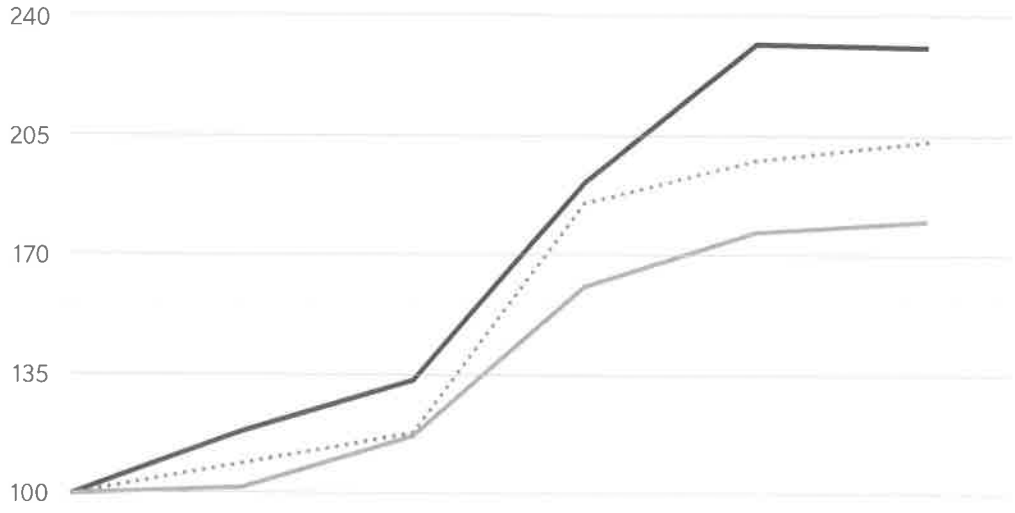
Stock performance graph

The following graph compares the annual cumulative stockholder return for the five-year period ended December 31, 2015 on: Marsh & McLennan Companies common stock; a management-constructed composite industry index; and the Standard & Poor's 500 Stock Index. The graph assumes an investment of $100 on December 31, 2010 in Marsh & McLennan Companies common stock and each of the two indices, with dividends reinvested.

Returns on the composite industry index reflect allocation of the total amount invested among the constituent stocks on a pro rata basis according to each issuer's start-of-the-year market capitalization. The composite industry index consists of Aon plc, Arthur J. Gallagher & Co., Towers Watson & Co. and Willis Group Holdings plc.

Comparison of Cumulative Total Stockholder Return

($100 INVESTED 12/31/10 WITH DIVIDENDS REINVESTED)



	2010	2011	2012	2013	2014	2015
Marsh & McLennan Companies	100	119	133	192	232	230
Composite Industry Index	100	109	118	186	198	203
S&P 500	100	102	118	157	178	181

Stockholder information

ANNUAL MEETING
The 2016 Annual Meeting of Stockholders will be held at 10:00 a.m., Thursday, May 19, 2016, at the following location:

Directors Guild of America
110 West 57th Street
New York, NY 10019

INVESTOR INFORMATION
Stockholders of record inquiring about reinvestment and payment of dividends, consolidation of accounts, stock certificate holdings, stock certificate transfers and address changes should contact:

Wells Fargo Shareowner Services
P.O. Box 64854
St. Paul, MN 55164-0854
Telephone: 800 457 8968 or
651 450 4064 (Outside US/Canada)

Mailing Address:
1110 Centre Pointe Curve, Suite 101
Mendota Heights, MN 55120-4100
Wells Fargo's website:
www.shareowneronline.com

Stockholders who hold shares of Marsh & McLennan Companies beneficially through a broker, bank or other intermediary organization should contact that organization for these services.

DIRECT PURCHASE PLAN
Stockholders of record and other interested investors can purchase Marsh & McLennan Companies common stock directly through the Company's transfer agent and the Administrator for the Plan, Wells Fargo. A brochure on the Plan is available on the Wells Fargo website or by contacting Wells Fargo directly:

Wells Fargo Shareowner Services
P.O. Box 64854
St. Paul, MN 55164-0854
Telephone: 800 457 8968 or
651 450 4064 (Outside US/Canada)
Wells Fargo's website:
www.shareowneronline.com

FINANCIAL INFORMATION
Copies of Marsh & McLennan Companies annual reports and Forms 10-K and 10-Q are available on the Company's website. These documents also may be requested by contacting:

Marsh & McLennan Companies, Inc.
Investor Relations
1166 Avenue of the Americas
New York, NY 10036
Telephone: 212 345 6902
Website: www.mmc.com

STOCK LISTINGS
Marsh & McLennan Companies common stock (ticker symbol: MMC) is listed on the New York, Chicago and London Stock Exchanges.

PROCEDURES FOR RAISING COMPLAINTS AND CONCERNS REGARDING ACCOUNTING MATTERS
Marsh & McLennan Companies is committed to complying with all applicable accounting standards, internal accounting controls, audit practices and securities laws and regulations (collectively, "Accounting Matters"). To raise a complaint or concern regarding Accounting Matters, you may contact the Company by mail, telephone or online. You may review the Company's procedures for handling complaints and concerns regarding Accounting Matters at www.mmc.com.

By mail:
Marsh & McLennan Companies, Inc.
Audit Committee
c/o Carey Roberts, Corporate Secretary
1166 Avenue of the Americas
New York, NY 10036

By telephone or online:
Visit www.ethicscomplianceline.com for dialing instructions or to raise a concern online.

FSC www.fsc.org MIX Paper from responsible sources FSC® C101537

MARSH GUY CARPENTER MERCER OLIVER WYMAN

Marsh & McLennan Companies, Inc.
1166 Avenue of the Americas
New York, NY 10036
www.mmc.com

APPENDIX B

Resumes

All resumes of proposed Mercer and USAUD staff are included in this section.

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Mercer Health & Benefits LLC Resumes

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Deidra Abbott, MPH

QUALIFICATIONS

Deidra has extensive experience with Medicaid and other public assistance programs, and has worked at length with long term services and supports (LTSS) and home and community based services (HCBS) initiatives. She has designed and implemented numerous HCBS waiver programs, including the development of waiver documents and working with state staff to guide the document through the Centers for Medicare & Medicaid Services (CMS) approval process. Deidra has consulted to several states, including Delaware, Florida, Louisiana, Ohio, Arizona, Hawaii, Missouri, New Mexico, Pennsylvania, Tennessee, the District of Columbia and the territory of Puerto Rico on a wide range of issues including program design and implementation, health plan readiness reviews, health plan contract issues and working with stakeholder groups to drive program improvement.

EXPERIENCE

Before joining Mercer, Deidra was a consultant at Alicia Smith & Associates, LLC, providing a wide range of services and supports to both public and private sector clients. Deidra worked at CMS from 2000 to 2006, where she served as the Technical Director for the HCBS waiver program. In this capacity, Deidra led development of federal policy, implementation, and coordination of LTSS programs and services.

Examples of Deidra's experience and accomplishments include:

- Assistance to the Ohio Department of Medicaid in redesigning their service delivery system for self-directed services and supports.
- Team leader for project assisting Delaware Health and Social Services, Division of Medicaid and Medical Assistance in developing and implementing its statewide HCBS transition plan. Activities include: providing project management support for and monitoring implementation transition plan activities; developing and implementing comprehensive stakeholder engagement strategy; leading the team developing and implementing participant and provider surveys; providing strategic guidance and assistance in updating the transition plan; and providing technical support in negotiations with CMS.
- Managing an engagement for the New Mexico Human Services Department to redesign and modernize the State's Medicaid program. The result is the development of an integrated managed care long-term care services and supports program, Centennial Care, in which Deidra was intricately involved in program design, drafting the 1115 waiver and negotiating with CMS. Tasks included:

Deidra Abbott, MPH
Principal

EDUCATION

Master's degree, Public Health Policy and Administration
University of Michigan

Bachelor's degree, Public Health
University of North Carolina

EXPERIENCE

28 years professional experience

CORE COMPETENCIES

LTSS program analysis, design, and implementation

Program operations

Procurement development and support

Evaluation, plan development, and implementation

Medicaid policy analysis

Project management

AFFILIATIONS

American Public Health Association

project management support for and monitoring program implementation and ongoing operation; managing/providing oversight to the engagement team; developing policies and conducting policy analysis on delivery system models; providing technical assistance in the development/modification of program design; developing health plan contracts and procurement documents; developing procurement evaluation tools; training State staff on evaluation processes; facilitating evaluation teams and designing readiness review tools. As the policy project manager, Deidra is also responsible for developing and monitoring project budgets and timelines.

- LTSS subject matter expert to the Louisiana Department of Health and Hospital Services in the development of an integrated LTSS managed care program. Tasks included: technical assistance in determining the appropriate waiver authority, program design, federal regulations, and requirements; and assisting in negotiations with CMS.
- Ongoing LTSS technical assistance and support to Office of Long-Term Living, Pennsylvania Department of Public Welfare in implementation of their HCBS waiver programs. Tasks included providing guidance on federal requirements and negotiations with CMS.
- Served as a project lead and technical expert for the Pennsylvania Department of Public Welfare's renewal of two 1915(c) HCBS waivers for persons with intellectual disabilities. The waivers were successfully renewed. Specific tasks included: establishing timelines and process steps for completing the renewal; creating tools to facilitate project completion and the State's decision making process; providing technical assistance to State staff on waiver design and policy issues; facilitating executive staff discussions on waiver renewal issues; providing guidance on federal and stakeholder engagement including strategy, policy considerations and timing; facilitating legal, budgetary and executive review and analyzing draft regulations to ensure alignment with waiver renewal language.
- Leading a project for the Tennessee Department of Finance and Administration, Bureau of TennCare to design and implement a statewide, managed LTSS program for eligible elderly and disabled persons (CHOICES). Tasks included researching best practices regarding adult care homes; developing issue papers to facilitate management decision making on delivery system design; developing policies and procedures and program guidance materials; providing technical assistance on program design elements such as care coordination, self-direction, nursing facility transition and transition of care; amending existing MCO contracts to include LTSS program requirements; analyzing policy options for effective program implementation; assessing MCO readiness and developing a stakeholder engagement plan and conducting outreach to stakeholders.
- Assisted the Hawaii Department of Human Services in comprehensive design of new managed LTSS program (QExA). Tasks included: technical assistance in program design; development of policy papers and options for consideration; development of RFP vehicle; development of procurement document and evaluation tools; development of RFP evaluation strategy; assistance in program readiness; and development of health plan contract.
- Assisted the Florida Agency for Health Care Administration in monitoring and evaluating the State's implementation of its Medicaid Reform Choice Counseling and Enhanced Benefits program and the operations of the State's vendor for these programs. The engagement required a strong onsite presence in the State. Specific tasks included monitoring vendor's call center operations and quality of services, updating program materials, developing the Choice Counseling script for call center staff and facilitating workgroups to obtain public feedback on program design and enhancements.

REFERENCES

Name:	*Angela Medrano, Deputy Director*
Entity:	*Medical Assistance Division* *Human Services Department*
Address:	*PO Box 2348* *Santa Fe, NM 87505*
Telephone #:	*+1 505 827 6213*

Name:	*Lisa Zimmerman, Deputy Director*
Entity:	*Division of Medicaid and Medical Assistance,* *Department of Health and Social Services*
Address:	*DMMA* *P.O. Box 906* *New Castle, DE 19720*
Telephone #:	*+1 302 255 9535*

Name:	*Virginia Brown, Bureau Director*
Entity:	*Bureau of Policy and Regulatory Management* *Office of Long-Term Living* *Department of Public Welfare*
Address:	*555 Walnut Street, Sixth Floor* *Harrisburg, PA 17101*
Telephone #:	*+1 717 783 4510*

Misti Beckman

QUALIFICATIONS

Misti combines her experience in client management, Medicaid rate-setting and team leadership/organization to effectively manage and lead some of Mercer's largest client engagements. Misti helps guide her clients through the strategic planning process, discussing the technical aspects of program and policy design as well as the financial implications. She is a team leader for Pennsylvania and South Carolina. She is a member of Mercer's business leadership team and also the lead of Mercer's long-term services and supports (LTSS) strategic initiative team.

Misti Beckman
Partner

EDUCATION
Bachelor's degree, Mathematics, Cum Laude
Minnesota State University

EXPERIENCE
18 years professional experience

CORE COMPETENCIES
Managed care programs
Long-term services and supports
Payment strategy and reform
Financial and programmatic analyses
Intellectual disabilities and MH/SUD populations
Client management
Team Leadership
Stakeholder facilitation and support

EXPERIENCE

Prior to joining Mercer in 2001, Misti gained valuable experience working for a national health care provider analyzing trends across multiple lines of business.

Misti's experience includes:

- Team leader for multiple home and community-based services and behavioral health Medicaid fee-for-service (FFS) and managed care actuarial rate development processes with multiple teams of actuaries, policy specialists, clinicians, data programmers and analysts.
- Leading Mercer's relationship with multiple agencies within the Commonwealth of Pennsylvania, providing strategic guidance and financial and programmatic analyses, as new program design and administrative oversight strategies are explored.
- Helped Pennsylvania, South Carolina, and Louisiana review their current HCBS fee schedules to identify services for which fees warranted review, evaluate resource allocation models and develop implementation options and plans for LTSS, including MLTSS, redesign.
- Facilitated several stakeholder workgroups, meetings, and presentation on services provided to individuals with ID/DD, Autism, and MH/SUD.
- Providing strategic guidance on designing and implementing a reimbursement system for intellectual and developmental disability programs, including administrative oversight structure, establishing financial and programmatic policies, developing reimbursement options and participating in stakeholder workgroups.
- Developing Medicaid managed care rates for specialty populations, such as the autistic population.
- Assisting states in the development of 1915(b), 1915(c), and 1115 waiver applications, including the development of cost-effectiveness, cost neutrality, and budget neutrality components, as well as providing advice on negotiations with CMS to effectively facilitate the approval process.

- Conducting FFS rate-setting projects, including collecting data through provider surveys and third-party data sources, developing rate assumptions and conducting budget impact analyses.
- Presenting rate-setting methodologies and programmatic changes at technical assistance sessions for potential contractors and other interested parties.
- Coordinating various client needs with internal resources to ensure projects are completed on time and within budget.
- Providing support for setting capitation rates, communicating rate-setting issues to clients, evaluating contractor bids, participating in rate negotiations, and developing final rates for Medicaid managed care programs.
- Performing onsite reviews of managed care organizations covering financial, quality of care and operational components.
- Assisting states in evaluation of program changes, such as state hospital closures, integration of services across state agencies, and evaluating expansion populations.
    - Providing ongoing technical assistance to online financial reporting of health plan data and provider-specific data, as well as providing training and support for data management tools, such as Cognos.
    - Assisting states in evaluation to program changes, such as state hospital closures, integration of services across state agencies, and evaluating expansion populations.

1)

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Home and Community-Based Services Fall Conference – Resource Allocation: Transforming State Long Term Services and Supports Payments in the Individual Support Needs Revolution, September 2016.

REFERENCES

Name:	*Nancy Thaler*
Entity:	*Commonwealth of Pennsylvania, Deputy Director for the Office of Developmental Programs*
Address:	*625 Forester Street Rm 502, Harrisburg, PA 17120*
Telephone #:	*+1 717 787 3700*

Name:	*Leesa Allen*
Entity:	*Commonwealth of Pennsylvania, Executive Medicaid Director*
Address:	*331 Health & Welfare Building, Harrisburg, PA 17120*
Telephone #:	*+1 717 787 2600*

Name:	*Scott Tanner*
Entity:	*South Carolina, DHHS Jefferson Square – DHHS Jefferson Square*
Address:	*1801 Jefferson Square, Columbia SC*
Telephone #:	*+1 803 898 0092*

Robert Butler

QUALIFICATIONS

Robert is a long-term care (LTC) specialist. His experience encompasses both Medicaid and the private sector, with an emphasis on nursing facilities. Robert has been involved in LTC services his entire Medicaid career and can help clients in all aspects of LTC.

Robert often leads client engagements in addition to providing specialized consulting in LTC. In this capacity, he is responsible for bringing all of Mercer's resources together for the most comprehensive and effective outcome. He is a team leader for Louisiana, and has worked with the Mercer team to help the state design and implement its Medicaid managed care program, to integrate behavioral health services into its main managed care program, and to assist the state in evaluating a managed long-term services and support program (MLTSS). He has worked on the Pennsylvania team in the development of home and community based services (HCBS) fee-for-service (FFS) rate development. As leader of a specific Ohio project, he helped the state with the development of a new level of care (LOC) assessment tool for children and adults.

Robert Butler
Principal

EDUCATION
Bachelor's degree, Accounting
Florida State University

EXPERIENCE
22 years
professional experience

CORE COMPETENCIES
Understanding client needs
Designing and implementing managed care programs, including MLTSS
Determining FFS rates and service definitions
Determining nursing facility rates and payment methodologies
Managing projects

EXPERIENCE

Prior to joining Mercer, Robert served the State of Florida by managing fiscal projections for the state Medicaid program, institutional rate development, and managed care rate development. His consulting career began with consulting for preparation of nursing home Medicaid cost reports. He also has operational experience through his experience working for a managed care plan and a nursing facility operator.

His experience and accomplishments include:

- Helping Ohio update its Nursing Facility Level of Care Assessment tools, including the creation of a tool specifically for children.
- Assisting in the development and design of a managed long-term services and supports program for Louisiana.
- Helping Louisiana design and implement its first Medicaid managed care program for physical health, and recently assisting the state in integrating behavioral health.
- Assisting in rate development for home and community based services in Pennsylvania, including stakeholder discussions with providers during rate development.
- Guiding stakeholder discussions for Connecticut nursing home right-sizing strategic planning.
- Completing desk reviews of CMS Medicare Advantage bids.

- Developing and planning transformation of the Louisiana Medicaid program through managed care, including policies, rates, and MMIS system changes.
- Developing fees and rates for multiple Medicaid programs, including federally qualified health clinics and psychiatric residential treatment facilities for children in Washington and Nebraska.
- Lead Medicaid stakeholder and provider meetings in Pennsylvania, and training on reporting requirements.
- Developing and negotiating the Florida Medicaid Reform 1115 Waiver.
- Managing the preparation of Florida Medicaid rates for hospitals, nursing homes, facilities for the developmentally disabled and other institutional providers.
- Managing and implementation of Florida managed care rates for Medicaid MCOs, Nursing Home Diversion Programs, and Prepaid Mental Health Plans.
- Reviewing and managing financial projections for multiple federal waivers, including those related to home and community based services and managed care programs.
- Managing Florida's program auditing institutional provider cost reports.
- Reviewing and managing Medicaid caseload and program expenditure projections for the Florida Medicaid state budget.
- Assisting with the development and management of Florida's Medicaid Disproportionate Share Program and Low Income Pool.
- Consulting and preparing nursing home costs reports for Florida facilities.
- Preparing financial projections for Florida regulatory filings for LTC facilities, including certificates of need.
- Reviewing and analyzing managed care rates and related methodologies.
- Promoting integration of Medicaid and Medicare services through coordinated rate development for Medicare Special Needs Plans (SNPs).

REFERENCES

Name :	*Jen Steele, Medicaid Director*
Entity:	*Louisiana Department of Health and Hospitals*
Address:	*628 North 4th Street, P.O. Box 91030, Baton Rouge, LA 70821*
Telephone #:	*+1 225 342 3892*

Name:	*Kim Donica*
Entity:	*Ohio Department of Medicaid*
Address:	*50 West Town Street, Suite 400, Columbus, OH 43215*
Telephone #:	*+1 614 752 3523*

Name:	*Lou Ann Owen*
Entity:	*Louisiana Department of Health and Hospitals*
Address:	*628 N. 4th Street, P.O. Box 91030, Baton Rouge, LA 70821*
Telephone #:	*+1 225 342 1353*

Jon Fortune, EdD, FAAIDD

QUALIFICATIONS

Jon's qualifications include providing support for designing, implementing, and monitoring Medicaid managed care programs. He also assists state programs with the analysis and redesign of payment methodologies for a variety of reimbursement systems while providing financial and policy support to various client teams.

EXPERIENCE

Prior to joining Mercer, John worked as a senior research specialist in intellectual and developmental disabilities, as a senior state official in developmental disabilities, and as a provider of community services for individuals with intellectual and developmental disabilities. His experience included:

- Providing and directing community services for people with intellectual and developmental disabilities and mental health challenges in urban and rural settings.
- Acquiring and maintaining Home and Community Based Services for children and adults with intellectual and developmental disabilities and adults with acquired traumatic brain injury while moving away from residential institutional services.
- Providing technical assistance to 15 states in LTSS service system transformation and resource allocation methodology.

Jon's current duties include, but are not limited to:

- Using cost, expenditure, assessment, and policy information to design and improve state resource allocation systems for developmental disability programs.
- Developing methods to use and analyze provider payment and cost data and Medicaid participants' assessment information while reviewing administrative oversight to establish financial policies developing reimbursement options and support studies related to reimbursement system redesign.
- Assist states with compliance with CMS HCBS Final Rules with compliant state transition plans, provider surveys, systemic assessment, and policy reviews.
- Assist states in LTSS projects, stakeholdering, and/or Medicaid delivery system design.

Jon Fortune, Ed.D, FAAIDD
Senior Consultant

EDUCATION
Doctoral degree, Special Education and Rehabilitation
University of Northern Colorado

Master's degree, Human Relations and Bachelor's degree, Human Services emphasizing adults with intellectual and developmental disabilities
Governors State University

EXPERIENCE
37 years professional experience

CORE COMPETENCIES
Subject expert on intellectual and developmental disabilities

Statistical analysis and research methodology and program evaluation

Assessment, community services, and HCBS long-term care policies, resource allocation, individual plan development, and implementation

AFFILIATIONS
Fellow of American Association on Intellectual and Developmental Disabilities

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- ResearchGate provides detailed listing of his153 publications and related public forum presentations.

REFERENCES

Name:	*Brandi Kelly, Ph.D., Clinical Director*
Entity:	*Louisiana Department of Health and Hospitals, OCDD*
Address:	*628 N. 4th Street, PO Box 3117, Bin #21, Baton Rouge, LA 70821-3117*
Telephone #:	*+1 919 855 4290*

Name:	*Kathy Nichols, LCSW Medicaid Director*
Entity:	*NC Department of Health and Human Services*
Address:	*1985 Umstead Drive, Raleigh, NC 27606*
Telephone #:	*+1 919 855 4290*

Name:	*Bob Clabby*
Entity:	*Previous Oregon, Wyoming, and Arizona State LTSS Official*
Address:	*P.O. Box 1145, Pendleton, OR 97801*
Telephone #:	*+1 541 276 2266 or cell +1 307 349 0611*

Fred Gibison Jr., MBA

QUALIFICATIONS

With Fred's many years' of Medicaid/health care experience, he combines his client management, analytical aptitude, actuarial rate-setting experience and team leadership/organization to effectively manage and lead some of Mercer's largest client engagements. Fred helps drive the strategic planning process, policy review and implications, actuarial decision-making process, project management as well as being a primary point-of-contact for a client relationship. He is the team leader for the client states of Pennsylvania and Delaware. Additionally, Fred is a member of Mercer's business leadership group and a member of Mercer's long-term services and supports (LTSS) strategic initiative team.

EXPERIENCE

Prior to joining Mercer in 1998, Fred gained valuable experience in all aspects of business operations, accounting, client interaction, sales, and workflow management in a small business in the rental/leasing industry.

Fred's experience includes:

- Team leader for multiple Medicaid, Program of All-inclusive Care for the Elderly (PACE) and Children's Health Insurance Program (CHIP) actuarial rate development processes with multiple teams of actuaries, analysts, clinicians, data programmers, and pharmacy consultants.
- Client leader for Mercer's engagements with the Commonwealth of Pennsylvania, State of Colorado, and State of Delaware.
- Co-Project Director for Mercer's engagement with the CMS Medicare-Medicaid Coordination Office for preliminary financial modeling of state Medicare/Medicaid dual eligible financial alignment demonstrations (aka, Duals Demo).
- Writing research report on LTSS options for Delaware, numerous rate-setting documentation letters for Pennsylvania and Delaware and a myriad of other white papers, options documents and evaluation papers related to health care payment, delivery and payment issues.
- Helped Delaware design and implement a risk-based managed LTSS expansion program (e.g., DSHP Plus).
- Conducting numerous presentations to clients, managed care plans and other entities.
- Rate setting, program design and purchasing strategies for Medicaid LTSS including Medicare/Medicaid dual eligibles.

Fred Gibison Jr., MBA
Partner/Client Leader

EDUCATION
Master's degree, Business Administration
University of Phoenix

Bachelor's degree
Mathematics/Actuarial Science
Cum Laude
Central Washington University

EXPERIENCE
18 years professional experience

CORE COMPETENCIES
Manage care program design
Capitation rate development
Long-term services and supports
Financial evaluations
Data analysis
Payment strategy and reform
Health plan rate negotiations
Client management
Team leadership

- Incorporating innovative analyses in managed care rate setting to promote value-based purchasing and improved outcomes (e.g., avoidable hospitalizations, preventable readmissions, unnecessary emergency room use, inappropriate related-party agreements, inefficient provider contracting).
- Developing 1915(b) managed care waivers and 1915(c) home- and community-based long-term care programs including integrated Medicaid/Medicare programs for dual eligibles.
- Negotiating annual prospective capitation rates with Medicaid/CHIP managed care organizations (MCOs).
- Ongoing work with information/data systems staff to collect, process, and analyze Medicaid fee-for-service (FFS) claims and eligibility data and managed care encounter data.
- Creating FFS data book, cost reports, and utilization exhibits for use in actuarial and financial analyses/cost reporting.
- Developing, implementing, and analyzing managed care financial cost reports on income, expenses, service utilization, and incurred claims for all types of services (e.g., inpatient, outpatient, pharmacy, physician, and clinics, professional).
- Explaining rate methodologies, analyses, assumptions and other aspects of the prospective payment system for managed care.
- Interpreting new federal regulations as they pertain to Medicaid and CHIP programs (e.g., Affordable Care Act, Medicaid Managed Care Final Rule, Mental Health/Substance Abuse Parity Act).
- Implementing and designing risk-adjusted rates strategies and policies using diagnostic and pharmacy information obtained from both managed care encounter data and FFS claims.
- Designing and calculating risk pool and risk sharing programs for high-cost/high-risk individuals and/or services (e.g., Hepatitis C, HIV/AIDS, hemophiliacs, and home nursing care services).
- Consulting engagements with CMS, Arizona, Colorado, Connecticut, Delaware, New Mexico, Ohio, Pennsylvania, Tennessee, and West Virginia.
- Mentoring team members on payment reform, data analyses, project management, and health policy issues.

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- National Governors Association Center for Best Practices – Medicaid Health Care Purchasing Compendium, January 2016.
- Testimony before Pennsylvania legislative committees on Medicaid pharmacy carve-out options, 2008.

REFERENCES

Name:	*Steve Groff, Director*
Entity:	*State of Delaware, Division of Medicaid & Medical Services*
Address:	*1901 N. DuPont Highway, Lewis Building, New Castle, DE 19720*
Telephone #:	*+1 302 255 9663*

Name:	*Lisa Zimmerman, Deputy Director*
Entity:	*State of Delaware, Division of Medicaid & Medical Services*
Address:	*1901 N. DuPont Highway, Lewis Building, New Castle, DE 19720*
Telephone #:	*+1 302 255 9535*

Name:	*Allen Fisher, Bureau Director*
Entity:	*Commonwealth of Pennsylvania, Department of Human Services, Bureau of Fiscal Management*
Address:	*Commonwealth Tower, 6th Floor, 303 Walnut Street, Harrisburg, PA 17101*
Telephone #:	*+1 717 772 6291*

Stefanie Kurlanzik, JD

Stefanie Kurlanzik, JD
Principal

EDUCATION
Juris Doctor
Boston University School of Law
Bachelor of Arts
University of Pennsylvania
History & Sociology of Sciences

EXPERIENCE
9 years
professional experience

CORE COMPETENCIES
Managed care contracts and Regulations
Program evaluation
Policy analysis

AFFILIATIONS
Member of New York State Bar

QUALIFICATIONS

Stefanie is a Principal in Mercer's Government Human Services Consulting group serving as a consultant on state policy and operations projects. Stefanie's area of focus is Medicaid policy consulting with a specific emphasis on assisting states and territories with developing requests for proposals for managed care contracts and associated waivers and Medicaid state plan amendments.

EXPERIENCE

Prior to joining Mercer, Stefanie practiced law with Akin Gump Strauss Hauer & Feld LLP and Cadwalader, Wickersham & Taft LLP where she specialized in corporate restructuring. Stefanie's exposure to financial restructurings and large lending transactions led to the development of excellent research, communication, strategy, and advocacy skills.

Stefanie has experience in providing clients with strategy and recommendations for Medicaid program design which includes drafting requests for proposals, managed care contracts, evaluations and readiness operational tools, and associated waivers and state plan amendments. She has assisted states in transitioning programs to managed care, developing integrated physical and behavioral health programs, and analyzing alternative payment models.

Stefanie's experience includes:

- Assisting Florida, Louisiana, New Mexico, and Puerto Rico in designing and implementing delivery system changes related to integration of long-term care services and supports and behavioral health.
- Drafting policy and strategy memorandums, reviewing regulations and providing a recommended course of action for Missouri, New Jersey, and Puerto Rico.
- Assisting Florida, Louisiana, Missouri, and New Mexico in strategizing and developing Medicaid program changes and developing and drafting 1915(b), 1915(c), and 1115 waivers.
- Developing requests for proposals for re-designed statewide managed care and for regional managed care programs for Delaware, Missouri, New Mexico, and Puerto Rico.
- Assisting Delaware, Missouri, New Mexico, and Puerto Rico in developing re-designed managed care contracts.
- Assisting New Mexico in revising agency rules and regulations for its re-designed managed care program.
- Contributing to the drafting of a state-only funded behavioral health contract in Washington.
- Leading stakeholder engagement sessions for Arizona's State Innovation Model.

- Drafting deliverables for Arizona's State Innovation Model.
- Analyzing and reviewing alternative payment model designs with Arizona and New York.
- Conducting managed care plan readiness reviews in Puerto Rico.

REFERENCES

Name:	*Michal Rudnick*
Entity:	*Arizona Health Care Cost Containment System*
Address:	*801 E. Jefferson St, Phoenix, AZ 85034*
Telephone #:	*+1 602 417 4065*

Name:	*Nancy Smith-Leslie*
Entity:	*Medical Assistance Division/HSD*
Address:	*PO Box 2348, Santa Fe, NM 87504*
Telephone #:	*+1 505 827 3100*

Name:	*Rebecca Logan*
Entity:	*Missouri Department of Social Services, MO HealthNet, Managed Care*
Address:	*615 Howerton Court, Jefferson City, MO 65109*
Telephone #:	*+1 573 526 4274*

Alan Schafer, RN, BSN

QUALIFICATIONS

Alan is a long-term services and supports (LTSS) consultant.

EXPERIENCE

He began his employment with Mercer May, 2014. He was also employed with Mercer in 2011. During his Mercer tenure he has worked with Arizona, Connecticut, Delaware, Florida, Louisiana, Massachusetts, New Mexico, New Jersey, New York, Ohio, Pennsylvania, and Virginia.

Alan was the Arizona Long Term Care System (ALTCS) manager at the Arizona's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS) (1989 – 2011). Alan was also the Director of LTSS for an organization with Medicaid managed care business (2012 – 2014).

Alan's experience includes:

- Participated in developing the LTSS program design for Delaware, Florida, and Louisiana. The designs considered the impacts of complex LTSS and dual non-LTSS populations (e.g., medical management, physical health, behavioral health, care management, provider network).
- Lead in writing the LTSS section of the New Jersey 1115 waiver application to CMS.
- Project lead for Connecticut's Nursing Home right-sizing project.
- Provide clinical support to the Mercer rate development teams supporting New Jersey, New Mexico, and New York.

Alan's other experiences and accomplishments include:

- Part of lead team that designed a Medicaid managed care organization's LTSS model that included the impacts across all business units (e.g., medical management, care management, claims, provider network).
- Participated in the responding to Medicaid managed care Request for Proposals (RFPs) issued by state Medicaid agencies including for the dual demonstrations programs.
- Participated in the implementation of Medicaid managed care organizations.
- Developed a care management time and staffing ratio model that can be adapted to state specific requirements.
- Responsible for the competitive RFP/contracting process with the ALTCS managed care organization and the annual contractual renewal for over 10 years.

Alan Schafer, RN, BSN
Senior Associate

EDUCATION
Bachelor's degree, Nursing
University of Colorado

EXPERIENCE
27 years professional experience

CORE COMPETENCIES
Clinical and program support in the development, implementation and oversight of state Medicaid managed care programs.

AFFILIATIONS
Registered Nurse (AZ – license number available upon request)
Former Chair, Arizona Direct Care Workforce Committee
Former member, Arizona Interagency Council on Long-Term Care

- Provided the clinical and program support in developing and revising ALTCS managed care organization capitation, nursing facility and HCBS rates.
- Responsible for the oversight of the ALTCS managed care organizations compliance with Federal and State operational and care management requirements.
- Invited speaker at many conferences on the topics of managed LTSS, coordination of care for dual eligible and consumer directed care.
- Participated in the development of Arizona's Self-Directed Attendant Care service (a consumer directed care model with a managed care environment and consumers directing skilled tasks).
- Participated in the renewal of the AHCCCS 1115 Waiver renewals.
- Participated in ALTCS program improvement initiatives including but not limited to performance measures, performance dashboards, legislation to allow self-directed consumer to direct their caregiver to provide skilled care, expanding private duty nursing to all ALTCS members, Adult Foster Care Homes for ventilator dependent members, dementia care guidelines, spouses as paid caregivers in lieu of institutionalization, interrater reliability requirements for case managers determining type, amount and duration of in-home services for ALTCS members and requirements for managed care organizations to provide support to members regarding education, housing and employment.
- Participant at the Long-Term Quality Alliance's "Charting a Path Forward for Uniform Assessment of LTSS Needs" roundtable (May, 2014).

REFERENCES

Name:	*Leah Gibbs, Administrative Operations Business Manager*
Entity:	*Department of Economic Security, Division of Developmental Disabilities*
Address:	*1789 W. Jefferson St., Phoenix AZ 85007*
Telephone #:	*+1 602 542 6874*

Name:	*Robin Wagner, Deputy Assistant Director*
Entity:	*Department of Health and Hospitals, Office of Aging and Adult Services*
Address:	*628 N. 4th Street, Baton Rouge, LA 70802*
Telephone #:	*+1 225 978 3428*

Name:	*Lisa Zimmerman, Deputy Director*
Entity:	*Division of Medicaid and Medical Assistance*
Address:	*1901 N. Du Pont Highway, Lewis Bldg., New Castle, DE 19720*
Telephone #:	*+1 302 255 9535*

Joel Schuenke

QUALIFICATIONS

Joel has managed numerous Medicaid and Medicare engagements during his career including managed care and fee-for-service rate development, benefit pricing, data analysis, actuarial tool development, strategic direction consulting, due diligence activities, and provider contracting evaluations. Joel is currently leading Mercer's rate setting team for Massachusetts' long term care products and is also providing leadership to Mercer's Missouri team.

EXPERIENCE

Prior to joining Mercer, Joel was employed at OptumInsight where he provided consulting services to Medicaid and Medicare Advantage health plans and provider groups. Joel has led several projects and provided expertise to clients in the areas of managed Medicaid, Medicare Advantage, managed long term services and supports and fully integrated dual eligible programs. Joel's experience includes:

- Developing actuarially sound capitation rates for managed long term services and support programs and fully integrated dual eligible populations.
- Providing strategic consulting services to numerous clients in the areas of program design, mergers, and acquisitions, financial, and actuarial.
- Calculating actuarially sound capitation rates for Medicaid managed care plans, including data analysis, development of completion adjustments, medical inflation factors, managed care impact adjustments, program changes, and administration allowances.
- Assisted clients to structure provider contracting methods and strategies including pay-for-performance and value-based purchasing alternatives concentrating on establishing appropriate incentives to achieve financial, program, and quality goals.
- Providing strategic direction for clients related to alternative health care delivery models such as Accountable Care Organizations and Health Homes.
- Assisting organizations develop and submit Medicare Advantage Part D bids.
- Participating in rate negotiations between health plans and states including technical support and actuarial related discussions.
- Performed in-depth medical trend analyses using historical health plan data, including adjustments for changes in population, covered benefits, and health status.
- Evaluated proposed changes in provider contracts and provided technical support and guidance for the provider contract negotiation process.

Joel Schuenke
Principal

EDUCATION
Bachelor's degree, Mathematics
Moorhead State University

EXPERIENCE
27 years professional experience

CORE COMPETENCIES
Specializing in financial/actuarial consulting services for long term services and supports and fully integrated dual eligible programs

PACE

Alternative health care delivery models

Leading client teams and providing strategic direction

Developing capitation rates

Risk adjustment

- Conducted evaluations of health-based risk adjusted rate methodologies for Medicaid programs concentrating on areas to improve data and thereby increasing risk scores.
- Analyzed, summarized, and compared health plan data to benchmark data sources to identify outliers and quantify medical cost savings related to cost saving initiatives.
- Participated in due diligence activities related to health plan acquisitions including evaluating the level of claim reserves, revenue projections, and medical inflation estimates.
- Analyzed reinsurance arrangements and other risk management mechanisms, including risk corridors as well as individual and aggregate stop-loss programs.
- Performed feasibility analyses of Medicare Advantage dual eligible Special Needs Plans (D-SNP).

REFERENCES

Name:	*Kristen Jefferies*
Entity:	*Commonwealth of Massachusetts, Executive Office of Health and Human Services*
Address:	*One Ashburton Place, 11th Floor, Boston, MA 02108*
Telephone #:	*+1 617 573 1657*

Name:	*Mark Miller*
Entity:	*Commonwealth of Massachusetts, Executive Office of Elder Affairs and MassHealth*
Address:	*One Ashburton Place, 5th Floor, Boston, MA 02108*
Telephone #:	*+1 617 222 7466*

Name:	*Andrew Bond*
Entity:	*State of Missouri – Missouri HealthNet Division*
Address:	*615 Howerton Ct, PO Box 6500, Jefferson City, MO 65102*
Telephone #:	*+1 573 751 1092*

Angie WasDyke, ASA, MAAA

QUALIFICATIONS

Angie utilizes her actuarial and management experience to lead state service teams on the design and implementation of health care programs and reimbursement structures. She is the Client Leader and Strategic Actuary for Missouri. Angie has also consulted to the states of Georgia, Florida, Indiana, Nebraska, Ohio, Oklahoma, Pennsylvania, and Texas in rate development, financial performance measurement and program design, implementation and monitoring. As a Senior Partner, Angie manages Mercer's Minneapolis Government Human Services Consulting specialty practice that includes approximately 55 staff of actuarial consultants, pharmacy consultants, data consultants, and analysts.

EXPERIENCE

Angie has worked in the health care actuarial field since 1991, working in both insurance and consulting environments with experience with Medicaid, commercial, and Medicare populations. She started with Mercer in 2000, was an actuarial consultant with Reden & Anders and prior to that, worked at Blue Cross Blue Shield of Kansas City as an actuarial analyst prior to her time at Reden & Anders.

Angie WasDyke, ASA, MAAA
Senior Partner

EDUCATION
Bachelor's degree, Actuarial Science
Maryville College – St. Louis

EXPERIENCE
25 years professional experience

CORE COMPETENCIES
Developing capitation rates
Evaluating program financial outcomes
Negotiating with contractors and CMS
Implementing and conducting risk adjustment

AFFILIATIONS
Associate Society of Actuaries
Member American Academy of Actuaries

Angie's experience includes:

- Establishing PACE Upper Payment Limits and capitation rates in the states of Missouri and Ohio.
- Advising on the pros and cons of different managed care programs (e.g., mandatory vs. voluntary programs, PCCM vs. full risk HMO programs), and strategizing with agencies on where to implement managed care, which populations to cover, and which benefits to capitate in the states of Georgia, Missouri, Nebraska, Ohio, and Pennsylvania.
- Conducting a full-risk managed care feasibility analysis for behavioral health and developmentally disabled populations and services for the state of Missouri.
- Assisting in the financial management of behavioral health programs with the development of a cost reporting tool, calculation of per diems for Psychiatric Residential Treatment Facility services and determination of provider reimbursement rates for specific services in the state of Nebraska.
- Assisting with strategy, design, and implementation of enhanced PCCM and disease management programs, including request for proposal development, proposal evaluations, capitation rate development, and vendor accountability metrics such as guaranteed savings calculations, risk sharing arrangements and clinical results in the states of Georgia, Missouri, Ohio, Pennsylvania, and Texas.

- Providing strategy on the design, purchasing, implementation, and evaluation of Medicaid reform initiatives for CHIP programs, pharmacy management, and ACA implementation for the states of Missouri and Nebraska.
- Developing rate-setting methods based on multiple sources of data, including FFS data, health plan financial data, and encounter data in the states of Georgia, Florida, Indiana, Missouri, Nebraska, Ohio, Oklahoma, and Pennsylvania.
- Presenting rate-setting methods at technical assistance sessions for potential contractors and other interested parties in the states of Georgia, Missouri, Nebraska, Ohio, and Pennsylvania.
- Assisting with rate negotiation strategies for states and negotiating with health plans in the states of Georgia, Missouri, Nebraska, Ohio, and Pennsylvania.
- Supporting the CMS state plan and waiver approval process, certifying that capitation rates paid to health plans are actuarially sound and the program is cost effective and providing the necessary documentation to comply with 42 CFR 438.6(c) in the states of Georgia, Florida, Indiana, Missouri, Nebraska, Ohio, Oklahoma, and Pennsylvania.
- Evaluating policy changes on capitation rates and state expenditures, including changes to pharmacy policy and reimbursement in the states of Florida, Indiana, Missouri, Nebraska, and Ohio.
- Calculating capitation rates for Non-emergent Medical Transportation programs in the states of Missouri and Oklahoma.
- Implementing capitation rate efficiency adjustments into rate development methodologies for the state of Missouri.
- Designing and implementing risk adjustment mechanisms into managed care reimbursement structures for the states of Missouri and Ohio.
- Determining actuarial equivalence of benefit plan designs under the requirements of the DRA for the state of Missouri.
- Designing and implementing state programs for the uninsured populations, including pricing of benefits and capitation rate setting for the states of Missouri and Nebraska.
- Conducting encounter data validation analyses in the states of Missouri and Ohio.
- Developing cost reporting tools for monitoring financial performance of health plans, auditing results, and identifying areas for follow-up action in the states of Missouri, Nebraska, and Ohio.
- Consulting on CCBHC Planning Grants with focus on completing planning grant applications; supporting cost report modifications, training, collection, review, and consolidation; developing PPS rates, performance metrics, and outlier payments; strategizing on system implementation and coordination with managed care and FQHC reimbursement; and completing implementation applications in the state of Missouri.
- Auditing Medicare Advantage and Prescription Drug Plan actuarial bids on behalf of the Centers for Medicare and Medicaid Services.

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Publication: "PACE Medicaid Rate-Setting: Issues and Considerations for States and PACE Organizations," May 2009, contributing member of National PACE Association Medicaid Rate-Setting Work Group.

REFERENCES

Name:	*Angie Brenner, Director of Federal Programs*
Entity:	*State of Missouri, Division of Developmental Disabilities, Department of Mental Health*
Address:	*1706 E. Elm Street, Jefferson City, MO 65102*
Telephone #:	*+1 573 526 1853*

Name:	*Andrew Bond, Director of Finance*
Entity:	*State of Missouri, MO HealthNet Division, Department of Social Services*
Address:	*615 Howerton Court, Jefferson City, MO 65102*
Telephone #:	*+1 573 751 1092*

Name:	*Donna Siebeneck, Medicaid Coordinator*
Entity:	*State of Missouri, Division of Administrative Services, Department of Mental Health*
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Telephone #:	*+1 573 751 9139*

Subcontractor (NASUAD) Resumes

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Lowell Arye, MS

QUALIFICATIONS

Lowell Arye is a nationally recognized leader, speaker, activist, and advocate in aging and disability policy. He has more than 34 years of experience and is passionate about ensuring that seniors and people with disabilities have an opportunity to live and work in the community and make a life that is meaningful and fulfilling. His work has spanned federal (Congress and Executive) and state government, academia, philanthropy and the non-profit sector. He is known for his objective and concise policy analyses, strategic thinking, and developing quality evidence-based solutions to social policy and services.

Lowell Arye
President, Aging and Disability Policy and Leadership Consulting

EDUCATION

Case Western Reserve University; Mandel School of Applied Social Sciences, Cleveland, OH
Masters in Science of Social Administration—Gerontology, 1982

Hiram College, Hiram, OH
Bachelor of Arts—Sociology, 1980

EXPERIENCE

Over 34 years' professional experience

CORE COMPETENCIES

Stakeholder Engagement

Program operations

EXPERIENCE

Aging and Disability Policy and Leadership Consulting, LLC
President, 2016-Present
Aging and Disability Policy and Leadership Consulting LLC offers in-depth planning, program and policy development, and leadership training to states, counties, national and state trade associations, foundations, and community-based and health care organizations.
Focus on development of supports and services which ensures that seniors and people with disabilities have an opportunity to live and work in the community and make a life that is meaningful and fulfilling.

New Jersey Department of Human Services, Trenton, NJ
Deputy Commissioner, 2012 2016
Responsible for management, policy and budget oversight of three divisions-Family Development, Disability Services, and Aging Services.

Served as Interim-Director of the Division of Aging Services for one year. These three Divisions have an annual budget of more than $6.5 billion with close to 1,000 employees.

Provided management support and direction as well as leadership in the coordination and streamlining of the activities and policies to the divisions, both at a central administrative and direct service level, including reviewing spending plans, budget requests, personnel issues and actions, legislation and administrative regulations.

Served as senior advisor to the Commissioner on all of the above matters and ensured that the Commissioner is aware of the ongoing operation of each division and that each division provides quality services to the Department's clients in a timely manner.

Successfully led the roll-out of Managed Long Term Services and Support.

Office of the Governor, Governor Chris Christie of New Jersey, Trenton, NJ
Policy Advisor on Human Services and Children and Families, 2011-2012
Led policy development in the areas of child protection and welfare, people with disabilities and behavioral health, as well as economically disadvantage individuals and families.

Liaised with the Departments of Human Services and Children and Families, including review of regulatory and budgetary initiatives.

ALLIANCE FOR THE BETTERMENT OF CITIZENS WITH DISABILIITES (ABCD), Trention, NJ
Executive Director, 1997-2011
Chief executive of New Jersey state wide advocacy organization for people with multiple physical and developmental disabilities.

Responsible for strategic planning, staff supervision, budget preparation and execution, and serving as spokesperson in the executive and legislative branches.

LEONARD DAVIS INSTITUTE OF HEALTH ECONOMICS CENTER FOR HEALTH POLICY, UNIVERSITY OF PENNSYLVANIA, Philadelphia, PA
Associate Director, 1994-1997
Senior position with responsibility for the day-to-day operations of the Center including: project development, staff supervision, and coordination of Penn faculty from different schools.

THE PEW CHARITABLE TRUSTS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Philadelphia, PA
Program Officer, 1992
Senior position with direct responsibility for managing the operations of a $24 million grant portfolio in health systems reform and health professions education and training.

OFFICE OF THE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Washington, DC
Senior Policy Analyst, Office of the Assistant Secretary for Planning and Evaluation, 1989-1992
Management responsibility for policy oversight, development and coordination of income security and related health care services affecting the elderly, and people with disabilities.

Program Analyst, Office of the Assistant Secretary for Management and Budget, 1988-1989
Managed the formulation and execution of the Social Security Administration's (SSA) $5 billion operating budget.

SUBCOMMITTEE ON RETIREMENT INCOME AND EMPLOYMENT, SELECT COMMITTEE ON AGING, U.S. HOUSE OF REPRESENTATIVES, Washington, DC
Acting Staff Director, 1986-1988
Deputy Staff Director, 1985-1986
Direct management of Subcommittee, five staff and twenty Members of Congress.

Responsible for legislative and administrative agenda with oversight of financing, benefit structure and administration of all governmental income maintenance programs affecting the elderly and people with disabilities.

Research Assistant, 1982-1985
Managed the Committee's activities resolving the problems associated with the accelerated disability

reviews.

REFERENCES

Name:	*Jennifer Velez, Esq*
Entity:	*Sr. Vice President, Barnabas Health*
Address:	*95 Old Short Hills Road, West Orange, NJ 07052*
Telephone #:	*+1 973 322 4572*

Name:	*Valerie Harr, Deputy Commissioner*
Entity:	*New Jersey Department of Human Services*
Address:	*222 South Warren Street, Trenton, NJ 08625*
Telephone #:	*+1 609 633 9645*

Name:	*Patti Killingsworth, Assistant Commissioner*
Entity:	*Bureau of TennCare*
Address:	*310 Great Circle Road, 2nd Floor East, Nashville, TN 37243*
Telephone #:	*+1 615 507 6468*

Camille I. Dobson, MPA

QUALIFICATIONS

Camille Dobson has over 20 years' experience with Medicaid managed care, both operations and regulatory compliance. She has spent the last 12 years providing technical assistance to states, brainstorming solutions and developing the structures to effectuate program goals. While at CMS, she was the primary author of CMS' requirements for MLTSS programs, as well as the strategic director of proposed Medicaid managed care regulations. She is currently providing intensive technical assistance to the State of New Hampshire as they implement an MLTSS program for older adults and persons with disabilities.

EXPERIENCE

NATIONAL ASSOCIATION OF STATES UNITED FOR AGING AND DISABILITIES, Washington, DC
Deputy Executive Director, January 2015-present

- Provides technical assistance to states on the administration of state health programs, focusing on managed long-term services and supports and quality measurement.
- Serves as liaison between NASUAD and other aging and disability partners at the federal, state, and local level.
- Successfully manages MLTSS business acumen Federal grant.
- Represents NASUAD on National Quality Forum's workgroup on Quality in Home and Community Based Services working to identify measurement gaps and recommendations for improvement.

Camille Dobson
Deputy Executive Director, NASUAD

EDUCATION
George Washington University, Washington, DC
MPA (Summa Cum Laude)—State And Local Government, 1988
B.A., (Cum Laude)—International Affairs, 1986

EXPERIENCE
Over 20 years' professional experience

CORE COMPETENCIES
Federal Medicaid regulatory analysis
Managed long-term services and supports program design
Long-term services and supports quality measurement
Aging and disability network business acumen
Stakeholder engagement

AFFILIATIONS
Maryland Association of Healthcare

CENTERS FOR MEDICARE & MEDICAID SERVICES, Baltimore, MD

- Served as the acknowledged agency policy expert Medicaid managed care policy issues. Provide information and policy interpretations to Center Director leadership, other CMS components (including OL, CCIIO, and MMCO), ASPE, and the Department of the Treasury on Medicaid and CHIP managed care policy issues.
- Provided technical assistance and regulatory guidance to states operating managed care delivery systems for Medicaid beneficiaries.
- Developed strategic approach to modernizing Medicaid managed care regulations.
- Developed and promulgated guidance for States using managed care plans to deliver long-term services and supports to Medicaid beneficiaries; educated states and other stakeholders on CMS' expectations for MLTSS programs.

  - Developed guidance on capitation rate-setting for States expanding coverage to low-income adults in 2014. Reviewed, provided feedback, and recommended for approval States' actuarial soundness certifications.
- Managed the work of a team of health insurance specialists, supervising work products and providing direction and guidance on reviews of 1915(b) managed care waiver applications and renewals, State plan amendments and section 1115 demonstration proposals to implement managed care delivery systems.
- Implemented key provisions of health care legislation including primary care payment increases; the application of Medicaid managed care oversight principles to Children's Health Insurance Program (CHIP); and the application of the Mental Health Parity and Addictions Equity Act of 2008 to Medicaid and CHIP.
- Acted as project officer for Medicaid demonstration programs in Regions I, II, III, and VII.
- Negotiated complex and ground-breaking demonstration to reform New York's health care system.

SCHALLER ANDERSON OF MARYLAND (d/b/a Maryland Physicians Care MCO), Baltimore, MD

- Managed TPA relationship with Maryland Health Insurance Plan Executive Director and Board of Directors.
- Successfully implemented TPA contract for 7,000 members and met all contract deliverables. Responsible for all aspects of contract management and performance, including profitability. Developed and implemented work plan for cross-functional team of 20 staff.
- Development and production of all performance metrics and reports, as well as all marketing and plan information materials; day-to-day management of company relationship with Executive Director and Board; and coordination with medical management on medical policy and implementation issues.
- Assisted in demonstrating company's compliance with enrollee rights and provider network adequacy standards for required external quality review audit under company's Medicaid contract.
- Managed demonstration project under auspices of Center for Health Care Strategies' Best Clinical and Administrative Practices program to improve health outcomes for children with special health care needs which resulted in 25% increase in number of children identified and screened for health service needs.

CAREFIRST BLUECROSS BLUESHIELD, Owings Mills, MD

- Managed all facets of compliance with State regulations for Medicaid MCO product.
- Developed and implemented workplan to operationalize new product.
- Developed broad understanding of managed care principles, including medical management, quality management, network development, and claims processing.
- Managed all facets of Medicaid Operations department's NCQA accreditation activities, resulting in excellent accreditation rating for Medicaid product in 2000.
- Developed and implemented customer service quality improvement projects resulting in greater customer service staff efficiency and more accurate key indicator reporting in 1999 and 2000.

REFERENCES

Name:	*J. Michael Hall, Executive Director*
Entity:	*Champlain Valley Area Agency on Aging, Former Secretary of Aging, Pennsylvania*
Address:	*jmh@cvaa.org*
Telephone #:	*+1 802 865 0360*

Name:	*Don Blanchon, Executive Director*
Entity:	*Whitman-Walker Clinic, Former CEO, Maryland Physicians Care*
Address:	*dblanchon@whitman-walker.org*
Telephone #:	*+1 202 797 4410*

Name:	*Penny Thompson, Principal*
Entity:	*Penny Thompson Consulting, MACPAC Commissioner*
Address:	*penny.thompson@pennythompsonconsulting.com*
Telephone #:	*+1 443 214 9942*

Martha A. Roherty, MPP

QUALIFICATIONS

Martha Roherty has over 20 years' experience advising and assisting states on a broad spectrum of issues, including agency consolidation and reorganization, change management, program redesign and public relations. Her background gives her a combination of Medicaid and aging/disability experience which will be particularly valuable for this work. As a parent of an adult child with special needs and a spouse with early on-set Alzheimer's, Ms. Roherty combines her personal experience and professional experience to help states manage stakeholder relations and expectations.

EXPERIENCE

NATIONAL ASSOCIATION OF STATES UNITED FOR AGING AND DISABILITIES, Washington, DC
Executive Director, 2008-present

- Develops strategic direction for the association under the guidance of the Association's Board of Directors.
- Promotes the association's public policy agenda and provides the liaison with federal policymakers in the legislative and executive branches, and other national partners.
- Manages all fiscal and programmatic management of the organization including the supervision of all staff.
- Provides technical assistance to states on the administration of state aging and disability programs.

NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS, AMERICAN PUBLIC HUMAN SERVICES ASSOCIATION, Washington, DC
Director, 2004-2007

- Developed and implemented strategic plan for the National Association of State Medicaid Directors (NASMD) and the Center for Workers with Disabilities (CWD).
- Provided testimony as a national health policy expert to state and federal commissions, legislatures, and the executive branch.
- Provided direct technical assistance to states on state health reform, long-term care, and disabilities issues.
- Organized and coordinates four national meetings per year; several national workshops per year; and monthly conference calls.
- Recruited and maintains members of NASMD and the Center; negotiates agreements with the states; manages the contracting process.
- Sought new funding opportunities through federal, state, foundation, and private sector opportunities.
- Managed and maintains a budget of over $2 million.
- Member of the Executive Team of the American Public Human Services Association.

Martha Roherty
Executive Director, NASUAD

EDUCATION

University Of Maryland, College Park
Master of Public Policy—Finance, 1993

Russell Sage College, Troy, New York
Bachelors of Science—Public Administration, 1986

EXPERIENCE

Over 20 years' professional experience

CORE COMPETENCIES

Stakeholder Engagement

LTSS agency structure design and implementation

Program operations

Medicaid policy analysis

Project management

LTSS program analysis

AFFILIATIONS

American Society of Association Executives

- Supervised health policy staff and consultants.

THE FINANCE PROJECT, Washington, DC
Outreach and Dissemination Coordinator, 2001-2004

- Developed national advertising campaign to promote better results for children, families, and communities through sound fiscal practices.
- Managed publication process from inception through publication.
- Redesigned The Finance Project's corporate website.
- Implemented strategic initiative to increase revenue through grants, partnerships, and publication sales.
- Identified new and creative ways of disseminating and brokering information to wider audiences.
- Collaborative problem solving with an outside network of organizations with similar missions.
- Member of the management team.

THE MULTISTATE TAX COMMISSION, Washington, DC
Senior Staff Associate, 1995-1997

- Project manager overseeing the analysis of the impact of federal legislation and judicial rulings on state property tax systems. Organized and summarized the collection of data and provided analyses to governors, legislators, and staff members, the impact of tax changes on their state systems.

NATIONAL GOVERNORS ASSOCIATION, Washington, DC
Senior Policy Associate, 1992

- Organized and staffed the first Joint Revenue Project between the National Governors Association, the National Conference of State Legislatures, the National Association of State Budget Officers, the Federation of Tax Administrators, and the Multistate Tax Commission. Responsibilities for the project included: research and writing on current state revenue systems; establishing and maintaining contacts with outside organizations; and, acting as a liaison between the various organizations and a team of outside academics and advisors.
- Prepared a weekly update for all Governors on behalf of the National Governors Association detailing federal changes in tax and budget policy as well as model state initiatives.

NATIONAL CONFERENCE OF STATE LEGISLATURES, Washington, DC
Senior Policy Specialist, 1988 – 1992

- Edited and prepared the Federal Budget Update for legislative staff which provided an analysis of the federal budget and tax policy and its impact on state budgets.
- Initiated a federal mandate bill tracking system—The Hall of the States Mandate Monitor.
- Managed NCSL's State-Local Relations Committee with sole responsibility for planning three national meetings a year, organized research projects on behalf of the group, and provided liaison to national organizations.
- Edited and prepared articles for *The Fiscal Letter*, a bimonthly report distributed nationally to state and local officials.
- Identified issues with potential outside funding, wrote grant proposals, and fulfilled requirements of existing contracts.

NEW YORK STATE LEGISLATURE, Albany, New York
Staff Associate, 1985-1988

- Director of a legislative study group to reform the legislative process of the New York State Legislature, entitled, *Project 1990: The Challenge of Effective Legislative Management in the State of New York.*

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Carol Sala

QUALIFICATIONS

Carol Sala retired in 2012 as the Administrator of the Nevada Aging and Disability Services Division (ADSD). In this capacity, Carol provided direction in the development, coordination, and delivery of support services to Nevada's senior citizens and persons with disabilities. Ms. Sala directed and coordinated state and federal funding for long term services and supports programs and oversaw two of Nevada's HCBS Medicaid waiver programs.

EXPERIENCE

NEVADA STATE ASSEMBLY, Las Vegas, Nevada
Assistant Chief Clerk of the Assembly, 78th Legislative Session, January 2015 – June 2015; 29th Special Session, December 16 – 19, 2015

- Processed all Bill Draft Requests to assure timely introduction as bills in the State Assembly.
- Provided support to Chief Clerk of the Assembly.
- Assured legislative process was followed correctly with regards to bills. Nevada State Legislature convenes biannually for 120 days per the Nevada Constitution.
- Employment is only during odd years.

NEVADA STATE ASSEMBLY, Las Vegas, Nevada
Assembly Recording Clerk, 28th Special Session, September 10 – 11, 2013; 77th Legislative Session, January 2013 – June 2013

- Generated all agendas for Assembly Floor Sessions.
- Recorded all business, generating a log of all activities during floor sessions.
- Transcribed all Assembly members' comments from floor sessions that pertained to legislative intent for entry into the Assembly Daily Journals.
- Nevada State Legislature convenes biannually for 120 days per the Nevada Constitution.
- Employment is only during odd years.

STATE OF NEVADA, AGING AND DISABILITY SERVICES DIVISION, Las Vegas, Nevada
State Director of Nevada State Unit on Aging & Disability, January 2003 – March 2012 (Retired from State of Nevada in March 2012)

- Provided leadership and direction in the development, coordination, and delivery of support services to Nevada's senior citizens and persons with disabilities.
- Directed and coordinated state and federal funding for statewide service programs. Provided leadership on state and national level for issues related to aging and disability services.
- Administered community-based service programs and programs to ensure health, safety, and welfare of older persons and persons with disabilities.

Carol Sala
Independent Consultant to NASUAD

EDUCATION
UNIVERSITY OF NEVADA, Reno
Nevada Licensed Associate in Social Work, 2014
13 Semester units of graduate level courses in Social Work, 1989-1991

UNIVERSITY OF CALIFORNIA, Berkeley
Bachelor of Science—Forestry, 1982

EXPERIENCE
25 years professional experience

CORE COMPETENCIES
Stakeholder Engagement
Program operations

- Led agency through the transition in 2005 of incorporating the services to person with disabilities into the Aging Services Division creating the Aging and Disability Services Division within the Department of Health and Human Services.
- Maintained core services during the 2007-2009 biennium when Nevada was faced with a devastating budget crisis due to the economic recession.

STATE OF NEVADA DIVISION FOR AGING SERVICES, Las Vegas, Nevada
Community Based Care Manager, January 2000 – January 2003

- Coordinated program activities within the Community Based Care Unit for 1915(c) waivers and state-funded community based care programs.
- Developed program policies in accordance with federal and state regulations. Developed and managed program budgets.

STATE OF NEVADA DIVISION FOR AGING SERVICES, Las Vegas, Nevada
Social Work Supervisor, May 1993 – January 2000

- Administered Community Based Care Programs; Community Home Based Initiatives Program (CHIP), Group Care Waiver Program (GCWP), Title XX Homemaker Program.
- Supervised eight Social Workers and two Program Assistants.
- Monitored budget, assisted with program development.

STATE OF NEVADA DIVISION FOR AGING SERVICES, Las Vegas, Nevada
Social Worker II, August 1992 – May 1993

- Evaluated and reassessed clients of the Community Based Care Programs.
- Monitored quality and appropriateness of services via monthly home visits.
- Arranged for needed equipment and accessed resources.
- Monitored costs and processed billing for services.

STATE OF NEVADA DIVISION OF CHILD AND FAMILY SERVICES, Las Vegas, Nevada
Social Work Trainee to Social Worker II, January 1985– August 1992

- Managed foster care and adoption caseload.
- Coordinated Title XX Homemaker and Title XIX Personal Care Aide Programs.
- Conducted Elder Protective Services and Child Welfare investigations.

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Telephone #:	*+1 775 684 8555*

APPENDIX C

Work Samples

All samples referenced in the proposal are included below as follows:

- LTSS Individual Service Plan Operational Assessment
- Delaware LTSS Research Options Report
- Connecticut LTSS Right Sizing Stakeholder Report
- Idaho SIM Stakeholder Communication Plan
- New Mexico Tribal Stakeholder Presentation
- Oklahoma LTSS Reform On-site Agenda
- Indiana Forum on Long Term Care Agenda

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MERCER

TALENT • HEALTH • RETIREMENT • INVESTMENTS

MEDICAID LONG-TERM SERVICES AND SUPPORTS - INDIVIDUAL SERVICE PLANNING OPERATIONAL ASSESSMENT

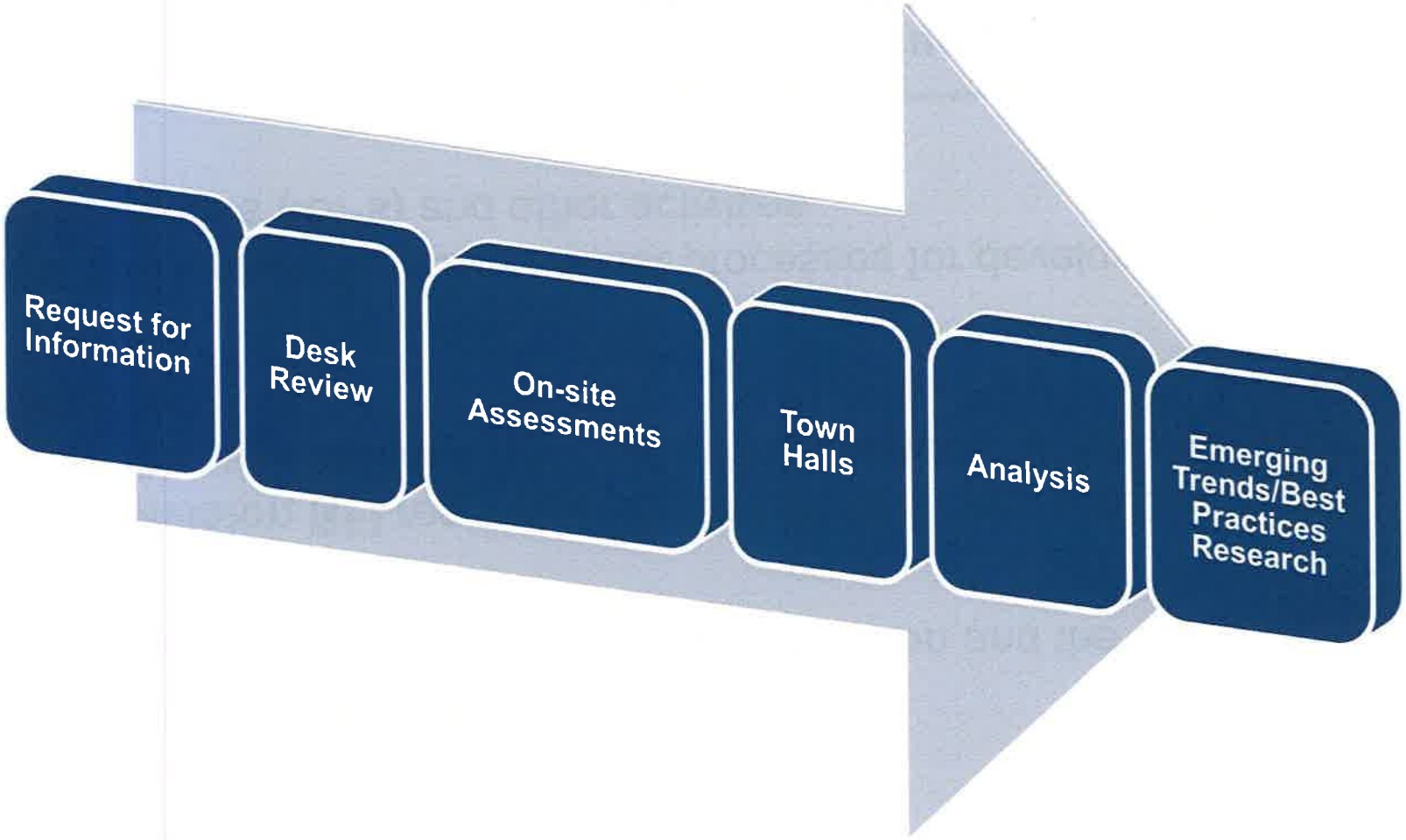
Excerpts from Mercer LTSS work product

MARSH & McLENNAN COMPANIES

Individual Service Planning Assessment
Introduction and Background

- **LTSS Division** engaged Mercer to lead an independent assessment of the ISP development and Service Coordination processes within their HCBS waiver program
  - Service Coordination is provided to waiver consumers through Service Coordination Entities (**SCEs**) which include Area Agencies on Aging, Service Coordination Agencies, and Centers for Independent Living
  - **SCEs** are contractors for **LTSS Division** who administer the waiver program
  - There are approximately 120 **SCEs** currently providing Service Coordination

Individual Service Planning Assessment
Methodology



Individual Service Planning Assessment
Methodology

Request for Information (RFI)

- An RFI was developed for both **LTSS Division** and the **SCEs**
- **LTSS Division RFI** requested documents necessary to complete a comprehensive on-site and process-wide assessment of waiver operations
- **SCE RFI** included a survey about processes for developing Individual Service Plans (ISPs) and other activities

The review of the submitted documents assisted in the development of standard interview and discussion questions that were utilized during the on-site assessments.

Individual Service Planning Assessment
Methodology

Desk Review

- **LTSS Division** provided and Mercer reviewed the following information:
  - HCBS waivers
  - Organizational charts
  - State regulations
  - Internal policies, procedures, flow charts, and job aids
- **SCEs** provided and Mercer reviewed the following information:
  - Pre-visit survey
  - Consumer assessment documents
  - Any additional internal tools utilized in the development of ISPs
  - Sample intake/admission documents provided to consumer upon enrollment
  - Sample consumer file

Individual Service Planning Assessment
Methodology

On-site Assessments

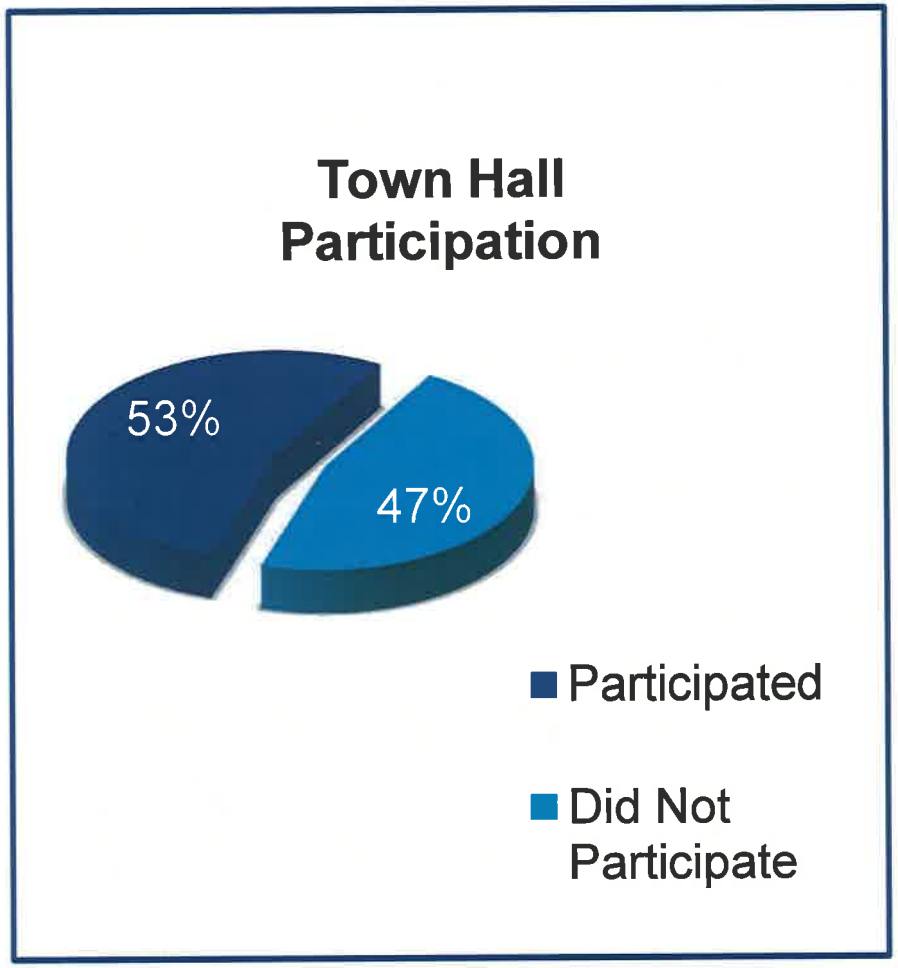
- **LTSS Division**
  - Interviewed over 20 staff members who conduct and/or supervise HCBS and ISP-related activities
  - Shadowed ISP review staff to observe daily job functions and learn more about technology platform functionalities
- **SCEs**
  - Visited and interviewed 8 SCEs in 4 different geographic regions
  - SCEs chosen by LTSS Division provided a representative sample of over-60 and under-60 providers in urban, suburban and rural areas

The goal of the on-site assessments was to identify challenges from multiple perspectives in order to find solutions that had a better chance of meeting the needs of all stakeholders.

Individual Service Planning Assessment
Methodology

Town Halls

- **LTSS Division** facilitated a series of town hall meetings to engage the SCE community across the State
- All **SCEs** were invited to attend 1 of the 4 meetings held in {text deleted}
- The meetings were **well attended** by a mix of over-60 and under-60 providers



Individual Service Planning Assessment Methodology

Analysis

- LTSS Division thought it was essential for the assessment to:

1. Provide an enhanced understanding of the **current state** of Service Coordination in the State

2. Outline a set of both short-term and long-term **recommendations** and opportunities for improvement

Individual Service Planning Assessment
Methodology

Emerging Trends and Best Practices Research

- Conducted research into how other states are **managing their long-term care populations**, which included:
  - Surveys of recent literature
  - Consultation with clinical members of the assessment team

- Nationwide, many best practices focus on the following areas:
  - Eligibility processes
  - Monitoring quality

Many of these emerging trends and nationwide best practices could be explored further and considered by LTSS Division in the context of operational enhancements.

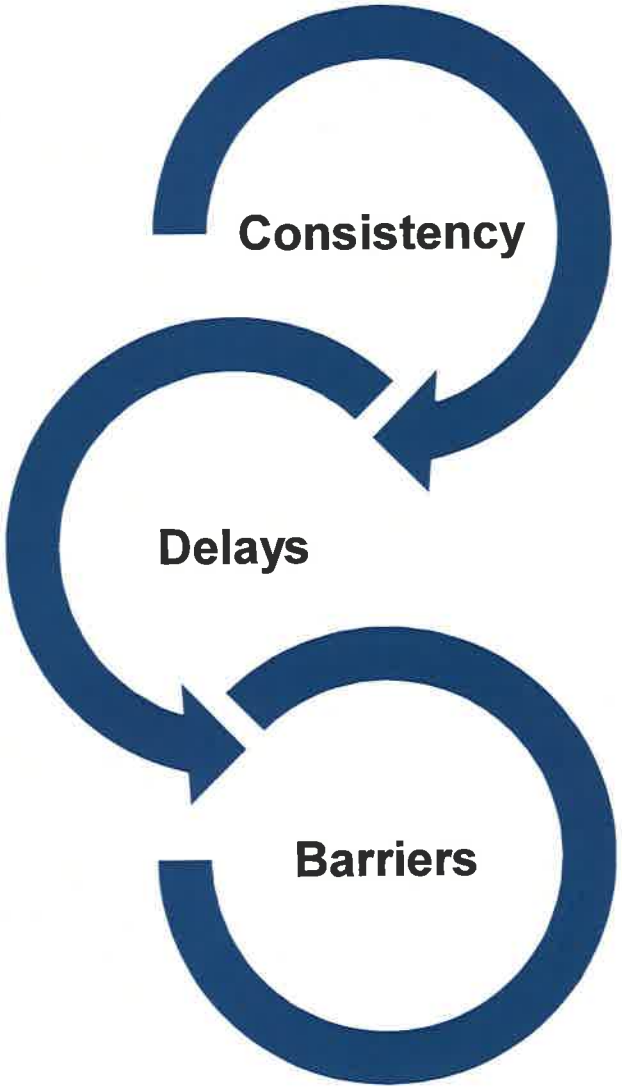
Emerging Trends and Best Practices Research

– Some of the key best practices include:

Reducing or eliminating fragmentation between acute and primary care, behavioral health, and long-term care services
Ensuring **coordination of benefits** that maximize alternate and third-party payer resources
Engaging **consumers and families** in service planning process
Developing educational support programs to **promote consumer understanding and choice**
Establishing appropriate **payment incentives** for coordinating care and integrating benefits
Building mechanisms to include **consumer voice** in service coordination design and plan governance

Individual Service Planning Assessment
Major Themes & Findings

- The major themes and findings are **sourced from**:
  - Interviews with LTSS Division
  - Interviews and on-site assessments with SCEs across the State
  - Regional town hall meetings
  - Related documents including policies and procedures, assessment tools, job aids, flow charts, and waiver consumer files



Individual Service Planning Assessment
Major Themes & Findings

The trends in each major theme included:

Consistency

- Lack of clarity around what LTSS Division requires to be included in ISPs
- Transparency in policy development
- Different preferences among ISP reviewers

Delays

- Long delays in ISP approval
- Timeliness in receiving responses to questions from LTSS Division on ISPs
- Duplicative information in information systems

Barriers

- SCEs request more autonomy and flexibility with ISPs based on consumer input
- Documentation requirements for home mods and DME requests
- Varied use of retired assessment tools

Individual Service Planning Assessment
Recommendations & Opportunities for Improvement

Comprehensive and effective tools are essential to the overall success of an HCBS program

- Several states currently incorporate functional assessments in their HCBS planning
- Functional assessment tools lower assessor subjectivity around service duration and frequency
- These tools also provide documentation of consumer needs for the service and frequencies selected and are complementary to a goals and outcomes-based service planning process

Individual Service Planning Assessment
Recommendations & Opportunities for Improvement

Sample State A

- Utilizes the Consumer Needs Assessment Questionnaire and Task/Hour Guide tool
- Evaluates all areas of the consumer functional abilities and natural supports
- Guides the assessor to determine the amount of support time that meets consumer needs

Sample State B

- Utilizes the Comprehensive Assessment Reporting Evaluation tool
- Case managers document consumers functional ability
- Determine eligibility for long-term care services
- Evaluate duration and frequency of assistance needed
- Develop plan of care

Individual Service Planning Assessment
Recommendations & Opportunities for Improvement

In addition to adopting a functional assessment tool, **LTSS Division** should also consider:

*LTSS Division could build the **knowledge base** within the SCE community and they could subsequently train their existing and newly hired staff*

*Trainings could be **limited to key SCE staff** who would be the identified trainers within their agencies and messaging could be **standardized** across the SCE community*

Individual Service Planning Assessment
Recommendations & Opportunities for Improvement
Short-Term

CONSISTENT, STREAMLINED PROCESSESS

Recommendations	Program Impact	Effort to Implement	Effect on Program
1. Establish uniform expectations across all regions for the type and format of data submissions	High	Medium	Less confusion for both SCEs and LTSS Division ISP reviewers
2. Focus on reducing duplicative data (data that is entered into multiple fields in the system)	High	High	Time savings on ISP reviews
3. Streamline the documentation requirements for home modifications and DME requests	Low	Low	Reduced administrative burden for SCEs and LTSS Division

Individual Service Planning Assessment
Recommendations & Opportunities for Improvement
Short-Term

REVIEW SUPPORT TOOLS

Recommendations	Program Impact	Effort to Implement	Effect on Program
1. Create tools to help ISP reviewers reduce subjectivity	High	High	Higher job satisfaction for ISP reviewers
1a. Re-assess the validity and reliability of waiver assessment tools (LOCA/CMI) to ensure they match services in review support tools	High	Low	Ensure consistency of consumer info

In evaluating new review support tools, LTSS Division should consider including a rubric of "typical" services for a consumer with a particular goal or clinical profile.

Individual Service Planning Assessment
Recommendations & Opportunities for Improvement
Short-Term

COMMUNICATION

Recommendations	Program Impact	Effort to Implement	Effect on Program
1. Provide SCEs with accurate, up-to-date directory of LTSS Division staff with a description of roles and contact information	High	Low	Establish key points of contact
2. Provide SCEs with guidance on who to contact with specific questions and preferred method of contact (phone, email, etc.)	High	Low	Strengthen relationship between SCEs and LTSS Division
3. Maintain an accurate and up-to-date registry of key SCE staff names, roles and contact information	Medium	Medium	Facilitate more direct communication channels

Individual Service Planning Assessment
Recommendations & Opportunities for Improvement
Short-Term

CRITICAL REVISIONS

Recommendations	Program Impact	Effort to Implement	Effect on Program
1. Revise the cap on the number of critical revisions that can be made to an ISP on behalf of a consumer throughout the waiver year	High	Medium	Decreased backlog and more SCE autonomy

Revisions could be limited to those that only involve changes to certain types of services or that would result in budget changes below a certain amount.

Individual Service Planning Assessment
Recommendations & Opportunities for Improvement
Long-Term

ISP REVIEW

Recommendations	Program Impact	Effort to Implement	Effect on Program
1. Limit the prospective review to a representative sample of service plans, with the rest automatically approved	High	High	Decreased backlog
2. Conduct a prospective review only of service plans with budgets over a certain amount, with lower-cost service plans automatically approved	High	Medium	Lowered administrative burden for both LTSS Division and SCEs
3. Initiate a two-part process where a consumer receives an ISP with "pre-set" array of services that can begin immediately, while a more comprehensive ISP is reviewed	High	Medium	Enhanced consumer access to services

Individual Service Planning Assessment
Recommendations & Opportunities for Improvement
Long-Term

COMMUNICATION

Recommendations	Program Impact	Effort to Implement	Effect on Program
1. Send newly-released guidance via multiple methods, such as emailing and posting to dedicated portion of LTSS Division website	Medium	Low	More effective dissemination of information
2a. Consider programming the website to send automatic email links to SCEs when LTSS Division uploads a new guidance document	Medium	Depends on system capabilities	Increased communication vehicles to promote transparency
3. Consider hosting regular webinars in conjunction with the release of waiver guidance	High	Medium	Less ambiguity regarding policy changes and guidance

Individual Service Planning Assessment
Recommendations & Opportunities for Improvement
Long-Term

GUIDANCE

Recommendations	Program Impact	Effort to Implement	Effect on Program
1. Initiate bi-weekly or monthly Q&A sessions for all LTSS Division ISP review staff to address questions on a regular and frequent basis	High	Low	Less ambiguity for ISP review staff
1a. Create minutes from the Q&A sessions and distribute to all attendees shortly after the meeting	High	Low	Enhanced clarity
1b. Over the course of a 6-12 month period, Q&A session minutes should be incorporated into a "policy manual" for staff	High	Medium	More consistency in the application of LTSS Division policy

Individual Service Planning Assessment
Recommendations & Opportunities for Improvement
Long-Term

GUIDANCE

Recommendations	Program Impact	Effort to Implement	Effect on Program
2. The Bureau of Policy and Regulatory Management should collect staff questions on a monthly basis and distribute the answers to these questions to both LTSS Division and SCEs in the form of an "FAQ" guidance document	Medium	Low	Enhanced understanding of LTSS Division guidelines and policy for both LTSS Division staff and SCEs

The LTSS Division Bureau of Policy and Regulatory Management could potentially play a larger role in this area on issues of ambiguity as they relate to waiver standards, bulletins and general policy guidance.

Individual Service Planning Assessment
Recommendations & Opportunities for Improvement
Long-Term

TRAINING (Systems)

Recommendations	Program Impact	Effort to Implement	Effect on Program
1. Offer trainings to new and existing staff, in conjunction with the IT department, on how to more efficiently navigate IT systems and identify any "shortcuts" that may exist	Medium	Medium	Lowered learning curve for new staff
2. Develop a "cheat sheet" for staff to utilize in order to bring them up to speed on how to use the system	Medium	Low	Process improvement for existing staff

Systems training could alleviate some of difficulty LTSS Division staff have reported in using technology platform.

July 23, 2010

Promoting Community-Based Alternatives for Medicaid Long-Term Services and Supports for the Elderly and Individuals with Disabilities

State of Delaware
Division of Medicaid & Medical Assistance

MERCER

MMC MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

Consulting. Outsourcing. Investments.

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Executive summary

Under the leadership of Governor Jack Markell and Secretary Rita Landgraf, the State of Delaware (State), Department of Health and Social Services (DHSS), Division of Medicaid & Medical Assistance (DMMA) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health and Benefits LLC, to produce this report. The purpose of this report is to provide information on Delaware's long-term care environment (e.g. demographics, Medicaid spending patterns, nursing home use), facilitate further discussion on options available to the State aimed at increasing community-based Medicaid long-term services and supports, and most importantly serve as a catalyst for implementation of the selected option(s).

There is no getting around the fact that Delaware, like the United States as a whole, is steadily aging. Delaware's population age 65 and older is expected to increase by 91 percent between 2010 and 2030 with the number of people age 85 years or older expected to more than double. As people age, there is a higher proportion of expensive chronic conditions (e.g., heart disease, diabetes, hypertension), a higher probability for disability, and a corresponding increase in the use of and need for health-related services and supports. At the same time, there will be fewer economically active individuals and workers in the 20 to 64 age range to either provide direct care services or indirectly support state and federal programs through payroll and other taxes. Moreover, Delawareans want to have alternatives to choose from when it comes to receiving long-term services and supports; to make Delaware a more livable state. Very few people want to be in institutions; the vast majority wishes to stay in their homes and communities for as long as practical.

Currently, for the elderly, Delaware spends nearly all of the associated Medicaid long-term care dollars on institutional care; less than 10 percent is directed to community-based alternatives for this population. This ranks Delaware near the bottom amongst all states. Conversely, even though Delaware has the fewest number of people in developmentally disabled waiver programs (due in part to Delaware's small size); community-based spending on individuals with developmental disabilities is nearly 74 percent as compared to 24 percent spending on institutions which are better than the national average. This presents an interesting dichotomy in how DMMA is serving both

the elderly and individuals with developmental disabilities through Medicaid long-term care programs.

Most studies indicate that on average the per person cost of serving an individual in the community is significantly less than the average per person cost of a nursing facility. The primary driver for this average per person cost differential is the service delivery system – community versus institutional. Other factors that contribute to the cost differential include differences in acuity level and the availability of unpaid family support to those able to be served in community settings. To the extent that community-based care is expanded to more of the population with greater health care needs, both average per person and total spending related to community-based care may increase, but ideally this increase in community-based spending leads to future reductions in facility-based spending to slow the overall growth in Medicaid long-term care expenditures.

DMMA will need to carefully evaluate aggregate spending levels to ensure that increasing community-based service alternatives has a positive impact on diverting or delaying the need for institutionalization to provide program sustainability over the long term horizon. Tools such as stricter level-of-care/eligibility policies, geographic coverage limits, spending caps (individual or aggregate), medical necessity criteria, waiver "slots", waiting lists for waiver services, aggressive look-back/estate recovery activities, moratoriums on new nursing home beds and certificate of need have been used by states to manage the supply and demand for Medicaid long-term care services. While some of these tools help to curtail unnecessary supply of specific services (e.g., nursing home beds); waiting lists for community-based waiver services can be an indicator of unmet need. DMMA should also consider the political and public reaction to policies that might be viewed as restricting access to desired services. Indeed, achieving a better balance and establishing a greater spectrum of non-institutional service offerings is not something that will change in one budget cycle. DMMA will need to take a long-term view to the Medicaid long-term care system.

Spending on nursing facility services in 2008 was over $176 million and most of that spending was on the low-income elderly and individuals with disabilities who have both Medicare and Medicaid (i.e., dual eligibles). Accordingly, the dual eligibles represent a key population in terms of reducing nursing facility spending. Thus one challenge and opportunity for DMMA in balancing the State's Medicaid long-term care system is to coordinate with Medicare more directly either through programs such as Program of All-Inclusive Care for the Elderly (PACE) or Medicare Advantage Special Needs Plans (SNPs). Changes in the very recent Patient Protection and Affordable Care Act (PPACA) make it clear that the federal government realizes the importance of the health and functional status of the 9 million dual eligibles that are now costing the nation around $250 billion a year in combined Medicare and Medicaid services. Due to Medicare's role as the primary caregiver for acute and preventative services, the actions or inactions by Medicare can directly impact DMMA's subsequent Medicaid long-term care expenditures. Finding innovative ways to integrate Medicare/Medicaid services can align financial and operational incentives for both the consumers' and the State's benefit.

To increase options and availability for community-based Medicaid long-term services and supports DMMA can pursue program initiatives in the State's fee-for-service (FFS)

system and/or implement new managed care programs. Changes in federal law have made it easier for states to deploy home- and community-based programs through simple state plan amendments such as 1915(i) or 1915(k) options without the need to develop and submit a Medicaid waiver. However, some state plan amendments lack the flexibility to target the population and services. Accordingly, Medicaid managed long-term care programs implemented under waiver authority such as a combination 1915(b)/(c) program are still an essential tool for most states.

The options presented within this report will fit within Delaware's overall Medicaid long-term care strategy in different ways. For example, if the State's primary objective is to offer additional Medicaid services related to home- and community-based care, most of the FFS state plan amendments are consistent with that goal and relatively easy to implement. However, if the State is seeking a broader strategy of impacting the delivery, management and integration of the Medicaid long-term care system, options involving managed care options and possibly the 1915(k) state plan option are more aligned with transforming the system of long-term services and supports, but will require much longer lead times to implement. Mercer recommends that as part of the next phase of this endeavor that DMMA, in conjunction with both internal and external stakeholders, discuss and evaluate the merits of these options in regards to how Delaware's strategy and objectives can be best complemented by the chosen initiative(s).

Regardless of the program initiatives selected, DMMA will be required to address a myriad of policy and operational design elements; not the least of which will be managing internal and external expectations. Other states that have endeavored to re-balance their Medicaid long-term care systems advise against going into it with the purpose being to "save money." Making more community-based services and supports available should be viewed as an initial investment that will benefit the State in the long run while at the same time improving consumer satisfaction and quality of life. Recent studies indicate that states with large community-based systems of care experienced slower rates of growth in Medicaid spending as compared to other states without established community-based programs.

Addressing imbalances in the Medicaid long-term care system is not an easy undertaking. The following is just a sampling of the types of issues and decision-points pending for DMMA staff: strategic planning, financing/payment options, program design, enrollment and disenrollment rules/processes, consumer/advocate input and reaction, provider comment, procurement and contracting of managed care plans, federal waiver development, and information technology/configuration issues (e.g., claims payment edits/rules, eligibility determinations, capitation payment processing). Accordingly, pursuing any new initiative will require devotion of human, financial and technological resources. The more complex the initiative (e.g., mandatory integrated Medicare/Medicaid manage care), the more skilled staff resources and time will be required to design, develop, implement and monitor.

Depending on the chosen initiative, the State should conservatively assume and plan for up to 24 months of lead time. Regardless of the initiative selected, the timeline for implementation will be heavily influenced by the availability of State resources to devote

the required time and energy. The following examples highlight the key factors that will directly impact the timeline for implementation:

- Availability of DMMA staff resources.
- Political support and prioritization of the State's agenda.
- Level of involvement and support from providers, consumers and families.
- Funding availability to support program start-up.
- Approval/involvement by the Centers for Medicare and Medicaid Services (CMS)/federal government.
- Information technology requirements and changes.

There were many existing priorities confronting DMMA staff prior to the passage of health care reform at the federal level, but now there are new issues and opportunities to address. It is therefore conceivable that the State's limited internal staff will need to be increased and/or augmented with external resources skilled in areas such as:

- Medicaid long-term care policy (e.g., level-of-care determinations, waiver services criteria, nursing facility policy and planning).
- Medicare/Medicaid interaction (e.g., enrollment/disenrollment rules, grievances and appeals, financing, performance reporting).
- Actuarial/financial services.
- Information technology edits and updates.

DMMA will want and need to engage both internal and external stakeholders in the process to ensure consumers and their advocates can offer suggestions and comments on pertinent program design issues. This will require having a solid communication strategy to manage information flow and exchange. Ideally, DMMA will establish a senior program "Champion" to coordinate efforts and be accountable for decision-making.

While the quantitative aspects of Delaware's changing demographics justify the need to take action, the qualitative aspects of a community-based system of Medicaid long-term services and supports can substantiate the benefits of having taken action. Delaware's leadership clearly embraces the need to move through the continuum of assessing the situation, taking action, implementing programs and measuring success so as to achieve a better balance in the State's long-term care system. This will enhance the sustainability of DMMA's programs for those who today or will tomorrow rely on Medicaid services and supports as well as organize State spending in more consumer-oriented ways.

This report is just one part of the means to a bigger end; with the end goal being increased community-based care options for Delaware's elderly and individuals with disabilities. How DMMA ultimately achieves this end goal will be determined based on a series of events, discussions and decisions that will be forthcoming. Making progress towards that end goal may involve implementing managed care programs and/or possibly enhancements to the current FFS delivery system. There may be multiple initiatives pursued to tackle specific issues or populations. At this point, DMMA has a type of "blank canvas" to work with since the existing Medicaid long-term care system is virtually all traditional FFS. To color this canvas with specific program initiatives will require communication, collaboration and compromise with both internal and external stakeholders. Throughout this process, Mercer recommends that those involved remain

mindful that the goal is to improve the quality of life and health status of individual people who lack the financial, physical, or cognitive resources and abilities to completely care for themselves.

2

Introduction

The State of Delaware (State) Division of Medicaid & Medical Assistance (DMMA) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health and Benefits LLC, to produce this report to facilitate discussion and subsequent implementation of program initiatives aimed at increasing community-based Medicaid long-term services and supports for the State's elderly and individuals with disabilities. To that end, this report intends to review and discuss the following topical issues:

- Why take action now?
- What does Delaware's current Medicaid long-term care system look like?
- How does the federal Medicare program affect Delaware's Medicaid long-term care system?
- What types of Medicaid program initiatives can be implemented to enhance DMMA's program offerings, and given Delaware's limited size, what are potential impacts on quality of care and financial/resource requirements?
- How may federal health care reform impact Delaware and the long-term care market environment?
- What are some of the major policy and operational concerns that will confront DMMA or be on the minds of consumers and stakeholders during this process?

Based on Mercer's experience with other state Medicaid programs, the issues and decision-points will be challenging due to the impact on a diverse group of stakeholders and changes in the landscape of long-term services and supports sponsored by DMMA. However, avoiding the combined challenges of an aging population, a limited amount of fiscal resources and the institutional bias inherent in every state Medicaid program, will undoubtedly result in more drastic decisions required at a later point in time when the options and choices may be more limited. DMMA realizes the urgency to begin to make improvements now in the State's system of care delivery and management so as to enhance consumer choice, quality of life, fiscal accountability and program sustainability.

Much has been written over the years concerning Medicaid's institutional bias and the corresponding concerns over quality of care, negative effect on health outcomes and consumption of a greater share of fiscal resources at the expense of other public programs. Likewise, much has already been written regarding the benefits of having a dynamic and consumer-friendly system of care delivery in which the needs of the elderly and individuals with disabilities are met through various community-based care settings with quality of life, functional health status, and consumer input promoted, measured and evaluated.

These issues are neither unique to Delaware nor unknown to DMMA as an attempt was made nearly 10 years ago to begin to balance the State's Medicaid long-term care system. Unfortunately, that previous effort stalled after much discussion and deliberation. Accordingly, Mercer seeks to assist Delaware in finding the most appropriate alternatives to its long-term care needs and joins other states such as Arizona, Massachusetts, Minnesota and Washington that have successfully developed and deployed innovative programs to serve Medicaid consumers in their homes and communities.

Addressing imbalances in the Medicaid long-term care system is not an easy undertaking. The following is just a sampling of the types of issues and decision-points pending for DMMA staff: strategic planning, financing/payment options, program design, enrollment and disenrollment rules/processes, consumer/advocate input and reaction, provider comment, procurement and contracting of managed care plans, federal waiver development, and information technology/configuration issues (e.g., claims payment edits/rules, eligibility determinations, capitation payment processing). Accordingly, pursuing any new initiative will require devotion of human, financial and technological resources. The more complex the initiative (e.g., mandatory integrated Medicare/Medicaid manage care), the more skilled staff resources and time will be required to design, develop, implement and monitor.

Depending on the chosen initiative, the State should conservatively assume and plan for up to 24 months of lead time. Regardless of the initiative selected, the timeline for implementation will be heavily influenced by the availability of State resources to devote the required time and energy. The following examples highlight the key factors that will directly impact the timeline for implementation:

- Availability of DMMA staff resources.
- Political support and prioritization of the State's agenda.
- Level of involvement and support from providers, consumers and families.
- Funding availability to support program start-up.
- Approval/involvement by CMS/federal government.
- Information technology requirements/changes.

There were many existing priorities confronting DMMA staff prior to the passage of health care reform at the federal level, but now there are new issues and opportunities to address. It is therefore conceivable that the State's limited internal staff will need to be increased and/or augmented with external resources skilled in areas such as:

- Medicaid long-term care policy (e.g., level-of-care determinations, waiver services criteria, nursing facility policy and planning).
- Medicare/Medicaid interaction (e.g., enrollment/disenrollment rules, grievances and appeals, financing, performance reporting).
- Actuarial/financial services.
- Information technology edits and updates.

This report is an initial step, with the end goal of increasing community-based care options for Delaware's elderly and individuals with disabilities. How DMMA ultimately achieves this end goal will be determined based on a series of events, discussions and decisions that will be forthcoming. Mercer suggests that DMMA's next steps include high-level strategic meetings over the next two to three months with key internal and external stakeholders to review and discuss the options available to the State and how those options best fit within the State's overall strategy. The outcome of these meetings should be decisions on what initiatives to pursue further and from there DMMA workgroups can be established to address the implementation and operational details applicable to the selected initiative.

Making progress towards the end goal of increasing community-based care options may involve implementing managed care programs and/or possibly enhancements to the current fee-for-service (FFS) delivery system. There may be multiple initiatives pursued to tackle specific issues or populations. At this point, DMMA has a "blank canvas" to work with. To paint this canvas with specific program initiatives will require communication, collaboration and compromise with both internal and external stakeholders. Throughout this process, Mercer recommends that those involved remain mindful that the goal is to improve the quality of life and health status of individual people who lack the financial, physical, or cognitive resources and abilities to completely care for themselves.

3

Re-visiting the need for action

It is not uncommon or unexpected that when a state Medicaid agency embarks on an effort to balance and modernize their long-term care system, a common question asked is why? Why now, why at all? Over the years, much has been written to answer this question and support the need to address imbalances in Medicaid long-term care programs across the country before the waves of baby boomers reach ages where use of long-term services and supports becomes inevitable.

Delaware's coming of age

In preparing this paper, Mercer choose to use objective survey and population data to assess and summarize the realities of what Delaware is facing in terms of demographic changes and potential Medicaid fiscal consumption. Additionally, we highlight consumer preferences pertaining to the availability of home- and community-based alternatives for long-term services and supports.

Population growth – age 65 and older

There is no getting around the fact that Delaware, like the United States as a whole, is steadily aging. And as people age, there is a higher proportion of expensive chronic conditions (e.g., heart disease, diabetes, hypertension), a higher probabillity for disability and a corresponding increase in the use of and need for health-related services and supports[1]. The following table clearly shows that Delaware is not unique in the demographic challenges it will be facing in the coming years.

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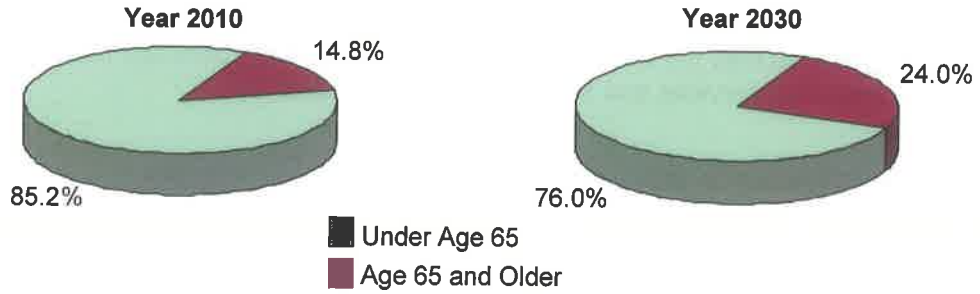
[1] Stanton, MW., Rutherford, MK.; The high concentration of U.S. health care expenditures. Rockville (MD): Agency for Healthcare Research and Quality; 2005. Research in Action, Issue 19, AHRQ Pub. No. 06-0060.

Table 1 – Projected population growth of age 65 and older[2]

Geographic area	Year 2010	Year 2020	Year 2030	Change from 2010 to 2030
State of Delaware	132,041	185,576	252,277	91.1% increase
South Atlantic Region[3]	8,357,101	11,978,028	16,787,108	100.9% increase
United States	40,243,713	54,631,891	71,453,471	77.6% increase

Table 1 makes it clear that whether on a state, regional or national level the percentage of the population that is age 65 and older is growing rapidly; much higher than the forecasted increase of the population in total which is estimated to be only 17.8 percent for Delaware and 17.7 percent nationally between 2010 and 2030[4]. Accordingly, while Delaware is expected to experience a similar percentage increase in total population as the U.S., the number of elderly Delawareans is expected to nearly double over the next 20 years. The following chart exhibit illustrates how the composition of Delaware's elderly and non-elderly population is expected to change from 2010 to 2030.

Chart 1 – Changing composition of Delaware's population



Population growth – age 85 and older

While it is clear that Delaware is facing a substantial increase in both the percentage and absolute number of elderly residents age 65 and older, a further drilldown into the population forecasts identifies a more substantial change with the oldest population segment composed of ages 85 and older.

People age 85 and older are typically more likely to experience problems associated with poor health status, more than one chronic illness, functional/cognitive limitations and poor mental health status; and thus are more likely to require institutional care or

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[2] Delaware data from the Delaware Population Consortium Population Projection Series October 29, 2009, Version 2009.0. Other population data from the U.S. Census Bureau Population Division Interim State Population Projections, April 21, 2005.

[3] South Atlantic Region includes Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia and West Virginia.

[4] See footnote #2.

assistance with performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs)[5]. Health care spending analyses show that people with multiple chronic conditions cost up to seven times as much as people with only one chronic condition[6]. Furthermore, in 2009 the national average percentage of adults over 85 years old who require help with personal care needs from other persons was 19.9 percent, but only 3.4 percent for those age 65 to 74[7].

As shown below in Table 2, the number of Delawareans age 85 and older is expected to more than double between 2010 and 2030; thus increasing from 2.1 percent to 3.6 percent of the State's total population over this twenty-year time horizon.

Table 2 – Projected population growth of age 85 and older

Geographic area	Year 2010	Year 2020	Year 2030	Change from 2010 to 2030
State of Delaware	18,580	26,509	37,831	103.6% increase
South Atlantic Region	1,201,867	1,493,731	2,095,055	74.3% increase
United States	6,123,458	7,268,908	9,603,034	56.8% increase

Old age dependency ratio

While the previous population figures focus attention on the swelling ranks of the elderly, a less often cited statistic is the number of age 65 and older expressed as a percentage of what is defined as "economically productive" ages 20 to 64[8]. This statistic is commonly referred to as the old age dependency ratio because as people age they typically become more dependent on the younger generations to provide direct care support as paid or unpaid caregivers or indirectly support state and federal programs through payroll and other taxes. Since people are generally healthier, living longer and working past age 65, this statistic is included in this report to only illustrate the significant population changes occurring in Delaware and across the country. For consistency in these statistics at the state, regional and national levels, the data represented in Table 3 is based on the U.S. Census Bureau's Interim State Population Projections.

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[5] Beyond 50.09, Chronic Care: A Call to Action for Health Reform, AARP Public Policy Institute.

[6] See footnote #1.

[7] CDC/NCHS, National Health Interview Survey, January-September 2009, Family Core component.

[8] Shrestha, L., Age Dependency Ratios and Social Security Solvency, Updated October 27, 2006, Congressional Research Service Report.

Table 3 – Old age dependency ratios[9]

Geographic area	Year 2010	Year 2020	Year 2030
State of Delaware	23.4%	32.1%	44.7%
South Atlantic Region	23.3%	30.8%	40.5%
United States	21.7%	28.4%	36.3%

The statistics in Table 3 indicate that today Delaware has nearly five "economically productive" individuals for every elderly person, but by year 2030, this ratio drops to just over two "economically productive" individuals for every elderly person. Therefore, as the number of elderly Delawareans increase there will be fewer and fewer people in the younger generations to provide direct and indirect support.

Living with disabilities

Even though people are generally living longer, it is statistical facts that as people age the prevalence of disabilities and disease increases. Therefore, with an aging population, there is a strong likelihood that there will be corresponding increases in rates of disability[10], although advances in medical technology and treatment may slow this advancement. Typically individuals with disabilities require more assistance and supportive services whether from unpaid or paid caregivers, private health insurance or government sponsored programs such as Medicare and Medicaid. In a 2008 national survey[11]:

- 36.4 percent of people age 65 and older said that at least one of nine physical activities was very difficult or cannot be done at all compared to only 10.4 percent of people between the ages of 18 and 64.
- Of the under age 65 survey group, those with Medicaid were over four times more likely than those with private health insurance to say that at least one physical activity was very difficult or cannot be done at all.
- Only 42.4 percent of people age 18 and older living below the federal poverty threshold reported their health status as excellent or very good compared to 68.1 percent of people at 200 percent or more of the federal poverty threshold.

Based on the 2008 American Community Survey, the estimated percentage of Delawareans with one or more disabilities by age group is shown in the following chart.

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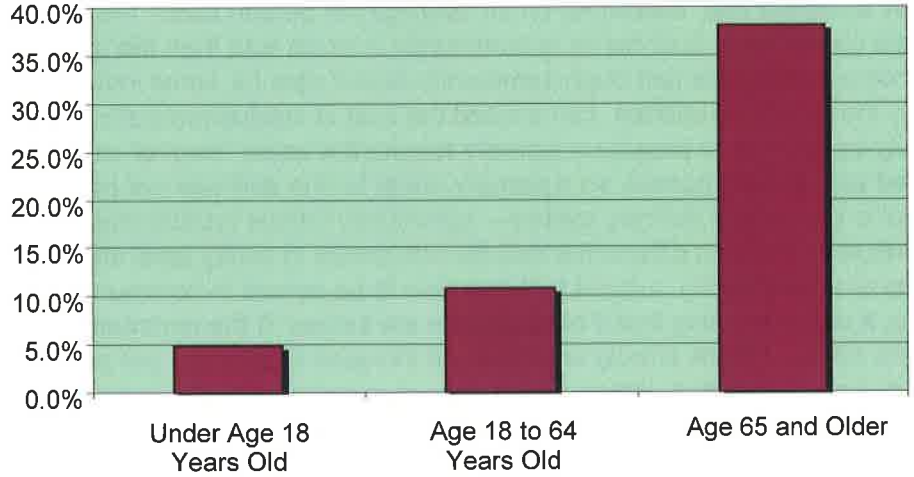
[9] Old age dependency ratio is calculated by dividing the number of age 65 and older by the total number of age 20 to 64.

[10] Smith, S., Rayer, S., and Smith, E.; Implications for the Housing Industry and Housing Policy, Journal of the American Planning Association, Vol. 74, No. 3, Summer 2008.

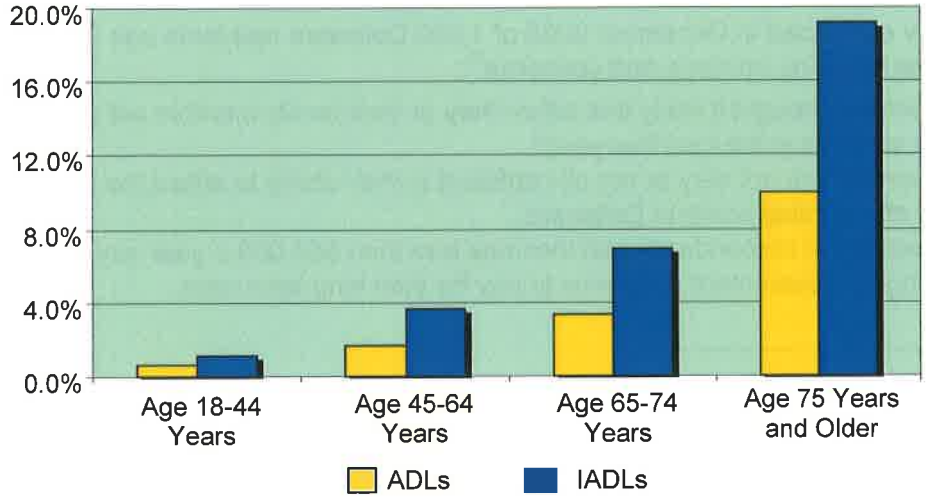
[11] Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2008, Centers for Disease Control and Prevention, Vital and Health Statistics, Series 10, Number 242, Tables 18 and 20.

Chart 2 – Delaware population with one or more disabilities[12]



The Delaware-specific results in the above exhibit correspond to national survey data that a person's ability to perform ADLs and IADLs become more limited with age. As the following chart shows, there is a direct correlation between age and a person requiring assistance/help in performing daily activities.

Chart 3 – Percentage of persons having limitations in ADLs and IADLs by age band – national survey data[13]



[12] Table C18108 from the U.S. Census Bureau, 2008 American Community Survey 1-year estimates.

[13] Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2008, Centers for Disease Control and Prevention, Vital and Health Statistics, Series 10, Number 243, Table 5.

Cost of care – community versus institutional

It is widely accepted that, measured on an average per person basis, the cost of serving a Medicaid consumer in their home or community is much less than the average cost of nursing home-based care (although community-based care for some individuals, especially those with disabilities, can exceed the cost of institutionalization). Eligibility for community-based waiver programs typically require the same "level-of-care" need associated with nursing homes, so a primary driver for the average per person cost differential is the service delivery system – community versus institutional. Other factors that contribute to the cost differential include differences in acuity level and the availability of unpaid family support to those able to be served in community settings. Therefore, it is worth noting that if more people are served in the community with greater health care needs, DMMA should anticipate an increase in average per person community-based spending. Whereas the annual average cost of nursing home care can be well over $50,000 or in Delaware more like $70,000 to $80,000, a person who is able to be served in their home or community can average less than half this amount. One study indicated a 63 percent reduction in per person spending for a nursing facility waiver program as compared to institutionalization[14]. Expressed in other ways, for the annual cost of one nursing home stay:

- Two to three people can be served in their home or community.
- Over 1,600 hours of home health aide services could be purchased[15].
- Over 18 months of assisted living services could be obtained[16].
- Over 1,000 days of adult day care services could be offered[17].
- Over 13,000 home delivered meals could be provided[18].

A survey conducted in December 2008 of 1,000 Delaware residents age 35 and older found the following opinions and concerns[19]:

- 42 percent thought it likely that either they or their family member will need long-term care services in the next five years.
- 50 percent are not very or not all confident in their ability to afford the annual $81,000 cost of a nursing home in Delaware.
- 51 percent of respondents with incomes less than $50,000 a year say they plan on relying on government programs to pay for their long-term care.

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[14] Kitchener, M., Ng, T., Miller, N., & Harrington, C.; Institutional and Community-Based Long-Term Care: A Comparative Estimate of Public Costs; Journal of Health & Social Policy, Vol. 22(2), 2006.

[15] Based on $43 Medicare-certified hourly rate for home health aides, 2008; AARP Across the States, Profiles of Long-Term Care and Independent Living, State of Delaware, 8th edition, 2009.

[16] Based on $3,774 average private pay rate per month in assisted living, 2008; Ibidem.

[17] Based on $67 average private pay daily rate for adult day care, 2008; Ibidem.

[18] Based on $5.14 national average cost; State of Aging: 2009 State Perspectives on State Units on Aging Policies and Practices, National Association of State Units on Aging, October 2009.

[19] The Road Ahead: AARP Survey on Community Services in Delaware, March 2009.

In December 2009, the percentage of all nursing facility residents for which Medicaid was the primary payor was just under 57 percent representing about 2,421 Medicaid residents[20]. Using population data from Table 1, the 2,421 Medicaid nursing facility residents translates into a 1.8 percent prevalence rate of institutionalization among Delaware's elderly age 65 and older. Assuming a constant rate of institutionalization, by year 2030 the number of nursing home residents paid by DMMA will increase to 4,626. On an annualized cost basis, this translates into well-over $150 million more in new Medicaid-funded nursing home stays or a combined total of over $320 million spent on nursing homes per year. This also assumes the annual cost of nursing home remains static at $70,000; it may be more realistic to assume the cost of care will gradually increase over time and thus push institutional spending to even higher levels.

Caution: aggregate spending is more critical than per person spending

The per person cost difference between nursing home and community care is impressive at face value, but there are limitations in the applicability of extrapolating these differentials into real reductions in total Medicaid expenditures. The biggest concern and caveat is that while per person spending is less in the community than institutionalization, if the number of people served by community programs rapidly increases then total long-term care spending will rise more quickly and more substantially than any off-sets in spending reductions for institutionalization can provide (often referred to as the "woodworking" effect)[21].

For example, if two people can be served in the community for the cost of one institutionalization, total spending would be same only if that institutionalization is indeed averted. However, if instead of two, four people actually seek community-based services, total spending is now higher than before (and even higher still if the additional services provided do not avert institutionalization). This dynamic can occur because often there is unmet need for community-based care or family caregivers who are unavailable or may defer to publicly-funded service providers when the opportunity is available[22]. But the existing research is inconclusive on many of these issues, as one recent study concluded that over the long run, state Medicaid programs that invested heavily in home- and community-based long-term care experienced slower increases in the growth of Medicaid long-term care spending as compared to other states; however, even this study noted the large initial outlay of funds to support the development, launching and funding of new programs[23] (e.g., additional staffing requirements, system changes,

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[20] American Health Care Association, compilation of OSCAR data, December 2009.

[21] Grabowski, D.; The Cost-Effectiveness of Noninstitutional Long-Term Care Services: Review and Synthesis of the Most Recent Evidence, Medical Care Research and Review, Vol. 63 No. 1, February 2006.

[22] Ibidem

[23] Kaye, S., LaPlante, M., Harrington, C.; Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending, Health Affairs, January/February 2009.

consulting services, lag time associated with the increase in community services spending prior to any reduction in institutional spending).

Delaware's decision-makers need to remain cognizant of the fiscal impact of pending policy decisions and how increased demand for community-based care can put more pressure on providers, caregivers and the State to continually make more quality services available. To the extent that community-based care is expanded to more of the population with greater health care needs, both average per person and total spending related to community-based care may increase, but ideally this increase in community-based spending leads to future reductions in facility-based spending to slow the overall growth in Medicaid long-term care expenditures.

Notwithstanding the caveats against extrapolating per person spending differences, increasing the availability of community-based alternatives for Medicaid long-term services and supports by most accounts is a socially preferred and more consumer-focused use of public funds.

Consumer preference – community versus institutional

Similar to the previous section on cost of care, virtually all surveys and studies of consumers indicate the same result: people prefer to remain in their homes and communities as compared to being institutionalized. The desire to avoid isolation in institutions and to be active participants in the community has led many individuals with long-term care needs and their families to advocate for opportunities to receive care in a variety of settings[24]. Despite their preferences, consumers may be directed toward institutional services because home care services are neither readily available nor easily accessible or they also may be directed to institutional care because it is an easier placement for health care professionals[25].

The following are examples from the literature on this topic:

- According to a national survey conducted by the AARP, 84 percent of those ages 50 and older want to remain in their homes as they age[26].
- Many people who become disabled due to injury or disease are forced to move into nursing homes or other institutions because their homes lack adequate accessibility features; this imposes high emotional and financial costs on the individual, and most likely inflicts high economic costs on taxpayers as well[27].

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[24] Summer, L.; Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities, Kaiser Commission on Medicaid and the Uninsured, October 2005, Report #7402.

[25] Long-Term Care Reform Leadership Project, Shifting the Balance: State Long-Term Care Reform Initiatives, Issue Brief No. 1 of 5, February 2009.

[26] AARP, Beyond 50.05 Survey, A Report to the Nation on Livable Communities: Creating Environments for Successful Aging, April 2005, http://assets.aarp.org/rgcenter/il/beyond_50_communities.pdf.

[27] See footnote #10.

- Most disabled people want to live independently for as long as possible and strongly desire housing features that will allow them to do so[28].

The December 2008 Delaware survey of residents age 35 and older also found:

- 72 percent believe it is extremely or very important to remain in their current residence for as long as possible.
- 86 percent believe that it is either extremely or very important to have long-term care services that would enable them to stay in their homes as long as possible.
- 74 percent prefer to receive services in their home; only 3 percent reported a desire to live in a nursing home as they age.

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[28] Ibidem

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Overview of Delaware's current Medicaid long-term care system

Delaware's Medicaid long-term care program is operated out of multiple Divisions within the Delaware Health and Social Services (DHSS) overall organizational structure. There are no Area Agencies on Aging (AAAs) in Delaware and funding for Medicaid services is managed at the State level.

Of particular interest, virtually all populations and services composing long-term care are delivered via FFS means. Although DMMA has a mandatory Medicaid managed care program, dual eligibles, nursing home residents, 1915(c) waiver recipients and the corresponding long-term care services are all excluded. This presents opportunities for new and innovative solutions, but also possible resistance to change from a system rooted in traditional FFS.

The following is a brief overview of the major Divisions and programs that Delaware provides to the elderly and individuals with disabilities through its Medicaid system[29].

Delaware Health and Social Services (DHSS)

DHSS is the second largest State agency, employing almost 5,000 individuals in a wide range of public service jobs. DHSS includes 12 divisions, which provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long-term care, visual impairment, aging and adults with physical disabilities, and Medicaid and Medical Assistance. The department includes four long-term care facilities and the State's only psychiatric hospital, the Delaware Psychiatric Center which is associated with other private psychiatric facilities.

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[29] http://dhss.delaware.gov/dhss/, accessed May 3, 2010.

Division of Medicaid & Medical Assistance (DMMA)

The mission of the DMMA is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner. In addition to managing Delaware's acute care Medicaid (Title XIX) and CHIP (Title XXI) programs, DMMA also oversees/provides the following programs and services:

- **Nursing Facility Program:** The applicant must be in need of a skilled or intermediate level of care provided by a nursing facility. Financial eligibility is set at 250 percent of the Supplemental Security Income (SSI) standard ($1,685/month for an individual in 2010) and assets are limited to $2,000 for the institutionalized client (there is a higher asset limit for the spouse still living in the community). The nursing facility program pays for the cost of care provided in Delaware nursing facilities that have Medicaid contracts. These nursing facilities provide room, board and nursing services to persons who are elderly, infirm or have disabilities and receive additional funds to provide psychosocial and rehabilitative services to some clients.
- **Qualified Medicare Beneficiary Programs:** If entitled to Medicare benefits and have low-income, DMMA may pay Medicare's premiums and, in some cases, other "out-of-pocket" expenses such as deductibles and coinsurance. Individuals must be entitled to Medicare Part A to qualify for any of these programs. Recipients under these programs may or may not receive regular Medicaid services.
- **Children's Community Alternative Disability Program:** This program provides Medicaid coverage to children with severe disabilities who meet the SSI disability criteria, but do not qualify for SSI or other Medicaid qualifying programs because of their parents' income and/or resources. The child's gross monthly income cannot exceed 250 percent of the SSI standard and countable assets cannot exceed $2,000. The parent's income and assets are not considered.
- **AIDS Home- and Community-Based (AIDS HCB) Waiver Program:** This is a statewide 1915(c) waiver that provides all the regularly covered Medicaid services plus the following special waiver services: case management, mental health services, personal care services, respite care and supplemental nutrition.
- **Money Follows the Person (MFP) Demonstration[30]:** Together with the DSAAPD (see below), DMMA was awarded a federal demonstration grant in 2007 to assist with the infrastructure necessary to continue and expand nursing home-to-community transition efforts. From 2008 to 2009, 22 clients were transitioned from institutions to the community. DMMA/DSAAPD intends to transition an additional 60 MFP clients by 2011 with an ultimate goal of 100 individuals over a four-year period.
- **SSI-related Programs:** Including Medical Assistance during Transition to Medicare (MAT), Medicaid for Workers with Disabilities (MWD), Disabled Adult Children (DACs), etc.

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[30] March 3, 2010 and March 4, 2010 presentations by Rosanne Mahaney and Guy Perrotti respectively, to Delaware's Joint Finance Committee Hearing.

- **Financial Eligibility Determinations:** DMMA is responsible for the determining financial eligibility for the State's Medicaid home- and community-based waivers.
- **Medical Eligibility Determinations:** DMMA is also responsible for determining medical eligibility for the Nursing Facility, AIDS HCB Waiver, and Children's Community Alternative Disability programs.

Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)

The mission of the DSAAPD is to improve or maintain the quality of life for Delawareans who are at least 18 years of age with physical disabilities or who are elderly. The Division is committed to the development and delivery of consumer-driven services which maximize independence through individual choice, enable individuals to continue living active and productive lives, and protect those who may be vulnerable and at risk. In addition to being Delaware's State Unit on Aging, DSAAPD oversees/provides a variety of programs and services including, but not limited to the following:

- **Assisted Living Waiver Program:** This is a statewide Medicaid 1915(c) waiver that provides services and supports for eligible older persons and adults with physical disabilities who otherwise would require care in a nursing home, but can be served in assisted living facilities. Waiver services provided include assisted living and case management.
- **Elderly and Disabled Waiver Program:** This is a statewide Medicaid 1915(c) waiver that provides an alternative to nursing home care for eligible older persons and adults with physical disabilities. The program includes services to help a person to continue living in his or her home safely. Nurses and social workers coordinate with participants and their caregivers to develop care plans that help to meet individual needs. Waiver services provided include adult day services, case management, personal care, personal emergency response system and respite care.
- **Nursing Home Transition Program:** A state-funded program led by DSAAPD with the overall goal of the program is to identify, inform and assist nursing home residents, especially those who are Medicaid-eligible, who want to move to a community-based setting. The program offers individualized case management to accomplish this goal. In three years, this program has transitioned 55 clients from nursing homes to the community, incurring set-up costs that average under $1,500 per client while promoting increased independence with the use of cost efficient community supports[31].
- **Acquired Brain Injury (ABI) Waiver Program[32]:** This is a new statewide Medicaid 1915(c) waiver that provides supports and services for eligible adults who have sustained an acquired brain injury and who otherwise would require care in a nursing home. The goal of the program is to provide services which respond to each person's needs and allow him or her to live as independently as possible. Waiver services

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[31] G. Perrotti, Ibidem.

[32] ABI waiver received CMS approval on December 1, 2007 and was expected to have approximately 50 participants in its first year growing to 70 by year 3. Delaware is currently evaluating merging the Assisted Living, Elderly and Disabled and ABI waivers.

provided include adult day services, assisted living, day habilitation, case management, cognitive services, personal care, personal emergency response system and respite care services.

- **Long-Term Care Ombudsman Program:** This is a statewide program available to all residents (and their families) of licensed long-term care facilities. The Ombudsman program investigates and resolves complaints made by (or on behalf of) residents of long-term care facilities (for example, nursing homes). The program also provides volunteer opportunities for friendly visitors/advocates in nursing homes.
- **Other Services:** In addition to the aforementioned programs, DSAAPD also provides the following services, mostly through the use of state-funds, but sometimes with other federal funds or block grants: assistive devices, Alzheimer's day treatment, attendant services, home-delivered meals, home modifications, housekeeping services and medical transportation[33].

Delaware Aging and Disability Resource Center (ADRC)

DSAAPD and partner agencies are in the process of developing a statewide, comprehensive Aging and Disability Resource Center (ADRC) in Delaware. The ADRC will provide a one-stop access point for information and services for older persons and adults with physical disabilities throughout the State. It is scheduled to begin operation in September 2010.

Division of Developmental Disabilities Services (DDDS)

The mission of the DDDS is aligned with the vision and the DHSS's mission to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations. In addition to the Stockley Center which is an intermediate care facility that provides habilitative training, health care, family services, and residential services for individuals with developmental disabilities, DDDS also operates the following program:

- **Mental Retardation/Developmental Disability Waiver Program:** This is a statewide Medicaid 1915(c) waiver for people with intellectual disabilities, autism, Asperger's, Prader-Willi or brain injury during the developmental period with concurrent adaptive limitations. In addition to regular Medicaid services the waiver services provided are case management, clinical support, day habilitation, institutional or in-home respite care and residential habilitation.

Division of Long-Term Care Residents Protection (DLTCRP)

The DLTCRP is responsible for the adult abuse registry, criminal background checks and mandatory drug testing, the Certified Nursing Assistant (CNA) registry, complaint and incident reporting related to long-term care facilities, licensing/certifying long-term care facilities, and developing regulations related to these areas.

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[33] Some other states have opted to provide these types of services through their 1915(c) waivers to obtain federal matching funds.

Delaware health and economic rankings

On most measures, Delaware is a small state[34]:

- 859,800 residents in 2008 rank Delaware 45th in the nation.
- 45 certified nursing facilities in 2008 ranks Delaware 46th in the nation.
- 4,111 total nursing facility residents in 2008 ranks Delaware 46th in the nation.
- Six community hospitals in 2007 (i.e., non-federal, short-term general, and specialty hospitals whose facilities and services are available to the public) was the fewest in the nation.

Although small in size, Delaware is also a relatively prosperous state in terms of various economic indicators[35]:

- $54,610 median household income in 2007 ranks Delaware 15th in the nation and slightly above the national average of $50,740.
- 76.8 percent homeownership rate in 2007 ranks Delaware 2nd in the nation.
- Only 10.5 percent of the population is estimated to be below the federal poverty level in 2007 ($20,650 for a family of four) ranks Delaware 39th lowest in the nation.
- Delaware's standard Federal Medical Assistance Percentage (FMAP) rate for Medicaid medical services is 50.21 percent for federal fiscal year 2010, just slightly above the minimum 50 percent rate (this does not reflect the temporary increase in FMAP associated with the federal stimulus package).

Delaware's Medicaid long-term care spending patterns

Looking more closely at Delaware's Medicaid program based on the most recently available data from 2005 through 2008[36]:

- Total Medicaid medical spending has increased from $868.3 million in 2005 to $1.1 billion in 2008 resulting in an average annual increase of 8.3 percent.
- Medicaid long-term care spending on institutional and waiver services increased from $258.3 million to $321.2 million resulting in an average rate of 7.5 percent; note that the average increase in long-term care spending is less than the average annual increase in total Medicaid program expenditures.
- Spending on Medicaid nursing facility services increased from $154.9 million to $176.3 million for an average annual growth rate of 4.4 percent.
- Spending on ICF-MR services increased from $25.8 million to $29.8 million for an average annual growth rate of 4.9 percent.
- Spending on Medicaid 1915(c) waivers increased from $70.7 million to $106.5 million for an annualized increase of 14.6 percent, but most of this spending has been on Delaware's waiver for individuals with developmental disabilities; spending on

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[34] Kaiser Family Foundation, 50 State Comparisons, http://www.statehealthfacts.org/compare.jsp

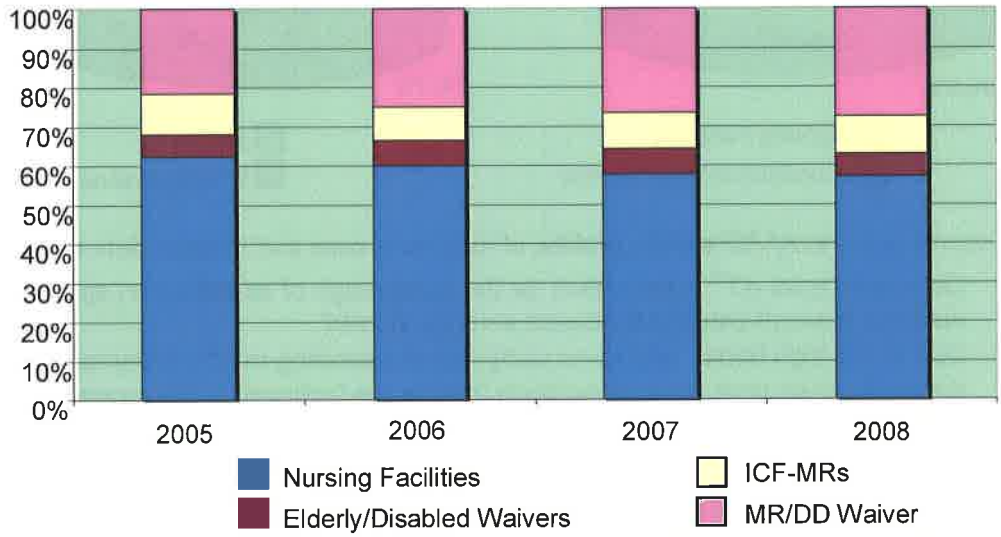
[35] The 2010 Statistical Abstract: State Rankings, U.S. Census Bureau.

[36] Calculated based on CMS-64 data compiled by Thomson Reuters Medicaid Long-Term Care Expenditures in FY 2008, December 1, 2009.

waivers targeted at the elderly and physically disabled increased from $14.4 million to $17.7 million for only a 7.1 percent annualized increase.

The following table displays the distribution of Delaware's spending on the four primary pathways for delivering Medicaid long-term care services.

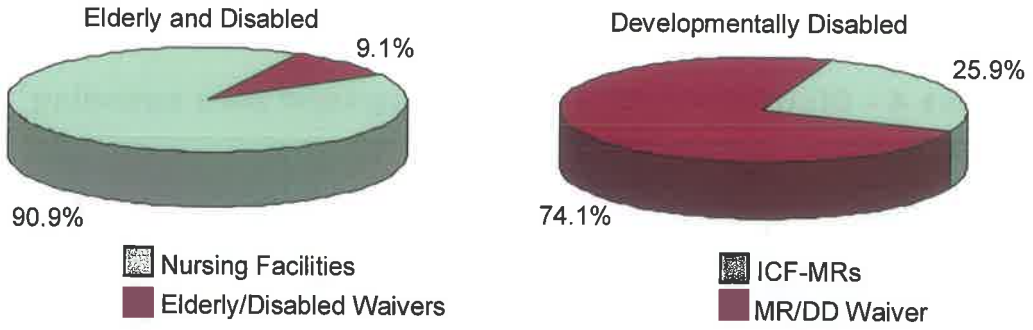
Chart 4 – Distribution of Medicaid long-term care spending[37]



Given these spending patterns, Delaware is exhibiting two distinctly different methods of providing Medicaid long-term care services for the elderly/disabled as compared to the developmentally disabled. As shown in the following chart exhibit, the proportion of 2008 Medicaid funds spent on home- and community-based services versus institutional care is over eight times more for the developmentally disabled as it is for the elderly and disabled. These percentages have been roughly the same in 2006, 2007 and 2008.

[37] Elderly/Disabled waiver data is for Delaware waivers #0136 and #0336; MR/DD waiver data is for Delaware waiver #0009; Ibidem.

Chart 5 – Percent of spending on 1915(c) waivers and institutional care by major population group – 2008[38]



According to the AARP's state profiles of long-term care and independent living[39]:

- Delaware ranks 43rd in the nation for the percentage of spending on aged and disabled through community-based settings in 2007.
- Due to the high home- and community-based spending on the developmentally disabled, when both major population groups are factored in, Delaware's ranking improved to 33rd.

Nursing facility residents and occupancy rates[40]

From 2005 to 2009 the total number of Delaware nursing facility residents increased from 3,799 to 4,256. In December 2009, the percentage of all nursing facility residents for which Medicaid was the primary payor was just under 57 percent representing about 2,421 Medicaid residents. Over the last few years, the percentage of all nursing facility residents with Medicaid as their primary payor has been consistently between 57 and 60 percent which is below the national average of approximately 65 percent. Occupancy rates at Delaware's nursing facilities have also remained stable at between 85 and 87 percent which closely parallels the national averages indicating that supply is approximating current demand. However, this does not mean that Delaware has an optimal level of nursing facilities. To the extent that people are willing and able to be served in non-institutional settings, but lack the service and support offerings, and availability to do so, results in more nursing facility residents than what is strictly required from a clinical level-of-care need basis.

The following table summarizes data on Delaware's Medicaid long-term care spending for the most recent years for which data was available on all delivery systems[41].

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[38] Ibidem

[39] AARP Across the States Profiles of Long-Term and Independent Living, State of Delaware, 8th edition, 2009.

[40] Harrington, C., Carrillo, H., Blank, B.; Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2003 through 2008, UCSF, November 2009. American Health Care Association, December 2009 OSCAR data.

Table 4 – Delaware Medicaid long-term care program summary

Medicaid delivery system	2004		2005		2006	
	# of people	Total spend	# of people	Total spend	# of people	Total spend
Nursing facilities[42]	2,139	$158.8m	2,260	$154.9m	2,133	$160.0m
E/D waivers	1,304	$13.0m	1,312	$13.7m	1,334	$15.9m
ICF-MRs[43]	194	$28.5m	175	$25.8m	154	$22.8m
MR/DD waiver	685	$48.1m	729	$54.3m	775	$63.9m
ABI waiver	N/A	N/A	N/A	N/A	N/A	N/A
AIDS HCB waiver	557	$2.3m	601	$2.4m	648	$2.7m
TOTAL	**4,879**	**$250.7m**	**5,077**	**$251.1m**	**5,044**	**$265.3m**

Given Delaware's small size, it is not too surprising that in terms of the number of individuals with developmental disabilities served through home- and community-based waiver programs, Delaware's 775 MR/DD waiver participants in 2006 placed the State last in the nation after Connecticut terminated its DD waiver in 2006. However, on a percentage of participants (83.4 percent) and expenditures (73.7 percent), Delaware did better than the national average in serving individuals with developmental disabilities through home- and community-based programs as compared to institutional ICF-MRs. While every state can do more to serve the elderly and individuals with disabilities, Delaware's heavy nursing home institutional bias for the elderly and corresponding poor ranking among the states is a clear area for improvement.

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[41] CMS-372 waiver data compiled from the Kaiser Commission on Medicaid and the Uninsured's Medicaid Home- and Community-Based Service Programs: Data Update, November 2009, December 2008 and December 2007.

[42] Spending from CMS-64 data. Number of Medicaid people from OSCAR data compiled by Harrington et al, UCSF, November 2009.

[43] Spending from CMS-64 data. Number of ICF-MR residents estimated from Prouty et al, Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007, UMN, August 2008.

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How does Medicare affect Delaware's long-term care picture[44]?

The 1965 Social Security Act created the two largest national health care programs for the elderly and the poor: the Medicare program as Title XVIII and the Medicaid program as Title XIX, respectively. Based on their original mission statements, Medicare and Medicaid each have their own distinctive characteristics such as:

- Medicare is run by the federal government; Medicaid is administered by states within broad federal guidelines.
- Medicare is limited to those age 65 or older, under age 65 with certain disabilities, or any age with End-Stage Renal Disease; Medicaid covers children, parents, adults (limited), pregnant women, aged and disabled people of all ages.
- Medicare is financed at the federal level by taxes on wages; Medicaid is jointly financed by revenue from both the states and the federal government.
- Medicare eligibility is based on age, disability and work/wage history; Medicaid eligibility is currently based on income, assets and categorical status.

Accordingly, because of these differences, Medicare and Medicaid typically operate in separate environments and have their own respective challenges to address. However, while there are key differences to each program, there are also several key similarities:

- As massive entitlement programs, both Medicare and Medicaid compete for finite public resources.
- As a national program, Medicare's provider fee levels are often a basis of comparison for the Medicaid program.
- Both programs deliver care to beneficiaries through traditional FFS and various forms of managed care.

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[44] Most of the information included in this section was obtained from the 2010 version of the Medicare & You handbook.

The interaction between Medicare and Medicaid is the most pronounced for the low-income elderly and individuals with disabilities who qualify and enroll in both programs concurrently and are commonly referred to as the dual eligibles. In the domain of long-term care, the two programs have often been described as exhibiting a type of "love-hate" relationship for the following reasons:

- While Medicare is a program for the elderly and disabled, it essentially provides only acute and outpatient care services; the bulk of long-term care services are financed by Medicaid.
- Medicare is primarily responsible for an elderly person during their "walking well" period; Medicaid typically takes over after a person's health and financial status has declined to the point of needing extensive services and supports or even institutionalization.
- Medicare's limited responsibility for long-term care services leads to disincentives, fragmentation and a sense of "passing the buck" to Medicaid.
- For most dual eligibles, Medicaid is responsible for paying some portion of Medicare's premiums, deductibles and/or coinsurance under the ironically-named Medicare Savings Program. More information on this important facet of the Medicare/Medicaid relationship is provided later in this Section.
- Medicaid is not responsible for payment of Medicare's drug benefit (i.e., Medicare Part D) copayments for dual eligibles and full-dual eligibles living in an institutional setting have no Medicare Part D copayments. Based on Section 3309 of Title III of PPACA, and no sooner than January 1, 2012, Part D copayments for dual eligibles receiving home- and community-based services (and who would otherwise be institutionalized) will also be eliminated.
- In developing new programs to reduce their Medicaid long-term care costs, state initiatives can often result in reduced acute care costs for the Medicare program (e.g., less inpatient hospital admissions, fewer emergency room visits); however, CMS does not permit states to "take credit" or share in these Medicare savings.

Because of the complex and often confusing rules and regulations associated with both the Medicaid and Medicare programs it is beyond the scope of this paper to describe how the Medicare program interplays with Medicaid in detail. However, if DMMA intends to improve and enhance the State's Medicaid long-term care system, it will be inevitable that Medicare will become a factor in designing and evaluating some program options and initiatives because of Medicare's primary role in providing acute care services. Accordingly, to evaluate Medicaid's options, it is first beneficial to briefly review the parts, delivery systems and cost structure of the Medicare program and then conclude with a description of the dual eligibles.

Medicare Parts A, B, C and D

The Medicare program is composed of four major "Parts" that provide specific program benefits/services to enrolled beneficiaries.

- **Part A Hospital Insurance:** Covers inpatient care in hospitals and limited skilled nursing facility, home health care and hospice services.

- **Part B Medical Insurance:** Covers doctors' services and outpatient care including, but not limited to durable medical equipment, emergency room services, outpatient surgery and laboratory service.
- **Part C Medicare Advantage Plans:** Alternate delivery system where people can voluntarily enroll to receive their Part A, B and usually D services and potentially "extra services" through various forms of managed care such as health maintenance organizations (HMOs), preferred provider organizations (PPOs) or Special Needs Plans (SNPs).
- **Part D Prescription Drugs:** A prescription drug option run by private insurance companies approved by and under contract with the federal Medicare program.

Medicare's long-term care benefits

As noted previously, the Medicare program offers very little coverage for long-term care services. Medicare also does not cover non-skilled "custodial care" support services such as activities of daily living like dressing, bathing and using the bathroom. In limited situations, Medicare will pay for medically necessary skilled nursing facility or home health care services for a specific duration of time under Part A as follows:

- **Skilled Nursing Facility Care:** Medicare helps pay for a person's recovery in a skilled nursing facility, but only after a minimum three-day hospital stay and coverage is for only a maximum of 100 skilled nursing facility days. Services include semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies. To qualify for care, a doctor must certify that daily skilled care like intravenous injections or physical therapy is needed.
- **Home Health Services:** Limited to medically-necessary part-time or intermittent skilled nursing care, physical therapy, speech-language therapy pathology or a continuing need for occupational therapy. A doctor must order the care and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment and medical supplies for use at home. A person must be homebound which means leaving home is a major effort.
- **Hospice:** For people with a terminal illness; a doctor must certify that life expectancy is less than six months. Coverage includes drugs for pain relief and symptom management, medical, nursing, social services and other covered services including grief counseling (not usually covered by Medicare). A Medicare-approved hospice provider usually provides care in a person's home or other facility. Inpatient respite care is also provided so that the usual caregiver can rest.

Medicare out-of-pocket beneficiary cost requirements

To receive Medicare benefits, most people are required to pay a monthly premium, annual deductibles and service-level coinsurance that are updated each year by the federal government. The premiums, deductibles and coinsurance levels vary by Part A and Part B, but are the same across the entire nation. The following are Medicare's premiums and related cost sharing requirements applicable to Part A and B with references to long-term care services where relevant.

The national Medicare premiums for 2010 are:

- $461/month for Part A premium. However, most people do not have to pay a monthly premium to get Part A coverage because they earned Part A coverage through their payroll taxes while working.
- $96.40/month for Part B premium for most people. Higher wage earners pay more.
- For 2010 the national base premium for Part D is $31.94.
- Depending on the Medicare Advantage Plan there may be a separate premium associated with Part C and Part D services.

The national Medicare deductibles for 2010 are:

- $1,100 for each hospital stay per benefit period.
- $0 for the first 20 days of a skilled nursing facility stay.
- $0 for hospice and home health care services provided under Part A.

The national Medicare coinsurance levels for 2010 are:

- $275/day for days 61 – 90 of a hospital stay per benefit period; $550/day after 90 days for up to 60 additional "lifetime reserve days"; all costs for each day after the lifetime reserve days are the responsibility of the individual to pay.
- $137.50/day for days 21 – 100 of a skilled nursing facility stay in each benefit period; all costs for each day after 100 days are the responsibility of the individual to pay.
- 20 percent of the Medicare-approved amount for most Part B services which is the amount the provider agreed to accept from Medicare and is typically less than the provider's actual billed charges.

Medicare program delivery systems

Medicare delivers services to beneficiaries through two main programs: Original Medicare and Medicare Advantage. A third delivery system called the Program of All-Inclusive Care for the Elderly (PACE) was established in federal law as a separate program.

Original Medicare is a traditional FFS program, much like Delaware's Medicaid FFS program, where individuals seek services at-will from any Medicare-approved participating provider and the federal government pays the provider's bill directly less any deductible or coinsurance amounts required from the beneficiary. Everyone enrolled in Medicare defaults into the Original Medicare program to receive services, although Part D drug benefits are provided through private prescription drug plans. Medicaid's interaction with Original Medicare is generally limited to paying Medicare's premiums and the applicable out-of-pocket Medicare deductibles and coinsurance for dual eligibles.

By contrast, Medicare Advantage is a managed care program where people voluntarily enroll in and receive services through a managed care entity like an HMO, PPO or SNP. Medicare Advantage plans are required to provide all the same Part A and Part B services that a person would get under the Original Medicare program except hospice care and also provide Part D drug benefits for members. Additionally, in exchange for a more restricted network of providers and possibly an additional monthly premium, plan

enrollees receive assistance with navigating the health care system, personal support from care managers such as registered nurses on staff at the HMO/PPO and possibly additional services not offered under the Original Medicare program such as dental, hearing and wellness services. Some Medicare Advantage Plans may also waive or otherwise modify Medicare deductibles and coinsurance levels.

Generally any Medicare beneficiary is eligible to enroll in a Medicare Advantage plan serving their geographic area. For each person that enrolls in a managed care plan, the federal government pays a monthly capitation rate to the plan for the Medicare risk of the enrolled population (rates vary for Part A and B, ESRD and are risk-adjusted to account for acuity differences). Medicare Advantage capitation rates vary across the country based on a complex formula developed by Congress. Like Original Medicare, Medicaid's interaction with Medicare Advantage HMOs and PPOs is typically limited to applicable premiums and out-of-pocket expenses of dual eligibles.

In Delaware, Medicare Advantage enrollment is quite low. Even though 16 percent of Delaware's population has Medicare (about 145,000), which mirrors the national average of 15 percent, the penetration rate of Medicare Advantage enrollment in 2009 was only 3.6 percent compared to the national average of 23 percent[45]. But less than half of the approximately 5,000 Medicare Advantage enrollment is actually in Medicare HMOs; the majority are enrolled in private FFS plans. So although there is multiple Medicare Advantage plans available in Delaware, consumers have not generally chosen this option for receiving their Medicare benefits.

Medicare Advantage Special Needs Plans (SNPs)

Medicare SNPs are a relatively new type of a Medicare Advantage plan and hence governed by Medicare's rules and regulations pertaining to the Medicare Advantage program just like other Medicare HMOs and PPOs. However, SNPs are not yet a permanent component of the Medicare program; instead SNPs are conditioned on Congress extending the authority for these entities to operate. Until the passage of the Patient Protection and Affordable Care Act (PPACA), SNP authority was set to end on December 31, 2010. Section 3205 of Title III of the PPACA provided a three-year extension of the SNP authority through to December 31, 2013.

The unique aspect of SNPs is that these plans are allowed to limit enrollment (a common practice in Medicaid, but generally prohibited in Medicare) to three different subsets of the Medicare population that has been deemed to have "special needs": 1) people who live in institutions, 2) people who have one or more specific chronic, or disabling conditions and 3) people who are eligible for both Medicare and Medicaid. The different types of SNPs are commonly referred to as Institutional SNPs, Chronic SNPs or Dual SNPs, respectively. The majority of enrollment has been in Dual SNPs.

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[45] Kaiser State Health Facts, Medicare Advantage Plan Penetration, 2009, Delaware.

SNPs are required by Medicare to provide the Part D prescription drug coverage in addition to Medicare's other benefits. Enrollment in SNPs is voluntary just like other Medicare Advantage plans except that Dual SNP enrollees have the added flexibility to enroll/disenroll each month whereas as other Medicare Advantage enrollees are limited to an annual enrollment period. An individual who has both Medicare and Medicaid is not restricted to enrolling in just a Dual SNP; a dual eligible individual can choose to enroll in another type of Medicare Advantage plan or stay in the Original Medicare program. Like other Medicare Advantage plans, all SNPs are paid monthly capitation rates directly from the federal government for the Medicare risk only.

While Dual SNPs enroll people who have both Medicare and Medicaid, the Dual SNP is not financially responsible for any Medicaid covered services. And until the passage of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Dual SNPs were not even responsible for any coordination efforts with the Medicaid program. MIPPA now conditionally requires that Dual SNPs contract with state Medicaid programs to provide for or arrange Medicaid benefits, must provide information on Medicaid benefits to their enrolled members and deploy evidence-based care treatment programs. The contract with a state may or may not involve a financial arrangement between the state Medicaid agency and the Dual SNP. Congress passed MIPPA to strengthen the connection between Medicare and Medicaid for this vulnerable population. Because SNPs are established under the federal Medicare Advantage program, state Medicaid programs have limited ability to make policies and programmatic decisions that impact Medicare's enrollment and coverage rules.

As with the Medicare Advantage program as a whole, SNP activity in Delaware is extremely limited. In 2009, only Evercare and Aetna were listed as offering a Dual SNP product (along with Evercare's separate Chronic and Institutional SNPs) and enrollment was quite small. In the 2010 Medicare Advantage SNP directory, only one SNP was listed, Evercare's Institutional SNP, enrolling approximately 200 people. However, the 2010 directory excluded Dual SNPs that did not have a state Medicaid agreement (a condition in MIPPA for new SNPs or SNP expansion) so it is possible that one or both Dual SNPs still exist.

Program of All-inclusive Care for the Elderly (PACE)[46]

The Balanced Budget Act of 1997 established PACE as a permanent, separate Medicare program and a state plan option under Medicaid. PACE is a voluntary program for individuals age 55 or older who live in the service area of a PACE site and have been certified by the state as meeting the need for nursing home level of care, but can be safely served in the community. The PACE program was one of the first programs to integrate Medicare and Medicaid funding at the provider/organization level to serve all of the needs of enrolled participants and is governed by specific federal regulations. PACE enrollment is open to qualifying individuals who have Medicaid or Medicare or both, but most people who join are dually eligible for Medicare and Medicaid.

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[46] For more details on the PACE program refer to Section 42 CFR 460 in federal regulations.

PACE is organized around a physical site and a team of health care professionals where community interaction and adult day services are provided, although PACE services can be provided in a person's home. While people enrolled in PACE are eligible for nursing home care, typically less than 10 percent of PACE participants reside in institutions. Unlike Medicare Advantage plans that enroll thousands of beneficiaries, PACE sites are typically small – often serving only 50 to 200 members per site.

PACE provider sites receive separate capitation payments from both the federal government and the state Medicaid agency for the provision of all Medicare and Medicaid services, respectively; and are hence financially at-risk for all capitated services. This pooling of resources allows the PACE site to find creative ways to meet the needs of each participant. Separate federal regulations govern the Medicare and Medicaid capitation rates applicable to the PACE program. If a state chooses the PACE state plan option, there is an application process and readiness review that the state must complete to establish a PACE site. Because PACE is an integrated Medicare/Medicaid program, state Medicaid programs do have some policy-decision making and oversight responsibilities in addition to being directly responsible for the Medicaid capitation rate development and payment.

Dual eligibles – few in number, large in cost

As noted previously, people who qualify and enroll in both Medicare and Medicaid are referred to as "dual eligibles" due to their dual enrollment in both government health care programs. Nationally, there are about 9 million low-income elderly and disabled duals which is not a overly large number of people; however, the cost of care for this group is now estimated at a staggering $250 billion annually – approaching half of all Medicaid expenditures and a quarter of Medicare spending[47]. Moreover, this vulnerable population segment is becoming ever more of concern to national and state policy-makers because over 80 percent of dual eligibles remain in uncoordinated and unmanaged FFS programs and this group is most likely to require Medicaid-funded long-term care services due to their low-incomes and generally poor health status.

According to September 2008 monthly and fiscal year Medicaid Statistical Information System (MSIS) enrollment and expenditure data available on Delaware[48]:

- There are 21,356 dual eligibles in Delaware composing 13.8 percent of total Delaware Medicaid enrollment.
- 54 percent of dual eligibles are categorized as Aged with an additional 44 percent categorized as Blind/Disabled.
- Approximately 45 percent of all duals appear to be full Medicaid benefit duals (i.e., entitled to medical benefits under the Medicaid program).
- Delaware's Medicaid spending on all dual eligibles totaled over $310 million.

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[47] Center for Health Care Strategies, Inc.; Options for Integrating Care for Dual Eligible Beneficiaries, March 2010.

[48] Analysis of data available from the CMS Medicaid Statistical Information System (MSIS) State Summary Datamart.

- Nearly 50 percent of the total amount spent on dual eligibles was for institutional nursing facility services.
- Over 86 percent of total Medicaid nursing facility spending was related to dual eligibles.
- Spending on dual eligibles accounted for nearly 28 percent of Delaware's $1.1 billion in total Medicaid expenditures.

Accordingly, in Mercer's opinion, any effort by DMMA to positively impact quality and spending in the State's Medicaid long-term care system will need to recognize the importance of dual eligibles and include this population group in any strategic planning efforts.

While the rules and regulations pertaining to dual eligibles are complex and beyond the scope of this paper; terminology is especially critical and can be confusing. The following sections are intended to provide a brief, educational overview of dual eligibles.

Types of dual eligibles and DMMA's financial obligations

Not all dual eligibles are the same in terms of Medicaid's responsibility and some are not technically even considered a dual eligible. Depending on a person's income and resources, there are several different categories of dual eligibles and each category represents a different level of interaction with Delaware's Medicaid program. In general, states may provide the full set of Medicaid benefits to dual eligibles if they otherwise meet all Medicaid requirements or may provide more limited assistance in the form of payment for Medicare premiums and cost-sharing commonly referred to as the Medicare Savings Program.

As it pertains to eligibility for the Medicare Savings Programs, Section 112 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 increased the resource limits for some dual eligibiles (Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualified Individuals) to conform to the resource limit for individuals who qualify for the full subsidy Medicare Part D low-income subsidy[49] (effectively $6,600 for an individual or $9,510 for a couple). These resource limit increases took effect in 2010 and would result in an increased number of people for which state Medicaid programs pay Medicare's premiums, deductibles and/or coinsurance. However, the increase in resource limits for the Medicare Savings Program did not impact general Medicaid eligibility for receiving Medicaid-funded program services for which states still typically rely on the SSI resource limit.

For Delaware, the MIPPA required resource limit increases should have minimal, if any, impact because Delaware does not impose any resource limit for the impacted populations in determining coverage under the Medicare Savings Program[50] (i.e., Qualified Medicare Beneficiary Programs). Accordingly, Delaware's program can be

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[49] February 18, 2010, State Medicaid Director Letter #10-003, Center for Medicaid and State Operations.

[50] Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities, Table 5, Kaiser Commission on Medicaid and the Uninsured, February 2010, Report #8048.

segmented into two primary classes of dual eligibles: those that receive full Medicaid medical benefits and those that receive only assistance with paying Medicare premiums, deductibles and coinsurance as described below:

- **Full Medicaid benefit dual eligibles (Full Benefit):** In Delaware, these individuals qualify for both Medicare and Medicaid and have incomes up to the SSI level ($674.00/month for an individual or $1,011.00/month in 2010) and resources up to the SSI limit ($2,000 for an individual or $3,000 for a couple). Due to their low incomes and limited resources, DMMA also pays the applicable Medicare premiums, deductibles and coinsurance. Additionally, under the special income rule, Delaware provides full Medicaid medical benefits for individuals up to 250 percent of FPL under the Medicaid nursing facility and home- and community-based waiver programs (resource test is $2,000 and spousal impoverishment rules apply in these cases).
- **Qualified Medicare Beneficiary Only (QMB Only):** These dual eligibles have incomes that do not exceed 100 percent of FPL and are entitled to receive assistance from DMMA in paying only the applicable Medicare premiums, deductibles and coinsurance consistent with the Medicaid state plan policies. The QMB Only group does not receive any supplemental Medicaid medical benefits. As noted previously, Delaware is one of a small number of states that has chosen to have no resource limit in determining eligibility for the Medicare Savings Program.
- **Specified Low-income Medicare Beneficiary Only (SLMB Only):** These dual eligibles have higher incomes between 100 and 120 percent of FPL, but are entitled to receiving Medicaid assistance in paying only the Medicare Part B premium. The SLMB Only group also does not receive any supplemental Medicaid medical benefits and no resource limit applies in Delaware.
- **Qualified Working Disabled Individuals (QWDI):** These individuals have incomes that do not exceed 200 percent of FPL and may have lost Medicare Part A benefits due to returning to work, but are eligible to enroll in and purchase Part A and not otherwise eligible for Medicaid. The only Medicaid benefit offered is payment of the Part A premium. The QWDI group also does not receive any supplemental Medicaid medical benefits and no resource limit applies in Delaware.
- **Qualifying Individuals-1 (QI-1):** This limited financial benefit is available to individuals with incomes between 120 and 135 percent of FPL as an extension of the SLMB Only benefit to pay the Medicare Part B premium only (no Medicaid medical benefits, no resource limit in Delaware). States receive 100 percent federal funding for the QI-1 program; however, funding is limited based on state allotments so financial assistance is typically provided on a "first come, first served" basis. The QI-1 program is subject to renewal by Congress and was most recently renewed through December 31, 2010 as part of the American Recovery and Reinvestment Act (ARRA).

Because of the additional Medicaid medical benefits, the Full Benefit dual eligibles are typically the mostly costly to Medicaid, especially in terms of Medicaid long-term services and supports.

Summary table on the interaction of Medicare and Medicaid for dual eligibles

The following table summarizes the interaction of Medicare and Medicaid for dual eligibles.

Table 5 – Interaction of Medicare and Medicaid for dual eligibles

Dual Eligible Group	Entitled to full Medicaid medical benefits?	Medicaid pays Part A premium?	Medicaid pays Part B premium?	Medicaid may pay deductibles and coinsurance
Full Benefit	Yes	Yes	Yes	Yes
QMB Only	No	Yes	Yes	Yes
SLMB Only	No	No	Yes	No
QWDI	No	Yes	No	No
QI-1	No	No	Yes	No

Delaware's Medicaid program will receive federal matching funds for any payment made pertaining to dual eligibles' Medicare premiums, deductibles or coinsurance at the same Medicaid FMAP rate as would be received for Medicaid provided medical services. Medicaid PACE capitation rates are also matched at the Medicaid FMAP rate like other capitated Medicaid managed care programs.

Conditional payment for Medicare/Medicaid cross-over claims

It is important to know that Medicaid does not pay providers first when it comes to dual eligibles. Medicare is primary; Medicaid's obligation is conditional based on what Medicare covers, the amount of the Medicare payment the provider received and benefits/policies in the state's Medicaid program. If a dual eligible receives a service that is jointly covered by both the Medicare and Medicaid programs, these "cross-over" claims should first be processed for payment by the Medicare program either through the Original or Medicare Advantage plan depending on what Medicare delivery system the person was enrolled in. Subsequently, the provider should submit the claim to the Medicaid program for any additional payment that is permitted under the state Medicaid plan.

Furthermore, Medicaid's payment responsibility for a cross-over claim can be on a conditional basis. Federal law provides that a state Medicaid program is not required to provide payment for any expenses incurred for a Medicare deductible or coinsurance in the event that the Medicare payment for the service exceeds the payment amount that would have been made by the Medicaid program. Therefore, it is possible that Medicaid's payment for a cross-over claim can be zero. Federal law disallows a provider from balance-billing a dual eligible for any unpaid claim amount.

New Federal Coordinated Health Care Office (CHCO) for dual eligibles

As noted previously, states and the federal government have often been at odds over program initiatives, policy issues and credit for savings when Medicaid and Medicare are both involved in the lives of the low-income elderly and disabled dual eligibles. Policymakers are coming to the realization that a vast amount of spending is generated by this one population group and that the separation of Medicare and Medicaid operations and oversight at the federal level has contributed to the fragmentation of care for this vulnerable and costly group. Indeed, this separation has directly led to much frustration for states that have experienced difficulty trying to get the Medicare program administrators to work with state Medicaid agencies more collaboratively and address the myriad of regulatory issues impacting both programs.

In a clear sign that things are changing at the federal level, Section 2602 of Title II of the recently enacted PPACA requires the Secretary to immediately establish a new Federal Coordinated Health Care Office (CHCO) within CMS. The purpose of the new CHCO is to "bring together officers and employees" of CMS in order to:

- More effectively integrate Medicare and Medicaid program benefits.
- Improve the coordination between federal and state entities for dual eligibles to ensure dual eligibles have full access to their entitled items and services.

The PPACA established the following goals for the new CHCO:

- Provide dual eligibles full access to all entitled Medicare and Medicaid services.
- Simplify the process for dual eligibles to access services.
- Improve quality of health care and long-term services for dual eligibles.
- Increase dual eligibles' understanding and satisfaction with the Medicare and Medicaid programs.
- Eliminate regulatory conflicts between rules governing the Medicare and Medicaid programs.
- Improve care continuity and ensure safe, effective care transitions for dual eligibles.
- Eliminate cost-shifting between the two programs.
- Improve quality performance of providers under both programs.

The PPACA also delineated specific responsibilities for the new CHCO:

- Provide states, SNPs and other providers with education and tools to develop programs that align program benefits for dual eligibles.
- Support state efforts to coordinate and align acute care and long-term care services for dual eligibles.
- Provide support for coordination, contracting and oversight by states and CMS related to the integration of Medicare and Medicaid services.

- Consult and coordinate with the MedPAC and MACPAC[51] commissions regarding relevant issues pertaining to dual eligibles.
- Study the provision of drug coverage for new full-benefit dual eligibles as well as monitor and report annual expenditures, health outcomes and access to benefits.

These changes at the federal level make clear the importance and significance of the dual eligibles in terms of the nation's health care system. While there will still be many policy and operational issues to address in implementing programs targeted at the dual eligibles, the new statutory requirements placed on CMS to collaborate with states indicates that DMMA can now expect to have more cooperation and assistance from CMS in pursuing programs aimed at this costly and vulnerable population.

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[51] Mark Hoyt, FSA who is Mercer's National Practice Leader for our Government Consulting Practice was selected as one of the first members of the MACPAC commission.

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Medicaid options for promoting community-based long-term services and supports

As stated previously, DMMA's goal is to develop more community-based alternatives for Medicaid long-term services and supports in lieu of institutionalization. There are several different program initiatives that can be deployed separately or together in both the traditional Medicaid FFS system or through new Medicaid managed care programs to support this goal. For purposes of this paper, we did not want to limit the discussion to just managed care initiatives, although an efficient and effective managed care program may align financial and operational incentives in the best way.

In the following sections, various options are presented and discussed. Along with a description of each option, a brief, qualitative opinion of the potential impact each option may have on fiscal expenditures and quality is also provided. However, it is beyond the scope of this paper to perform any financial/actuarial forecasts of program spending or estimate the specific staffing resources and internal costs associated with each option. Additionally, where applicable, comments are provided regarding the practicality of implementing each option in Delaware including estimates of the lead time required to implement each option.

While we have reflected changes stemming from the recently enacted PPACA in presenting these options, additional guidance from CMS has not been released as of the date on this report. Therefore, the specific references to the PPACA are a preliminary assessment and subject to change or revision in application once further guidance becomes available. At the end of this Section, we provide a table that summarizes and provide brief pros and cons of each option.

It is also important to note that while the following options promote and align fiscal/operational incentives towards community-based care delivery; these options in themselves do not necessarily create tangible alternatives. For example, contracting with Medicaid HMOs to coordinate and manage long-term services and supports does not immediately increase the number of home health care workers in the State or result in

the construction of new affordable housing units. A Medicaid HMO that is held financially and operationally accountable for their members' care will seek to find ways to provide quality and cost-effective services such as more home care, home modifications, medication management and personal outreach and connection to help the member stay active and healthy. Implementing these types of options re-directs the focus of care managers, providers, consumers and State staff to use financial and human resources in more consumer-friendly, cost-effective and innovative ways (e.g., paying for home modifications as a new benefit). Over time, aligning these resources in the right way shifts attention and energy to more proactively addressing health status and functional limitations which will then lead to direct, tangible changes in service offerings and lead to changes in social attitude towards how Medicaid cares for the elderly and individuals with disabilities and delay further functional deterioration.

The options in this Section are organized into three main groups based on the type of delivery system for delivering care as follows:

- Group A options enhance the State's Medicaid FFS long-term care system.
  - Option A1: Coverage of personal care services under the state plan.
  - Option A2: 1915(i) state plan option for home- and community-based services.
  - Option A3: 1915(j) state plan option for consumer-direction of personal care services.
  - Option A4: 1915(k) state plan option for attendant care services in home and community settings (Community First Choice Option).
  - Option A5: 1915(c) home- and community-based waivers.
- Group B describes different Medicaid-only managed care program options.
  - Option B1: 1932(a) state plan managed care option.
  - Option B2: 1915(a) voluntary managed care authority.
  - Option B3: 1915(b) mandatory managed care waivers.
  - Option B4: Concurrent authorities for managed long-term care programs.
  - Option B5: 1115 demonstration waiver.
- Group C present options for integrated Medicare/Medicaid managed long-term care for dual eligibles.
  - Option C1: Program for All-inclusive Care for the Elderly (PACE)
  - Option C2: Medicare Advantage plans – Special Needs Plan (SNPs)

The options presented herein will fit within Delaware's overall strategy in different ways. For example, if the State's primary objective is simply to expand care available in home- and community-based settings, most of the FFS state plan amendments described in Group A are consistent with that goal. However, if the State is seeking a broader strategy of impacting the delivery, management and integration of the Medicaid long-term care system, the managed care options described in Groups B and C and possibly the 1915(k) state plan option are more aligned with transforming the system of long-term services and supports. If the State's goal is to implement a new initiative in less than a year, the more complex options involving managed care development and procurement, 1115 waivers and integrating Medicaid with Medicare are not practical choices.

Mercer recommends that as part of the next phase of this endeavor that DMMA, in conjunction with both internal and external stakeholders, discuss and evaluate the merits

of these options in regards to how Delaware's strategy and objectives can be best complemented by the chosen initiative(s).

Group A options: Enhancing the Medicaid FFS long-term care system

The following options can be implemented through relatively simple state plan amendments that provide DMMA the regulatory authority to offer and pay for alternative services intended to delay or divert the need for institutionalization. However, some of these options have limitations on DMMA's ability to manage the breadth, scope and/or quality of coverage. Therefore, these options should be considered in light of those realities and whether these options represent the best fit for achieving the State's goals.

Even though the act of amending the state plan is significantly less complicated and time consuming than developing a new managed care wavier and/or procuring contractors, the need for DMMA staff to evaluate the ramifications of amending the state plan on fiscal spending, provider supply and payment rates, consumer demand, quality of care, information technology updates and data reporting will still require appropriate staff time and resources.

Option A1: Coverage of personal care services under the state plan

Personal care services (PCS) is an optional Medicaid benefit. PCS encompasses a relatively broad description of unskilled services that include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks such as ADLs or IADLs that they would normally do for themselves if they did not have a disability; assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cueing (prompting the person to perform the task) so that the person performs the task by themselves[52]. PCS are approved as part of person's plan of care and can be provided inside or outside the home, but not in institutions like hospitals or nursing facilities.

Based on 2008 CMS-64 reported expenditures, over 30 states provided PCS (sometimes referred to as personal assistance services or attendant care services) through their Medicaid state plans. Delaware does not currently offer PCS as part of the State's Medicaid plan, instead PCS is available on a limited basis to those who qualify for one of Delaware's existing 1915(c) waiver programs that offers PCS as a special waiver service. However, Delaware does offer adults with physical disabilities a state-funded Personal Attendant Services program that provides similar types of services.

Since this option involves amending the State's Medicaid plan to cover optional PCS, the service would have to be made available statewide to every eligible Medicaid participant.

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[52] State Medicaid Manual, Section 4480(c).

DMMA would have the ability to define medically-necessity criteria, establish provider qualifications, and deploy utilization management techniques, but otherwise the service would be available to everyone. Furthermore, Section 1915(j), discussed later, provides Delaware the option to also allow self-direction of PCS via a state plan option.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** Because this option involves amending Delaware's state plan to add a new entitlement service, it would be difficult for DMMA to effectively target PCS to those most at-risk of institutionalization to reduce aggregate spending. Moreover, spending on PCS can grow extremely quickly and due to the unskilled nature of the service providers has a high potential to replace unpaid caregivers with public funds. For example, CMS-64 data indicates North Dakota first began reporting PCS expenditures in 2004; in 2005 the state spent $2.0 million and by 2008 the amount reported was a remarkable $12.6 million. Over the same time, North Dakota reported expenditures on nursing facilities increased from $158.2 million to $168.3 million. However, it is possible that Delaware's state-funds spent on personal attendant services could be re-directed to partially off-set the total new spending on PCS which would draw down federal matching funds instead of being completely funded with state dollars only.
- **Potential impact on quality issues:** Since PCS is intended to provide hands-on assistance to people with chronic disease or disabilities, this service would likely be viewed favorably by those beneficiaries who could obtain services. Moreover, if minimal assistance with ADLs or IADLs is all that is needed to maintain home- or community-living in lieu of institutionalization, this service could be helpful in creating a larger continuum of services available under the State's Medicaid program.
- **Practicality of implementing in Delaware:** Delaware can simply cover this service by submitting a state plan amendment. Developing service criteria, provider qualifications, payment rates, claims processing edits, and educating providers, consumers and families about this new benefit would require staff time, but conceivably some of this work has already been completed because of the coverage of PCS in some of Delaware's 1915(c) waivers. An estimate of 6 to 12 months should be reasonable to implement this option. The unskilled nature of the work suggests that caregiver supply issues would be less of a concern as compared to skilled home nursing care, but there is a general shortage of home health/personal care aides today.

Option A2: 1915(i) state plan option for home- and community-based services

Originally created by the Deficit Reduction Act of 2005 and most recently updated in Section 2402 of Title II of PPACA (effective April 1, 2010), Section 1915(i) gives states the option to provide home- and community-based services through a state plan amendment instead of a more burdensome waiver process. Under this option, states are able to do the following:

- Use eligibility criteria that are less restrictive than the state's nursing facility clinical eligibility standard (i.e., target eligibility on a "needs-basis" as defined by the state).
- Cover individuals up to 300 percent of SSI (a limitation prior to PPACA).

- Are not required to demonstrate that community-based care is cost-effective as compared to institutionalization.
- Expands the service offerings available under the 1915(i) state plan option to include the "other services clause" consistent with1915(c) waiver authority. Services must be provided statewide but do not have to be comparable across enrolled populations.
- Prohibits states from setting limits on the number of participants.
- Establish recipients receiving services through 1915(i) as an optional categorical group for Medicaid program coverage purposes.
- Requires a "grandfathering" provision to allow program participants to retain coverage in the event that the state tightens its eligibility criteria as long as the person continues to meet the prior eligibility criteria.
- Can still target specific populations and vary scope of services on a five-year conditional renewal basis; including phasing-in populations and services.

While the 1915(i) state plan option is easier to implement and maintain than a waiver, prior to PPACA, the financial/categorical eligibility requirements for the program were effectively much more restrictive than 1915(c) waivers which could cover individuals up to 300 percent of SSI. Accordingly, only a very limited number of states initially took advantage of the 1915(i) option such as Nevada, Colorado and Washington.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** The 1915(i) option operates much like 1915(c) waivers where spending is directed towards home- and community-based services to support the functional and health status of individuals and ideally delay or divert the need for costly institutional care (i.e., spend more now to try and save some later). Implementing a 1915(i) option will increase total Medicaid spending if more people seek services than institutional diversion can off-set especially in the early years. This option may also redirect spending under one of Delaware's existing waivers thus lessening the potential for increases in aggregate spending. Even with no current waiting lists, the relatively small number of the elderly/disabled currently served through 1915(c) waivers, opening a new state plan option to provide community-based services could quickly increase spending if there is a large unmet need presently in the State (unknown at this point).
- **Potential impact on quality issues:** The 1915(i) option allows Delaware to provide additional services that are typically not available under the state plan aimed at assisting people with their needs in community-based settings. Accordingly, these new services would likely impact quality much the same way as Delaware's 1915(c) waivers have done by promoting more cost-effective and consumer-oriented services to enable consumers to remain in their homes and communities.
- **Practicality of implementing in Delaware:** Because the 1915(i) option closely mirrors many of the facets of existing 1915(c) waivers, it is practical for DMMA to consider the benefits of this option and leverage existing policies and provider rates established in the waiver(s). However, because this option now requires statewide coverage and more importantly no limits on the number of program participants, DMMA would have to carefully consider whether the elimination of the administrative effort of 1915(c) waiver(s) justifies the additional exposure generated by this option. Given these types of policy issues, this option would likely require more time to

implement than Option A1 to cover personal care services. Even though a 1915(i) option can be implemented via a state plan amendment, Mercer suggests a minimum of 9 to 12 months to provide time for deliberation and evaluation. Consideration would also have to be given to whether sufficient workforce exists to meet demand if the service availability becomes part of the state plan on a broader basis. It is feasible that DMMA could define the needs-based criteria sufficiently well to indirectly place some control on the potential population seeking services. But DMMA may be limited to having just a single 1915(i) option whereas today different waivers can target different populations (subject to further CMS guidance).

Option A3: 1915(j) state plan option for consumer-direction of personal care services

The Deficit Reduction Act created the new Section 1915(j) state plan option, effective January 2007, to permit states to provide individuals with the option to self-direct their personal assistance services already offered under either the state plan or a waiver. This option has sometimes been referred to as "cash and counseling." Section 1915(j) does not create any new service; it only provides a new delivery model for an already covered service that is intended to promote greater consumption and use of community-based long-term services and supports. As noted previously, Delaware does not offer personal care services under the state plan, so this option would only be applicable to the respective 1915(c) waivers (unless DMMA implemented PCS as a regular state plan service). States that have submitted and received approval for state plan amendments for the self-direction option includes Alabama, Arkansas, California, Florida, New Jersey, Oregon and Texas.

Consumer participation in 1915(j) self-direction is voluntary and for those consumers who do elect self-direction their responsibilities include:

- Qualifications of workers who will furnish their services.
- Train, hire and fire appropriate service providers (including family relatives).
- Authority for determining provider payment rates.
- Managing their budgets with the ability to purchase permissible personal assistance and related items to increase independence or substitute for human assistance.

The State's responsibilities under the Section 1915(j) option include:

- Providing assurances that the necessary safeguards have been taken to protect the health and welfare of the Medicaid participants.
- Assuring the financial accountability for funds expended for self-directed services. Most states employ fiscal intermediaries to provide accounting/administrative support services to participants (this would be a new cost for Delaware).
- Providing support to the participants with information, counseling, training in regards to the participant's employer-related responsibilities.

If electing self-direction via a state plan option instead of through a 1915(c) waiver, states can still limit the availability of self-direction to certain geographic areas as well as just a targeted population. This flexibility enables states to retain some control and

discretion over the availability of self-direction in comparison to other state plan options that have to be made available statewide to everyone.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** If Delaware wanted to provide self-direction as an optional service under the State's regular Medicaid state plan, the availability of personal assistance services would first have to be covered by the state plan. Accordingly, previous comments pertaining to PCS impact on spending are relevant. Whereas the self-direction option can be limited on a geographic or population basis, the availability of PCS cannot; therefore, this option carries with it prerequisites that might expand spending beyond what DMMA may want to see happen. Contracting with a fiscal intermediary to provide support functions would be a new cost to the State. Notwithstanding these concerns, the self-direction option is intended to involve consumers more actively in their own service utilization and spending patterns. The ability to offer consumers a monthly budget for which they direct, use and could possibly save to purchase other related goods and services is intended to better direct funds to best meet the needs of consumers and conceivably reduce the level of ineffective or unnecessary spending.
- **Potential impact on quality issues:** Since the 1915(j) option gives a level of authority and decision-making ability to Medicaid consumers for their personal assistance services, these programs are typically viewed favorably as the consumers obtain a sense of independence and empowerment over their own lives. Furthermore, if the consumers can use funds in ways that they view as best meeting their needs (within a framework established by the state), quality of life and satisfaction should correspondingly increase. Indeed, the Agency for Healthcare Research and Quality, cash and counseling programs resulted in increased access to personal care services, significantly fewer unmet personal care needs, and enhanced beneficiary satisfaction[53].
- **Practicality of implementing in Delaware:** Without the coverage of personal care services under the Medicaid state plan, application of this option is limited to specific 1915(c) waivers that offer personal care services that can be subject to self-direction. To the extent that self-direction has been an aspect of the state-funded Personal Attendant Services program, the groundwork and experience may exist to expand this option to Medicaid-funded services. DMMA would be required to establish the required assurances and support functions to carry-out the Section 1915(j) requirements. Given these policy issues and the potential need to procure a fiscal intermediary, Delaware would likely need a minimum of 12 to 16 months to effectively implement a 1915(j) option. As noted before, self-direction does not result in any new service being available, instead like other options being discuss herein, the different delivery model is intended to alter the landscape of Delaware's long-term care

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[53] AHRQ, Self-Directed, Self-Controlled Budget for Personal Assistance Services Reduces Unmet Needs, Improves Quality of Life for Medicaid Beneficiaries, http://www.innovations.ahrq.gov/content.aspx?id=1800, April 14, 2008.

system by empowering consumers to take their health care needs more into "their own hands".

Option A4: 1915(k) state plan option for attendant care services in home and community settings (Community First Choice Option)

Section 2401 of Title II of the PPACA created a completely new state plan option program for home- and community-based attendant care services called the Community First Choice Option. Beginning in October 2011, states can provide community-based attendant services and supports via a simple state plan amendment instead of obtaining waiver authority and are given an enhanced FMAP as an incentive. The following are key provisions of the new 1915(k) option (some provisions resemble those in 1915(c) waivers):

- Institutional level of care requirements apply to the 1915(k) option.
- Financial eligibility is limited to 150 percent of the FPL; however, if the state has opted to use the special income rule for nursing facility eligibility, the 1915(k) financial eligibility can default to this higher standard which could be up to 300 percent of SSI. Delaware uses a 250 percent of SSI financial requirement for Medicaid nursing facility services[54].
- Services must be provided in non-institutional settings consistent with a person-centered plan based on an assessment of the functional need and agreed to in writing.
- Mandatory community-based attendant services must be provided to assist individuals in ADLs, IADLs, and health-related tasks through hands-on assistance, supervision or cueing.
- Optional services that can be provided include institution-to-community transitional costs such as; rent and utility deposits, bedding, basic kitchen supplies, and other necessities identified in the person's care plan.
- Services specifically excluded are room and board, special education and vocational rehabilitation services, most assistive technology devices, medical supplies and equipment, and home modifications.
- Services can be provided either through an agency-model or some other model as long as services are selected, managed and dismissed by the individual (or their representative) to the maximum extent practical.

In order for a state plan amendment to be approved under the 1915(k) option, the PPACA contained specific conditions that the state must satisfy:

- State must work in collaboration with a Development and Implementation Council established by the state that includes a majority of members with disabilities, elderly individuals and their representatives.

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[54] Kaiser Commission on Medicaid and the Uninsured, Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities, Publication #8048, February 2010.

- Services must be provided statewide in the most integrated setting without regard to the person's age or disability.
- In the first full year of operations, states must maintain or exceed their level of expenditures on the aged and disabled as was made in the preceding year.
- Establish and maintain a comprehensive, continuous quality assurance system that includes standards for training, appeals for denials, incorporates feedback from consumers, maximizes consumer control, monitors the health and well-being of each individual, mandatory reporting and investigation of abuse/neglect allegations, and provides information on these quality issues to each individual receiving services.
- Collection and reporting of cost, utilization and enrollment data to the federal government.

If all of the aforementioned conditions are met, states that select this option will receive an increase in FMAP rate of six percentage points on related 1915(k) attendant services and support expenditures.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** Since this is a brand new option, there is no related experience from other states or within Delaware to base an opinion on. The mandatory 1915(k) services resemble the services available in Delaware's elderly/physically disabled waiver which also does not cover home modifications. The financial and functional eligibility requirements mirror those of Delaware's Medicaid waivers/nursing facilities suggest that the eligible population may be several thousand, but this number is almost double the total enrollment in all of Delaware's 1915(c) waivers and the 1915(k) option does not permit caps on the number of people served. The six percentage point increase in FMAP is attractive, but can be quickly off-set by only a small increase in the number of people accessing services.
- **Potential impact on quality issues:** The 1915(k) option allows Delaware to provide additional services that are not available under the state plan aimed at assisting people with their needs in community-based settings. Accordingly, these new services would likely impact quality much the same way as Delaware's 1915(c) waivers have done by promoting more cost-effective and consumer-oriented services to enable consumers to remain in their homes and communities. The focus on person-centered planning and individual control of services combines elements found in both the 1915(i) and 1915(j) options so as to maximize consumer satisfaction and involvement in decision-making.
- **Practicality of implementing in Delaware:** The federal government created the 1915(k) option to make it easier for states to provide home- and community-based services through their state plans. However, the conditional elements of establishing a Development and Implementation Council (unless one already exists) and the quality/data requirements suggests that this new option will carry a significant amount of administrative effort to implement and oversee. Due to these reasons and the lack of detailed federal guidance, Delaware should conservatively assume a minimum of 18 months to launch a 1915(k) program option. Based on current elderly/disabled waiver spending, the six percentage point FMAP increase is tantalizing, but may not be sufficient to make the decision any easier on whether this is a viable option for

DMMA. As with all other options, offering community-based services requires sufficient workforce numbers to meet the increased demand.

Option A5: 1915(c) home- and community-based waivers

Delaware is quite familiar with the Medicaid 1915(c) waiver in that the State currently operates five different waivers applicable to elderly/disabled, MR/DD, HIV/AIDS, assisted living and acquired brain injury. As noted in Section 4, Delaware's elderly and disabled waiver has the largest number of persons served, but spending on the MR/DD waiver dwarfs all other waivers.

States may offer a variety of services to consumers under a 1915(c) waiver program and the number of services that can be provided is not limited These programs may provide a combination of both traditional medical services (e.g., dental services, skilled nursing services) as well as non-medical services (e.g., respite, case management, environmental modifications). Family members and friends may be providers of waiver services if they meet the specified provider qualifications. However, in general spouses and parents of minor children cannot be paid providers of waiver services.
Within the parameters of broad federal guidelines, states have the flexibility to develop 1915(c) waiver programs designed to meet the specific needs of targeted populations. Federal requirements for states choosing to implement a 1915(c) waiver program include:

- Demonstrating that providing waiver services to a target population is no more costly than the cost of services these individuals would receive in an institution.
- Ensuring that measures will be taken to protect the health and welfare of consumers.
- Providing adequate and reasonable provider standards to meet the needs of the target population.
- Ensuring that services are provided in accordance with a plan of care.

Section 2402(a) of Title II of PPACA requires the Secretary to further promulgate regulations related to the administration of home- and community-based services, including ensuring that states allocate resources that are responsive to consumers, support individualized self-directed services, improve coordination among and regulation of providers such as coordination of eligibility determinations, development of quality systems, and assuring an adequate number of qualified direct care workers.
States have the discretion to choose the number of consumers to serve in a 1915(c) waiver program and limit the program to a specific geographic area. Once approved by the federal government, a state is held to the number of persons estimated in its application, but has the flexibility to serve greater or fewer numbers of consumers by submitting an amendment for approval. The 1915(c) waiver provisions allow a state to make waiver services available to people at risk of institutionalization, without being required to make waiver services available to the Medicaid population at large. Virtually every state in the nation operates at least one 1915(c) waiver and many states operate as many 10 or more different waivers aimed at different populations and service offerings.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** As Delaware has already experienced, spending on Medicaid 1915(c) waivers can grow rapidly as consumers access and use these additional services to meet their needs. While the per person costs for most 1915(c) waivers is much less than the per person institutional costs (DD waivers can be quite expensive even in comparison to ICF-MR costs), often the number of people served in waiver programs or the utilization of services can create its own challenges causing states to place limits on services or waiver "slots" to contain spending growth. Ideally, the financial benefit of 1915(c) waivers is to provide cost-effective community-based long-term services and supports to those who are at-risk of needing institutionalization to divert or delay the institutionalization.
- **Potential impact on quality issues:** As noted in previous Sections of this paper, virtually all consumer surveys and studies indicate that individuals are much happier and satisfied with being able to receive support services in their homes or communities. Community-based care positively impacts social interaction, self-esteem and quality of life. Very few people want to be institutionalized.
- **Practicality of implementing in Delaware:** Delaware already has several 1915(c) waivers in operation and is thus quite familiar with the operational protocols for developing and supporting this option. The challenge is whether these waivers are providing the right services to the appropriate populations. As noted earlier in this paper, Delaware directs very little spending on the elderly/disabled via home- and community-based care in relation to nursing facilities. This suggests there is great potential to increase the amount of community-based care directed at this population. However, to do this through 1915(c) waivers would entail either amending the State's existing elderly/disabled waiver to cover many more people, increasing the number of services available under the waiver (e.g., home modifications) or creating new waivers targeted at different segments of the population. More waivers increase the administrative burden and internal State staff resources required to oversee the program and can create challenges to effectively coordinate and focus the State's finite resources. Other states have also experienced "competition" between waivers as the number of community caregivers is limited yet the demand is great, which can lead to preferential treatment of different waivers and even different provider reimbursement rates for similar services in different waivers. To some degree, consolidating waivers can streamline operations, focus resources more directly and alleviate inconsistencies in polices and procedures that may exist across different waivers. Accordingly, DMMA should conservatively assume a minimum of 9 to 12 months to develop and launch a new 1915(c) waiver program.

Group B options: Medicaid-only managed long-term care programs

Unlike the preceding options that focused on traditional FFS, the following options pertain to what DMMA can do in regards to using managed care and waiver flexibilities to advance the State's goal of increased community-based long-term services and supports. Through these following options, DMMA would contractually partner with external third-party managed care entities who would be financially and operationally

accountable for the provision of Medicaid services and quality of care received by their enrolled members.

Although 1932(a), 1915(a) and 1915(b) programs are presented in the sections that follow; in reality these programs are not necessarily viable as stand-alone options for increasing community-based Medicaid long-term services and supports because these programs generally include only state-plan covered services. Instead, these options should be viewed as separate, but complimentary authorities that can enable delivery system changes, including managed care, for persons in need of institutional or home- and community-based long-term care. Regardless of the authority, Delaware should assume a minimum of 18 to 24 months to successfully implement a managed long-term care program.

A benefit of capitated managed care is the flexibility to adjust the capitation rates and contracts to reflect the provision of home- and community-based services even if these services are not covered in the state plan and the managed care program is effectively a "stand-alone" program (i.e., without a concurrent 1915(c) waiver or 1915(i) option). This rate-setting approach can be accomplished in one of the following ways:

- If there is a separate 1915(c) waiver or 1915(i) state plan amendment available in the same geographic area that contains the same community-based services that would be available to the same population enrolled in the managed care program, CMS will allow the community-based services to be included in the managed care contract and rates.
- The managed care capitation rates can be explicitly built on the assumption that cost-effective, non-state plan community-based services will be provided "in lieu of" more costly covered state-plan services such as institutional care. The managed care contract cannot require the plans to provide these alternative services, but contract language can be written to encourage a plan to provide more cost-effective services.
- Under a 1915(b) waiver that utilizes the authority in section 1915(b)(3), states can use the savings in state plan services from managed care to contractually require the plan to provide additional non-state plan services such as home- and community-based services. A state must have processes in place to summarize the specific 1915(b)(3) expenditures each and the savings must be sufficient to justify the additional services.

Along with the benefits of risk-based managed care comes the cash-flow challenge of transitioning from post-paid FFS to prepaid capitation, often referred to as the "claims tail lag." This results in a limited period of time during which a state pays FFS claims on behalf of individuals for past periods while making prepaid capitation payments. However, Mercer has worked with other states to mitigate the cash-flow impact of transitioning to prepaid capitation.

As compared to the prior FFS options that amend the state plan, developing, launching and supporting a new managed care program require additional dedicated and skilled staff time and resources. Not only do managed care plans have to be procured and contracted, specific policies and procedures must be developed and implemented to support the managed care enrollment process, service coverage, grievance system,

quality strategy, data reporting, financial oversight, and plan monitoring. Managed care programs also typically have more extensive information technology requirements related to eligibility determination, edits to deny claims submitted via FFS for a capitated service, capitation payment processes and managed care encounter data collection. Therefore, the following options generally require longer lead times than the options presented in Group A and will put further strain on DMMA's limited staff resources. To the extent that DMMA seeks to transform the delivery system for Medicaid long-term care, the options presented below may fit better within that strategy as compared to the FFS state plan options presented previously.

Option B1: 1932(a) state plan managed care option

Under the authority of Section 1932(a), states are permitted to selectively contract with certain types of managed care plans and mandatorily enroll certain population groups such as Temporary Assistance for Needy Families (TANF), pregnant women and some children into managed care organizations without a formal waiver and the associated administrative burden of demonstrating cost-effectiveness and renewal of a waiver. The ease associated with the 1932(a) authority is attractive to states that want to mandatorily enroll traditional families and children into managed care to receive their standard Medicaid state-plan services. However, in the realm of long-term care, 1932(a) authority may only be used to voluntarily enroll special needs children, children receiving SSI benefits and dual eligibles[55]. Furthermore, under this authority, states are not able to offer the special home- and community-based services found in 1915(c) waivers.

Accordingly, this option is very limited, but may be suitable for programs that voluntarily enroll allowable individuals in need of long-term services and supports into managed care and want to contract with fewer than all qualified managed care providers. Given these limitations, we do not comment on the potential impact on spending, quality or practicality of implementing in Delaware. However, this option may be part of a more comprehensive consideration of authorities.

Option B2: 1915(a) voluntary managed care authority

Under 1915(a), states can implement voluntary Medicaid managed care programs. 1915(a) is not a waiver program and hence does not carry with it the administrative burden of supporting a waiver including not being subject to a cost-effectiveness test. Nor is a 1915(a) a state plan amendment either. Instead, 1915(a) provides separate operating authority (implemented through CMS approval of a contract) to permit voluntary enrollment into managed care plans for any Medicaid population a state may select including dual eligibles, the elderly and individuals with disabilities, or special needs children. New York uses 1915(a) authority to operate a voluntary HMO program for long-term care services for its disabled adults and elderly population.

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[55] Refer to 42 CFR 438.50 in for more information.

However, similar to the 1932(a) and 1915(b) programs, states cannot use 1915(a) authority to provide non-state plan home- and community-based services. Accordingly, states would be limited to only including Medicaid state plan acute, behavioral or long-term care services in a 1915(a) managed care program. Unlike 1932(a) and 1915(b) programs, 1915(a) programs may not be used to selectively contract with fewer than all qualified managed care providers. Given the limited state plan long-term care services in Delaware, as a stand-alone program option this would do very little in terms of increasing the options available for community-based Medicaid long-term services and supports and therefore we do not comment on the potential impact on spending, quality or practicality of implementing in Delaware. Later in this Section we do comment on a combination 1915(a)/(c) waiver program as part of a more comprehensive consideration of authorities.

Option B3: 1915(b) mandatory managed care waivers

States may request section 1915(b) waiver authority to operate programs that impact the delivery system of some or all of the individuals eligible for Medicaid by mandatorily enrolling beneficiaries into Medicaid managed care programs or creating a separate delivery system for specialty care, such as behavioral health care. Several states operate 1915(b) waivers such as Pennsylvania, New Jersey and Connecticut; this is a common avenue for states to operate large and comprehensive managed care programs.

Section 1915(b) waiver programs do not have to be operated statewide and there is no authority to expand eligibility to cover individuals not otherwise eligible for Medicaid. To implement a 1915(b) waiver program, the federal government may waive certain Medicaid requirements (statewideness, comparability of services and freedom of choice of provider).

In regards to long-term care services, 1915(b) waivers do not provide the special services found in 1915(c) waivers. Typically states use 1915(b) waivers to move large populations into capitated managed care where the managed care plan is financially at-risk for the provision of services. Services usually include most Medicaid state plan acute care (e.g., hospital, physician, drugs and outpatient) and/or behavioral health (e.g., counseling, alcohol/drug abuse services and inpatient mental health) services.

Due to the difference in services and needs of the elderly and disabled, many states completely exclude or severely limit any long-term care populations and services from being included in their 1915(b) waiver programs because the contracted plans can lack experience with serving this unique group. For example, Pennsylvania does not permit adult dual eligibles to enroll in the mandatory Medicaid acute care program and disenrolls any nursing facility resident or aging waiver participant from both the mandatory behavioral health and acute care programs after 30 days. Furthermore, the inability to offer any additional non-state plan community-based services under 1915(b) waivers would limit the capitated entities to being responsible for institutional costs, but not have the tools and alternative services available to care for those at-risk of institutionalization. Accordingly, by itself, a 1915(b) managed care program alone would

do little in terms of increasing the options available for community-based Medicaid long-term services and supports; therefore, we do not comment on the potential impact on spending, quality or practicality of implementing this option in Delaware. Later in this Section we do comment on 1915(b)/(c) combination waivers.

Option B4: Concurrent authorities for managed long-term care programs

As the name suggests, the multiple managed care authorities discussed above may be used in conjunction with home- and community-based authorities, such as the 1915(c) authority or even the 1915(i) state plan option to use a managed care delivery system to provide community-based services. This option most directly equates to DMMA's goals. States may opt to simultaneously utilize managed care authorities along with home- and community-based program authorities to provide a continuum of services to all or specifically-defined elderly and/or individuals with disabilities (DMMA can select what populations to include in the program). In essence, states use the managed care authority to allow for voluntary enrollment or mandatory enrollment into managed care and the home- and community-based authority to target eligibility for the program as well as provide non-state plan community-based services in addition to whatever state-plan services are also included in the program (e.g., acute, behavioral health, home health and institutional care).

Through the combined use of these authorities, states can provide long-term services and supports in a targeted managed care environment as long as all federal requirements applicable to both program elements are met. For example, states must demonstrate cost neutrality in the 1915(c) waiver and cost effectiveness in the 1915(b) waiver. States must also comply with the separate reporting requirements for each waiver which significantly raises the administrative burden associated with combination waiver programs. However, the ability to develop an innovative managed care program that integrates home- and community-based services with traditional state plan services is appealing enough to some states to outweigh the potential barriers. While less of an administrative burden due to the lack of a second waiver, the combination 1915(a)/(c) voluntary managed long-term care program may be less viable in Delaware since the program likely needs to have significant enrollment to attract interest from private-sector managed care plans. Texas has operated a concurrent 1915(b)/(c) waiver program for many years; and Minnesota operates a combined 1915(a)/(c) waiver for its Minnesota Senior Health Options program.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** A combination of Medicaid authorities delivers Medicaid home- and community-based services through capitated managed care. Accordingly, these programs have the potential to align fiscal and operational incentives for the benefit of the consumer as well as the State's budget. Through this option, DMMA would work through and with the contracted managed care plans to develop and increase community-based alternatives. Cost and quality controls are shifted to the managed care plans. Expected savings can be included as part of the capitation rate negotiations, although the additional managed care administrative

costs would partially off-set these expectations. However, this option applies to the Medicaid program only, there is still no integration with Medicare for the dual eligibles.

- **Potential impact on Medicaid quality:** As with all other Medicaid managed care programs, quality and performance monitoring is a required element in all Medicaid managed care and 1915(c) authorities. Consumers sometimes have mixed feelings about managed care, but if the DMMA can effectively monitor plan performance, these combination programs can be very successful in meeting consumer needs and provide more flexibility for the capitated managed care plans to use funds in new and innovative ways.
- **Practicality of implementing in Delaware:** Delaware has already been able to successfully deploy both mandatory managed care and home- and community-based waivers in the State. This option combines those two program/delivery systems so it should be possible for Delaware to implement such a combined program. However, combination programs, especially 1915(b)/(c) programs involve significant staff resources and time to develop and apply for each waiver as well as procure and contract with manage care plans and thus would require additional staff resources to implement. Attracting qualified health plans with experience in effectively managing long-term care services may also be a challenge for DMMA. Although, it is possible that one or both of DMMA's existing Medicaid MCOs would be interested in this new business opportunity. Because of Delaware's small population size, it may not be practical to do a voluntary 1915(a)/(c) program even though the associated administrative burden and oversight is less than a combination 1915(b)/(c) waiver. Additionally, given that Medicaid long-term care is virtually all FFS in Delaware today, a mandatory 1915(b)/(c) initiative may be viewed by providers and some consumers as creating the most disruption and change in a system rooted in its ways. Accordingly, it is reasonable for DMMA to assume a minimum of 18 to 24 months to launch a concurrent Medicaid managed long-term care program under 1915(a)/(c) or 1915(b)/(c) authority.

Option B5: 1115 demonstration waiver

Under the flexibility provided by 1115 Medicaid waivers, DMMA could test new and innovative long-term care solutions. By nature, 1115 waivers permit a range of new ideas, delivery systems and care coordination programs to be tried. For example, Delaware could evaluate the possibility of becoming a capitated entity to be at-risk for both Medicare and Medicaid benefits for dual eligibles. This would enable the State to act as the managed care plan and be responsible for all services provided to dual eligibles. This concept has never been tested before so it is unclear if federal regulations would permit such a plan, but this is an example of the interesting options available under 1115 waiver authority.

Arizona and Vermont are examples of two states that have used 1115 waiver authority for their Medicaid long-term care programs. The Arizona Long Term Care System (ALTCS) is a statewide program implemented in 1988 that combines Medicaid acute, behavioral health and long-term care services through mandatory managed care. ALTCS contractors include managed care plans as well as some counties acting as the

managed care entity. Arizona's Division of Developmental Disabilities contracts with ALTCS as a capitated entity to serve the developmentally disabled. ALTCS uses a blended capitation rate for all enrollees that promotes use of home- and community-based services. Arizona has achieved success with the ALTCS with a majority of Medicaid consumers residing in home or community settings.

In October 2005, Vermont implemented a new 1115 waiver authority to create their Choices for Care program[56]. This program effectively places Vermont at-risk for changes in Medicaid program expenditures (i.e., global cap) in exchange for greater freedom from federal regulatory oversight. If actual costs exceed the agreed to funding level, Vermont is responsible for any additional costs or it will have to limit services provided to stay under the funding cap.

Vermont's waiver was designed to increase access to home- and community-based services while reducing the use of institutional services and controlling overall costs. The demonstration is operating as a managed care program, but Medicaid providers are not capitated and providers are not at-risk financially. The waiver established the following three levels (or groups) of need for long-term care based on an independent living assessment: highest need, high need and moderate need.

- "Highest need" individuals meet specific functional criteria and are entitled to either nursing home or community services.
- "High need" individuals have access to long-term care services within the waiver as funds become available. This group consists of individuals who do not meet the criteria for the highest need group, but have extensive needs for personal care and rehabilitation services.
- The "moderate need" group is an expansion population not previously receiving Medicaid long-term care services. It consists of persons who do not qualify for an institutional level of care. The moderate need program was designed to test the theory that early interventions can be cost-effective by helping to prevent increased disability and maintain people in community settings.

Since implementing Choices for Care, Vermont has significantly expanded the number of people receiving community-based services, while experiencing a modest reduction in people receiving services in nursing facilities. Since October 2005, nursing home enrollment has declined by ten percent from 2,286 to 2,059 adults. During the same period, enrollment in all community-based programs has increased. In the home- and community-based waiver program, enrollment has increased 50 percent, from 998 to 1,494 individuals. Additionally, Vermont now provides a limited package of services to 1,100 "moderate need" individuals who were not receiving Medicaid long-term care services prior. Satisfaction with the program appears high among state officials. Many stakeholders, however, reported tighter financial management and reductions to

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[56] Most of the information provided on Vermont's Choices for Care program was obtained from the Kaiser Commission's report: Vermont's Choices for Care Medicaid Long-Term Services Waiver: Progress and Challenges as the Program Concluded its Third Year, November 2008.

individual plans of care. Waiting lists are also present for "high need" and "moderate need" individuals, and even this program is not immune to budget cuts during difficult economic times.

Due to the vast range of options permissible under 1115 waivers, it is beyond the scope of this paper to assess the practicality or impact on spending associated with unknown program ideas and the timeline for launching an 1115 program is often be measured in years not months. While replicating Vermont's Choices for Care program is theoretically possible in Delaware (there are some similarities between Delaware and Vermont) evaluating the feasibility and impact of a similar program being implemented in Delaware would require a much more intensive and in-depth analysis than what can be covered in this one paper.

Group C options: Integrated Medicare/Medicaid managed long-term care programs for dual eligibles

As discussed in Section 5, dual eligibles are a costly group of low-income elderly and disabled who are entitled to services under both the Medicare and Medicaid programs. Whereas Medicare primarily covers acute and preventative care services, Medicaid is the primary payer for long-term care services. Accordingly, the actions or inactions of Medicare impacts DMMA's spending and failures by Medicare to meet the health care needs of dual eligibles directly leads to significant (albeit potentially preventable) Medicaid long-term care spending.

Unfortunately, because of the regulatory conflicts and complex policy issues (e.g., grievance and appeals), lack of permanent authority for SNPs, and the inability of states to share in any savings that Medicaid interventions might cause to accrue to Medicare, most states have not taken action to effectively integrate Medicare and Medicaid care for dual eligibles through managed care programs. Instead, dual eligibles remain mostly in uncoordinated and unmanaged FFS programs for both Medicaid and Medicare services. Indeed, as noted previously, DMMA spent over $150 million on nursing facility services for dual eligibles, representing nearly half of all dual eligible spending and over 86 percent of total Medicaid nursing facility expenditures.

In the absence of major regulatory changes that would fully transfer all financial and operational responsibility for dual eligibles to either Medicaid or Medicare (not likely to happen in the foreseeable future), DMMA will need to use the program options available today to find innovative solutions for this important segment of the population. There are some good program and demonstration options available to DMMA and the new attitude at CMS to be more supportive and helpful to states in regards to integrating Medicare and Medicaid should be an encouraging sign to DMMA to pursue one or more of these initiatives.

As with the Group B options, the managed care options presented in Group C have the benefits of risk-based managed care along with the cash-flow challenge of transitioning from post pay FFS to prepaid capitation.

PACE is a well-established program throughout the country with standard operational protocols and "checklists" from CMS to assist states through the implementation process. PACE programs are open to both dual and non-dual beneficiaries although experiences in other states indicate that the vast majority of PACE enrollees are dual eligibles. On the other hand, integrating Medicare/Medicaid benefits through Medicare Advantage SNPs is relatively new and very complex with just a few examples from other states to draw upon. Furthermore, since there is no standard design for an integrated Medicare/Medicaid program there is a wealth of opportunities to customize the program to fit Delaware's strategy, but correspondingly a host of policy issues to decide upon. The benefit of integrated Medicare/Medicaid managed care is the ability to extend the program to potentially cover all dual eligibles in the State as compared to the PACE program which has scalability limits. Both options have an extended timeline due to the Medicare application review and approval process that DMMA will not have direct authority over.

Option C1: Program for All-inclusive Care for the Elderly (PACE)

PACE is a permanent, separate Medicare program and a state option under Medicaid organized around a physical site and a team of health care professionals where community interaction and adult day services are provided. Many states offer PACE as one alternative in the spectrum of Medicaid long-term services and supports including California, Massachusetts, New York, Pennsylvania and Virginia. States will typically contract with multiple distinct PACE sites to service different geographic areas.

A unique advantage of the PACE program is that the regulations provide for one set of requirements regarding eligibility, application procedures, administrative requirements, services, payment, participant rights, quality assurance and marketing. These regulations allow an organization to enter into a PACE agreement with both CMS and DMMA for the operation of a PACE program. A PACE organization can be an entity of a city, county, state, tribal government or a private 501(c)(3) not-for-profit entity. Also, because PACE is an integrated Medicare/Medicaid program, state Medicaid programs do have some policy-decision making and oversight responsibilities in addition to being directly responsible for the Medicaid capitation rate development and payment. Federal PACE regulations do not require Medicaid PACE capitation rates to comply with the actuarial-soundness requirements associated with other forms of Medicaid managed care. Instead, the Medicaid PACE rate must be less the FFS equivalent upper payment limit (UPL) for an equivalent population taking into consideration the relative frailty of the PACE population. Some states have their actuary develop PACE UPLs, but it is not required that an actuary develop the PACE UPL.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** Medicaid capitation rates to PACE providers are required by regulation to be less than the amount DMMA would have paid in FFS if the person was not enrolled in PACE (which can be the cost of institutionalization). This results in a FFS-equivalent UPL that must be calculated to assure CMS that the PACE Medicaid rates are compliant with federal rules. Typically, the monthly Medicaid PACE capitation rates are less than the monthly cost of a

nursing facility by 5 to 15 percent depending on the state. This ensures that PACE is cost-effective as compared to institutionalization, but due to the unique delivery model, PACE is typically more expensive than a standard 1915(c) waiver on a per member per month (PMPM) basis. Therefore, from a financial perspective, PACE does not generate much "savings", but does provide a socially-focused alternative to institutionalization.

- **Potential impact on Medicaid quality:** Participants in PACE generally express high levels of satisfaction with the program due to the interdisciplinary team of health care professionals, social activity, personal interaction and communal atmosphere associated with the focus being placed on a physical site where adult day/social activities occur.
- **Practicality of implementing in Delaware:** Given Delaware's small population and geographic size, PACE could be an excellent option for the DMMA to consider. Most PACE sites are small (50 to 100 or more participants) so this would fit well with Delaware's already small population base and the relative proximity of all major urban areas makes this a feasible option to add diversity to DMMA's system of Medicaid long-term services and supports. A potential challenge for DMMA will be identifying a willing provider entity interested and skilled to become a full PACE provider, willing to make the upfront capital outlays and be capitated for the Medicare and Medicaid risk. DMMA will also be required to devote internal staff time to the PACE application and readiness review process required to start a PACE site and the annual contract, payment and monitoring activities will need to be supported for a relatively small program. The timeline for launching a new PACE site will depend on DMMA's actions, the provider's responsiveness and the CMS review and approval process. Accordingly, it is difficult to estimate how quickly a PACE provider will become a viable program option. Mercer suggests that DMMA assume a minimum 24 months to launch a PACE site.

Option C2: Medicare Advantage plans – Special Needs Plan (SNPs)

Medicare Advantage plans include HMOs, PPOs and SNPs. DMMA can develop capitated managed care programs to integrate Medicare and Medicaid services with any of these entities because dual eligibles can enroll in any Medicare Advantage plan. However, for purposes of integration, because federal regulations require Dual SNPs to establish agreements with state Medicaid agencies and hence state Medicaid agencies have some authority over Dual SNPs, it makes the most sense for DMMA to consider an integrated care program with Dual SNPs. Otherwise, DMMA will have very little influence or authority with all other types of Medicare Advantage plans. Other states that have successfully deployed or transitioned programs to integrate care with Dual SNPs include Massachusetts, Minnesota and New York.

While other states have had the benefit of relatively large existing Dual SNP enrollment, a challenge for DMMA will be determining the potential for a Dual SNP partner in Delaware. It is quite possible that if DMMA surveyed the marketplace and made some inquiries there could be entities who would express interest in becoming Dual SNPs and equally important, interested in contracting with DMMA for the additional Medicaid risk.

Because the PPACA requires that Dual SNPs have capitated contract agreements with states for Medicaid benefits including long-term care as a condition of receiving higher frailty-adjusted Medicare capitation rates, DMMA may find more interest from the marketplace now than prior to the PPACA.

Implementing an integrated Medicare/Medicaid managed care program with Duals SNPs requires much of the same steps and approvals as it would to implement a Medicaid-only managed care program (as discussed in Group B), but has more complex issues to address because of the intention to integrate with Medicare as much as practical (e.g., enrollment/disenrollment policies, grievance/appeals, consumer information/marketing). DMMA would need to decide whether to seek mandatory 1915(b) or voluntary 1915(a) enrollment for the Medicaid side and decide whether to use 1915(c) waiver authority or possibly state plan option under 1915(i) or 1915(k) to provide Medicaid home- and community-based services based on the desired target population. For purposes of achieving DMMA's goal, the State would definitely want to include Medicaid institutional and home- and community-based services.

Much of this decision-making will be based on DMMA's goals and objectives. Given Delaware's small size and relatively small number of dual eligibles, Mercer recommends that DMMA opt for mandatory enrollment to increase the level of attraction in the marketplace (although this requirement would not extend to the Medicare side of the program). Mandatory enrollment mitigates some concern about selection issues, but the only-voluntary enrollment rule in Medicare Advantage still poses a challenge to ensure that Dual SNPs are not "cherry picking" members.

Additionally, DMMA must decide whether to capitate the Dual SNPs for the risk and provision of Medicaid acute, behavioral health and/or long-term care services. If the goal is to integrate care as much as possible, consideration should be given to including all services; however, some states have expressed concern about the experience and sophistication of Dual SNPs to appropriately manage Medicaid's behavioral and/or long-term care benefits. Another issue is whether Dual SNPs will be willing to accept financial risk and responsibility for the full gamut of Medicaid services. To the extent that Medicaid services are partially capitated and partially paid for by FFS will impact the information technology requirements needed to support this type of program. If not fully integrated, dual eligibles would still have to navigate both the Medicare/Medicaid managed care program and the traditional Medicaid FFS program to obtain all services.

Although Dual SNPs provide a viable platform to integrate Medicare and Medicaid, the two programs still operate under distinct rules and hence are not truly integrated in terms of regulatory requirements (although as noted in Section 5, the new CHCO office is specifically intended to help integrate the two programs better). One notable challenge is that while DMMA can mandate dual eligibles to enroll from the Medicaid side, present law precludes dual eligibles from mandatory Medicare enrollment into Dual SNPs. Furthermore, Medicare allows dual eligibles to enroll/disenroll in any given month. This presents a logistical challenge to coordinating this type of program. So while this option better integrates and aligns incentives, quality and funding for dual eligibles, it still presents some obstacles that would need to be overcome.

Our initial comments on this option in regards to:

- **Potential impact on Medicaid spending:** Depending on what Medicaid services DMMA included in the Medicaid capitation rates will directly impact the potential for positive impact on Delaware's cost over the long-term. The more integrated the care is, the more the Dual SNPs will be incentivized to maintain the health and functional status of enrolled members because Medicaid capitation rates can be designed to promote home- and community-based services over institutionalization. DMMA also needs to realize that integrating care may have more immediate impact on Medicare's costs than Medicaid's cost. For example, use of the emergency room or hospital inpatient may decline which will save Medicare money, but savings in Medicaid long-term care will take much longer to realize.
- **Potential impact on Medicaid quality:** As with most managed care programs, federal regulations require robust quality reporting and monitoring. CMS requires quality metrics and now NCQA approval (effective in 2012 per PPACA) for SNPs and existing Medicaid managed care regulations require quality assurances and external quality reviews as Delaware has experienced under the State's current Medicaid managed care program. Dual eligible consumers value the "one stop shopping" approach that comes with integration because navigating the complex world of both Medicare and Medicaid can be extremely daunting. Successful integrated care programs in other states focus attention on the individual through consumer feedback sessions, personal connection with case managers and continuity in care managers creating relationships between the consumer and the Dual SNP.
- **Practicality of implementing in Delaware:** Since Delaware's Medicare Advantage enrollment is quite low (less than four percent in 2009) and it is unclear whether there are any Dual SNPs currently operating in the State, it is difficult to assess whether this option is viable for DMMA. The national attention being placed on integrating care for dual eligibles suggests that there may be some momentum that DMMA can take advantage of. The low number of dual eligibles in Delaware, relative to other states, implies that any integrated managed care program would likely need to have mandatory Medicaid enrollment and hence a 1915(b)/(c) combination waiver authority which will increase the burden on DMMA staff to develop and implement. The large Medicaid spending on dual eligibles and significant amount of nursing facility use makes this option attractive as a way to reduce Medicaid program expenditures by improving the health and functional status of dual eligibles in their homes and communities. Due to the complex issues involving both Medicaid and Medicare, DMMA should assume a minimum of 24 months to launch this type of integrated program. This timeline can be impacted by the Medicare Advantage contracting and bid process which begins early in the calendar year for the contract period beginning the following January 1. Interested Medicare Advantage plans will likely want to know details of the State's integrated Medicare/Medicaid program design to formulate their Medicare bids, so if the State is "out of sync" with the Medicare Advantage process, there could be a longer timeline for implementation. DMMA should also closely monitor the status of the statutory expiration of the SNP authority.

Summary table of options with pros and cons

The following table summarizes the options presented in this Section along with selected pros and cons. Due to similarity in some options, not all pros or cons are repeated for each option.

Table 6 – Summary of options with pros and cons

Option	Pros	Cons
Option A1: Cover personal care services under the Medicaid state plan – estimate 6 to 12 months to implement	▪ Easy to implement. ▪ Expands community-based service offerings under the Medicaid state plan. ▪ Possibly get federal match for currently state-funded services. ▪ Cost and utilization data captured through the FFS MMIS system.	▪ Creates new entitlement service. ▪ Difficult to control/target spending and may result in higher aggregate spending without diverting/delaying institutionalizations. ▪ Difficult to manage/monitor quality of care provided. ▪ Delivery system is still unmanaged.
Option A2: 1915(i) state plan option for home- and community-based services – estimate minimum of 6 to 9 months to implement	▪ Relatively easy to implement. ▪ Eligibility based on a state-defined "needs basis" that is less restrictive than nursing facility requirements. ▪ Offer full range of home- and community-based services like 1915(c) waivers. ▪ Cost and utilization data captured through the FFS MMIS system. ▪ Allows for a phase-in of services and eligibility over five years.	▪ No detailed guidance from CMS yet available. ▪ Creates new entitlement service. ▪ Difficult to control/target spending due to statewide requirements and no limits on number of participants.

Option	Pros	Cons
Option A3: 1915(j) state plan option for consumer-direction of personal care services – estimate minimum of 12 to 16 months to implement	▪ Relatively easy to implement. ▪ Empowers consumers to be more active in their own care. ▪ Consumers may use funds more efficiently and effectively. ▪ Can limit consumer-direction to certain geographic areas as well as targeted populations. ▪ DMMA may have some infrastructure to leverage from the existing state-funded personal attendant services program. ▪ Cost and utilization data captured through the FFS MMIS system.	▪ Does not create any new community-based service, just a different delivery system for existing service. ▪ Personal care services are not covered in Delaware's state plan, so only available under applicable 1915(c) waiver unless state plan is changed or if 1915(i) option selected. ▪ Requires DMMA to provide safeguards and financial accountability. ▪ Cost of a third-party entity to provide fiscal intermediary services. ▪ More administrative oversight responsibilities on DMMA staff.
Option A4: 1915(k) state plan option for attendant care services – estimate minimum of 18 months to implement	▪ Easier to implement than a waiver, but would likely have the longest lead time of the non-managed care program options. ▪ Expands community-based service offering. ▪ Range of attendant care service offerings available. ▪ Focus on consumer involvement. ▪ Enhanced FMAP on related expenditures. ▪ Cost and utilization data captured through the FFS MMIS system.	▪ No detailed guidance from CMS yet available. ▪ Administrative burden to work collaboratively with Development and Implementation Council. ▪ Administrative burden of collecting and reporting data. ▪ Need for sufficient workforce numbers to meet demand/provide services. ▪ Enhanced FMAP benefit could be off-set by increased users and/or unit cost of services.

Option	Pros	Cons
Option A5: 1915(c) waiver for home- and community-based services – estimate minimum of 9 to 12 months to implement	▪ Expands home- and community-based services offerings. ▪ Can target eligibility and service offerings. ▪ Can include consumer-direction option to empower consumers. ▪ Wide range of special waiver services to select from. ▪ Strong quality monitoring requirements of waiver. ▪ Cost and utilization data captured through the FFS MMIS system. ▪ Familiarity to DMMA.	▪ Administrative effort to develop and support more waivers. ▪ Delivery system is still unmanaged. ▪ Contrary to a goal of consolidating waivers to streamline program management. ▪ Concern over sufficient workforce numbers to meet demand/provide services. ▪ Demand for services can lead to higher provider fees. ▪ Can initially increase aggregate spending.

Option	Pros	Cons
Option B1: 1932(a) state plan option for managed care – not recommended as a stand alone authority	▪ Administratively easier to implement and maintain as compared to waivers. ▪ Mandatory enrollment allowed (limited). ▪ No cost-effectiveness or other administrative burden of a waiver. ▪ Benefits of more coordinated system of managed care. ▪ Strong quality and performance monitoring requirements. ▪ Prepaid capitation can provide more budget stability than FFS. ▪ Flexibility in capitation rate development for community-based services. ▪ DMMA can partner with entities experienced in service delivery and care management. ▪ Leverage applicable contract language from existing Medicaid managed care program. ▪ Allows for selective contracting with fewer than all qualified providers.	▪ Cannot mandatorily enroll dual eligibles or special needs children. ▪ Does not authorize non-state plan home- or community-based services. ▪ Does not directly create new community-based service offerings. ▪ Limited impact on achieving end goal. ▪ Prepaid capitation with FFS lag may put cash-flow strain on Delaware. ▪ Administrative resources and lead time to procure and contract with managed care plans and do managed care systems updates. ▪ Cost and utilization data must be reported by the managed care plans via encounter data submittals. ▪ Additional administrative efforts/costs related to external quality reviews, actuarial rate development and other managed care regulations. ▪ DMMA not directly responsible for care delivery, but must oversee health plan performance.

Option	Pros	Cons
Option B2: 1915(a) operating authority for voluntary managed care – not recommended as a stand alone authority	▪ Administratively easier to implement and maintain as compared to waivers. ▪ No cost-effectiveness or other administrative burden of a waiver. ▪ Can apply to all populations. ▪ Benefits of more coordinated system of managed care. ▪ Strong quality and performance monitoring requirements. ▪ Prepaid capitation can provide more budget stability than FFS. ▪ DMMA can partner with entities experienced in service delivery and care management. ▪ Flexibility in capitation rate development for community-based services. ▪ Leverage applicable contract language from existing Medicaid managed care program.	▪ Voluntary enrollment only (may not be sufficient to induce plans to participate). ▪ Does not directly create new community-based service offerings. ▪ Prepaid capitation with FFS lag may put cash-flow strain on Delaware. ▪ Small State population coupled with voluntary managed care may not induce plans to participate. ▪ Limited impact on achieving end goal. ▪ Administrative resources and lead time to procure and contract with managed care plans and do managed care systems updates. ▪ Cost and utilization data must be reported by the managed care plans via encounter data submittals. ▪ Additional administrative efforts/costs related to external quality reviews, actuarial rate development and other managed care regulations. ▪ Does not allow for selective contracting with providers. ▪ DMMA not directly responsible for care delivery, but must oversee health plan performance.

Option	Pros	Cons
Option B3: 1915(b) waiver for mandatory managed care – not recommended as a stand alone authority	▪ Mandatory enrollment allowed (all populations). ▪ Prepaid capitation can provide more budget stability than FFS. ▪ Benefits of more coordinated system of managed care. ▪ Strong quality and performance monitoring requirements. ▪ Flexibility in capitation rate development for community-based services. ▪ 1915(b)(3) authority permits savings from managed care to fund additional non-state plan community-based services. ▪ Leverage applicable contract language from existing Medicaid managed care program.	▪ Does not directly create new community-based service offerings. ▪ DMMA not directly responsible for care delivery, but must oversee health plan performance. ▪ Administrative burden to develop waiver, program policies, procure and contract with managed care plans, and system edits/updates to support managed care enrollment/payment processes. ▪ Prepaid capitation with FFS lag may put cash-flow strain on Delaware. ▪ Cost and utilization data must be reported by the managed care plans via encounter data submittals. ▪ Additional administrative efforts/costs related to external quality reviews, actuarial rate development and other managed care regulations.

Option	Pros	Cons
Option B4: Concurrent 1915(a)/(c) or (i), or 1915(b)/(c) or (i) program – estimate minimum of 18 to 24 months to implement	▪ Expands home- and community-based services offerings. ▪ Delivers all capitated services including community-based services through more coordinated system of managed care. ▪ Can target eligibility and service offerings under the waiver. ▪ Better aligns fiscal and operational incentives via capitated managed care. ▪ Voluntary or mandatory managed care enrollment. ▪ Leverage applicable contract language from existing Medicaid managed care program.	▪ Longer lead time due to multiple operating authorities/program design issues. ▪ Administrative effort associated with potentially two waivers. ▪ Administrative effort of managed care policies and more extensive system edits to combine acute and long-term care data inputs. ▪ Prepaid capitation with FFS lag may put cash-flow strain on Delaware. ▪ May be viewed as most significant change to existing FFS system (concerns to consumers or providers). ▪ Cost and utilization data must be reported by the managed care plans via encounter data submittals. ▪ Procuring qualified health plans to efficiently and effectively manage the spectrum of acute, behavioral health and long-term care services. ▪ Does not explicitly integrate with Medicare for dual eligibles. ▪ Mandatory enrollment needed to attract plans.
Option B5: 1115 waiver for new and innovative ideas – time to implement is difficult to estimate; assume minimum of 24 to 36 months	▪ Can test and deploy new and innovative solutions. ▪ Familiarity to DMMA.	▪ Lengthy process of working with CMS. ▪ Administrative effort to support and monitor waiver. ▪ Some ideas may be unproven and could be risky for DMMA.

Option	Pros	Cons
Option C1: Program of All-inclusive Care for the Elderly (PACE) – estimate minimum of 24 months to implement	▪ Proven delivery model. ▪ Relatively standardized process for launching new site. ▪ Focus on community-based services and social interaction. ▪ Multi-disciplinary team of health care professionals. ▪ Well-received by consumers. ▪ Integrates Medicare and Medicaid funding and all services. ▪ Standardized regulations. ▪ Most PACE sites are small which is suitable to Delaware's population.	▪ Administrative effort to develop new PACE site(s) due to 3-way agreement between DMMA, the provider and CMS. ▪ CMS approval process for the Medicare application will impact timeline. ▪ Voluntary enrollment only. ▪ Small participating numbers limits overall impact. ▪ Monitoring and Medicaid capitation rate development requirements. ▪ Procuring qualified entities to be a PACE site in Delaware who are willing to invest the upfront capital to develop a site. ▪ Prepaid capitation and FFS lag may put cash-flow strain on Delaware. ▪ Cost and utilization data must be reported by the PACE sites via encounter data submittals. ▪ PACE Medicaid capitation rates are typically near the cost of a nursing facility.

Option	Pros	Cons
Option C2: Medicare Special Needs Plans (SNPs) for dual eligibles – estimate minimum of 24 months to implement	▪ Ability to integrate Medicare and Medicaid funding for a costly and vulnerable population group. ▪ Potential for ease of one-stop shopping for consumers and focus on personal connection between SNP and member. ▪ Dual SNPs specialize in caring for the needs of dual eligibles. ▪ Opportunity for Medicaid to benefit from Medicare savings. ▪ Stronger federal regulations on connection of Dual SNPs and state Medicaid agencies. ▪ CMS recognizing the importance of caring for the dual eligibles and more willing to provide assistance to DMMA. ▪ Can use 1915(a)/(c) or 1915(b)/(c) for Medicaid enrollment and expanded community-based long-term care services.	▪ Medicare and Medicaid still operate as separate programs subject to their respective regulations. ▪ Potentially even longer lead time to implement due to Medicare Advantage contracting/bid process. ▪ Complex set of policies and operational protocols to develop and communicate including Medicaid capitation rate setting. ▪ Prepaid capitation and FFS lag may put cash-flow strain on Delaware. ▪ Medicare Dual SNP enrollment is voluntary, regardless of what Medicaid requires leading to concerns over selection and inconsistent enrollment. ▪ May reduce Medicare service expenditures more quickly than Medicaid long-term care services, especially in the early years. ▪ If all Medicaid services not fully integrated, dual eligibles still need to navigate Medicaid FFS system. ▪ Cost and utilization data must be reported by the managed care plans via encounter data submittals. ▪ Dual SNPs are not a permanent part of the Medicare program. ▪ May be difficult for Delaware to attract/retain SNPs.

7

Major policy and operational subject matter

Based on Mercer's experience with other Medicaid programs, depending on what program initiatives are pursued, a myriad of policy and design issues will occur as DMMA progresses through the planning, designing, implementing, monitoring and measuring stages of each respective endeavor. This report addressed the initial phases of this process and accordingly DMMA will need to engage a variety of stakeholders (e.g., consumers, advocates, providers, legislators, managed care entities) to make informed decisions. While the following is not meant to be an exhaustive discussion of all possible issues DMMA will face or concerns stakeholders will raise, these are the types of policy and operational issues likely to require DMMA's attention in the coming months.

Establishing realistic expectations

DMMA will need to establish and then manage realistic expectations on issues involving financial costs/savings, timeline for implementation and staffing resources needed to support any new initiative. Mercer recommends, from first-hand experience with other states such as Massachusetts, Minnesota and New Mexico, that Delaware should not go into this endeavor with the sole objective to save money. Increasing community-based alternatives for long-term services and supports requires several years to show meaningful results and involves financial matters as well as quality of life issues. While some initiatives like amendments to the state plan can be accomplished relatively quickly over a few months, other more complex programs like capitated managed long-term care can take a minimum of 18 to 24 months or even longer to fully implement. As noted previously, Delaware should take a long-term view on the Medicaid long-term care system and devote the necessary, skilled staff resources to make any new initiative successful in a systematic, but not rushed manner.

Results may also be difficult to document conclusively because it often involves assuming what would have happened in absence of actions having been taken by DMMA. For example, community-based alternatives should enable more institutional

diversions or delays in the need for institutional care. Nursing home diversions are akin to compound interest on money, it is an easy concept to grasp, yet it takes years for the effects to pay off. And as presented in Section 3, actually achieving nursing home diversions or delays is essential to achieve any form of reduction in total Medicaid spending, but can prove elusive if the program is not managed/operated properly.

Potential for woodworking and snowball effect

On a purely financial basis, if home- and community-based services are provided to people who would not otherwise require institutional care or even seek services, there are no aggregate spending reductions and spending may actually increase. This is commonly referred to as the "woodworking effect." Some states have struggled to operate programs that benefit those who are most at-risk for institutionalization as often the enrollment and eligibility criteria are broad enough to encompass a larger portion of the population who do benefit from the additional programs, but essentially produce no cost savings to fund the program's existence[57]. However, on a moral and social basis, this may be acceptable to DMMA, but the State should be aware of this dichotomy before proceeding with program development.

A related issue involves the potential for internal and/or external sources to push DMMA to adopt less restrictive level-of-care and/or medical necessity policies and requirements pertaining to home- and community-based long-term services and supports. While the intentions are good, adopting this strategy can lead to a "snowball effect" where it becomes increasingly easier for more and more individuals to qualify for services. The ramifications on administrative oversight, fiscal sustainability, workforce sufficiency, quality of care and regulatory oversight should be weighed in the policy decision-making process.

Other states have used tools such as stricter level-of-care/eligibility policies, geographic coverage limits, spending caps (individual or aggregate), medical necessity criteria, waiver "slots", waiting lists for waiver services, aggressive look-back/estate recovery activities, moratoriums on new nursing home beds, and certificate of need to manage the supply and demand for Medicaid long-term care services. While some of these tools help to curtail unnecessary supply of specific services (e.g., nursing home beds); waiting lists for community-based waiver services can be an indicator of unmet need. DMMA should also consider the political and public reaction to policies that might be viewed as restricting access to desired services. Moreover these tools and related policies add to the administrative burden of supporting a new program initiative.

Some may contend that given Delaware's relatively high incomes, homeownership rates and educational levels that more emphasis should be placed on long-term care insurance partnerships, but these avenues can be difficult to gain mass appeal

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[57] See footnote #22.

especially given the specific socioeconomic factors attributed to the Medicaid population. A challenge for DMMA will be in designing new programs that can effectively meet the needs of the elderly and individuals with disabilities without creating an equally unsustainable new increase in Medicaid expenditures.

Role of external stakeholders

As DMMA pursues ways to improve the Medicaid long-term care system, proactively seeking input and collaboration from stakeholders is essential for effective planning and program development. The more innovative and far-reaching the program enhancements are, the more stakeholders, especially consumers and their advocates, will seek to have their voices heard and considered. DMMA should be open to this input because consumers and advocates have first-hand experience with the present system – its good points and its shortcomings. Some stakeholders may also have experience from other markets that could be of value to DMMA.

DMMA will need to determine, upfront, the role non-governmental stakeholders have in the process: decision-making or advisory. Given Delaware's small size and communal atmosphere, DMMA likely already knows who the advocates and consumers will be in pursuing any new program initiative. Opting to give these players decision-making authority can have advantages and disadvantages. The biggest advantage is that these parties will be responsible for developing and implementing any new initiative and hence will have a strong sense of ownership in the process. A challenge for DMMA in ceding decision-making to external consumers/stakeholders is to make timely progress knowing that it may be difficult to get consensus on what to do, how to do it, why to do it or when to do it.

On the other hand, collaborating with these external parties in an advisory role enables DMMA to retain primary responsibility for program design and operational decisions. An advantage to this approach for DMMA is the ability to leverage input from the key players within the overall framework for implementation, utilizing their knowledge and experience to make final decisions in an objective manner. A downside to this approach is that some players may feel that their input is being trumped by State objectives resulting in more resistance than support for the new initiatives.

Based on Mercer's experience, we recommend that DMMA engage consumers and their advocates in an advisory manner. For this to be successful, DMMA will need to work collaboratively with these external groups, keeping the lines of communication open and realize that on some issues compromise will be required from all involved.

Communication strategy

Stakeholders, whether internal or external, will want to be informed in a timely manner on the progress DMMA is making towards the goal of increasing community-based alternatives for long-term services and supports. DMMA will need to have a

communication strategy to not only provide this information to stakeholders in practical and appropriate forums, but also a process to manage and coordinate the input and questions from stakeholders. To that end, Mercer recommends that DMMA empower a "Champion" with sufficient DMMA seniority to actively oversee the initiative, serve as a change-manager and move those involved in a coordinated action. If multiple initiatives are pursued that are sufficiently complex and resource consuming, multiple Champions could be assigned to ensure accountability and coordination.

Although sometimes difficult to arrange and time-consuming to conduct, face-to-face meetings with key stakeholders are often very helpful, especially in the early stages of program development when it is vital to achieve buy-in and personal connection with key stakeholders and other interested parties. Once momentum is obtained, more interaction could be held via teleconference and even written correspondence to streamline the process and add flexibility for participation (conference calls are easier to attend than in-person meetings). Mercer also recommends that DMMA document meetings and calls and make appropriate information available publicly such as through a web location on the DHSS internet site.

DMMA should also recognize that different stakeholders and constituencies will likely have different concerns and priorities as well as a need for different levels and amount of information. For example:

- **Consumers/Advocates:** In addition to generally being more sensitive to government actions related to health care, these groups will be less concerned with the intricacies of Delaware's budget cycle as compared to what these new programs will do for them or their families including any applicable caregiver support programs. Therefore, Mercer recommends that DMMA simplify the message as practical, laying out clear and easily understandable objectives and desired outcomes.
- **Providers:** Providers will be keenly interested in what role they will have under any new initiative and whether their responsibilities will be increasing or decreasing and in what ways. Since DMMA's long-term care system is currently all FFS, providers will wonder whether any new initiative will require them to do business with entities other than DMMA and how those new arrangements will impact their bottom line, administrative duties and level of autonomy. Traditional facility-based providers (e.g., nursing facilities) may see their role diminishing as other providers such as home health care agencies and personal care aides gain more attention. This can raise concerns and resistance to change among these traditional facility-based providers.
- **Managed care entities:** As potential new contractors with DMMA, managed care entities will want to know specifically; what their contractual responsibilities will be, how they will be judged on performance, what will be the basis for and the amount of financial compensation, and how DMMA will operationalize any new program initiative? DMMA should expect detailed and technical questions from this group. If an initiative is pursued that involves managed care contracting, DMMA must realize that it is effectively becoming business partners with these entities and the managed care plans, not DMMA, will be responsible for care delivery.

- **Elected/Appointed officials:** This group will need to be effectively managed and informed as they will either support or suspend any potential initiative through funding allocations, political will and program prioritization. Due to their elected or appointed status, these individuals are accountable to their voting constituencies or senior leaders and hence will want details and perspectives on the impact of any new initiative on consumers, providers and the State's budget both short- and long-term. Delaware, like most states, is still reeling from the effects of the great recession, so legislators will be more attuned to the State's cash-flow position. DMMA should establish and then actively manage realistic expectations with this group and discuss options that might mitigate cash-flow concerns (e.g., capitation payment delay).
- **CMS:** Depending on what initiative DMMA pursues, involving CMS in the process may be limited or quite extensive. Simple state plan amendments require little interaction with CMS whereas as more complex initiatives involving waivers or coordination with Medicare will require DMMA to make more visits to Baltimore. The important thing for DMMA to remember is that CMS typically does not like surprises and appreciates being kept in the loop. Indeed, CMS may be a valued partner in evaluating specific policy and regulatory decisions, especially when it involves provisions stemming from the PPACA.

Workforce and affordable housing supply issues

Increasing community-based alternatives for long-term services and supports is not practical unless there is a supply of caregivers to render services and affordable housing options in which beneficiaries can receive services. The interdependency of these two issues will impact the feasibility and level of success of some of the options DMMA will be evaluating.

As described in Section 3, the aging population will contribute to a greater demand for services as well as shift the composition of the workforce from younger to older workers. Demand for services typically leads to competition for resources and DMMA could find itself competing with Medicare, the private sector, managed care plans and other entities for the supply of workers. Indeed, the U.S. Bureau of Labor and Statistics (BLS) expects that health care and social assistance will be the largest contributor to job creation over the next 10 years growing by 24 percent and adding 4 million new jobs; ranking home health aides and personal/home care aides as the third and fourth fastest growing occupations behind only biomedical engineers and network/data systems analysts[58].

While the demand is expected to be great, the standard wage and work environments for these occupations present challenges to attract and retain qualified workers who can excel in the one-on-one caregiver role, meet the frequent travel requirements and handle the emotional and physical job requirements. According to the AARP, Delaware's 2007 median hourly wage for home health aides and personal/home care aides was $11.50

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[58] U.S. Bureau of Labor Statistics, Occupational Handbook, 2010-11 Edition; Overview of the 2008-18 projections.

and $10.83[59], respectively, which pales in comparison to Delaware's $54,610 median income. Accordingly, there may be more pressure to increase provider payment rates for home- and community-based services which can further increase Delaware's community-based long-term care spending.

Section 3 also noted that Delaware has the 2nd highest home ownership rate in the nation. This is a good indicator that personal residential settings are prevalent within the State. However, an underlying issue is whether existing residential units are appropriately equipped and constructed (e.g., stairs versus wheelchair accessibility) to facilitate home-based care delivery and whether DMMA will need to allocate funds to invest in enabling home modifications.

Assisted living

Assisted living helps fill the gap between facility-based institutionalization and unsupervised home-based residence and provides another option in the continuum of care for Delaware's elderly and individuals with certain disabilities. Assisted living allows a resident more independence than a nursing home and provides care in a more homelike setting. While community-based assisted living can be less expensive and more consumer-friendly than institutionalization, Medicaid rules allow for payment of only certain services provided to residents; typically Medicaid is precluded from paying the room and board. Therefore, even though assisted living may be an appropriate care setting for certain individuals who can safely reside in this type of living arrangement, the room and board cost can make it a difficult financial choice for the low-income elderly and individuals with disabilities. According to a report from the National Center for Assisted Living, Delaware had 12 assisted living facilities serving 179 participants through 1915(c) Medicaid waivers[60] in 2009.

Of the total $814 a month in combined federal SSI and State-supplemental payment, DMMA's policies cap assisted living charges to $692 a month with a $122 personal needs allowance according to 2009 data. Not all states cap the amount assisted living facilities can charge Medicaid recipients which makes Delaware more attractive from the recipient's perspective, but it is unclear from available literature as to effect this has on provider willingness to accept a Medicaid recipient. Additionally, some advocates cite concerns that they want addressed regarding the absence of substantive federal Medicaid requirements placed on assisted living facilities in comparison to nursing homes such as: accepting Medicaid-specified payment as payment in full from the resident, medically-needy eligibility, requirement to accept Medicaid payment from

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[59] AARP, Across the States Profiles of Long-Term And Independent Living; State of Delaware; 8th Edition, 2009.

[60] Mollica, Robert L.; State Medicaid Reimbursement Policies and Practices in Assisted Living, National Center for Assisted Living, September 2009.

Medicaid-eligible residents, quality of care standards, equivalent "bed hold" policies and private occupancy[61].

An advanced notice of proposed rule making released by CMS in the June 22, 2009 edition of the federal register was a good indication that CMS is interested in providing clearer guidance and policy standards around "identifying the home and community character" of settings of care. Taken together with the new focus on home- and community-based care at the federal level suggests that this might be a good opportunity for DMMA to explore discussions with CMS about maximizing community-based care alternatives involving assisted living. Ideally, if DMMA could effectively obtain CMS approval to apply the Medicaid institutional payment policies related to such things as room and board for assisted living services, there could be a wider range of non-institutional service offerings available to Delaware's elderly and individuals with disabilities. The supply, licensing and quality monitoring of assisted living arrangements would concurrently become a larger issue for DMMA's staff to address.

Delivery system design choices

Section 6 described the various options for achieving DMMA's goal of a more robust system of Medicaid long-term services and supports. To that end, DMMA will need to decide whether the State should take direct actions to improve options and alternatives that are delivered through the traditional Medicaid FFS channel or contract with separate managed care plans to carry-out DMMA's goals or some sort of hybrid such as accountable care collaborations where providers are collectively held responsible for health outcomes and spending.

Pursuing refinements to the FFS system continues to put DMMA in the forefront of any endeavor and directly engaged with both the providers and consumers which will require staff time and devotion. However, the system will still be rooted in FFS which has inherent challenges with fragmentation and misaligned financial incentives for the provision of more care, not necessarily the right care.

Conversely, the various forms of managed care available can allow DMMA to contract with external qualified entities that will operate on behalf of DMMA. This takes DMMA off of the "front lines" of consumer and provider interaction and thus will require DMMA staff to change focus to enforcing contract requirements and contractor management in the realm of long-term care. Providers and consumers will also view managed care as a significant change from the present status quo, for better or for worse.

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[61] Medicaid Payment for Assisted Living: Current State Practices, And Recommendations For Improvement, National Senior Citizens Law Center, January 2010.

Decisions on program design should be geared towards aligning financial, clinical and operational incentives to promote improved health outcomes, fiscal accountability and informed evaluation among providers, consumers and program managers.

Mandatory or voluntary – operating authority

DMMA will need to decide if any new initiative will require mandatory enrollment or if beneficiaries will be given the choice to participate or even opt-out if the default is set at enrollment. While some programs like PACE are small and voluntary by design, other programs can be set up as mandatory. If DMMA elects to engage Medicaid managed care entities, most likely the program will need to be mandatory due to Delaware's small population size. A typical private sector managed care plan will be less likely to invest resources in the systems and operational overhead necessary to comply with state/federal regulations if the potential enrollment numbers are small. Furthermore, risk-based capitation has more appeal when large numbers of people are involved so as to mitigate the potential for large swings in financial gains or losses that create program instability. Indeed, Delaware's small size may even make it a challenge to find willing partners even if the program is mandatory.

If an initiative is pursued that involves integrating Medicare and Medicaid for dual eligibles through some form of capitated managed care (e.g., SNPs), DMMA will need to be cognizant of the fact that Medicare Advantage is voluntary and dual eligibles can disenroll from their Medicare Advantage plan at any time. Obtaining a Medicare waiver to require mandatory Medicare Advantage is technically possible, but not practical. Accordingly, there may be limits to the extent of DMMA's options in integrating Medicaid with Medicare.

Medicaid managed care programs that involve the elderly and individuals with disabilities typically require federal waiver authority (e.g., 1915(b) or possibly an 1115) to require mandatory enrollment. This adds an additional level of administrative effort by DMMA to implement and operate a new program. Although the recent PPACA provided Delaware more flexibility to offer home- and community-based services through state plan amendments, DMMA may elect an initiative that still requires a formal 1915(c) waiver which again will add administrative burden to implement and renew.

Covered populations and services

Existing Medicaid regulations coupled with the new provisions in the PPACA offers DMMA many choices on what populations and services will be included in any new initiative. Some program options, like PACE or Medicare SNPs, have firm rules governing eligibility requirements and benefits provided. However, there will still be many design decisions to make. For example:

- Electing a state plan option is simpler than a waiver, but may result in a much broader impact than a more targeted solution. Which is a better solution for DMMA?
- Should a managed care initiative be limited to just the elderly and not open to individuals with disabilities?

- How is disability defined in terms of program exclusion: physically, mentally or developmentally, and what entity will be responsible for making this determination?
- Can additional populations be phased-in over time?
- Of Medicaid's acute, behavioral and long-term care services, what services will be capitated and what services will still pass through to FFS?
- If DMMA partners with managed care plans, what level of due diligence will be required to ensure the plans are capable of providing such a diverse array of services and how much financial risk is DMMA able to transfer to these plans?
- To what extent will DMMA's information technology systems need to be modified and coordinated to support changes to the existing FFS long-term care system?
- How will any new home- and community-based services be defined and paid for to ensure CMS compliance and federal funding?
- Are there existing state-funded services that can be "federalized" thus allowing DMMA to do more with the same amount of state dollars?

Information technology requirements

Since DMMA's current long-term care system is FFS-based, the systems requirements are focused on adjudicating claims, confirming eligibility and making level-of-care determinations. If new initiatives are implemented that remain rooted in FFS, there could be less information technology changes forthcoming and hence a smoother implementation horizon. However, as DMMA knows from its experience with the Diamond State Health Plan (DSHP), implementing managed care programs involves more extensive system logic, edits and information exchanges. For example:

- Provider claims for long-term care services that are the responsibility of the managed care plans should be rejected by the State, so new programming edits will be required.
- Level-of-care determinations are a central aspect of long-term care programs and can be used to adjust capitation rates: who completes these determinations, how timely is the information uploaded, where is the data stored for reference and how will requests for new determinations be processed?
- Personal plans-of-care outline the service needs of individuals and are used to approve specific services. Will these plans-of-care be accessible on-line to DMMA's managed care partners through secure interfaces?
- Similar to DSHP, edits and logic will be required to only permit those eligible for the respective program to enroll and/or receive appropriate services and if disability status is a condition for eligibility systems will need to be designed to collect and determine disability status.
- Integrated Medicare/Medicaid programs involve additional complex policies and procedures on coordinated enrollment and outreach within the framework of the Medicare Advantage program.

Return on investment – quality and health outcomes

Achieving DMMA's stated goals will require investments of time, staff and fiscal resources – significantly more if the initiative is complex and multi-faceted like mandatory managed long-term care. Improving the lives and functional health status of the elderly and individuals with disabilities is not something that can be changed within one budget cycle. Instead, DMMA will need to take a long-term view on long-term care. These are investments that must be considered within the context of what is important to the consumer as well as what will result in a positive long-term investment. Changes in quality of life measures, distribution and patterns of spending and consumer and advocate feedback are just a sampling of the types of qualitative and quantitative metrics DMMA will need to develop to monitor progress, make adjustments along the way and report successes to external stakeholders.

Timeline for implementation

To reiterate, the purpose of this report is to stimulate and facilitate further discussion and most importantly decision-making on initiatives that DMMA will pursue to better balance the State's system of long-term services and supports. DMMA should devote appropriate time and resources in discussion and consensus building with key constituents, but discussion without measurable progress and action can be ultimately self-defeating as momentum succumbs to stagnation and collaboration to dissent. Accordingly, DMMA should establish a reasonable timeline for implementation that is not overly aggressive and a cause for concern (e.g., moving too fast), but does create a need for purposeful action.

Depending on the chosen initiative, implementation will likely take up to 24 months of lead time and this timeline will be heavily influenced by the availability of State resources to devote time and energy to the new initiative. As noted previously, amendments to the state plan to implement new FFS options are less complex and time consuming than managed long-term care waivers and integrated care programs. Regardless of the initiative selected, the following factors will directly impact the timeline for implementing a new program initiative:

- Availability of DMMA staff resources.
- Political support and prioritization of the State's agenda.
- Level of involvement and support from providers, consumers and families.
- Funding availability to support program start-up.
- Approval/involvement by CMS/federal government.
- Information technology requirements/changes.

There were many existing priorities confronting DMMA staff even prior to the passage of health care reform at the federal level, but now there are new health reform issues, requirements and opportunities to address. Consideration could be given to phasing-in a new long term-care program over time and/or doing a pilot program if practical given Delaware's demographics. Compromise will be required at times and DMMA may want to value the virtue of not letting the perfect prevent the very good from happening.

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Other relevant long-term care provisions in the PPACA

In addition to the options presented in the previous Section, the PPACA contained provisions that pertain to long-term care that may be of interest to DMMA. These other provisions could indirectly influence DMMA's assessment of program initiatives and/or provide a sense of how the marketplace may change in coming years. Some provisions within the PPACA target new demonstration programs for the Medicare program that may be of just informational interest to DMMA.

Since the PPACA was signed into law on March 23, 2010, additional guidance from CMS has not been released as of the date on this report. Therefore, the following provisions are subject to change or revision in application once further guidance becomes available and/or the required regulations have been promulgated.

Extension of the Money Follows the Person (MFP) rebalancing demonstration

Delaware is already participating in the second allocation of MFP demonstration funding, so this option is already being deployed to help transition individuals from institutions to the community. Delaware is able to receive an enhanced FMAP for the long-term services and supports provided in the first year in which an individual is successfully transitioned back into the community. Section 2403 of Subtitle E in Title II of the PPACA extended the MFP demonstration through September 2016 and modified eligibility rules for participation. Whereas the original MFP required that individuals reside in a hospital, nursing facility or ICF-MR for not less than six months and not more than two years, the PPACA now lowers the criteria to not less than 90 consecutive days. To support additional transitions, the PPACA provides an additional $2.25 billion in appropriations through 2016.

State balancing incentive payments program

Section 10202 of Subtitle B in Title X of the PPACA allows states to submit an application for a higher FMAP rate on Medicaid long-term services and support expenditures if the following structural reforms are made within six months after application:

- Development of a statewide system to enable consumers to access all long-term services and supports through a single entry point (i.e., No Wrong Door).
- Adopt conflict-free case management services to develop a service plan, arrange for services, support the beneficiary (and caregivers) in directing the provision of services, and conduct ongoing monitoring.
- Implement uniform core standardized assessment instruments statewide to be used in determining beneficiary's needs for training, support services, medical care, transportation and other services as well as for developing individual service plans.

The following conditions apply:

- Only states where less than 50 percent of Medicaid long-term care spending was spent on non-institutionally-base services can be selected for this program.
- Application must include a budget that details the state's plan to expand and diversify non-institutionally-based long-term services and supports.
- Eligibility standards and methodologies for non-institutional services cannot be more restrictive than what were in effect on December 31, 2010.
- The state must collect data on service utilization, core quality measures and outcome measures.

For states selected, the following conditional FMAP incentives are provided:

- If non-institutional long-term spending was less than 25 percent in fiscal year 2009, the state will receive a five percentage point increase in FMAP for federal fiscal years 2011 – 2015. These states will be expected to reach 25 percent spending on non-institutional services by October 1, 2015.
- For other selected states with less than 50 percent non-institutional long-term spending, the state will receive a two percentage point increase in FMAP and be expected to reach 50 percent spending level by October 1, 2015.
- The increased FMAP rate is applicable on only the non-institutional Medicaid long-term services and support expenditures.
- The balancing incentive period ends on September 30, 2015, and there is an aggregate limit of $3 billion for the program.

Due to the relatively large percentage of community-based services for the developmentally disabled, Delaware is likely to be one of the "less than 50 percent" non-institutional long-term spending states.

Five-year demonstration projects to improve coordination for dual eligibles

Section 2601 of Subtitle H in Title II of the PPACA appears to allow 1915 or 1115 waivers that include dual eligibles (including any non-dual populations that may be enrolled as well) to be on a five-year renewal cycle.

Community Living Assistance Services and Supports (CLASS) plan

Section 8002 of Title VIII of the PPACA establishes a new national voluntary insurance program for purchasing community living assistance services and support. The program will be financed by voluntary payroll deductions or contributions from eligible adults age 18 and older who opt to remain in the program after an initial automatic enrollment. Regulations must be promulgated to implement the CLASS act.

- Premiums will be set by the federal government at a level necessary to maintain program solvency for 75 years.
- Monthly premiums for low-income individuals (less than the federal poverty level) will not exceed $5.00 – increased by the percentage increase in the consumer price index for all urban consumers for each year occurring after 2009.
- Persons in a hospital, nursing facility or ICF-MR and receiving Medicaid medical assistance are not eligible to participate.
- To be eligible for benefits, a person must have paid premiums for at least 60 months, have a disability expected to last at least 90 days and meet specific functional/cognitive criteria.
- Benefits are in the form of cash payments to eligible individuals. Minimum amount is not less than an average of $50.00 per day, but the benefit is scaled based on functional ability. There are no lifetime or aggregate limits on benefits.
- Institutionalized Medicaid recipients (as well as institutionalized PACE participants) are permitted to retain five percent of the cash benefit, the remaining 95 percent applies towards the facility's cost of care.
- Home- and community-based Medicaid recipients (as well as community-based PACE participants) are permitted to retain 50 percent of the cash benefit, the remaining 50 percent applies towards their cost of care, but only to the extent that case management, personal care, habilitation and respite care services are provided under either a waiver or state plan amendment.

Medicaid health homes for people with chronic conditions

Section 2703 of Subtitle I in Title II of the PPACA gives state Medicaid programs the option to provide coordinated care through medical health homes to individuals with chronic conditions through a state plan amendment beginning January 1, 2011. Health homes involve a team of health care professionals providing services such as comprehensive care management, care coordination, transitional care, and referrals to community and social support services.

- Planning grants are available beginning January 2011. States will have flexibility to propose alternate methods of paying providers in lieu of standard PMPM rates.
- States that elect this option will receive 90 percent FMAP rate on payments related to the health homes for the first eight quarters of services.
- An independent evaluation will be conducted by the federal government on the effect of health homes on reducing hospital admissions, emergency room visits and nursing facility admissions.

Educational training opportunities for direct care workers

Section 5302 of Subtitle D in Title V of the PPACA provides grants directly to certain institutions of higher learning to provide new training opportunities for direct care workers employed in long-term care settings such as nursing homes, assisted living facilities, ICF-MRs, and home- and community-based settings.

- Awarded grants will be used to off-set tuition costs and other required academic enrollment fees.
- A condition of receiving assistance is that the individual agrees to work in the field of geriatrics, disability services, long-term services and supports or chronic care management for a minimum of two years following completion of the training program.
- There is a total of $10 million in grant funding available for years 2011 through 2013.

State demonstration project to develop training and certification programs for personal and home care aides

Section 5507 of Subtitle F in Title V of the PPACA provides grant funding for demonstration programs in up to six states to develop core training competencies and certification programs for personal and home care aides including written materials and protocols for training and a certification test. Demonstration project will not be less than three years and $5 million is available per year. However, to qualify to receive funding, states must offer personal care services through the Medicaid state plan which Delaware currently does not.

Funding for Aging and Disability Resource Centers (ADRCs)

Section 2405 of Subtitle E in Title II of the PPACA appropriates $10 million for each fiscal year from 2010 through 2014 to carry out (expand) ADRC initiatives as provided by the Older Americans Act.

Nursing facilities – accountability requirements

Section 6102 of Subtitle B in Title VI of the PPACA requires nursing facilities to have compliance and ethics programs in effect three years after the date of enactment. These compliance and ethics programs will be effective in preventing and detecting criminal, civil and administrative violations as well as promote quality of care. Additionally, not later than December 31, 2011, the federal government will establish a quality assurance

and performance improvement (QAPI) program for nursing facilities. Regulations must be promulgated to implement this Section of the PPACA.

Nursing facilities – comparison and reporting of expenditures

Sections 6103 and 6104 of Subtitle B in Title VI of the PPACA require the collection and disclosure of specific nursing facility metrics.

- Section 6103 requires the federal government not later than one year after enactment to make available on the internet nursing facility staffing turnover and tenure data, relationships between nurse staffing levels and quality of care, links to related state websites, summary information on nursing facility complaints, and the number of criminal violations by a facility or its employees.
- Section 6104 requires the federal government within one year of enactment to revise the nursing facility cost report forms to separately report expenditures for direct care staff, indirect care services, capital assets (building/land costs) and administrative costs. Facilities will be required to complete these new reports on or after two years following enactment. The information collected via Section 6104 will be made available to "interested parties."

Nursing facilities – standardized complaint form

Section 6105 of Subtitle B in Title VI of the PPACA requires the federal government to develop a standardized complaint form for use by a resident (or person acting on behalf of a resident) in filing complaints with a state survey and certification agency and a state long-term care ombudsman program. States must also establish a complaint resolution process. This provision is effective one year after enactment of the PPACA.

Medicare FFS – accountable care organizations

Section 3022 of Subtitle A in Title III of the PPACA creates the Medicare Shared Savings program effective not later than January 1, 2012, that promotes accountability for a patient population and coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.

- Groups of providers of services and suppliers can form accountable care organizations (ACOs) that work together to manage, coordinate and be accountable for the quality, cost and overall care of the Medicare FFS beneficiaries assigned to them.
- ACOs will be required to promote evidence-based medicine, patient-centered processes, and report data on cost and quality of care.
- Medicare will continue to pay providers under the Original Medicare program via FFS.
- ACOs will also be eligible to receive extra payments based on shared savings.

Medicare FFS – independence at home medical practice demonstration

Section 3024 of Subtitle A in Title III of the PPACA creates a new Medicare demonstration program to test a payment incentive and service delivery model that uses physician and nurse practitioner directed home-based primary care team to care for and provide services to the chronically ill.

- Eligible Medicare beneficiaries may not be enrolled in either Medicare Advantage or PACE.
- Demonstration begins January 1, 2012, and may cover not more than a three-year period.
- The number of Medicare beneficiaries is capped at 10,000.

Medicare FFS – community-based care transitions program

Section 3026 of Subtitle A in Title III of the PPACA provides funding to hospitals and community-based organizations that provide transition services across a continuum of care to high-risk Medicare beneficiaries (e.g., chronic disease, depression, cognitive impairment) who are not enrolled in Medicare Advantage plans.

- The program commences on January 1, 2011, and will be conducted for a five-year period.
- The scope and duration of the program can be expanded if it would reduce Medicare spending without reducing quality.

9

Conclusion

We hope that the information compiled and presented within this report stimulates further discussion among DMMA, and its internal and external stakeholders. Moreover, our primary goal is to see Delaware make measurable strides in deploying programs that promote better health outcomes, enhance the sustainability of DMMA's programs and organize State spending in more consumer-oriented ways for the elderly and individuals with disabilities who are or will rely on Medicaid's long-term services and supports.

Whereas the aspects of Delaware's current financing of care for the elderly and individuals with disabilities in relation to changing demographics justify the need to take action, the qualitative aspects of more community-based alternatives for Medicaid long-term services and supports can substantiate the benefits of having taken action. Addressing imbalances in the Medicaid long-term care system is not an easy undertaking. The following is just a sampling of the types of issues and decision-points pending for DMMA staff: strategic planning, financing/payment options, program design, enrollment and disenrollment rules/processes, consumer/advocate input and reaction, provider comment, procurement and contracting of managed care plans, federal waiver development and information technology/configuration issues (e.g., claims payment edits/rules, eligibility determinations, capitation payment processing). Accordingly, pursuing any new initiative will require devotion of human, financial and technological resources.

Delaware's leadership clearly embraces the need to move through the continuum of assessing the situation, taking action, implementing programs and measuring success so as to achieve a better balance in the Medicaid program's system of long-term services and supports.

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REPORT FROM THE LONG-TERM CARE RIGHT-SIZING STRATEGIC PLANNING RETREAT:

PARTICIPANT STRATEGIES TO ADDRESS LONG-TERM CARE REBALANCING EFFORTS

STATE OF CONNECTICUT

APRIL 16, 2012

MARSH & McLENNAN COMPANIES

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1

Introduction

The State of Connecticut (State) is committed to creating a more efficient and effective long-term support and service system aligned with the principles of choice, autonomy and dignity. The envisioned system will allow Medicaid recipients who need long-term services and supports (LTSS) to choose whether they want to receive these services in a nursing facility (NF) or in a community setting. When asked whether or not an individual would prefer to receive services in a NF or in their home in the community, the vast majority of individuals indicated that they prefer to remain in their homes. The State also acknowledges that over the next several years the number of people who need LTSS will increase dramatically due to the aging population. In order to attain the vision of enhanced qualify of life and increased choice for individuals within their own communities, the concept of a town-based LTSS continuum was developed. Honoring the autonomy of the towns within Connecticut, the State supports a town-based approach to LTSS continuums that will provide choices apart from independent living in the community, ranging from various types of assisted living settings to care provided in a nursing facility; these options will support a seamless transition from hospital to short-term rehabilitation and back into the community. These continuums will be based on the preferences of the people they are designed to serve.

The trend toward receiving LTSS in the community, combined with the aging population, will cause a rapid growth of the need for community-based LTSS over the next ten to fifteen years. A change of this magnitude requires careful planning and collaboration between State, local and private entities. The Right-sizing Initiative was developed to accomplish this. Data from various sources will be incorporated into the State's utilization and cost projection model described in Section 2 of this report. Updated on a quarterly basis, this model will be used to project supply and demand for LTSS at a town level. More specifically, it will identify areas of the state where there is an excess of NF beds and areas where there may not be enough beds, and areas where transitional programs and additional community LTSS are needed. The model will extrapolate trends within towns at a sufficient level of detail so that supply and demand of specific services such as personal care attendants, transportation or housing will be readily identifiable. Based on the principle of choice, the model assumes that barriers preventing choice in where Medicaid recipients receive LTSS are removed. It will serve as an important tool guiding decisions regarding investments in LTSS moving forward.

According to the US Administration on Aging's Profile of Older Americans[1], the number of people age 65 and older is expected to grow to 19.3% of the population by 2030, marking a significant growth as a portion of the population nationally. This trend is evident in the Connecticut, where projections indicate a 40% growth in individuals age 65 and older between 2010 and 2025.[2] Notably, in the November 2011 report entitled *90+ in the United States: 2006-2008*[3], Connecticut ranked second among States with the highest percentage of the population Aged 90 and Over of Aged 65 and Over: 2006–2008. . The report also notes that research shows that age is positively associated with the presence of physical difficulty, and the oldest have the highest levels of physical and cognitive disability. By 2025, demand for LTSS is expected for more than 64,000 individuals in Connecticut – an increase of more than 24,000 individuals over current levels.[4]

The following graph displays the projected growth of the total demand for long-term care (LTC) services in Connecticut as well as the expected change in the mix between home- and community-based services (HCBS) and NF services. While the demand for LTC services is expected to grow to close to 64,000 users in 2025, the mix between HCBS and NF services is expected to move from the current HCBS/NF mix of 53%/47% to 83%/17% in 2025.[5] Changes in the HCBS/NF mix are largely attributed to interventions funded by the State's Money Follows the Person (MFP) rebalancing demonstration. Interventions are designed to eliminate barriers which prevent choice in where users receive their LTSS.

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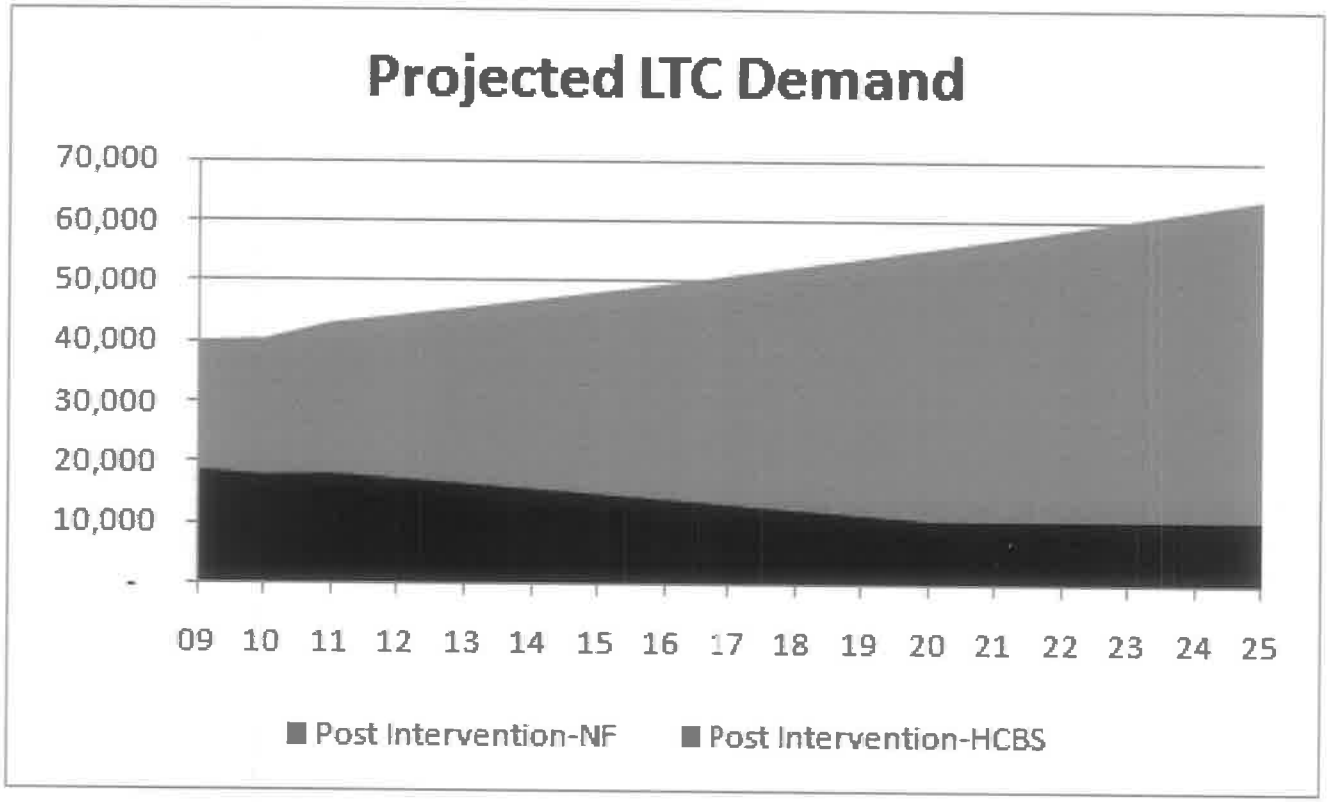
[1] US Administration on Aging. A Profile of Older Americans: 2010 (updated February 25, 2011).

[2] Connecticut Long Term Care Planning Committee, "Long Term Care Plan: A Report to the General Assembly", January 2010, page 42, table 5.

[3] Wan He and Mark N. Muenchrath, US Census Bureau, American Community Survey Reports, ACS-17, *90+ in the United States: 2006-2008*, US Government Printing Office, Washington, DC,2011.

[4] Jaramillo, Ernest ASA, MAAA, MBA; Medicaid Long Term Care Services and Supports Utilization and Cost Projection Model, State of Connecticut – Department of Social Services. November 30, 2011.

[5] Ibid.



To structure a service delivery system to meet the anticipated needs for LTSS and improve person-centered care systems for individuals with disabilities and aging individuals Connecticut has embarked on a LTC Right-sizing Initiative to identify system strengths and strategies to ensure the availability and service arrays preferred by and necessary to support the current and future users of LTC in the State. In partnership with individuals who are aging, individuals with disabilities, their families, community and institutional LTSS providers, advocates and other stakeholders, Connecticut seeks to align the supply of LTSS within the system with the anticipated demand for increased home- and community-based options. Connecticut recognizes that this effort has broad implications for individuals

receiving services, entities that provide those services and other critical stakeholders. To that end, Connecticut seeks to identify strategies that reflect both the strategic and the business considerations in these efforts.

Currently, Connecticut spends 65% of its LTSS dollars on institutional care for individuals who are aging and individuals with physical disabilities (excluding individuals with intellectual or developmental disabilities).[6] A 2011 analysis of adults age 31 and over using Medicaid LTC services shows that Connecticut has the highest or the second highest nursing home rate per 1,000 population in each of the following categories in both 2000 and in 2008: Total state nursing home rate of use, rate of use for ages 31-64 and rate of use for age 65 and older.[7] Offering greater options for community-based services as an alternative to the continued reliance on institutional care will enable the State to be more cost effective and more responsive to the preferences of the individuals likely to need services.

The right-sizing initiative will draw upon the strengths of the existing system, ensuring that the institutional providers within the State continue to serve an essential role in the care continuum while also diversifying and bringing their significant expertise to bear in other areas of the service system. The initiative further relies on the expert input of a wide array of stakeholders to ensure that the rebalanced LTSS system embodies the structures, philosophies and options necessary to meet the needs and preferences of individuals served for the coming decades.

Through a multi-month process of deliberate stakeholder briefing, engagement, data and system analysis, culminating in the LTC Right-sizing Strategic Planning Retreat, Connecticut has sought the input and expertise of those interested in building a sustainable LTSS system within the State. With an unprecedented level of partnership and collective work toward the common goals, the participants in these efforts have contributed heavily to this strategic planning retreat which will be considered by the State to establish a LTC right-sizing strategic plan and LTSS system designed to meet the unique needs of the State's future.

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[6] Connecticut Long Term Care Planning Committee; Long Term Care Plan: A Report to the General Assembly; January 2010; p. 54, Table 15.

[7] *American Journal of Public Health*, September 2011, Vol. 101, No. 9; "Relations Among Home- and Community-Based Services Investment and Nursing Home Rates of Use for Working-Age and Older Adults: As State-Level Analysis", Nancy A. Miller, PhD.

Specifically, this planning retreat addressed key elements within the LTC system that require further re-engineering in order to meet the State's LTC right-sizing goals such as:

- Home and Community Based Services
- Workforce
- Housing and transportation
- Hospital transitions
- NF diversification and modernization
- MFP grants

While representing distinct features and challenges within the system, these elements are interrelated, and in some instances, interdependent – and all must be addressed to improve the LTSS system to ensure a strong and responsive person-centered care continuum and to establish State policies that maximize individuals' independence and control. Initiatives developed within a plan as a result of this retreat will be aligned with the State's vision for a LTC continuum as defined by the LTC Planning Committee and MFP rebalancing demonstration; the vision is guided by the principles of individual participant choice, dignity and autonomy. The vision and principles are also aligned with the Department of Social Services' (DSS') mission of being committed to promoting and supporting individuals' choice to reside in their own home and community.

Throughout the process the level of engagement, interest and collaboration of the planning retreat participants in providing their time, expertise and candid comments have helped to shape the participants' recommendations for LTC right-sizing strategy as it appears below. The State would like to recognize their efforts in support of advancing the right-sizing vision. The next steps are to convene a smaller group and use this report to create a strategic rebalancing plan by identifying strategic leverage points emerging from the recommendations. The plan implemented in coordination with individual towns and communities will include:

- Specific strategies and tactics
- Methods for measuring progress and baseline data
- Estimated costs
- Timelines for implementation
- Potential new funding streams and opportunity to coordinate with existing funding streams

2

Utilization and cost-projection model for Medicaid long-term services and supports

In order to assist in the development of the State's right-sizing strategy, a data model was developed to project the demand for LTSS at the State level. The purpose of this data model is to estimate the future demand for LTSS as well as the impact of changes in the mix of services between institutional and HCBS. As part of the model development, the State emphasized the necessity of ensuring the model illustrated the impact of honoring the choice of consumers.

The model construction is divided into two phases: First, a high-level model, which will be carefully monitored and updated by the State, focusing on a macro view of LTSS over the next 15 years, including information regarding the array of individuals presenting a need for LTSS. In this first phase the model will use readily-summarized data from the American Community Survey as well as the historical Medicaid NF and HCBS participant information from State fiscal year 2004 to the present from the State's Office of Policy and Management.

The model construction during the first phase was broken down into three steps:

- Projecting the overall demand for LTC services
- Examining the effect over time to the HCBS/NF mix if existing trends persist absent the impact of any new initiatives
- Factoring in the impact to the HCBS/NF mix if existing initiatives accelerate or new ones are introduced

The second phase of the project is to construct a more detailed model to assess and address strategies at the local level. It is important to examine the issue at the macro level prior to the development of the more detailed local view so that potential systemic infrastructure issues which may exist can be taken into account. The more detailed model, which will use actual State Medicaid data, is expected to be completed in early February 2012.

3

Strategies for right-sizing

The workgroup that participated in the LTC right-sizing retreat and developed these strategies was comprised of a cross-section of individual LTSS stakeholders. Specifically, representation on this group included family members, advocates, ombudsmen, State staff, providers (community and institutional), academics and others. The strategies identified by this team are vital in achieving success and in building an equitable, objective and seamless system. While the State recognizes that a robust set of strategies are necessary to realize the LTC right-sizing goals that have been established, given the fact that resources are limited, the approach taken must be pragmatic. **Thus, the final set of recommendations that will comprise the first phase of activity will be selected based on considerations relating to the timing, resources and funding necessary to complete each strategy.**

Home- and community-based service options

Overview

HCBS support individuals with disabilities or individuals who need assistance with activities of daily living (ADLs) to live in their own home, with family or in other community settings. A diverse set of community-based service options is critical to support individuals to live in the most integrated setting possible outside of institutional settings such as NFs. As Connecticut develops these systems of support for community-based alternatives and improves the quality of the services, the State must consider how to best inform individuals of service choices and make new options available.

The strategies outlined below represent key steps to improve the home- and community-based system and its ability to support individuals based on their needs, regardless of diagnosis, including individuals with significant support needs and those who are returning to the community from institutional stays.

Strategies

Strategy	Tactic	Metric
Create parity across age and disability resources based on functional support needs rather than diagnosis – Access, eligibility, payment, service availability, cost caps, age requirements or gaps.	• Create a consolidated waiver for adult individuals who are aging or adults with physical disabilities that would blend existing waivers with expanded services to better meet the needs of people under the age of 65 • Make access to services and processes simpler, easier to understand and navigate • Increase understanding of Medicaid policy and spousal protections available under waivers • Address current discrepancies in rates for similar services • Eliminate waiting lists for services • Establish a seamless quality improvement strategy across waivers • Establish methods to share practices across target groups and programs to encourage and facilitate use of best practices across the system	• System baselines were established for the following: — HCBS system performance (were the most robust segments of the system meeting needs or over-serving?) — Unmet needs (for individuals currently enrolled or awaiting waiver services) — Capacity (providers, State oversight, etc.) — Current processes (including process time/effort) and standards (access/eligibility, including cost caps) — Current complexity • Deliverables and timeframes for waiver consolidation and improvement were identified • System performance: Quality for individuals receiving service improved • Unmet needs decreased • Institutionalization or re-institutionalization of individuals eligible for HCBS demonstrated downward trends or delays in institutional utilization • Comprehension of all system facets increased: Eligibility (including protections for spouses in the community), access, services, providers, consumer protections and safeguards • Comparable rates for similar services rendered by similar providers were established

Strategy	Tactic	Metric
		• A seamless quality improvement strategy was established and in place
Close service gaps and improve existing services or identify new services to better serve the needs of all populations. Assess access to other services critical to success in community living.	• Undertake comprehensive review to ensure adequate, appropriate service availability within HCBS waivers and State Plan (all services needed to support individuals in the community). For example: – Review and expand chronic disease education and self-management programs with a focus on geriatrics and supports for aging individuals – Increase and improve physician access and physician understanding of community capacity to meet individual needs – Increase and encourage greater use of peers or caregivers in the delivery of service – Identify strategies to expand and grow successful, person-centered, affordable assisted living communities – Simplify and better inform individuals on availability of home modifications – Improve and promote importance of employment services (and discredit related eligibility myths)	• Baselines across all populations (using available service array and utilization patterns) were established • Services that demonstrated improved community retention or return (using available national data) were incorporated into the program

Strategy	Tactic	Metric
	— Improve care transitions and care management — Identify strategies to utilize HCBS as a tool to prevent or delay institutionalization.	
Create mechanisms to ensure quality in the care provided through HCBS	• Review and incorporate strategies employed within Connecticut and across the nation to ensure sound discovery and remediation techniques to identify and fix issues quickly within the community. • Use information gathered from discovery and remediation efforts to continually improve systems and operations	• Strong performance on established outcome-based performance measures
Build, improve and make provider networks accessible to wider array of individuals.	• Provide education around informed risk parameters and person-centered strategies for risk mitigation • Change legislation to allow for reduced liability to agencies who may be caring for individuals with significant support needs and who seek to undertake some informed risk beyond the care typically provided by the agency • Review and improve medication administration regulation and training in an effort to enable wider opportunities for the use of medication administration technicians across all settings. Pay rates to	• Baselines for providers of HCBS were established including: — Existing availability across waivers, measured over time, for increased capacity and quality • Legislation to address medication administration and risk/liability issues for HCBS provider entities was proposed • Consistent or reciprocal provider qualifications across all waivers were established and in place • Payment for similar services across the service system were aligned • Methodology to ensure provider quality was seamless and consistent across provider entities was developed

Strategy	Tactic	Metric
	enable livable wages and benefits (commensurate with NF pay and benefit levels) • Cross-train and align provider qualifications across waivers and the continuum of care so that one provider can offer a package of services to all who need it • Ensure quality of care through independent evaluation of provider – Identify strategies to support providers who care for complex and high-risk individuals to encourage, rather than discourage, provision of care with significant support needs – Ensure disaster preparedness, establish partnerships to meet individual needs in emergency situations/circumstances	

Challenges to success

Whether the strategies identified above are undertaken individually or as a package for comprehensive HCBS system reform, there are some challenges that must be overcome for successful execution. These challenges, though not unique to the efforts to ensure a rich HCBS system, have a direct impact on the ability or timeliness of possible implementation.

1. Affordable, accessible housing: Individuals are only able to avail themselves of HCBS if they are able to secure or retain housing in the community.
2. Fiscal considerations: Changes to rates and services (amounts, duration and scope) will have fiscal implications. Quantifying these considerations and identifying available resources will be key to moving forward.

3. Conflicting regulations between Medicare and Medicaid: Issues requiring resolution include formulary coverage or gaps for pharmacy benefits, disparate requirements for home health, homebound and others.
4. Transportation challenges: Availability of transportation as well as inability of personal care providers to provide transportation.
5. Availability of standard assessment that identifies needs objectively, based on need not diagnosis, and streamlined tools for service initiation and data collection.
6. Disparate rates and provider requirements across existing waivers. While noted above as an issue to address, changes will require engagement and negotiation with wide array of providers and individuals served.
7. Lack of disaster preparedness strategies such as utilization of NFs to house and care for consumers when provision of HCBS services is not possible due to short-term catastrophic events.

Other strategies

The strategies noted above represent those identified by the group as being the highest priority; however, other critically important steps and considerations were raised during this dynamic stakeholder retreat. The items noted below should be addressed as a part of the broader overall strategies addressed above or should be sequentially addressed once the broader strategies have been implemented:

1. Deliberately incorporate employment discussions/plans into all service planning discussions with people seeking services.
2. Undertake deliberate, comprehensive support efforts for informal caregivers: Education, support services, respite, linkages with peers, etc. Expand understanding of existing informal caregiving network (and its likely expansion with expanded HCBS utilization).
3. Provide one-stop shopping or informed choice about all resources available across populations/communities (no wrong door approach). Aging and Disability Resource Centers (ADRCs) have been helpful but many people are not yet aware of ADRCs and these are not available across the State.
4. Provide comprehensive, concise education of providers, families and potential service recipients of what is available and how to access it.
5. Increase access to advocacy and protection while residing in the community. Ensure quality of care.

Workforce

Overview

As the State begins to operationalize its efforts to right-size its LTC services between NFs and HCBS, there are many important issues to consider. Chief among them is assessing the workforce capacity as a result of rebalancing the delivery system. As demand for HCBS services increases, the demand for paid and unpaid direct care workers will also increase. Between 2006 and 2030, the population over the age of 65 is expected to increase by 64%, while the working-age population is expected to decrease by 2%. This gap will decrease the supply of informal caregivers as well as the pool of direct care workers. Understanding and leveraging the informal caregiver supply while making the direct care field an attractive option for job seekers is a key component of LTC rightsizing. As Connecticut aggressively pursues Medicaid rebalancing goals, the need for focused efforts to recruit, train, retain and support paid and unpaid caregivers is essential. Without a focused, coordinated approach, lack of caregivers will stall rebalancing efforts and Connecticut will fail to meet its goals.

Goal: Attract and support paid and unpaid direct care workers. Increase the direct care workforce to adequately supply the future demand for LTSS. There are expected to be 24,000 LTC users over the next 15 years, with the majority of users receiving services and supports in their homes and communities.

Strategies

Strategies	Tactic	Metric
Recruit new direct care workers, retain existing direct care workers and support unpaid caregivers.	• To attract more workers, reform the pay structure, including benefits of LTC industry workers. Develop incentive packages that may include housing and transportation options. • Increase connectivity, networking and training among paid and unpaid caregivers. Use model mentoring, peer support, support broker and employer training programs to provide networking, support and education to direct care workers, consumer/employers and unpaid caregivers.	• Began formulization of incentive packages and identified funding. • Authorized the use of peer supports and support brokers/employer supports as a service of Medicaid HCBS waivers. • Developed mentoring pilot programs.

Strategies	Tactic	Metric
Review, analyze and change (as necessary) the infrastructure that affects the direct care workforce.	• Create equity across State systems. Review, analyze and catalog similarities and difference across State agencies' programs, policies, regulations and practices that affect the direct care workforce (i.e. training and support, consumer direction, wages, unemployment insurance and workers' compensation). • Develop a local repository or clearinghouse that provides opportunities for linkages at a local level and allows consumers to identify providers of services and supports. • Restructure the waivers to allow for a more streamlined approach of entry into the HCBS waiver programs and to provide for a more uniform approach for the access of services.	• Completed analysis of state systems • Dependent on analysis, sought regulation and legislative changes to equalize the system • Developed a local repository
Provide training and supports for providers, employers and unpaid caregivers	• Foster training and re-training programs for direct care workers. Collaborate with the community college system to design direct-care curricula using a foundation of person-centered care. • Develop career pathways and career lattices for direct care workers. • Identify model re-training programs that would allow the existing pool of institutionally-based paid direct-care workers to be trained to provide services and supports in the community.	• A proposal to partner with existing and new educational outlets in response to the need for education of the workforce (new, existing and future). • Enrollment and post-training job statistics tracked and demonstrating a dwindling gap in workforce needs • The number of new workers increased from X to Y

Strategies	Tactic	Metric
	• Develop a marketing plan to make others aware of the opportunities for direct care workers. Marketing plans may focus on the flexibility of the job and target potential workers seeking this type of flexibility (e.g., parents, college students). • Offer mentoring and peer support to formal and informal caregivers.	

Challenges to success

Development of a LTSS workforce that is sustainable, respected and skilled is critically important for the State's right-sizing initiative to be successful. Although not insurmountable, there are some challenges that must be overcome for successful execution. These challenges have direct implication for the timelines in meeting the State's right-sizing goals.

After discussion about the primary challenges for success identified by the group, two basic issues were identified. First, the Connecticut waiver structure and second, the policies, regulations and practices in State agencies that do not support dignity, choice and autonomy of individuals with disability and older adults. These issues were viewed to seriously hamper the ability to achieve a more efficient and standardized structure and workforce. In short, the workgroup felt that a systemic review of the policies, procedures, regulations and practices across State agencies, with the goal of creating more equity across systems, could result in greater workforce efficiencies. If these systemic issues cannot be examined and rectified at the State level, workgroup participants felt there would be little that could be done to meet the demand for an increased workforce.

In addition, participants agreed that another challenge to meeting the workforce demand included the economics behind living in Connecticut where the cost of living compared to the wage earned presented a unique barrier. The current HCBS pay structure does not offer enough incentives to attract new workers. While the group also identified the supply of adequate housing and transportation for workers as a challenge, the group feels that the influx of workers as a result of pay reform will spark subsequent movement in housing and transportation.

Other strategies

As noted earlier, many of the distinct features and challenges within the system have elements that are interrelated, and in some instances, interdependent. The group discussed the impact of housing and transportation on workforce development; however, the discussion remained targeted on workforce development.

The MFP demonstration has a Workforce Development workgroup that has been developing strategies for two years on home and community-based workforce development. The MFP workgroup had many participants that also took part in the strategic right-sizing breakout group. The MFP Workforce Development workgroup has a comprehensive strategic plan entitled "Direct Care Workforce Development – Strategic Plan" that includes vetted goals and action steps. Through engagement and support of this committed statewide workgroup DSS will ensure unduplicated efforts, strengthen established partnerships across LTC, education and workforce sectors and solidify messaging.

Housing and transportation

Overview

Housing

Provision of affordable, safe and accessible housing plays a critical role as Connecticut assists Medicaid consumers to either remain in or return to the community. Appropriate housing opportunities for HCBS consumers can vary greatly and are frequently the primary barrier for LTC consumers to receive HCBS. In order for the State to accomplish its LTC right-sizing goals, it will be necessary to have an adequate supply of housing so the established rebalancing targets may be accomplished.

Housing options include a person's own home (owned, leased, shared), supportive housing, shared living arrangement, congregate housing, assisted living services/managed residential communities and residential care homes. Finding adequate housing can be more challenging than developing the array of services needed to assist consumers to remain in or return to the community.

Transportation

Transportation becomes central in providing Medicaid consumers access to the community. Additionally, transportation plays a pivotal role in bringing caregivers to HCBS consumers in order to provide the care needed for consumers to successfully remain in or return to the community. Transportation is frequently acknowledged to be one of the greater unmet needs in communities. Transportation (when available) is frequently not accessible or affordable, leading to additional challenges to bring the consumer and the service providers together.

Strategies

Strategy	Tactic	Metric
The State should foster greater partnership and cross-agency collaboration between agencies focused on housing and transportation.	Establish a strategic partnership between DSS, Connecticut Housing Finance Authority (CHFA), Department of Economic and Community Development (DECD)/Office of Housing Development & Finance (OHDF), Department of Transportation (DOT) and the US Housing and Urban Development (HUD) DSS should establish a housing and transportation unit to specifically build relationships with partners in order to increase available units and resources for housing and transportation Leverage new relationships to access additional housing vouchers via grants and identify project-based housing units that are currently vacant for housing of transitional clients Foster collaboration with DOT to establish different guidelines for caregivers providing transportation which leads to an increase in pay	A formal partnership between DSS and HUD, DECD/OHDF, CHFA and DOT established A housing and transportation unit within DSS established Available housing options from X to Y expanded Guidelines to allow caregivers to provide transportation revised

Strategy	Tactic	Metric
Provide natural supports and caregivers with transportation and housing assistance	Provide caregivers and clients priority with tenant-based and project-based housing vouchers as well as help to establish community coalitions to assist in transportation Analyze additional means to establish how home sharing could assist family and caregivers with respite Establish coalitions for community transportation to assist with ride shares Explore the use of Zip car-like rentals service Explore the use of school buses during the day Develop more opportunities to utilize the 202 housing program to assist in housing shortage	Workforce survey on perceived transportation barriers improved from X to Y Expansion of shared housing increased from X to Y Ride share use increased from X to Y 202 housing units increased from X to Y
Preserve system funding that is the result of savings from rebalancing by allocating funds specifically to housing and transportation.	Establish a housing trust to hold funds from cost savings of transitions in order to reuse savings specifically toward housing and transportation instead of allowing funds to go back to the State's general funds	Calculated savings placed in trust improved from baseline to X%
Improve financing dollars for housing.	CHFA to obtain new bonding dollars for affordable housing and to the extent permissible under the funding stream, to allow NFs to modernize and introduce culture change and for capital improvements/conversions (e.g., greenhouse concepts, home-like environments, more common space, designs for more space and environmental efficiencies)	Bonding funds increased from X to Y

Strategy	Tactic	Metric
Convert select NFs to assisted living.	Support the development of assisted living communities through the conversion of skilled nursing home buildings and on the campuses of skilled nursing homes	X many conversions over Y many years

Challenges to success

During the course of discussion the workgroup observed the following challenges to affordable housing and transportation:

1. Current housing options require significant retrofitting/restoration.
2. There is considerable fragmentation between State agencies such as DOT, DSS, CHFA and DECD/OHDF.
3. There is a lack of data preventing an understanding of issues by geography.
4. There are considerable regional differences throughout the State related to housing needs.
5. Transportation is not available for the community workforce to reach clients.
6. The bias against assisted living and campus of care settings in MFP grants.
7. Housing requires considerable development funding and the operating subsidy for the actual affordable housing site which requires a federal and State collaborative effort.

Other strategies

The follow-up comments supported the following additional strategies:

1. Foster and improve ability to use assisted living communities.
2. Expand and develop the State's current affordable housing with assisted living models and pilots (congregate, HUD 202 and the demonstration pilots).

Hospital discharges

Overview

Hospital discharge planning activities often drive patients to NFs in order to provide a safe discharge environment and act as an effective mechanism in transitioning consumers along the continuum of care to ensure that they receive the appropriate follow-up care and services they require. For Medicaid participants discharged from a hospital to a nursing home, the risk of long-term institutionalization is significant. Data shows that 65% of all Medicaid participants who enter NFs are still there after months.[8] Thus, for vulnerable populations, entry into a NF can often lead to permanent institutionalization and loss of community ties and individual freedom of choice. Additionally, health services research indicates NFs could provide viable alternatives to acute inpatient admissions/re-admissions, effectively bypassing emergency departments (EDs) (structured carefully to ensure adherence to all federal and state service provision requirements) and subsequent inpatient stays through direct NF admissions. From this perspective, NFs can ensure that patients receive the right care in the right place at the right time and can be quickly transitioned back into their community.

The strategies outlined below represent those steps the Hospital Discharge workgroup identified as being critical in the State's efforts to promote more efficient and effective hospital discharge planning processes. Through more integrated and streamlined processes and with greater collaboration and education, it was felt that more effective transitions of care could be obtained, recognizing the non-delegable nature of the function for hospitals. Thus, as consumers need to access acute care services, hospital case managers, assistive personnel and physicians could (1) promote home- and community-based support and service alternatives when appropriate effectively reducing potentially inappropriate NF admissions that can lead to long-term institutionalization, and (2) target and reduce inappropriate ED and subsequent inpatient admissions through either a direct NF admission process or home health service delivery options.

[8] Connecticut Commission on Aging Strategy Paper, December 2010, http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCkQFjAA&url=http%3A%2F%2Fwww.cga.ct.gov%2Fcoa%2FPDFs%2FFact%2520Sheets%2FCoA%2520LTC%2520strategies%252012-7-10.pdf&ei=WIThTt2NLKHm0QG_mdCJBg&usg=AFQjCNFzEWtVJVgGcjMgOiDc5Rs0NHNTzw&sig2=1HNf3nqhsWUNuxCZBopnlQ, last accessed December 9, 2011.

Strategies

Strategy	Tactic	Metric
Convene a statewide Person-Centered Community Care Collaborative, focused on the development and dissemination of educational tools and materials and promotion of the State's right-sizing strategy through support of the cultural change necessary with the State's health care professional community, with a special emphasis on the integration of services and supports for both physical health (PH) and behavioral health (BH) issues.	Develop statewide definitions for key HCBS terms such as "choice", "person-centered plan" and "dignity of choice" that will drive cultural change Devise and implement a global communication plan raising awareness of LTC options Continue to build on a centralized, web-based repository for LTC information, making it meaningful and relevant to the medical/hospital community Develop strategies to promote electronic health records LTSS settings (NF and HCBS). Note: Such providers were not among those eligible for federal electronic health record funding and incentives, so other strategies for funding and/or incorporation should be explored. Build greater synergies between the various State, regional and city organizations that all have a role in promoting LTC and HCBS options	Established systems baselines: What was the hospital community's understanding of HCBS options? What barriers existed for hospital case managers in promoting HCBS options? How could the current pre-admission screening process have been revised to promote options for HCBS? Were there screening tools that could have been employed to better stratify at-risk individuals? Assessed current fragmentation or available options in obtaining services for individuals with BH conditions Satisfaction measures related to knowledge, resources and ability to access services by the health care community Satisfaction measures related to knowledge, resources and ability to access service by consumers Number of "hits" on centralized website Employed survey for individuals accessing the website Used data to re-design/update web content as appropriate

Strategy	Tactic	Metric
Develop and implement a Transition of Care model specific to individuals who are receiving or are at risk for receiving LTC services. Specifically, it is key to build the bridge from the hospital discharge to the community and strengthen the hospital ties with community resources. (Note: This was viewed by the workgroup to be a separate strategy to be employed in tandem with the Person-Centered Community Care Collaborative)	Improve collaboration to develop more definitive "handoffs" between hospitals and community resources. Coordinate all efforts of this type within the State to ensure maximum coordination and collaboration. Develop and deploy a comprehensive educational program targeted at hospital case managers and hospital physicians that provides information on the options available to care for individuals in the community setting and assists the medical community in becoming more person-centered and less paternalistic. Web-based training program globally accessed by all hospital case management staff providing basic training on LTC options Increase and improve understanding of key HCBS terms and how that effects care planning and discharge efforts Implement a tool that assists hospital case managers in determining at-risk patients for LTC services Tool could be web-based and algorithmic, allowing for LTC options to be displayed based on what the individual's needs were, promoting individualized and person-centered planning Hire and train LTC ED coordinators who could be responsible to more effectively identify and engage resources to assist in transition of a person back into a community setting or minimize the length of stay in a NF through effective care planning Build on work currently underway relating to the transition model of care as well as develop a cohesive approach that encompasses various State initiatives currently underway such as the dual eligible integration initiative	All measures were for those individuals, new or existing, that received LTC services: Readmission rates To hospital from community To hospital from NF To NF from community To NF from hospital For those who required LTSS upon discharge from hospital, X percent increase in discharges to community versus institutions Reduction in length of stay (LOS) Acute inpatient LOS NF LOS The overall community tenure of individuals who received HCBS services increased Standardized discharge planning survey assessed: Patient/caregiver understanding of discharge plan Support in successfully implementing the discharge plan and engaging LTC services Timeframe for follow up with primary care provider or specialty care provider post discharge Understood long-term options that were available to the consumer

Challenges to success

Whether the strategies identified above are undertaken individually or as a package for comprehensive HCBS system reform, there are some challenges that must be overcome for successful execution. These challenges, though not unique to the efforts to ensure a rich HCBS system, have a direct impact on the likelihood or timeliness of implementation:

1. In addition to cultural and attitudinal barriers that require education and dialogue to overcome, the State/Department of Public Health regulations may not have kept pace with the times:
   a. The medical concept of a "safe discharge" is often at odds with the community-based mantra of "dignity of choice", making the necessary health care community's culture change to support rebalancing difficult.
   b. The ability to obtain physicians orders for services outside of a hospital or clinical setting is a challenge to ensure that the individuals receive the most array of services within a timely fashion.
2. Medicaid and waiver structure:
   a. When trying to coordinate service planning for individuals with BH issues, provider qualifications and low reimbursement rates make it difficult to recruit and retain providers (i.e., mid-level mental health (MH) nurse practitioners are not recognized by some waivers as viable providers of service).
   b. Disparity in provider reimbursement between PH and their MH counterparts undervalues the provision of MH services.
   c. The varied structure, service packages and eligibility process make accessing services difficult and those delays contribute to institutionalization and then the 90 day wait period for MFP options starts and delays community discharge even further.
3. The Centers for Medicare & Medicaid Services (CMS)/federal regulations:
   a. The Medicare regulation for a three-day hospital stay (with "traditional" Medicare) precludes direct SNF admissions. Observation stays do not count as admissions; therefore, they do not count towards a three-day hospital stay.
   b. The definition of "community setting" makes it difficult for LTC providers wishing to diversify their business model to enact timely and efficient change to their service delivery array (e.g., certain assisted living arrangements may not qualify for MFP grants).

Nursing facility diversification and modernization

Overview

The current State LTC institutional landscape includes 238 NFs with a total of 28,780 beds and an average occupancy rate of 92%. The State ranks number three in the country for the number of facility residents per 100 State residents over age 65, at 5.8 compared to the national average of 3.8. The State also has ranked high in the proportion of low-acuity residents that live in NFs. According to data from the CMS *2008 Online Survey, Certification and Reporting* database, the average ADL score of a Connecticut NF resident was 3.7 while the national average was 4.0. Four states tied with Connecticut and only two states had a lower acuity score, demonstrating Connecticut's opportunity to transition or maintain more individuals in community settings.

NFs are a critical component to any state's Medicaid LTC program. Recent studies, however, conclude that consumers increasingly want to remain or return to their own homes.[9] In response to consumer desires, the State has implemented initiatives that are designed to result in an increased proportion of the Medicaid LTC consumers residing in the community. Regardless of this shift to providing supports and services for consumers to remain in or return to their communities, NFs will continue to be a vital component to any LTC program. NF operators will however need to consider what their presence in the local community will look like in the future: Will it be a smaller facility? Will it provide specialized care? Will it be an operation that also provides supports and services to consumers who reside in the community?

This group was tasked with identifying different strategies NFs might consider in order to diversify and modernize their health care operations so that they may effectively react to the changing LTC environment.

Note: CMS has proposed rules regarding what conditions must be met to qualify as a home- and community-based setting (e.g., assisted living). What impact that may have on options for NF operators who wish to diversify is not fully known at this time since CMS is reviewing a significant number of comments before it can finalize the rule.

[9] Connecticut Long-Term Care Needs Assessment Part I: Survey Results, June 2007 (REVISED March 2010), Page 56, Table III-10.

Strategies

Strategy	Tactic	Metric
Transform NFs into comprehensive assessment centers for all LTSS.	• Adoption of a common assessment tool or common assessment elements that address all LTSS and related conditions and disabilities. The tool should be person-centered, include collaboration with hospital discharge planners and MFP initiatives, and consider available community resources and make recommendations when community supports are lacking. • Redefine the Certificate of Need (CON) process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports the transformation process. • Determine a payment rate for the assessments and how such payments will be funded. • Change community interaction (e.g., communication channels, means of obtaining information, requests for assistance, grievances, etc.) with NFs to support person-centered care.	• Identification of a single assessment tool • Number of assessments • Number of referrals for community-based services increased from X to Y • MFP payments for development of an assessment tool or conversion of NF building/ operational/workforce to assessment centers • Consumer surveys on the role of NFs and HCBS in their communities • Revision of CON policies and procedures • Payments for assessments at the State level, including MFP payments • Revenue and units of service for assessment at the facility level • NF operational changes reflecting focus on person-centered care • Ombudsmen surveys
Develop NF services to include transitional programs that support the movement of individuals from a variety of care settings back into the community.	• Expand Medicaid- and Medicare-covered therapies to support rehabilitation and training for community living (e.g., occupational therapy, etc.) • Create additional transitional training programs within NFs (including possible transitional units), including training and	• Changes to Title XIX and Title XVIII supporting community living therapies • Revenue/billed units for identified therapies • Repurposed square footage to support transitional programs

Strategy	Tactic	Metric
	support for caregivers • Revise NF licensure and regulatory requirements to allow for transitional programs and new levels of care (LOCs) • Develop Medicaid rates for transitional services • Redefine the CON process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports transitional services • Coordinate with other integrated care and home health initiatives	• Revenue/billed units for identified services • MFP payments for development of transitional programs or NF building/ operational/workforce changes for addition of transitional services • Number of educational programs for caregivers • Consumer surveys • Changes to Title XIX and Title XVIII supporting transitional living services • Statutory and regulatory revisions • Medicaid (or MFP) fee schedule or rate methodology for transitional services was developed • Revision of CON policies and procedures
Transform NFs into continuing care providers that allow individuals to receive a continuum of services from the same entity.	• Reissue business plans and financial projections, such as those supporting financing arrangements, debentures and investor communication (i.e. annual reports, board meetings, etc.). • Provision of community-based services through NFs, including but not limited to therapies, home health, personal care, home-delivered meals, hospice (facility and home), respite, memory impairment, transportation, concierge, adult day and assisted living, etc. This concept reflects the MFP ideology of care following the person and the caregiver following the person, regardless of setting. Facilities will	• MFP payments for strategic assessments/feasibility analyses and development of business plans • Number of business plans that include continuing care programs • The number of non-NF services provided by NF entities • Non-NF revenue paid to NF entities • Non-NF individuals served • Changes in licensure of NF square footage • Changes in licensure allowing hospice services in individual rooms within a NF

Strategy	Tactic	Metric
	become similar to alcohol and drug recovery centers and centers for coordination and support • Development of community space at NFs • Redefine the CON process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports community services	and coverage by Medicaid/Medicare • MFP payments for development of community-based services or NF building/operational/workforce changes for addition of community services • MFP or other grants for development and implementation of electronic health records for LTC services • Consumer surveys • Changes in licensure of NF square footage • Revision of CON policies and procedures

Challenges to success

The current bias for NF care has evolved based upon historic Medicare and Medicaid policies, which have then influenced a host of other issues, including workforce development, financing, licensure/certification and other federal and State policies. For the above strategies to be successful, action will be needed to revise how LTSS are typically provided, including challenges inherent in the current system such as those listed below:

1. CON policies and decisions that restrain the transformation of NFs or deter closure/de-licensing of beds, including outdated moratorium statute.
2. Lack of funding for development and adoption of a single assessment tool that reflects person-centered planning. Note: In such efforts, the State should consider how and/or if such an assessment relates to the Minimum Data Set.
3. Lack of or insufficient funding for assessment payments; rates too low to support such services.
4. Coordinating BH and substance abuse services with LTC assessments and services.
5. The three-day hospital stay requirement under Medicare, which limits NF utilization in place of hospital services.
6. Resistance to changes in revenue projections and business plans that may require the approval or notification of financing entities (e.g., mortgage holders, bond trustees, banks, etc.).
7. Funding for building and property changes to support comprehensive assessment services and adequacy of revenue to support costs of such changes.
8. Resistance to changes in hourly rates, job classifications and available positions that may require approval or negotiations with the Service Employees International Union.
9. Funding for training and workforce development for comprehensive assessments, transitional and other community-based services.
10. Lack of coordination with other MFP initiatives, resulting in competition and duplication of services and costs.
11. Lack of changes to statutory and regulatory governance of Medicaid (Title XIX), Medicare (Title XVIII), CON and licensure programs to support transitional services and mixed-facility use.
12. Lack of funding (MFP, Medicaid or Medicare payments) for transitional and community service development (e.g., direct funding, loan guarantees, etc.).
13. Lack of inclusion of occupational therapy as a covered MFP, Medicaid and/or Medicare service.
14. Coordination/collaboration with existing HCBS providers and financial viability of new and existing services.
15. Need to ensure ability to provide enhanced hospice services delivered within NFs (or space formerly used for NF services).
16. Lack of funding (federal grants, MFP funding, etc.) for LTC providers for electronic medical records.

17. Continued use of nursing homes for care prior to Medicaid eligibility determinations and rendered without compensation (exacerbated by challenges with timely eligibility determinations).
18. Adequate resources (i.e. payments, trained staff, etc.) for higher acuity care within nursing facilities as the rightsizing initiative moves forward.

Other strategies

Strategies that were discussed but considered lower priorities than those identified above:

1. Add other community services at NFs to make them more attractive for community involvement.
2. Support coordination between NF and other HCBS so the NF is a community backup when other HCBS providers have difficulty meeting individuals' needs.
3. Enhance NFs as centers for community and family support for LTC services and education rather than as the last and least desirable option. Focus should be on the individual's needs and desires and how to coordinate those needs and desires within the community and family.
4. Allow NFs to "think outside of the box" and develop use of beds for services other than LTC Medicaid stays.
5. Encourage the establishment of a more collaborative and flexible approach to regulation and reimbursement with both the funding and the licensing agencies working together to encourage innovation.
6. Consider a variety of uses for nursing home beds such as short-term rehabilitation, overnight respite, emergency shelter, and specialized service units.
7. Modernization of nursing homes to create physical sites reflecting the nursing home of the future. Modernization efforts to create the systems and services that are desired by consumers and which are required in the new system of health care reform. Greenhouse models, culture change modifications, energy efficiencies, electronic health records, transportation systems, and other capital improvements should be encouraged throughout the system of grants, loans, reimbursement and funding.
8. Promote, including the availability of resources, electronic records for LTSS.
9. Conversion to assisted living beds, even if not paid for by the Medicaid/MFP programs.
10. Reduction of the nursing bed supply via a multi-pronged approach which might include permanent bed reduction through a temporary bed reduction through a mothballing or reclassifying bed use, the relocation of beds, and other options for the right-sizing and redistribution of bed supply throughout the State.

4

Money Follows the Person grants

Overview

As the State moves forward with its LTC rebalancing initiatives, there is no doubt that the State's LTC system will look very different in the future. To assist in this transformation effort, the State has secured approximately $20 million in funding from CMS so that "institutions will begin to redefine their role in the delivery of LTC from 'final placement' to an environment that supports long-term living". This funding will provide the opportunity for financial assistance to NF providers that desire to transform their current business model in a way that will expand the opportunities for individuals to reside in the community setting of their choice.

The State will develop grant opportunities for the planning and implementation of LTC right-sizing initiatives for which NF providers may apply. In order to evaluate proposals and fund diversification plans the MFP Grant workgroup was tasked with developing strategies to assist the State in issuing a request for grant proposals. The MFP Grant workgroup was also tasked with developing guiding principles and criteria that the State could use to evaluate and fund the various plans that may be submitted.

Per the State's current MFP Operational Protocol (revised February 10, 2011), this funding will be divided into two phases: Phase I for planning activities for potential diversification and Phase II for funding viable plans that the State selects. The funds for Phases I and II will be targeted to NFs interested in diversifying their operations by providing community services or serving in another capacity that supports the successful provision of services to individuals in the community while also decreasing the number of NF beds. Phase II funding may go towards paying a NF for each person they return to the community in order to compensate the entity for its effort to support the individual during the transition. Funding from Phase II can also be used for infrastructure costs associated with the development of a HCBS business model. Examples of infrastructure costs CMS grants can cover include:

- Technical assistance/consulting
- Legal fees for establishing a separate home health agency structure and other start-up costs
- Fees for becoming a certified adult day provider
- Business interruptions costs during conversion

- Licensure costs
- Meetings costs
- Infrastructure costs associated with information technology
- Training and professional development
- Travel
- Community market research
- Outreach activities
- Print materials for adult day center or home health agency

In addition, for facilities wishing to develop community housing, expenses attributed to accessibility modifications can be covered; however, costs associated with renovating on institutional grounds for the purpose of creating housing on institutional grounds will not be covered.

If the final MFP grant program differs from what the current MFP Operational Protocol would allow, the State may amend the current protocol to align with the program adopted by the State and request CMS approval.

Note: CMS has proposed rules regarding what conditions must be met to qualify as a HCBS setting (e.g., assisted living). What impact that may have on options for NF operators who wish to diversify is not fully known at this time since CMS is reviewing a significant number of comments before it can finalize the rule. This proposed rule is separate from, but related to, the statutory requirement that qualified community settings for MFP include no more than four unrelated individuals residing together. CMS has provided guidance to MFP grantees on how assisted living may be considered to meet those requirements.

Strategies

Strategy	Tactic	Metric
Determine the interest of NFs regarding grants for planning and implementing LTC right-sizing initiatives.	• Develop a survey and survey NFs regarding their interest in grants for planning and implementing LTC right-sizing initiatives; questions could include but not be limited to interest in grants, interest in receiving technical assistance, type and amount of planning that has already occurred at the nursing home, and what would be appropriate amounts for grants; this information can be used to determine how the grant funds should be allocated between Phase I and Phase II	• Survey developed • The number of NFs that completed the survey • A report that summarized the results of those NFs that completed the survey
Inform the NFs about the opportunities to apply for and receive grants for planning and implementing LTC right-sizing initiatives.	• Develop a training module to educate the NFs about the opportunities to apply for and receive grants for planning and implementing LTC right-sizing initiatives • Educate the NFs about the opportunities to apply for and receive grants for planning and implementing LTC right-sizing initiatives; provide these through one or more of the following: — Meetings — Webinars — Web page	• Training module developed • The number of education meetings and webinars, including the number of participants and locations of meetings • A webpage where all information about the grants and background material on the LTC right-sizing initiative is accessible was developed
Make technical assistance available to NFs in preparation for submitting their proposals for planning grants and implementing LTC right-sizing initiatives.	• Arrange with CMS MFP technical advisory contractor to provide 1:1 technical assistance with NF providers who want to submit proposals for	• The State established formal arrangements for 1:1 technical assistance • The number of NF providers that received 1:1 technical assistance for planning grants

Strategy	Tactic	Metric
	planning grants and implementing LTC right-sizing initiatives • Consider additional methods to obtain feedback on submitted provider plans	• The number of NF providers that received 1:1 technical assistance for implementing initiatives
Provide to NFs grants for planning and implementing LTC right-sizing initiatives.	• Develop and issue a grant proposal that is based on the input provided at the State's LTC Right-sizing Strategic Planning Retreat, a utilization and cost-projection model to identify where grants are needed, NF survey results and any other comments that the State may receive from providers, advocates and others • Develop the associated data that can be used by NF providers in preparing for their grant proposal and also utilized by the State in the evaluation of proposals	• A grant proposal was developed and issued • Data was available for use by the NF providers and the State (data and other right-sizing-related documents made available on a State website/page) • The number of NF providers that submitted proposals and received planning grants; included the amount requested and amount awarded • The number of NF providers that received grants for implementing initiatives; include the amount requested and amount awarded • The number of home health agencies created • The number of NFs that provided emergency back-up support in the community • The number of affordable housing units created • Increased percentage of Medicaid LTC participants living in the community compared to institutions

Guiding principles and evaluation criteria

The MFP grants workgroup identified several principles that the State should follow when developing the MFP grant proposals and awarding grants. The final plan should include agreed upon guiding principles such as the following:

1. The criteria must align with the State's LTC right-sizing strategic plan and MFP operational protocol.
2. The MFP grant expectations must align with the funding that is available.
3. The evaluations criteria should be transparent. In other words, providers should know exactly how they will be evaluated and what priorities the State will establish when awarding a grant (i.e., one region versus another region of the State, two NFs with equal proposals).
4. There should be the ability to skip Phase I (planning) if the provider has already completed their planning without any funding. This would require the State to issue Phase II opportunities should they be made available. Don't delay Phase II for providers.
5. The grants that are made available should be based on regional needs and not on statewide criteria.
6. Criteria for the evaluations must align with needs of the community.
7. Facilities should develop relationships with and partner with existing HCBS providers/agencies.
8. Phase I planning grant criteria should be more flexible than Phase II implementation of LTC right-sizing initiatives.

The MFP Grants workgroup believes that before the grant proposals are developed, in addition to the guiding principles, there should also be a list of basic evaluation criteria to guide the authors of the grant proposal. The workgroup identified several criteria that should be considered when establishing how grant applications will be evaluated. The following is the list of evaluation criteria discussed within the workgroup and offered for the State's consideration:

1. The provider should be able to demonstrate that they have been in compliance with State licensure and CMS certification requirements.
2. A NF's low occupancy rate does not mean that they would have a higher priority for receiving a grant.
3. A provider should be able to demonstrate its successes with its current NF workforce.
4. A quality provider should not necessarily have to reduce its beds if their grant request demonstrates the ability to meet a community need.
5. A provider's demonstration that their project has an established need in the community.
6. A provider must demonstrate that it has supported efforts to inform consumers of their choices (informed choice) regarding all LTSS that are available.
7. A provider's demonstration of its support of and competency at delivering a person-centered approach to providing LTSS.

8. A provider's demonstration of how it has undergone or begun to undergo a culture change in their NF (e.g., Greenhouse).
9. A provider's demonstration of its financial viability.
10. A provider's demonstration that its proposed project is sustainable.
11. A provider's demonstration of how its project will be aligned with the other community providers and supports (e.g., Memorandum of Understanding to demonstrate a commitment to collaboration).

Data

MFP grants will be targeted towards alignment of estimated demand for LTSS, including the NF bed supply. NF bed supply will be addressed through grant incentives to adjust capacity where needed. NF bed capacity will be decremented by grant awards for those providers who seek the opportunity. The State will take a pragmatic approach in grant evaluation.

Numerous workgroup members discussed the need and desire to have a more robust dataset to understand and analyze the effects of rebalancing. To address that need, the State is in the process of establishing a "live" data book for the primary purpose of providing reliable data on which the State can base decisions to ensure the appropriate balance of supply and demand. While the NF bed supply will be adjusted primarily through grant incentives and the development of additional HCBS capacity, decreasing NF bed utilization will likely impact the delivery of LTSS in many ways, including ones that are significant and unpredictable at this time.

The data book may be used by the NF providers who may submit grant proposals to ascertain information regarding capacity within their area.

The next phase of development of the strategic plan will consider how the data, maps and adopted strategies will affect supply and demand in the coming years. As the initiative unfolds, this information (in conjunction with the experience of providers and local communities) will be reviewed and analyzed to understand the interactions between the implemented programs, changes to the market (population, workforce, regulation, etc.) and provider experience. This view of the State's LTSS will continue to evolve as the variables change, but regular evaluation should provide an appropriate context for determining next steps in the process.

The data book will be located on a Connecticut DSS webpage: http://www.ct.gov/dss/xxxxx. The data book will be refreshed on a minimum of a six-month basis so that it can be relied upon as a valid source of information. The State will also be adding additional information that might be useful to NF providers, the State and others.

The current data book will have the following information available:

- NF performance and rates matrix. (This document includes individual information on all Connecticut NFs. Some of the information included is regarding the number of registered nurse hours per resident day, quality measures star rating, overall star rating and percent of beds occupied.)
- Maps that show the location of NFs, residential care homes, assisted living services agencies, home health care agencies and homemaker/home health aide agencies. These maps are by county and also include regional population density information.
- Maps by county that show the locations and bed size of NFs and residential care homes.
- Maps by county that show the occupancy rates of NFs and residential care homes.
- Several NF and residential care home bar charts that indicate type of ownership (e.g., for profit – not multi-ownership), number of beds per facility, percent of beds occupied, rates (per diems) ranges and overall star ratings.

Challenges to success

There will be challenges in developing a fair and comprehensive MFP grant request for proposals. The development of this document will be guided by the principles and evaluation criteria noted above. A fair and comprehensive document can be developed by also understanding some of the challenges related to the MFP grants. The challenges that were identified by the MFP Grant workgroup include but are not limited to the following:

1. Providing adequate funding for the planning and implementation of LTC right-sizing initiative grants.
2. CMS' MFP funding restriction of providing assisted living through HCBS waivers on institutional grounds.
3. Criteria for being awarded a grant could be too limiting to be creative.
4. Not having the available community/HCBS workforce to align with a LTC right-sizing initiative.
5. Availability of appropriate data to fairly evaluate where rightsizing should occur.
6. Availability of appropriate data to fairly evaluate providers applying for a right-sizing grant.

5

Conclusions

The recommended strategies identified within this plan for each of the key system elements represent important steps toward building a strong system of LTSS. Collectively, they provide direction to the State when developing a redesigned service system that will afford individuals, even those with significant support needs, maximum choice and control over the type and location of their services. The planning retreat participants identified these strategies to represent the very important efforts necessary to reconfigure the infrastructure as well as needed improvements to services and processes used within that frame.

Through this stakeholder process, some common themes emerged across the strategies and system elements:

Partnership and collaboration – across all stakeholders – are key to all of the strategies. Leveraging existing relationships and forging new partnerships will be essential to make the system changes that will form the backbone of a right-sized system.

Simplifying, streamlining, educating and using resources strategically also emerge as themes across the issue areas. This emphasis is represented at the macro or systems level with strategies identified to utilize budgeting techniques and resource decisions that will incentivize the needed system movement. The strategies also emphasize individual-level considerations, as strategies encourage the State to make service and individual resource allocation decisions based upon objective assessments of individual needs and not solely based on diagnosis. The encouragement toward streamlining is to make the system efficient, cost effective and understandable to the individuals who use it and their families.

Supporting informal and formal care providers to ensure a quality workforce also emerges across many strategies. The compensation, supports and learning opportunities for this increasingly critical network is key to any strong HCBS system.

Additionally, there were commonalities in the identified challenges which Connecticut must overcome. Some of these challenges are posed by federal program requirements in Medicaid for HCBS and MFP, particularly as they relate to assisted living and the interface between Medicare and Medicaid. Others are State requirements such as rules around nursing delegation, direct admission to NF

requirements and safe discharge standards, differences across various agency requirements (around LOCs and financial eligibility) and service fragmentation that must be smoothed in order for seamless transitions and access to services to occur. A stark challenge also identified in each area is the lack of affordable, accessible community-based housing and transportation. Additionally, the adequacy and training of the needed network of support workers is a concern across the issue areas. Finally, fiscal considerations will be important as the State determines the extent and timing of expanded HCBS opportunities, any changes to provider reimbursement or the implementation of other strategies that may require resources. These challenges and others are not insurmountable but will require thoughtful deliberation and creativity to overcome.

As the recommended strategies identified within this report reveal, significant work on the part of the State to prioritize resources and develop timelines is required in order to address the critical needs identified and to realize the State's LTC rebalancing goals. Through application and consideration of the projected LTC needs at the State and local level and informed by a data book, the State can make pragmatic choices in determining where to allocate resources. Current and future LTC service users should be invigorated by the dedication and long-term vision of the State.

The next phase of development of the strategic plan will consider how the data, maps, and adopted strategies will affect supply and demand in the coming years. As the initiative unfolds, this information in conjunction with the experience of providers and local communities will be reviewed and analyzed to understand the interactions between the implemented programs, changes to the market (population, workforce, regulation, etc.) and provider experience. This view of the State's LTSS will continue to evolve as the variables change, but, with regular evaluation, they should provide an appropriate context for determining next steps in the process. Through the continued level of engagement and commitment of the State and the stakeholders, the goals of the initiative are achievable.

APPENDIX A

Statutory Authority

The authority to create this report can be found under Section 83 of Connecticut's Public Act Number 11-242 (AN ACT CONCERNING VARIOUS REVISIONS TO PUBLIC HEALTH RELATED STATUTES) establishing the requirements for a strategic plan, consistent with the long-term care plan established pursuant to section 17b-337.and which revises Section 17b-369 of the Connecticut general statutes. In summary, this bill outlines the following authorities related to the generation of this report:

- The bill requires the DSS commissioner to develop a strategic plan, consistent with the state's long-term care plan, to rebalance Medicaid long-term care supports and services, including supports and services provided in-home, in a community-based setting, and in institutions. He must include providers from all three setting types in the development of the plan.
- The bill permits the DSS commissioner to contract with nursing homes and home- and community-based providers to carry out the plan. It also permits him to revise a rate paid to a nursing home to carry out the plan. The bill authorizes the commissioner to fund plan initiatives with federal grants available under the Money Follows the Person Demonstration Program and the State Balancing Incentive Payment Program provisions in federal law.

The full text of this statute may be found at http://www.cga.ct.gov/2011/act/pa/2011PA-00242-R00HB-06618-PA.htm

APPENDIX B

List of Attendees

Agency	Invitee Name
AARP Connecticut	Brenda Kelley
Agency On Aging Of South Central Connecticut	Cynthia Scott
Agency On Aging Of South Central Connecticut	Julie Gelgauda
Apple Health Care	Brian Bedard
ARC	Quincy Abbot
Avon and West Hartford Health and Rehabilitation	Russell Schwartz
Bureau of Rehabilitation Services	Amy L. Porter
Bureau of Rehabilitation Services	Patti J. Clay
Central Connecticut Senior Health Services	Patricia Walden
Communities	George Ducharme
Companions and Homemakers	Linda Grigerek
Companions and Homemakers	Martin Acevedo
Connecticut Association for Homecare and Hospice	Tracy Wodatch
Connecticut Association of Health Care Facilities	Matthew V. Barrett
Connecticut Commission on Aging	Deborah Migneault
Connecticut Community Care	Sherry Ostrout
Connecticut Community Care - Northwest	Beth Mielcarek
Connecticut Community Care - Northwest	Judy DiTommaso
Connecticut Community Colleges	Jane Williams

Agency	Invitee Name
Connecticut Hospital Association	James Iacobellis
Connecticut Housing Finance Authority	Nancy O'Brien
Connecticut Legal Rights Project, Inc.	Karyl Lee Hall
Connecticut State Senator	Edith Prague
Connecticut Women's Education and Legal Fund	Alice Pritchard
Consultant	Phyllis A. Belmonte
Consumer	Jessica Dybdahl for Heather Northrop
Corporation for Supportive Housing	Sarah Gallagher
Department of Developmental Services	Siobhan C Morgan
Department of Developmental Services - Commissioner	Macy, Terry
Department of Economic and Community Development	Frances Messina
Department of Mental Health & Addiction Services	Barbara Bugella
Department of Mental Health & Addiction Services	Jennifer Glick
Department of Mental Health & Addiction Services	Laurel Reagan
Department of Mental Health & Addiction Services	Megan Goodfield
Department of Mental Health & Addiction Services	Pat Rehmer
Department of Mental Health & Addiction Services	Steve Dilella
Department of Public Health	Maureen Klett
Department of Public Health	Wendy Furniss
Department of Public Health - Commissioner	Jewel Mullen
Department of Social Services	Christopher A. Lavigne
Department of Social Services	Frances A. Freer
Department of Social Services	Mairead Phillips
Department of Social Services	Mark C. Schaefer

Agency	Invitee Name
Department of Social Services - Alternate Care Unit	Kathy A. Bruni
Department of Social Services - Bureau of Aging, Comm. & Social Work	Pamela A. Giannini
Department of Social Services - Commissioner	Roderick L. Bremby
Department of Social Services - Deputy Commissioner	Claudette J. Beaulieu
Department of Social Services - Financial Management & Analysis	Helen Chan
Department of Social Services - Financial Management & Analysis	Krupali Patel
Department of Social Services - Financial Management & Analysis	Lee Voghel
Department of Social Services - Financial Management & Analysis	Mari Spallone
Department of Social Services - Financial Management & Analysis	Michael J. Gilbert
Department of Social Services - Financial Management & Analysis	Nick Venditto
Department of Social Services - Money Follows the Person	Barbara Swenson
Department of Social Services - Money Follows the Person	Dawn Lambert
Department of Social Services - Money Follows the Person	Eileen Murray
Department of Social Services - Money Follows the Person	Karen M. Law
Department of Social Services - Money Follows the Person	Michael Rooney
Department of Social Services - Money Follows the Person	Paul Ford
Department of Social Services - Money Follows the Person	Tamara Lopez
Department of Social Services - Money Follows the Person	Vanessa Soares Bowden
Department of Social Services - Public and Government Relations	Carolyn Treiss
Department of Social Services - Public and Government Relations	David S. Dearborn
Department of Social Services - Rate Setting	Kathleen A. Shaughnessy
Department of Social Services - Social Work Services	Dorian J. Long
Geer Nursing and Rehabilitation Center	John Horstman
Geer Nursing and Rehabilitation Center	John Horstman

Agency	Invitee Name
Genesis Healthcare (attended for Dick Blinn)	Patricia Quinn
Interim Health Care	Andrea Matthews
Interim HealthCare	Ben Petersen
Law Offices of Sharon L. Pope, LLC	Sharon L. Pope
LeadingAge Connecticut	Mag Morelli
Long Term Care Ombudsman Program	Nancy B. Shaffer
Manchester and Vernon Manor Health Care Centers	Paul Liistro
Masonicare	Steve McPherson
National Alliance on Mental Illness of CT	Alicia Woodsby
National Alliance on Mental Illness of CT	Sheila Amdur
National Healthcare Association	Marvin Ostreicher
National MS Society	Susan Raimondo
New England Home Care	Kim Nystrom
New England Home Care	Nancy Leonard
New Samaritan	Bill Fairbairn
Nursing Home Administration	Rosemarie Clark
Office of Policy and Management	Anne Foley
Office of Policy and Management	Barbara Wolf
Office of Policy and Management	Judith Dowd
Office of Policy and Management	Susan M. Eccleston
Office of Policy and Management - Secretary	Ben Barnes
Office of the Attorney General	Henry A. Salton
Organization & Skill Development	Laurie Ann Wagner
Revera Health Living	Tina Thomas

Agency	Invitee Name
Saint Joseph Living Center	Lynn Iverson
Southwestern Connecticut Agency on Aging	Chris Crain
Special Assistant	Khampasong Kantivong
State Commission on Aging	Julia Evans Starr
State Representative	Jonathan Steinberg
The Connecticut Association of Personal Assistance, Inc.	Cathy Ludlum
University of Connecticut Health Center - Center on Aging	Julie Robison
University of Connecticut Health Center - Center on Aging	Martha Porter
US Department of Housing and Urban Development	Suzanne Piacentini
VNA Healthcare, Ind. Living Svs	Michelle Parlato

* Mercer staff was in attendance to facilitate all stakeholder meetings

APPENDIX C

Formal Comments

CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC.

January 4, 2012

Connecticut Department of Social Services
Money Follows the Person Program
25 Sigourney Street
Hartford, CT 06106
Attn: Dawn Lambert, Program Director

Dear Dawn:

Thank you for this opportunity to submit additional comments on the draft Long-Term Care Right-Sizing Strategic Plan (from the input compiled and recorded at the November 30, 2011 strategic planning retreat). Please consider these additional comments as a supplement to the comments submitted on December 2, 2011, which continue to reflect the views of the Connecticut Association of Health Care Facilities (CAHCF) concerning the draft plan.

As is customary in governmental reports of this type, we are asking that our submitted comments be included as an addendum to the final report.

CAHCF looks forward to our ongoing participation in this stakeholder input process as Connecticut seeks to rebalance and right-size its long term care system in a manner which continues to recognize the strong need for high quality and financially viable nursing homes now and in the future.

Sincerely,

Matthew V. Barrett
Executive Vice President

111 Founders Plaza • Suite 1002 • East Hartford, CT 06108 • Telephone (860) 290-9424 • Fax (860) 290-9478

Connecticut Association of Health Care Facilities (CAHCF) Comments on Long-term Care Right-sizing Strategic Plan (draft) – January 4, 2012 – page 1

Page 3 – the draft report states: "A 2011 analysis of adults age 31 and over using Medicaid LTC services shows that Connecticut has the highest or the second highest nursing home rate per 1,000 population in each of the following categories in both 2000 and in 2008: Total state nursing home rate of use, rate of use for ages 31-64 and rate of use for age 65 and Older."

CAHCF Comment: The final rightsizing report should acknowledge that the unusually large numbers of persons age 90 and over in Connecticut from the most recent data, in large measure, explains higher nursing home utilization rates and thus should be a factor in the future NF/HCBS projections.

> The November 2011 report *90+ in the United States: 2006–2008* published by the U.S. Department of Health and Human Services and U.S. Department of Commerce offers an explanation as to why Connecticut needs more NF beds than the norm --- Connecticut ranks second in the number of persons over 90 year of age. The report states, "An older person's likelihood of living in a nursing home increases sharply with age." The report further states: "Almost everyone (98.2 percent) residing in institutional group quarters (e.g., nursing homes) had some type of disability, compared with 80.8 percent of those who lived in households or non-institutional group quarters. For most measures of disability, rates for those institutionalized were drastically higher than for those not institutionalized. The largest differences were in cognitive ability (concentrating, remembering, or making decisions) and limitations in dressing or bathing (indicator for ADL), with the institutionalized population aged 90 and older more than twice as likely to have those limitations than their non-institutionalized counterparts." Accordingly, age is the driver with respect to institutionalization and in that CT ranks second in terms of its over 90 population in the over 65 age cohort, demonstrates why more nursing home beds per 1,000 population are needed in CT than the norm. There is a simply correlation that explains the situation in CT --- CT ranks second in the nursing home rate per 1,000 population because CT ranks second in the percentage aged 90 and over of the age 65 and over.

Additional CAHCF Comments:

Page 12 - Add: Strategy: Create mechanisms to ensure quality in the care provided through HCBS. Add Tactics and Metrics for this Strategy. Training alone is not sufficient.

Connecticut Association of Health Care Facilities (CAHCF) Comments on Long-term Care Right-sizing Strategic Plan (draft) – January 4, 2012 – page 2

Page 22: #1.a. Change "LTC mantra" to "HCBS mantra."

#1.b. The authors of the draft report assume that NFs can somehow operate without physician orders, which is quite simply not possible. The issue is not having to have physician orders. The problem is how to obtain them outside the hospital setting.

Page 27 - Many of the recommendations here will require federal as well as state law changes. For example, if a "person-centered assessment" is developed, will NFs then be required to do that assessment in addition to the current 56-page MDS already required?

#15. Delete. Hospice services are already widely available in NFs.

#16. Clarify by adding "CHANGE THE FEDERAL exclusion of LTC providers for grants for electronic medical records."

January 4, 2012

Dawn Lambert
Project Director
Money Follows the Person Rebalancing Demonstration
Department of Social Services
Hartford, CT 06106

Re: Comments of LeadingAge Connecticut on the Draft Right-sizing Report

Dear Dawn:

On behalf of LeadingAge Connecticut, I would like to thank you for this opportunity to submit comments on the draft report of the right-sizing strategic planning retreat that was released on December 16, 2011. We appreciated the opportunity to participate in the retreat and the webinars that followed. We understand that our comments today are to be limited to edits and corrections related to the actual strategic planning retreat. We have also taken into consideration the written comments that we submitted immediately following the retreat. I have attached our page by page comments regarding the draft report on the forms provided by your office.

I would also like to offer the following general comments. We submit these general comments knowing that the report will be read and referred to by persons outside of the planning process and with limited knowledge of the long term care field. It is important that the final report not be misinterpreted or misrepresented by such readers.

- We have included in our submitted comments a suggestion that the report's title be changed to represent that it is not in itself a strategic plan, but rather a report of the potential strategies that were raised during a planning retreat. We would further request that the report include a disclaimer or explanation stating that while the strategies included in the report were all raised as a part of that planning retreat,

the report does not represent a consensus agreement or an endorsement of the strategies by the participants.

- The phase one projections that are set forth on page one are estimates of the future demand, but no explanation is provided to the reader as to how that will be measured, monitored or adjusted over time, even though we have been told that they will be reviewed every six months. While the potential phase two data analysis could include a live data book, it would be helpful to make it clear to the reader at the onset of the report that the macro view projections will be closely monitored. We would also like to note that we would find a detailed a trend analysis over the projected time period to be very helpful and we are looking forward to the second phase of the data analysis.

- We continue to question whether "65 and over" is this the correct demographic to use in estimating demand for long term care services and supports. While our membership reports a higher average age of entrance into the system for aging services, there are individuals of all ages who will potentially need long term care services and supports. Again, we look forward to the second phase of the data analysis to provide more detail into the demand trends for all ages and demographics.

- We are hopeful that the second phase of data analysis will include current and projected demand for nursing home beds for uses other than Medicaid funded long term care stays such as for short term rehabilitation stays.

- The report never explains the next steps in the planning process or how the actual strategic plan will be developed or implemented. This information is important to the reader's understanding of the report.

- We note a general lack of recognition that the discontinuance, diversification, or development of long term care services and supports is a not only a strategic decision, but is also a business decision for providers and must be viewed and evaluated within that context. Issues such as financial and contractual obligations, economies of scale, market share, and capital investment are very important and must be taken into consideration when making these decisions.

- There is an emphasis in the report on the creation of new businesses/entities and little recognition of new services derived from potential partnerships and collaborations between existing providers/businesses. This is notable in the tactics and metrics

sections where there is a reliance on measuring the development of new businesses rather than measuring client outcomes, satisfaction and experience.

- There is also a lack of potential strategies and tactics to achieve nursing home modernization. The need to invest in nursing home infrastructure and modernization, including electronic medical records and technology, is crucial to the entire long term care system and therefore to the rightsizing planning process.

- We again would encourage the state to create a collaborative and efficient regulatory and reimbursement environment that is adaptive and receptive to individual provider's forward thinking ideas and planning. Such an environment would encourage providers of the long term care continuum to adjust, modernize and diversify their models of care to address current and future consumer needs and expectations.

Thank you again for the opportunity to provide these comments and we look forward to continuing our involvement as the planning process moves forward.

Sincerely,

Mag Morelli

Mag Morelli, President
LeadingAge Connecticut
1340 Worthington Ridge
Berlin, CT 06037
mmorelli@leadingagect.org
(860) 828-2903

MERCER
MAKE TOMORROW, TODAY

STATE OF IDAHO

STAKEHOLDER COMMUNICATION PLAN

Version 1.3

Mercer Government Human Services Consulting

NOTE: Detailed information within this communication plan has been deleted for the purposes of RFP response XXX to limit the amount of information necessary for evaluator's review.

MARSH & McLENNAN COMPANIES

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1

Stakeholder Communication Plan Goals

Consistent, effective, and accurate communication is critically important to ensure that the collaboration needed to reach Idaho's healthcare transformation goals is achieved. Idaho's transformation goals are bold and far-reaching, requiring communications with stakeholders throughout the State to explain the benefits of the patient-centered medical home (PCMH) model, to recruit healthcare practices and those in the Medical/Health Neighborhood to participate in implementation of the model, and engage local and State partners in improving population health. In addition, efficient and effective internal communication is needed between Idaho Healthcare Coalition (IHC) members, Idaho Health and Welfare Department (IDHW) staff, workgroup members, advisory groups, Regional Health Collaboratives (RCs), contractors, and federal agency staff to ensure State Innovation Model (SIM) Model Test activities are coordinated and milestones and goals are achieved.

This Stakeholder Communication Plan describes the general communication activities that the IHC and IDHW will undertake both internally and with external stakeholders to carry out Idaho's healthcare transformation and SIM Model Test activities. The activities and processes outlined in the Communication Plan are intended to help IHC and IDHW effectively manage communications to achieve the goals of:

1. Communicating a clear vision of the transformation process and realized system.
2. Delivering a consistent message to all stakeholders.
3. Using the right language to provide an effective, audience accessible message.
4. Communicating with the appropriate levels of clarity and detail.
5. Answering stakeholder questions accurately and in a timely manner.
6. Tracking stakeholder feedback, concerns, and questions in order to use stakeholder input to further advance transformation.
7. Outlining the process for evolving the transformation message as new communication needs emerge.

In addition to these goals, planned communication with external stakeholders also aims to:

- Effectively introduce the transformation broadly to a variety of stakeholders, including:
  a. Patients
  b. The general public

c. Primary care providers
d. Policymakers
e. RCs
f. Ancillary service providers and non-medical community-based organizations that make up the Medical/Health Neighborhood.

- Effectively market the changes in healthcare delivery and payment reform to achieve statewide participation in and future sustainment of the model.

The Communication Plan describes the strategies and activities that will be developed, deployed, measured, and reported to ensure the communication processes facilitate effective delivery of the messaging to both internal and external stakeholders.

2

Internal Stakeholder Communication Messages and Activities

Note: This section in Idaho's communication plan includes information identifying Idaho's internal stakeholders and has been deleted here.

A communications matrix will serve as a roadmap for producing and disseminating messages to internal stakeholders to ensure that communications occur appropriately and consistently. The matrix includes the following information:

- Person(s) or groups who will receive the information.
- Information to be communicated.
- The delivery method and frequency of the communication.
- Person(s) or organization(s) responsible for communicating the information.

Communication Matrix for Internal Stakeholders

Note: The table below is only a sample section of the communication matrix included in Idaho's Communication Plan.

Audience	Message	Delivery Method and Frequency	Communicator
IHC Workgroups	IHC information and decisions.	Monthly and as needed through IHC meeting agendas, minutes, and presentations.	• IHC co-chairs • IDHW SHIP Team
	Operational Plan updates.	Monthly through updated Operational Plan and dashboards.	• IDHW SHIP Team
	Workgroup status reports.	Monthly through IHC meeting agendas, minutes, and presentations.	• IDHW SHIP Team

3

External Stakeholder Communication Plan Strategies and Activities

External stakeholders are those who are not directly participating in Idaho's healthcare transformation governance or organizational structure at the State or regional level, but are individuals and organizations that will likely impact and/or be impacted by Idaho's healthcare system transformation. These stakeholders represent broad and diverse interests across the State. To effectively introduce the transformation broadly and market participation in the new healthcare system model, Idaho has identified key audiences that will receive targeted communications in order to help accelerate and sustain changes to Idaho's healthcare delivery and payment system.

Key External Stakeholders

Note: This section of Idaho's Communication Plan includes information that identifies goals for stakeholder engagement , Idaho's external stakeholders, key messages to be communicated, and strategies for engagement.

Key messages have been identified for each of the external stakeholder groups to clearly convey the vision and goals for Idaho's healthcare transformation. In addition, the messages will be designed to *effectively* market the changes to the healthcare system to convey the benefits of the model and achieve statewide participation. In preparation for presentations and messaging, the platform should include the key messaging elements identified for each external stakeholder group; however, special attention should be paid to the return on investment and "what's in it for me?" statements that will require customization depending on the audience.

A toolkit (see Section 4) is being developed, and will include resources to help facilitate effective and consistent communications. Resources will include materials, such as presentations and talking points with key messages, for key stakeholder groups. The toolkit will also include a list of individuals who have agreed to be a primary communicator for certain external key stakeholder groups, so that others may contact them as a resource for communicating with specific audiences.

Note: The table below is only a sample section of the communication matrix for external stakeholders included in Idaho's Communication Plan.

Audience: Patients and Community Members	
Purpose of the Communication	To increase understanding of how care will be improved and what benefits they will see.
Key Messages	a. You will receive better care because the services you receive will be coordinated. b. Your usual source of care is where your care will be coordinated. c. Coordination of your care will be delivered by a team. d. You are an important part of your healthcare team, and there will be many opportunities for you to take an active role in your care and learn how to improve your health with the support of your team. e. Information about when patients and community members can expect to see these benefits at their usual source of care.
Communicators	RC, RCE, PHD SHIP staff, healthcare provider members of the IHC.
Delivery Frequency	Frequency TBD in coordination with PCMHs and other stakeholders.
Delivery Method	Town hall meetings, opinion editorials, news media updates, and SHIP website.
Resources/Materials Needed	Presentation, talking points, brochures/handouts, and FAQs.

4

Toolkit

Note: The information in this section has been revised to provide only a sample of the information included in Idaho's Communication Plan.

A toolkit of multi-audience communication strategies will be maintained to provide those who are participating in external stakeholder communication activities with a core set of materials that can be tailored and used for communication and education of external stakeholders. The toolkit will include presentations, FAQs, and other documents that will be updated as the transformation occurs.

A list of common acronyms and definitions will be included in the toolkit to facilitate understanding of the transformation across all internal and external stakeholders. This list should be used when developing and distributing communication documents.

Lastly, the toolkit will also include a list of individuals who have agreed to be a primary communicator for certain external key stakeholder groups, so that others may contact them as a resource for communicating with specific audiences.

The toolkit will also suggest communication platforms that are believed to be appropriate for the intended audience to facilitate opportunities to communicate with external stakeholders. The following table provides an overview of the communication platforms for each external stakeholder group. A list of communication platforms available in Idaho will be maintained and can be found in Appendix B. The list will be updated regularly as new communication platforms are identified.

Communication Platform	Patients	Primary Care Providers	Medical/Health Neighborhood	RCs	Payers	Policymakers
Website	✓	✓	✓	✓	✓	✓
White Paper		✓	✓	✓	✓	✓
Presentation Slide Deck	✓	✓	✓	✓		✓
Fact Sheet	✓	✓	✓	✓		✓

Communication Platform	Patients	Primary Care Providers	Medical/Health Neighborhood	RCs	Payers	Policymakers
Social Media	✓					
Testimonials	✓	✓		✓	✓	✓
Talking Points	✓	✓		✓	✓	✓
Recruitment Toolkit		✓	✓	✓		

Accessing the Toolkit

This section includes information on how to access the Toolkit materials in Idaho's Communication Plan

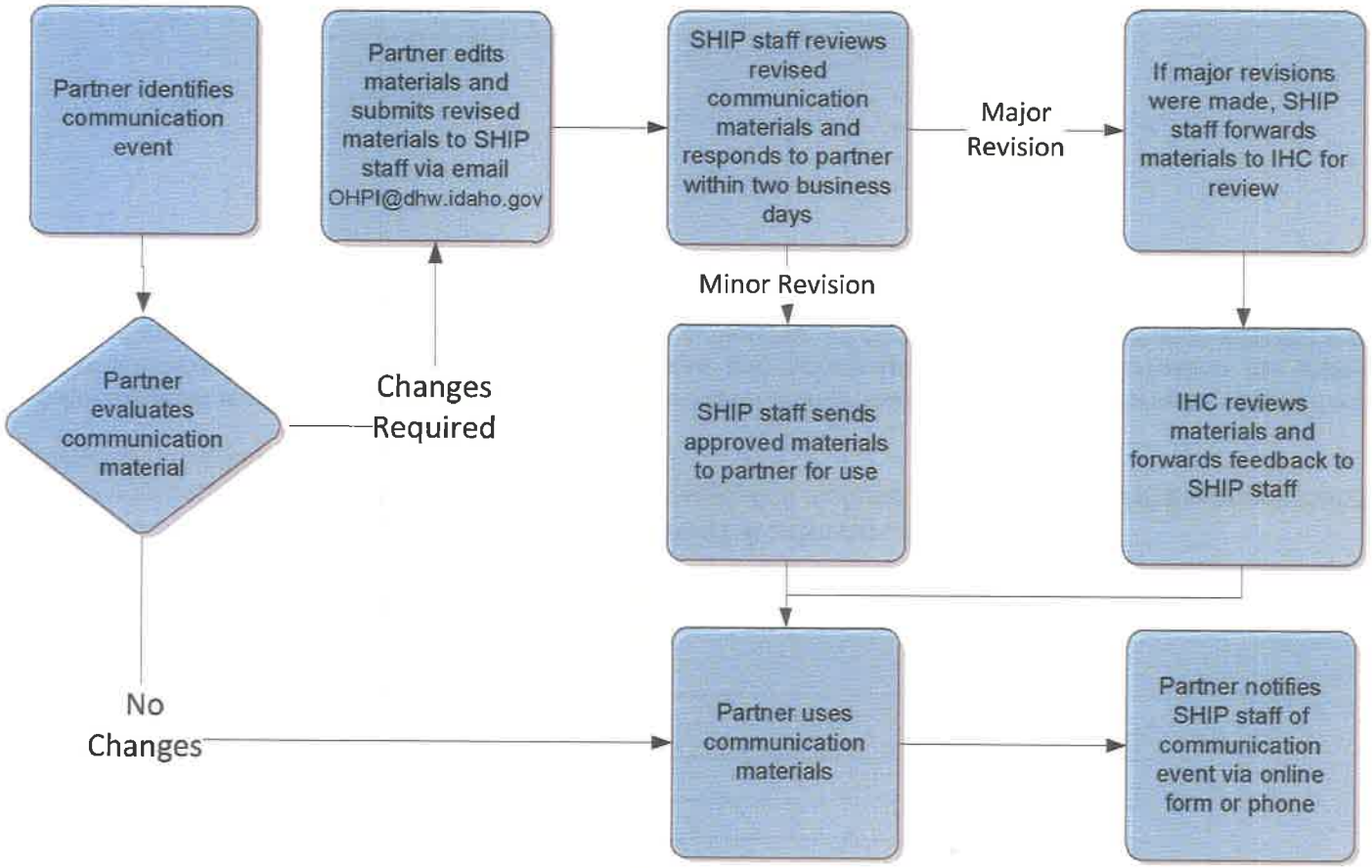
Tailoring Communication Material to Different Audiences

In the Plan, this section includes information on why communication material should be tailored to the unique needs of audiences and the process for modifying Toolkit materials.

The communication toolkit is intended to provide a standard level of information in a variety of formats, targeted to six broad external stakeholder groups. While each toolkit will be unique and include audience-specific information, the underlying intent of the Communication Plan is to reach the widest of audiences. To do so effectively, information should be as relevant to the audience and up-to-date as possible to generate deeper stakeholder interest and engagement. This will require tailoring of the toolkit materials by stakeholder partners to reflect the needs and concerns of the specific audience with up-to-date information.

Material Modification Review Process

Figure 4 — Communication Material Revision Process



5

Stakeholder Communication Monitoring and Control

Note: The information throughout Section 5 has been revised to provide only a sample of the information included in Idaho's Communication Plan.

Monitoring Process

Despite best intentions, a communication plan without checks and balances will produce hollow results. Actively monitoring communication activities and collecting feedback will inform if the communication plan is being followed as planned and, if necessary, where it should be modified. It is important that partners understand expectations, processes, and appropriate SHIP staff contacts to support the execution of the Communication Plan and to support its evolution in an effective and productive manner. The Communication Plan should be a living, breathing document, as should the process for monitoring it.

Monitoring Communication Materials

In addition to reviewing materials for each communication event, SHIP staff will also review all toolkit materials on a regular basis using a messaging review checklist to ensure that the general messaging of materials is up to date with the latest information. Refer below for a sample checklist. The review will ensure that the materials are:

1. Communicating a clear vision of the transformation process and realized system.
2. Delivering a consistent message to all stakeholders.
3. Using the right language to communicate effectively.
4. Communicating with the appropriate levels of clarity and detail.
5. Effectively introducing the transformation broadly to a variety of stakeholders.
6. Effectively marketing the changes in healthcare delivery and payment reform to achieve statewide participation in and future sustainment of the model.

SAMPLE CHECKLIST

Messaging Checklist for Review Process

Y	N		
☐	☐	1.	Do the materials align with the intended purpose of the messages for the specific audience (see key messages identified in Section 3 of the Communication Plan)?
☐	☐	2.	Do the messages in the material contradict key messages described in Section 3 of the Communication Plan?
☐	☐	3.	Is the person communicating considered to be part of the primary communicators group listed in Section 3 of this Plan?
☐	☐	4.	Does the method and frequency of the communication comply with the requirements in Section 3 of this Plan?

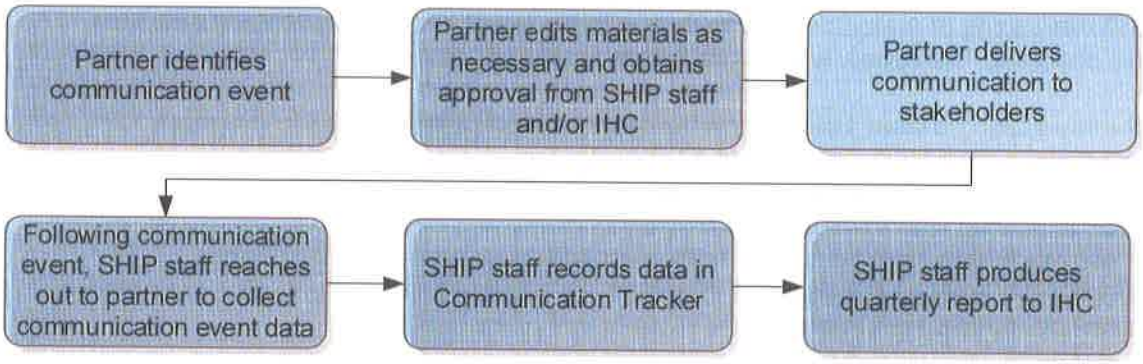
☐	☐	5.	Are the resources and materials needed to communicate available and appropriate?
☐	☐	6.	Is a clear vision of the transformation process and realized system reflected in the materials and presentation?
☐	☐	7.	Do the materials and presentation reflect that a consistent message to all stakeholders is being delivered?
☐	☐	8.	Is the right language used to communicate an effective, audience accessible message?
☐	☐	9.	Is the message delivered with the appropriate levels of clarity and detail?
☐	☐	10.	Does the messaging effectively introduce the transformation broadly to the specific stakeholder group?
☐	☐	11.	Does the message effectively market the changes in healthcare delivery and payment reform to achieve statewide participation in and future sustainment of the model?

Communication Reporting Process (Post Communication Event)

Reporting on communication activities is an important part of the communication monitoring process.

Sample illustration of the Communication Reporting Process.

Figure 5 — Communication Event Reporting



Other Monitoring Activities

In addition to monitoring communications with external stakeholders, the SHIP communication staff member will monitor other components of the plan, including use of broad-based communication tools and the internal stakeholder communication matrix.

Communication Tracker Template

A communication tracker template to easily identify what communications have been made, when they occurred, and what future communications are scheduled will be maintained to assist IHC and IHDW in ensuring statewide communications.

Communication Change Management

When changes to the Communication Plan occur, the revision will be documented using the Document Change Control form below.

Version Number	Date of Issue	Author(s)	Brief Description of Change

Communication Plan Signatures

SAMPLE OF DOCUMENTS IN APPENDICES

Communications Tracker

Stakeholder Group	Date of Communication	Time of Communication	Type of Communication (Email, Presentation, etc.)	Materials Presented	# Stakeholders Reached	Issues/Concerns/ Comments
	Insert Month					
	Insert next month					

Communications Platforms

Communication Platform	Purpose	Owner
Idaho SHIP Website	To provide information to the public on the model and updates on its implementation.	IDHW
Idaho Public Health Association (IPHA) website	To inform and engage participation in healthcare transformation among members of the IPHA.	IPHA
IHDE quarterly newsletter	To provide information to IHDE membership on the model and updates on its implementation.	IHDE
Idaho Medical Association newsletter	To provide in-depth, educational information to membership on the model, focusing on primary care practitioners and specialists in the Medical/Health Neighborhood.	IMA
Family Medicine Residency of Idaho newsletter	To provide information and education regarding the model, with a focus on relevant workforce issues, such as the CHW and CHEMS opportunities.	Family Medicine Residency of Idaho
Idaho Primary Care Association website	To provide education information on the model and updates on its implementation.	IPCA

MEDICAID
Preserving the Program Now and for the Future

Tribal Consultation Meeting Presentation

Julie Weinberg, Director, Medical Assistance Division
New Mexico Department of Human Services

Preserving Medicaid

- Medicaid is a critical safety net health care program for New Mexico
- 1 out of every 4 New Mexicans receives health care through the Medicaid program
- Medicaid spending will rise to 16% of our total state budget by next year
- The number of people relying on the program is growing because of our state's poor economy. The numbers will grow even more in 2014 when newly eligible people come on the program
- We must do everything we can now to protect and preserve the program and to assure that we spend our limited resources fairly and wisely.

The Four Principles of Medicaid Preservation

Principle 1: *Develop and Implement a Comprehensive, Coordinated Service Delivery System*

- Health Plans will provide and manage a full array of services and wellness to acute medical services through home and community-based and long-term care services; this will replace our existing, fragmented systems of care
- Care Coordination will be at the heart of our comprehensive system of care; members with special health care needs will receive a health assessment and work with a care coordinator to develop a plan of care to address their medical needs
- We are seeking additional input about how best to provide for the home and community based needs of all our members; what services do we need to have more of and how can we help families keep their loved ones at home whenever possible.
- We are still thinking about how best to deliver home and community based services to those with developmental disabilities or those needing behavioral health services.

The Four Principles of Medicaid Preservation (cont'd)

Principle 2: *Personal Responsibility*

- Research tells us that everyone (whether insured through Medicaid, Medicare, or privately) uses health care resources more wisely if they have some personal responsibility for the cost of care.
- We are looking at various ways to increase everyone's sense of responsibility; one way is to ask people to help pay a little bit for the cost of their care and another is to reward people who become actively engaged in healthy behaviors
- We think the right approach is a combination of both
- We have some questions that we will be seeking your help with as we figure out the best ways to increase personal responsibility

The Four Principles of Medicaid Preservation (cont'd)

Principle 3: *Pay for Performance*

- In today's health care system, health care providers and health plans tend to get paid whether or not the services they provide lead to healthier people
- The State is interested in ways to make sure that what we pay for is quality care; care that helps people be as healthy as they can be
- We want work with our health care providers to identify the kinds of health outcomes we want for our people and then reward them for achieving those outcomes.

The Four Principles of Medicaid Preservation (cont'd)

Principle 4: *Administrative Simplicity*

- Right now, our Medicaid program operates under 13 different kinds of federal authority. We want to simplify our system so that we can focus our attention and energy on managing our health plans and working with our health care providers.
- We believe the right way to do this is to have our whole Medicaid program authorized by a single, 1115 waiver. This is NOT a block grant.

Tribal Consultation Question # 1: Opt In or Opt Out?

- Currently the Salud Managed Care program includes an "opt out" option for Native Americans. The CoLTS Program does not.
- Should the Modernization include an "opt out" option for Native Americans?
  - What are the benefits to Native American Medicaid recipients of "opting out"?
  - What are the benefits of staying within a statewide coordinated care system?
  - If there was no opt-out option in the Modernization, what concerns in the Native American communities should be addressed?

Tribal Consultation Question # 2: The Role of Traditional Healers

- How could the traditional resources in tribal communities contribute to improved health status?
- What role should Traditional Healers play in the New Mexico Medicaid Modernization?
- What kinds of supports do Native Americans need to be successful in taking more responsibility for their personal health?

Tribal Consultation Question # 3: The Role of Tribal Health Systems

- What opportunities do you see for your own health care delivery systems to play in the New Mexico Modernization, especially tribal 638 facilities? Some opportunities could be:
  - Accountable Care Organizations (ACOs) with increased management responsibilities for care delivery
  - Medical Home model with an increased role in care coordination
  - Fee-for-Service providers
  - Other?
- What role will 638 facilities and IHS providers play in the 1115 waiver?
- How will the concept of pay-for-performance be applied to 638 and IHS providers?

Tribal Consultation Question #4: Program Simplification

- What ideas do you have that would help us to simplify administration of the Medicaid program for Native Americans and decrease the burden on your providers and administrative staff?

Tribal Consultation Question # 5
What are the Priorities for Health Care Interventions?

Examples:

- Obesity, Diabetes ,and Hypertension
- Long Term Care for the Elderly and Disabled
- Maternal and Child Health
- Mental Health and Substance Abuse
- Suicide and Accidental Trauma
- Other?

Other Opportunities for Input

- The State has a website that has more information about our Modernization project.
- The web site address is: http://www.hsd.state.nm.us/Medicaid%20Modernization/index.html

NASUAD
National Association of States United for Aging and Disabilities

Agenda

Oklahoma LTSS Reform: Site Visit

Oklahoma City, OK

WEDNESDAY, OCTOBER 7, 2015

5:00 pm to 7:00 pm	**Dinner and Briefing of State Aging Director**

THURSDAY, OCTOBER 8, 2015

8:00 am to 9:00 pm	**Breakfast with former Medicaid Director Mike Fogarty**
9:30 am to 12:00 pm	**Briefings with Key Managers of Aging Department on Possible Impact of LTSS Reform** Oklahoma Staff: in-person/ Tulsa staff: on phone • Discussion of No Wrong Door/ADRC • Impact to AAAs/CILs • Potential Impact on Agency Budget • How to Measure Quality in the New System (Possibly using NCI-AD)
12:00 pm to 1:00 pm	**Lunch**
1:00 pm to 3:00 pm	**Facilitated Dialogue between Key State Staff and MCOs** Discussion topics based on issues raised by staff prior to visit • National trends in MLTSS • Differences between waiver program and MCOs

	• Potential state and local staffing issues • Finding Sufficient Providers in Rural Districts
3:00 pm to 5:00 pm	**Facilitated Stakeholder Dialogue with Key Advocacy Groups, State Aging Department Staff, and MCOs**

FRIDAY, OCTOBER 9, 2015

8:00 am to 9:00 am	**Meeting with OHCA to discuss LTSS Reform** • National trends in MLTSS • Role Aging and Disability Agencies Play in Other states Potential Impact on Agency Budget • Unique opportunities and challenges for Oklahoma
9:30 am to 11:00 am	**Meeting with Key Providers and MCOs** Discussion informed by input prior to visit • AAAs Association • President of Waiver Provider Group • Disability Rights • CILs • Parent Advocacy Groups
11:00 am to 12:00 am	**Wrap Up and Summary of Discussion with State Aging and Medicaid Staff**

NASUAD
National Association of States United for Aging and Disabilities

Agenda

Rebalancing for the Future

A Forum on Long Term Care in Indiana

University of Indianapolis, Indiana

WEDNESDAY, DECEMBER 16, 2015

9:30 am to 10:00 am	**Registration**
10:00 am to 10:15 am	**Welcome** • Dr. John Wernert, Secretary, Indiana Family and Social Services Administration • Yonda Snyder, Director Indiana Division of Aging • Joe Moser, Indiana Medicaid Director
10:15 am to 11:15 am	**Why is Innovation in Long Term Care Challenging?** Moderator: • Ellen Miller, Director University of Indianapolis Center for Aging & Community Panelists: • Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities • Matt Salo, Executive Director, National Association of Medicaid Directors • Mary Lee Fay, Executive Director, National Association of State Directors of Developmental Disabilities
11:15 am to 1:00 pm	**Panel Discussion: Been There, Done That: A Conversation with States** Moderator: • Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities

	Panelists: • Gary Jessee, Medicaid Director, Texas Health and Human Services Commission • Dave Halferty, Senior Manager, Myers and Stauffer, former Chief Financial Officer at Kansas Department on Aging
1:00 pm to 2:30 pm	**Luncheon Plenary: AARP Scorecard: How Does Indiana Stack Up?** • Elaine Ryan, Vice President of State Advocacy & Strategy Integration Liaison, AARP
2:30 pm to 3:00 pm	**Indiana's Current Medicaid Spending on Long Term Care** • Christine Mytelka, Principal and Consulting Actuary, Milliman
3:00 pm to 3:15 pm	**Break**
3:15 pm to 4:30 pm	**Panel Discussion: Indiana's Rebalancing Project** Moderator: • June Lyle, Regional Vice President, AARP Panelists: • Joe Moser, Indiana Medicaid Director • Yonda Snyder, Director Indiana Division of Aging • Debbie Pierson, Deputy Director of Operations, Division of Aging • Chris Fletcher, Director, Reimbursement Section, FSSA
4:30 pm to 5:00 pm	**Wrap Up and Next Steps** • Joe Moser, Indiana Medicaid Director • Yonda Snyder, Director Indiana Division of Aging

Mercer Health & Benefits LLC
333 S. 7th Street, Suite 1400
Minneapolis, MN 55402 USA

State of Nebraska
REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

RETURN TO:
DHHS-MLTC Attn: Julie Gillmor
Post Office Box 95026
Lincoln, NE 68509
Phone: (402) 471-3371
Fax: (402) 742-1155

SOLICITATION NUMBER	RELEASE DATE
RFP 2016-LTSSZ1	**March 11, 2016**
OPENING DATE AND TIME	PROCUREMENT CONTACT
April 7, 2016 2:00 p.m. Central Time	**Julie Gillmor**

This form is part of the specification package and must be signed in ink and returned, along with proposal documents, by the opening date and time specified.

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska, Department of Health and Human Services (DHHS), is issuing this Request for Proposal, RFP Number 2016-LTSSZ1 for the purpose of selecting a qualified Contractor to provide long-term supports and services (LTSS) redesign consultation.

Written questions are due no later than March 22, 2016, and should be submitted via e-mail to dhhs.ltssrfp@nebraska.gov. Written questions may also be sent by facsimile to (402) 742-1155.

Bidder should submit one (1) original of the entire proposal. Proposals must be submitted by the proposal due date and time.

PROPOSALS MUST MEET THE REQUIREMENTS OUTLINED IN THIS REQUEST FOR PROPOSAL TO BE CONSIDERED VALID. PROPOSALS WILL BE REJECTED IF NOT IN COMPLIANCE WITH THESE REQUIREMENTS.

1. Sealed proposals must be received in DHHS, Division of Medicaid and Long-Term Care (MLTC) by the date and time of proposal opening indicated above. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.
2. This form "REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES" MUST be manually signed, in ink, and returned by the proposal opening date and time along with bidder's proposal and any other requirements as specified in the Request for Proposal in order to be considered for an award.
3. It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchasing.html

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. § 84-602.02, all State contracts in effect as of January 1, 2014, and all contracts entered into thereafter, will be posted to a public website. Beginning July 1, 2014, all contracts will be posted to a public website managed by the Department of Administrative Services.

In addition, all responses to Requests for Proposals will be posted to the Department of Administrative Services public website. The public posting will include figures, illustrations, photographs, charts, or other supplementary material. Proprietary information identified and marked according to state law is exempt from posting. To exempt proprietary information you must submit a written showing that the release of the information would give an advantage to named business competitor(s) and show that the named business competitor(s) will gain a demonstrated advantage by disclosure of information. The mere assertion that information is proprietary is not sufficient. (Attorney General Opinion No. 92068, April 27, 1992) The agency will then determine if the interests served by nondisclosure outweigh any public purpose served by disclosure. Cost proposals will not be considered propriety.

To facilitate such public postings, the State of Nebraska reserves a royalty-free, nonexclusive, and irrevocable right to copy, reproduce, publish, post to a website, or otherwise use any contract or response to this RFP for any purpose, and to authorize others to use the documents. Any individual or entity awarded a contract, or who submits a response to this RFP, specifically waives any copyright or other protection the contract or response to the RFP may have; and, acknowledge that they have the ability and authority to enter into such waiver. This reservation and waiver is a prerequisite for submitting a response to this RFP and award of the contract. Failure to agree to the reservation and waiver of protection will result in the response to the RFP being non-conforming and rejected.

Any entity awarded a contract or submitting a RFP agrees not to sue, file a claim, or make a demand of any kind, and will indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the posting of contracts, RFPs and related documents.

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions unless otherwise agreed to (see Section III) and certifies that bidder maintains a drug free work place environment.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ NEBRASKA CONTRACTOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

_____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

FIRM: _____

COMPLETE ADDRESS: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

SIGNATURE: _____ DATE: _____

TYPED NAME AND TITLE OF SIGNER: _____

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GLOSSARY OF TERMS

Acceptance Test Procedure: Benchmarks and other performance criteria, developed by the State of Nebraska or other sources of testing standards, for measuring the effectiveness of products or services and the means used for testing such performance.

Addendum: Something to be added or deleted to an existing document; a supplement.

After Receipt of Order (ARO): After Receipt of Order

Agency: Any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any other office or agency established by the Constitution of Nebraska.

Agent/Representative: A person authorized to act on behalf of another.

Amend: To alter or change by adding, subtracting, or substituting.

Amendment: A written correction or alteration to a document.

Appropriation: Legislative authorization to expend public funds for a specific purpose. Money set apart for a specific use.

Award: All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

Best and Final Offer (BAFO): In a competitive bid, the final offer submitted which contains the bidder's (vendor's) most favorable terms for price.

Bid/Proposal: The offer submitted by a vendor in a response to written solicitation.

Bid Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the vendor will not withdraw the bid.

Bidder: A vendor who submits an offer bid in response to a written solicitation.

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity.

Business Day: Any weekday, except State-recognized holidays.

Calendar Day: Every day shown on the calendar including Saturdays, Sundays, and State/Federal holidays.

Cancellation: To call off or revoke a purchase order without expectation of conducting or performing it at a later time.

Central Processing Unit (CPU): Any computer or computer system that is used by the State to store, process, or retrieve data or perform other functions using Operating Systems and applications software.

Collusion: An agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful, or unlawful purpose.

Commodities: Any equipment, material, supply or goods; anything movable or tangible that is provided or sold.

Commodities Description: Detailed descriptions of the items to be purchased; may include information necessary to obtain the desired quality, type, color, size, shape, or special characteristics necessary to perform the work intended to produce the desired results.

Competition: The effort or action of two or more commercial interests to obtain the same business from third parties.

Confidential Information: Unless otherwise defined below, "Confidential Information" shall also mean proprietary trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In

accordance with Nebraska Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Contract: An agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law; the writing that sets forth such an agreement.

Contract Administration: The management of the contract which includes and is not limited to contract signing, contract amendments and any necessary legal actions.

Contract Management: The management of day to day activities at the agency which includes and is not limited to ensuring deliverables are received, specifications are met, handling meetings and making payments to the Contractor.

Contract Period: The duration of the contract.

Contractor: Any individual or entity having a contract to furnish commodities or services.

Cooperative Purchasing: The combining of requirements of two or more political entities to obtain advantages of volume purchases, reduction in administrative expenses or other public benefits.

Copyright: A property right in an original work of authorship fixed in any tangible medium of expression, giving the holder the exclusive right to reproduce, adapt and distribute the work.

Critical Program Error: Any Program Error, whether or not known to the State, which prohibits or significantly impairs use of the Licensed Software as set forth in the documentation and intended in the contract.

Customer Service: The process of ensuring customer satisfaction by providing assistance and advice on those products or services provided by a Contractor.

Default: The omission or failure to perform a contractual duty.

Deviation: Any proposed change(s) or alteration(s) to either the terms and conditions or deliverables within the scope of the written solicitation or contract.

Evaluation: The process of examining an offer after opening to determine the vendor's responsibility, responsiveness to requirements, and to ascertain other characteristics of the offer that relate to determination of the successful award.

Evaluation Committee: Committee(s) appointed by the requesting agency that advises and assists the procuring office in the evaluation of bids/proposals (offers made in response to written solicitations).

Extension: Continuance of a contract for a specified duration upon the agreement of the parties beyond the original Contract Period. Not to be confused with "Renewal Period".

Free on Board (F.O.B.) Destination: The delivery charges are included in the quoted price and prepaid by the vendor. Vendor is responsible for all claims associated with damages during delivery of product.

Free on Board (F.O.B.) Point of Origin: The delivery charges are not included in the quoted price and are the responsibility of the agency. Agency is responsible for all claims associated with damages during delivery of product.

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of another state, government, or country.

Installation Date: The date when the procedures described in "Installation by Contractor", and "Installation by State", as found in the RFP, or contract is completed.

Late Bid/Proposal: An offer received after the Opening Date and Time.

Licensed Software Documentation: The user manuals and any other materials in any form or medium customarily provided by the Contractor to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently.

Long Term Supports and Services (LTSS): Supports and services provided to individuals of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the individual to live or work in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a

nursing facility, or other institutional setting. These are largely non-medical and focused on functionally supporting people living in the community and notes that individuals with chronic illnesses include those with mental health conditions and substance use disorders.

LTSS service delivery system: All processes for provision of LTSS, from an individual's initial eligibility determination and assessment, through care planning, service delivery, documentation, claims payment, monitoring and quality improvement activities. This also includes infrastructure associated with provision of services such as statutory and regulatory authorities, information systems, policies and procedures, and responsible entities.

Managed care model: A health care delivery system organized to manage cost, utilization and quality.

Mandatory/Must: Required, compulsory, or obligatory.

May: Discretionary, permitted; used to express possibility.

Module (see System): A collection of routines and data structures that perform a specific function of software.

Must: See Shall/Will/Must.

National Institute for Governmental Purchasing (NIGP): National Institute of Governmental Purchasing – Source used for assignment of universal commodity codes to goods and services.

Open Market Purchase: Authorization may be given to an agency to purchase items above direct purchase authority due to the unique nature, price, quantity, location of the using agency, or time limitations by the AS Materiel Division, State Purchasing Bureau.

Opening Date and Time: Specified date and time for the public opening of received, labeled, and sealed formal proposals.

Operating System: The control program in a computer that provides the interface to the computer hardware and peripheral devices, and the usage and allocation of memory resources, processor resources, input/output resources, and security resources.

Outsourcing: The contracting out of a business process which an organization may have previously performed internally or has a new need for, to an independent organization from which the process is purchased back.

Payroll & Financial Center (PFC): Electronic procurement system of record.

Performance Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the Contractor fulfills any and all obligations under the contract.

Platform: A specific hardware and Operating System combination that is different from other hardware and Operating System combinations to the extent that a different version of the Licensed Software product is required to execute properly in the environment established by such hardware and Operating System combination.

Pre-Bid/Pre-Proposal Conference: A meeting scheduled for the purpose of clarifying a written solicitation and related expectations.

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption.

Program Error: Code in Licensed Software which produces unintended results or actions, or which produces results or actions other than those described in the specifications. A program error includes, without limitation, any Critical Program Error.

Program Set: The group of programs and products, including the Licensed Software specified in the RFP, plus any additional programs and products licensed by the State under the contract for use by the State.

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and services to be provided under the contract.

Proposal: See Bid/Proposal.

Proprietary Information: Proprietary information is defined as trade secrets, academic and scientific research work which is

in progress and unpublished, and other information which if released would give advantage to business competitors and service no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific named competitor(s) advantaged by release of the information and the demonstrated advantage the named competitor(s) would gain by the release of information.

Protest/Grievance: A complaint about a governmental action or decision related to a Request for Proposal or resultant contract, brought by a vendor who has timely submitted a bid response in connection with the award in question, to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Public Proposal Opening: The process of opening correctly submitted offers at the time and place specified in the written solicitation and in the presence of anyone who wished to attend.

Recommended Hardware Configuration: The data processing hardware (including all terminals, auxiliary storage, communication, and other peripheral devices) to the extent utilized by the State as recommended by the Contractor.

Release Date: The date of public release of the written solicitation to seek offers

Renewal Period: Optional contract periods subsequent to the original Contract Period for a specified duration with previously agreed to terms and conditions. Not to be confused with Extension.

Request for Information (RFI): A general invitation to vendors requesting information for a potential future solicitation. The RFI is typically used as a research and information gathering tool for preparation of a solicitation.

Request for Proposal (RFP): A written solicitation utilized for obtaining competitive offers.

Responsible Bidder: A bidder who has the capability in all respects to perform fully and lawfully all requirements with integrity and reliability to assure good faith performance.

Responsive Bidder: A bidder who has submitted a bid which conforms to all requirements of the solicitation document.

Shall/Will/Must: An order/command; mandatory.

Should: Expected; suggested, but not necessarily mandatory.

Software License: Legal instrument with or without printed material that governs the use or redistribution of licensed software.

Sole Source – Commodity: When an item is available from only one source due to the unique nature of the requirement, its supplier, or market conditions.

Sole Source – Services: A service of such a unique nature that the vendor selected is clearly and justifiably the only practical source to provide the service. Determination that the vendor selected is justifiably the sole source is based on either the uniqueness of the service or sole availability at the location required.

Specifications: The detailed statement, especially of the measurements, quality, materials, and functional characteristics, or other items to be provided under a contract.

System (see Module): Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the Contractor as functioning or being capable of functioning, as an entity.

Termination: Occurs when either party, pursuant to a power created by agreement or law, puts an end to the contract prior to the stated expiration date. All obligations which are still executory on both sides are discharged but any right based on prior breach or performance survives.

Trade Secret: Information, including, but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. § 87-502(4)).

Trademark: A word, phrase, logo, or other graphic symbol used by a manufacturer or vendor to distinguish its product from those of others, registered with the U.S. Patent and Trademark Office.

Upgrade: Any change that improves or alters the basic function of a product of service.

Vendor: An individual or entity lawfully conducting business in the State of Nebraska, or licensed to do so, who seeks to provide goods or services under the terms of a written solicitation.

Vendor Performance Report: A report issued to the Contractor by State Purchasing Bureau when products or services delivered or performed fail to meet the terms of the purchase order, contract, and/or specifications, as reported to State Purchasing Bureau by the agency. The State Purchasing Bureau shall contact the Contractor regarding any such report. The vendor performance report will become a part of the permanent record for the Contractor. The State may require vendor to cure. Two such reports may be cause for immediate termination.

Will: See Shall/Will/Must.

Work Day: See Business Day.

GLOSSARY OF ACRONYMS

A&D: Aged and disabled

AS: Administrative Services

CFR: Code of Federal Regulations

CHIP: Children's Health Insurance Program

CMS: Centers for Medicare & Medicaid Services

COB: Close of business

DAS: State of Nebraska, Department of Administrative Services

DD: Developmental disabilities or disabled

DHHS: Nebraska Department of Health and Human Services

Federal DHHS: U.S. Department of Health and Human Services

FFS: Fee-for-service

HCBS: Home and community-based services

ICF-DD: Intermediate care facility for individuals with developmental disabilities

ICF-ID: Intermediate care facility for individuals with intellectual disabilities

LTSS: Long-term supports and services

MCO: Managed care organization

MFP: Money Follows the Person Program

MITA: Medicaid Information Technology Architecture

MLTC: Nebraska DHHS, Division of Medicaid and Long-Term Care

PACE: Program of All-inclusive Care for the Elderly

PAS: Personal assistance services

RFP: Request for Proposal

SFY: State fiscal year

TBI: Traumatic brain injury

I. SCOPE OF THE REQUEST FOR PROPOSAL

The State of Nebraska, Department of Health and Human Services, is issuing this Request for Proposal, RFP Number 2016-LTSSZ1 for the purpose of selecting a qualified Contractor to provide LTSS redesign consultation. The State considers a consultant qualified if the consultant has supported a state in the redesign of its LTSS program. Any resulting contract is not an exclusive contract to furnish the services provided for in this Request for Proposal, and does not preclude the purchase of similar services from other sources.

A contract resulting from this Request for Proposal will be issued approximately for a period of three (3) years effective the date of the award. The State reserves the right to extend the period of this contract beyond the termination date when mutually agreeable to the Contractor and the State of Nebraska.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR PROPOSAL CAN BE FOUND ON THE INTERNET AT**:** http://das.nebraska.gov/materiel/purchasing.html

A. SCHEDULE OF EVENTS

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change.

	ACTIVITY	DATE/TIME
1.	Release Request for Proposal	March 11, 2016
2.	Last day to submit written questions	March 22, 2016
3.	State responds to written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	March 29, 2016
4.	Proposal opening Location: Nebraska Department of Health and Human Services Division of Medicaid and Long-Term Care 301 Centennial Mall South, Lower Level D Lincoln, NE 68509	April 7, 2016 2:00 p.m. Central Time
5.	Review for conformance of mandatory requirements	April 7-8, 2016
6.	Evaluation period	April 11-14, 2016
7.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
8.	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	April 18, 2016
9.	Contract finalization period	April 18-28, 2016
10.	Contract award	April 29, 2016
11.	Contractor start date	May 2, 2016

II. PROCUREMENT PROCEDURES

A. PROCURING OFFICE AND CONTACT PERSON

Procurement responsibilities related to this Request for Proposal reside with the DHHS. The point of contact for the procurement is as follows:

Name: Julie Gillmor
Agency: DHHS Division of Medicaid and Long-Term Care
Address: 301 Centennial Mall South
Lincoln, NE 68509

OR

Address: P.O. Box 95026
Lincoln, NE 68509
Telephone: (402) 471-3371
Facsimile: (402) 742-1155
E-Mail: dhhs.ltssrfp@nebraska.gov

B. GENERAL INFORMATION

The Request for Proposal is designed to solicit proposals from qualified vendors who will be responsible for providing LTSS redesign consultation at a competitive and reasonable cost. Proposals that do not conform to the mandatory items as indicated in the Request for Proposal will not be considered.

Proposals shall conform to all instructions, conditions, and requirements included in the Request for Proposal. Prospective bidders are expected to carefully examine all documentation, schedules, and requirements stipulated in this Request for Proposal, and respond to each requirement in the format prescribed.

A fixed-price contract will be awarded as a result of this proposal. In addition to the provisions of this Request for Proposal and the awarded proposal, which shall be incorporated by reference in the contract, any additional clauses or provisions required by the terms and conditions will be included as an amendment to the contract.

C. CUSTOMER SERVICE

In addition to any specified service requirements contained in this agreement, the Contractor agrees and understands that satisfactory customer service is required. Contractor will develop or provide technology and business procedures designed to enhance the level of customer satisfaction and to provide the customer appropriate information given their situation. Contractor, its employees, Subcontractors, and agents must be accountable, responsive, reliable, patient, and have well-developed communication skills as set forth by the customer service industry's best practices and processes.

D. COMMUNICATION WITH STATE STAFF AND EVALUATORS

From the date the Request for Proposal is issued until a determination is announced regarding the selection of the Contractor, contact regarding this project between potential Contractors and individuals employed by the State is restricted to only written communication with the staff designated above as the point of contact for this Request for Proposal. Bidders shall not have any communication with, or attempt to communicate with or influence in any way, any evaluator involved in this RFP.

Once a Contractor is preliminarily selected, as documented in the intent to contract, that Contractor is restricted from communicating with State staff until a contract is signed. Violation of this condition may be considered sufficient cause to reject a Contractor's proposal and/or selection irrespective of any other condition.

The following exceptions to these restrictions are permitted:

1. Written communication with the person(s) designated as the point(s) of contact for this Request for Proposal or procurement;
2. Contacts made pursuant to any pre-existing contracts or obligations; and
3. State-requested presentations, key personnel interviews, clarification sessions or discussions to finalize a contract.

Violations of these conditions may be considered sufficient cause to reject a bidder's proposal and/or selection irrespective of any other condition. No individual member of the State, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this Request for Proposal. The buyer will issue any clarifications or opinions regarding this Request for Proposal in writing.

E. WRITTEN QUESTIONS AND ANSWERS

Any explanation desired by a bidder regarding the meaning or interpretation of any Request for Proposal provision must be submitted in writing to the DHHS-MLTC and clearly marked "RFP Number 2016-LTSSZ1; LTSS Redesign Consultation Questions." It is preferred that questions be sent via e-mail to dhhs.ltssrfp@nebraska.gov. Questions may also be sent by facsimile to (402) 742-1155, but must include a cover sheet clearly indicating that the transmission is to the attention of Julie Gillmor, Buyer, showing the total number of pages transmitted, and clearly marked "RFP Number 2016-LTSSZ1; LTSS Redesign Consultation Questions."

It is recommended that Bidders submit questions sequentially numbered, include the RFP reference and page number using the following format.

Question Number	RFP Section Reference	RFP Page Number	Question

Written answers will be provided through an addendum to be posted on the Internet at http://das.nebraska.gov/materiel/purchasing.html on or before the date shown in the Schedule of Events.

F. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The Evaluation Committee(s) may conclude after the completion of the Technical and Cost Proposal evaluation that oral interviews/presentations and/or demonstrations are required in order to determine the successful bidder. All bidders may not have an opportunity to interview/present and/or give demonstrations; the State reserves the right to select only the top scoring bidders to present/give oral interviews in its sole discretion. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical and Cost Proposals. The presentation process will allow the bidders to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Bidders' key personnel may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Bidders shall not be allowed to alter or amend their proposals. Only representatives of the State and the presenting bidders will be permitted to attend the oral interviews/presentations and/or demonstrations.

Once the oral interviews/presentations and/or demonstrations have been completed the State reserves the right to make a contract award without any further discussion with the bidders regarding the proposals received.
Detailed notes of oral interviews/presentations and/or demonstrations may be recorded and supplemental information (such as briefing charts, et cetera) may be accepted; however, such supplemental information shall not be considered an amendment to a bidders' proposal. Additional written information gathered in this manner shall not constitute replacement of proposal contents.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

G. SUBMISSION OF PROPOSALS

The following describes the requirements related to proposal submission, proposal handling, and review by the State.

To facilitate the proposal evaluation process, one (1) original of the entire proposal must be submitted. Proposals must be submitted by the proposal due date and time**. A separate sheet must be provided that clearly states which sections have been submitted as proprietary or have copyrighted materials.** All proprietary information the bidder wishes the State to withhold must be submitted in accordance with the instructions outlined in Section III, Proprietary Information. Proposal responses should include the completed Form A, Bidder Contact Sheet. Proposals must reference the Request for Proposal number and be sent to the specified address. Please note that the address label should appear in Section II part A as specified on the face of each container or bidder's bid response packet. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. If a recipient phone number is required for delivery purposes, (402) 471-3371 should be used. The Request for Proposal number must be included in all correspondence.

Emphasis should be concentrated on conformance to the Request for Proposal instructions, responsiveness to requirements, completeness and clarity of content. If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming, it is likely that the bid will be rejected.

The Technical and Cost Proposals should be packaged separately (loose-leaf binders are preferred) on standard 8 ½" by 11" paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables must be numbered and referenced in the text by that number. They should be

placed as close as possible to the referencing text. The Technical Proposal must not contain any reference to dollar amounts. However, information such as data concerning labor hours and categories, materials, Subcontracts, and so forth, shall be considered in the Technical Proposal so that the bidder's understanding of the scope of work may be evaluated. The Technical Proposal shall disclose the bidder's technical approach in as much detail as possible, including, but not limited to, the information required by the Technical Proposal instructions.

H. PROPOSAL OPENING

The sealed proposals will be publicly opened and the bidding entities announced on the date, time, and location shown in the Schedule of Events. Proposals will be available for viewing by those present at the proposal opening. Vendors may also contact the State to schedule an appointment for viewing proposals after the Intent to Award has been posted to the website.

I. LATE PROPOSALS

Proposals received after the time and date of the proposal opening will be considered late proposals. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. The State is not responsible for proposals that are late or lost due to mail service inadequacies, traffic, or any other reason(s).

J. REJECTION OF PROPOSALS

The State reserves the right to reject any or all proposals, in whole or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal and do not improve the bidder's competitive position. The State reserves the right to reject any or all proposals and re-advertise for proposals; and further reserves the right to waive any informality or irregularity. All awards will be made in a manner deemed in the best interest of the State.

K. EVALUATION OF PROPOSALS

All proposals that are responsive to the Request for Proposal will be evaluated. The State will conduct a fair, impartial, and comprehensive evaluation of all proposals in accordance with the criteria set forth belowThe State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation. Areas that will be addressed and scored during the evaluation include:

1. Corporate Overview should include but is not limited to:
- **a.** the ability, capacity, and skill of the bidder to deliver and implement the system or project that meets the requirements of the Request for Proposal;
- **b.** the experience of the bidder with projects similar in size, scope, and complexity, relevant to the LTSS redesign goals;
- **c.** the character, integrity, reputation, judgment, experience, and efficiency of the bidder;
- **d.** whether the bidder can perform the contract within the specified time frame;
- **e.** the quality of bidder performance on prior contracts;
- **f.** such other information that may be secured and that has a bearing on the decision to award the contract;

2. Technical Approach; and

3. Cost Proposal.

Neb. Rev. Stat. § 73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible bidder, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident bidder, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection and (ii) the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection. Any contract entered into without compliance with this section shall be null and void.

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a bid in accordance with Neb. Rev. Stat. §73-107 and has so indicated on the RFP cover page under "Bidder must complete the following" requesting priority/preference to be considered in the award of this contract, the following will need to be submitted by the vendor within ten (10) business days of request:

1. Documentation from the United States Armed Forces confirming service;
2. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions);
3. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and
4. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the bidder from consideration of the preference.

Evaluation criteria weighting will be released with the Request for Proposal. Evaluation criteria weighting and a list of respondents will be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html

L. EVALUATION COMMITTEE

Proposals will be independently evaluated by members of the Evaluation Committee(s). The Evaluation Committee(s) will consist of staff with the appropriate expertise to conduct such proposal evaluations. Names of the members of the Evaluation Committee(s) will not be published.

Prior to award, bidders are advised that only the point of contact indicated on the front cover of this Request for Proposal for Contractual Services Form can clarify issues or render any opinion regarding this Request for Proposal. No individual member of the State, employee of the State, or member of the Evaluation Committee(s) is empowered to make binding statements regarding this Request for Proposal.

Any contact, or attempted contact, with an evaluator that is involved with this RFP may result in the rejection of this proposal and further administrative actions may be taken.

M. MANDATORY REQUIREMENTS

The proposals will first be examined to determine if all mandatory requirements listed below have been addressed to warrant further evaluation. Proposals not meeting mandatory requirements will be excluded from further evaluation. The mandatory requirement items are as follows:

1. Request for Proposal For Contractual Services form, signed in ink;
2. Corporate Overview;
3. Completed Section III;
4. Technical Approach; and
5. Cost Proposal.

N. REFERENCE CHECKS

The State reserves the right to check any reference(s), regardless of the source of the reference information, including but not limited to, those that are identified by the company in the proposal, those indicated through the explicitly specified contacts, those that are identified during the review of the proposal, or those that result from communication with other entities involved with similar projects. The State may use a third-party to conduct reference checks

Information to be requested and evaluated from references may include, but is not limited to, some or all of the following: financial stability of the company, project description and background, job performed, functional and technical abilities, communication skills and timeliness, cost and schedule estimates and accuracy, problems (poor quality deliverables, contract disputes, work stoppages, et cetera), overall performance, and whether or not the reference would rehire the firm or individual. Only top scoring bidders may receive reference checks and negative references may eliminate bidders from consideration for award.

O. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS

All bidders shall be authorized to transact business in the State of Nebraska. All bidders are expected to comply with all Nebraska Secretary of State Registration requirements. It is the responsibility of the bidder to comply with any registration requirements pertaining to types of business entities (e.g. person, partnership, foreign or domestic limited liability company, association, or foreign or domestic corporation or other type of business entity). The bidder who is the recipient of an Intent to Award will be required to certify that it has so complied and produce a true and exact copy of its current (within ninety (90) calendar days), valid Certificate of Good Standing or Letter of Good Standing; or in the case of a sole proprietorship, provide written documentation of sole proprietorship. This must be accomplished prior to the award of the contract. Construction Contractors are expected to meet all applicable requirements of the Nebraska Contractor Registration Act and provide a current, valid certificate of registration.

Further, all bidders shall comply with any and all other applicable Nebraska statutes regarding transacting business in the State of Nebraska. Bidders should submit the above certification(s) with their bid.

If a bank is registered with the Office of Comptroller of Currency, it is not required to register with the State. However, the Office of Comptroller of Currency does have a certificate of good standing/registration. The bank could provide that for verification. (Optional)

P. VIOLATION OF TERMS AND CONDITIONS

Violation of the terms and conditions contained in this Request for Proposal or any resultant contract, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's proposal;
2. Withdrawal of the Intent to Award.
3. Termination of the resulting contract.
4. Legal action.
5. Suspension of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation, such period to be within the sole discretion of the State.

III. TERMS AND CONDITIONS

By signing the "Request for Proposal for Contractual Services" form, the Bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions and certifies bidder maintains a drug free work place environment.

Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal**. Bidders must include completed Section III with their proposal response.**

The State of Nebraska is soliciting bids in response to the RFP. The State of Nebraska will not consider proposals that propose the substitution of the bidder's contract, agreements, or terms for those of the State of Nebraska's. Any License, Service Agreement, Customer Agreement, User Agreement, Bidder Terms and Conditions, Document, or Clause purported or offered to be included as a part of this RFP must be submitted as individual clauses, as either a counter-offer or additional language, and each clause must be acknowledged and accepted in writing by the State. If the Bidder's clause is later found to be in conflict with the RFP or resulting contract the Bidder's clause shall be subordinate to the RFP or resulting contract.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. Amendment to Contract Award with the most recent dated amendment having the highest priority;
2. Contract Award and any attached Addenda;
3. The Request for Proposal form and the Contractor's Proposal signed in ink;
4. Amendments to RFP and any Questions and Answers; and
5. The original RFP document and any Addenda.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to Contract Award with the most recent dated amendment having the highest priority, 2) Contract Award and any attached Addenda, 3) the signed Request for Proposal form and the Contractor's Proposal, 4) Amendments to RFP and any Questions and Answers, 5) the original RFP document and any Addenda.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. AWARD

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, in whole or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.

By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once intent to award decision has been determined, it will be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html

Grievance and protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchase_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf.

Any protests must be filed by a vendor within ten (10) business days after the intent to award decision is posted to the Internet.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensations, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for services to be covered by any contract resulting from this Request for Proposal.

D. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State of Nebraska shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or derived by the Contractor pursuant to this contract.

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that the State Purchasing Bureau has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any Subcontractors, the Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all Subcontractor (s). Contractor is also responsible for ensuring Subcontractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any Subcontractor to commence work on any Subcontract until all similar insurance required of the Subcontractor has been obtained and approved by the Contractor. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Insurance coverages shall function independent of all other clauses in the contract, and in no instance shall the limits of recovery from the insurance be reduced below the limits required by this paragraph.

1. WORKERS' COMPENSATION INSURANCE

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance

carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned and Hired vehicles.

3. INSURANCE COVERAGE AMOUNTS REQUIRED

WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
USL&H Endorsement	Statutory
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
SUBROGATION WAIVER	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
LIABILITY WAIVER	
"Commercial General Liability & Commercial Automobile Liability policies shall be primary and any insurance or self-insurance carried by the State shall be considered excess and non-contributory."	

4. EVIDENCE OF COVERAGE

The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements, which shall be submitted to the attention of the Buyer.

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
301 Centennial Mall South
Lincoln, NE 68509
Facsimile: (402) 742-1155.

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to DHHS, MLTC when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.

2. The Contractor shall agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

H. INDEPENDENT CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the Contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the Contractor's proposal, and the resulting contract. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any Subcontractor's services, the Subcontractor's level of effort, tasks, and time allocation must be clearly defined in the Contractor's proposal. The Contractor shall agree that it will not utilize any Subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified Subcontractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work on the project.

Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or Subcontractor employee.

In respect to its employees, the Contractor agrees to be responsible for the following:

1. any and all employment taxes and/or other payroll withholding;
2. any and all vehicles used by the Contractor's employees, including all insurance required by state law;

3. damages incurred by Contractor's employees within the scope of their duties under the contract;
4. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
5. determining the hours to be worked and the duties to be performed by the Contractor's employees.

K. CONTRACT CONFLICTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall insure that contracts or agreements with sub-contractors and agents, and the performance of services in relation to this contract by sub-contractors and agents, does not conflict with this contract.

L. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not, at any time, recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project.

M. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

N. PROPOSAL PREPARATION COSTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this Request for Proposal.

O. ERRORS AND OMISSIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

P. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

Q. ASSIGNMENT BY THE STATE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

R. ASSIGNMENT BY THE CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

S. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal, mandatory requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

T. GOVERNING LAW

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

U. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party.

V. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

W. STATE PROPERTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

X. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor.

Y. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II. A., Procuring Office and Contact Person, of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title, and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests, or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

2. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the Contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Communication about the contract between Contractor and individuals not designated as points of contact by the State is strictly forbidden.

Z. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract immediately for the following reasons:

a. If directed to do so by statute;
b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
c. A trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
d. Fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
e. An involuntary proceeding has been commenced by any party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
f. A voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
g. Contractor intentionally discloses confidential information;
h. Contractor has or announces it will discontinue support of the deliverable;
i. Second or subsequent documented "vendor performance report" form deemed acceptable by the Agency; or
j. Contractor engaged in collusion or actions which could have provided Contractor an unfair advantage in obtaining this contract.

AA. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of any termination, and advise the Contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

BB. BREACH BY CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, if the Contractor fails to perform its obligations under the contract in a timely and proper manner. The State may, by providing a written notice of default to the Contractor, allow the Contractor to cure a failure or breach of contract within a period of thirty (30) calendar days (or longer at State's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing the Contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

CC. ASSURANCES BEFORE BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the Contractor shall deliver assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

DD. ADMINISTRATION – CONTRACT TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. Contractor must provide confirmation that upon contract termination all deliverables prepares in accordance with this agreement shall become the property of the State of Nebraska; subject to the ownership provision (section E) contained herein, and is provided to the State of Nebraska at no additional cost to the State.

2. Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days. Notwithstanding the above, Contractor may retain one copy of any information as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures.

EE. PENALTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

In the event that the Contractor fails to perform any substantial obligation under the contract, the State may withhold all monies due and payable to the Contractor, without penalty, until such failure is cured or otherwise adjudicated. Failure to meet the dates for the deliverables as agreed upon by the parties may result in an assessment of penalty due the State of $1,000 dollars per day, until the deliverables are approved. Contractor will be notified in writing when penalty will commence.

FF. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

GG. PROHIBITION AGAINST ADVANCE PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Payments shall not be made until contractual deliverable(s) are received and accepted by the State.

HH. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services.

II. INVOICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within	NOTES/COMMENTS:

		RFP Response (Initial)	

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Invoices must classify the contract deliverable (per IV.F Deliverables) associated with each expense. Invoices are to be submitted no later than 30 calendar days following MLTC's approval of deliverable(s). A final invoice must be submitted within 30 days of the last day of the contract period. Invoices should be sent to:

DHHS-MLTC Attn: Managed Care & HCBS Administrator
Post Office Box 95026
Lincoln, NE 68509

The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

JJ. RIGHT TO AUDIT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit contract. The State and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this contract kept by or under the control of the Contractor, including, but not limited to those kept by the Contractor, its employees, agents, assigns, successors, and Subcontractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence.

Contractor shall, at all times during the term of this contract and for a period of five (5) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. If an audit has been initiated and audit findings have not been resolved at the end of six (6) years, the records must be retained until resolution of the audit finding. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and Subcontractors, and the obligations of these rights shall be explicitly included in any Subcontracts or agreements formed between the Contractor and any Subcontractors to the extent that those Subcontracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the

Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor.

KK. TAXES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

LL. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

MM. CHANGES IN SCOPE/CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may, upon the written agreement of Contractor, make changes to the contract within the general scope of the RFP. The State may, at any time work is in progress, by written agreement, make alterations in the terms of work as shown in the specifications, require the Contractor to make corrections, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, or a pro-rated value.

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification.

Changes or additions to the contract beyond the scope of the Request for Proposal are not permitted; however, this Request for Proposal must meet all applicable federal legal requirements and regulations, including but not limited to Medicaid laws, rules and regulations, and any future amendments to this Request for Proposal that are required to bring Nebraska into compliance with federal Medicaid law shall be deemed part of the scope of the requested bid.

NN. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within	NOTES/COMMENTS:

		RFP Response (Initial)	

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

OO. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be handled in accordance with federal and state law, and ethical standards. The Contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a Contractor; Contractor shall notify the State immediately of said breach and take immediate corrective action. The Contractor's subcontracts must explicitly state expectations about the confidentiality of information, and the subcontractor is held to the same confidentiality requirements as the consultant. Any releases of information to the media, the public, or other entities require prior approval from MLTC. This clause shall be included in all subcontracts.

It is incumbent upon the Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to Contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a Contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

PP. PROPRIETARY INFORMATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. **All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal, and provide supporting documents showing why such documents should be marked proprietary.** The separate package must be clearly marked PROPRIETARY on the outside of the package. **Bidders may not mark their entire Request for Proposal as proprietary.** Bidder's cost proposals may not be marked as proprietary information. Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the

information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

QQ. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submission of this proposal, the bidder certifies, that it is the party making the foregoing proposal and that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted the proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

RR. STATEMENT OF NON-COLLUSION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The proposal shall be arrived at by the bidder independently and be submitted without collusion with, and without any direct or indirect agreement, understanding or planned common course of action with, any person; firm; corporation; bidder; Contractor of materials, supplies, equipment or services described in this RFP. Bidder shall not collude with, or attempt to collude with, any state officials, employees or agents; or evaluators or any person involved in this RFP. The bidder shall not take any action in the restraint of free competition or designed to limit independent bidding or to create an unfair advantage.

Should it be determined that collusion occurred, the State reserves the right to reject a bid or terminate the contract and impose further administrative sanctions.

SS. PRICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All prices, costs, and terms and conditions outlined in the proposal shall remain fixed and valid commencing on the opening date of the proposal until an award is made or the Request for Proposal is cancelled.

Contractor represents and warrants that all prices for services, now or subsequently specified, are as low as and no higher than prices which the Contractor has charged or intends to charge customers other than the State for the same or similar products and services of the same or equivalent quantity and quality for delivery or performance during the same periods of time. If, during the term of the contract, the Contractor shall reduce any and/or all prices charged to any customers other than the State for the same or similar products or services specified herein, the Contractor shall make an equal or equivalent reduction in corresponding prices for said specified products or services.

Contractor also represents and warrants that all prices set forth in the contract and all prices in addition, which the Contractor may charge under the terms of the contract, do not and will not violate any existing federal, state, or municipal law or regulations concerning price discrimination and/or price fixing. Contractor agrees to hold the State harmless from any such violation. Prices quoted shall not be subject to increase throughout the contract period unless specifically allowed by these specifications.

TT. BEST AND FINAL OFFER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State will compile the final scores for all parts of each proposal. The award may be granted to the highest scoring responsive and responsible bidder. Alternatively, the highest scoring bidder or bidders may be requested to submit best and final offers. If best and final offers are requested by the State and submitted by the bidder, they will be evaluated (using the stated criteria), scored, and ranked by the Evaluation Committee. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

UU. ETHICS IN PUBLIC CONTRACTING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator, employee or evaluator based on the understanding that the receiving person's vote, actions or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau or any evaluator.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.
If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

VV. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. GENERAL

The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Contractor agrees it will at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall at the Contractor's sole cost and expense promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. PERSONNEL

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the Contractor.

4. SELF-INSURANCE

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 *et seq.* and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

5. ALL REMEDIES AT LAW

Nothing in this agreement shall be construed as an indemnification by one party of the other for liabilities of a party or third parties for property loss or damage or death or personal injury arising out of and during the performance of this lease. Any liabilities or claims for property loss or damages or for death or personal injury by a party or its agents, employees, contractors or assigns or by third persons, arising out of and during the performance of this lease shall be determined according to applicable law.

WW. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request that contract comply with the changed standard at a cost mutually acceptable to the parties.

XX. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

YY. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under these specifications in the event of a disaster.

ZZ. TIME IS OF THE ESSENCE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

AAA. RECYCLING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per Neb. Rev. Stat. § 81-15,159.

BBB. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor certifies that it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

CCC. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an newly hired employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at: http://das.nebraska.gov/materiel/purchasing.html

The completed United States Attestation Form should be submitted with the Request for Proposal response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

DDD. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor, by signature to this RFP, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The Contractor also agrees to include the above requirements in any and all Subcontracts into which it enters. The Contractor shall immediately notify the Department if, during the term of this contract, Contractor becomes debarred. The Department may immediately terminate this contract by providing Contractor written notice if Contractor becomes debarred during the term of this contract.

Contractor, by signature to this RFP, certifies that Contractor has not had a contract with the State of Nebraska terminated early by the State of Nebraska. If Contractor has had a contract terminated early by the State of Nebraska, Contractor must provide the contract number, along with an explanation of why the contract was terminated early. Prior early termination may be cause for rejecting the proposal.

EEE. POLITICAL SUB-DIVISIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor may extend the contract to political sub-divisions conditioned upon the honoring of the prices charged to the State. Terms and conditions of the Contract must be met by political sub-divisions. Under no circumstances shall the State be contractually obligated or liable for any purchases by political sub-divisions or other public entities not authorized by Neb. Rev. Stat. § 81-145, listed as "all officers of the state, departments, bureaus, boards, commissions, councils, and institutions receiving legislative appropriations." A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

FFF. OFFICE OF PUBLIC COUNSEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

GGG. LONG-TERM CARE OMBUDSMAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

IV. PROJECT DESCRIPTION AND SCOPE OF WORK

The bidder should provide the following information in response to this Request for Proposal.

A. CURRENT LTSS DELIVERY SYSTEM

Nebraska DHHS, MLTC provides eligible individuals with coverage and payment for LTSS through personal assistance services (PAS), home health, hospice, private duty nursing programs, and the Program of All-Inclusive Care for the Elderly (PACE). Since the mid-1980s, DHHS has made great strides in rebalancing its LTSS delivery system by taking advantage of waivers available under Section 1915(c) of the Social Security Act, and other initiatives, including the Money Follows the Person (MFP) program and PACE.

Medicaid-funded home and community-based programs and services are provided through:

- Approximately 210 assisted living facilities (aged and disabled [A&D] waiver), and one assisted living facility (traumatic brain injury [TBI] waiver)
- Approximately 4,800 individual providers and 51 agency providers (A&D waiver and PAS)
- Approximately 90 agency providers and 850 individual providers for three DD waivers (Adult Day, Adult Comprehensive, and Children's)
- One PACE provider
- Three State-employed transition coordinators and thirteen transition planning and support specialists (MFP)
- DHHS service coordinators (providing targeted case management for DD and A&D waiver participants)
- Nine contracted community agencies (providing targeted case management for A&D and TBI waiver participants)
- Multiple agency providers of home health, hospice, and private duty nursing

Medicaid-funded institutional programs and services are provided through:

- 212 nursing facilities of which four also have special needs units
- One State-operated (Beatrice State Developmental Center) and nine privately-operated intermediate care facilities for individuals with developmental disabilities (ICF-DD)

The population most affected by the redesign effort consists of Medicaid-eligible individuals receiving LTSS or individuals at risk for needing LTSS, including but not limited to:

- Individuals who are aged, blind, or disabled:
  - Individuals who reside at home (if not included in other categories below)
  - Individuals who reside in nursing facilities or ICF-DD
  - Home and community based services (HCBS) waiver participants (including DD, A&D, and TBI waivers)
  - Katie Beckett Program participants (http://dhhs.ne.gov/Pages/hcs_programs_katie-beckett.aspx)
- Individuals receiving Supplemental Security Income, determined disabled, and eligible for Medicaid

Many of the individuals in the above populations are also eligible for Medicare.

B. BACKGROUND AND VISION FOR LTSS PROGRAM REDESIGN

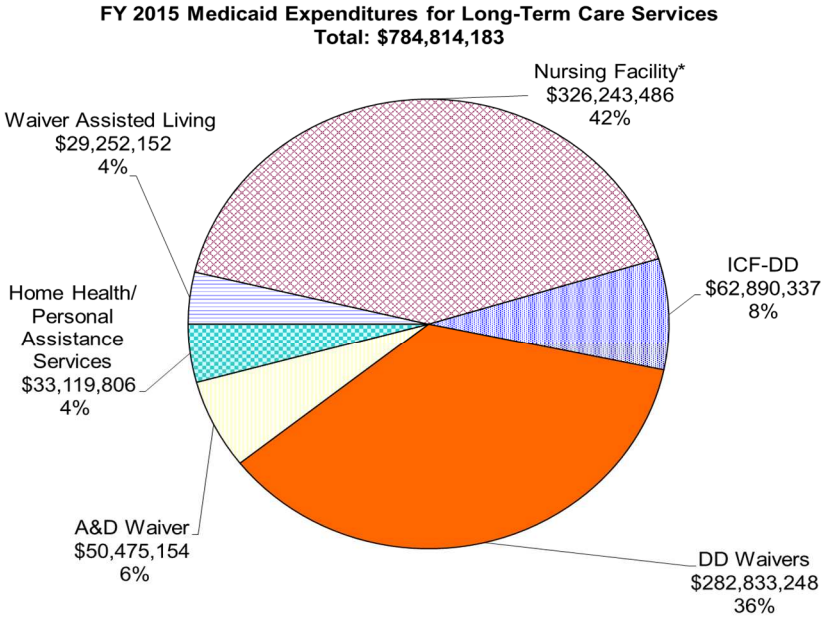
There is growing pressure on the existing LTSS infrastructure in Nebraska. An aging population and workforce of experienced staff combined with the increasing cost of medical care and State budget concerns are challenging LTSS programs across the nation and in Nebraska. Nationally, approximately 5% of adults receive LTSS. The majority (57%) are 65 and older, but a substantial portion (43%) are between the ages of 18 and 64.[1] State Medicaid programs are the largest payer of LTSS. In Federal fiscal year 2013[2], the Federal and state governments spent $146 billion on Medicaid LTSS combined, representing 34% of all Medicaid spending.[3] In State fiscal year (SFY) 2015[4], the total Nebraska Medicaid expenditures for LTSS were $784,814,183, evenly split between institutional services (nursing facilities and ICFs for the intellectually or developmentally disabled) and HCBS

[1] National Spending for Long-Term Services and Supports, 2012. The George Washington University, March 27, 2014.
[2] October 1, 2012 to September 30, 2013
[3] Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013. Truven Health Analytics, June 30, 2015.
[4] July 1, 2014 to June 30, 2015

(1915(c) waivers, personal care, home health, and other HCBS). This is an increase from SFY 2010[5] when expenditures for LTSS were $645,041,559. This amount is anticipated to grow in the future as the population ages.

The U.S. Census Bureau estimates that more than 25% of Nebraska's population will be over age sixty by the year 2030, an increase of 32% from 2012.[6]

Figure 1 below depicts the distribution of Nebraska expenditures across LTSS programs in fiscal year 2015.



As MLTC moves forward with transforming the way services are delivered to Medicaid clients through the Heritage Health managed care program, MLTC will also be working on improving the State's LTSS delivery system. The LTSS redesign project will be a collaborative initiative between MLTC, the consultant, and LTSS stakeholders to evaluate the current LTSS landscape, identify key opportunities for improvement, and redesign the system to meet the future challenges and growing demand for LTSS. For additional background information, bidders should review the concept paper (http://dhhs.ne.gov/medicaid/Pages/medicaid_LTSS.aspx) developed by MLTC for greater detail on the State's vision.

The State has identified key principles for redesign including:

- Improve quality and outcomes
- Promote independent living in the least restrictive setting
- Strengthen access to, coordination of, and integration of care
- Better match available resources with individual need
- Decrease fragmentation in programmatic and administrative framework
- Refocus and rebalance system to match growing need and improve sustainability

The State has identified potential areas of opportunity for improvement:

- Program administration, i.e., making it easier for individuals to navigate the LTSS service delivery system, access services that match needs, and reduce duplication and silos across programs. Designing an individual assessment process and instrument(s), for the purpose of eligibility determination, assessment of individual needs, care planning, reducing duplication, program planning, and comparing levels of acuity in various settings and across managed care organizations.

[5] July 1, 2009 to June 30, 2010

[6] U.S. Department of Health and Human Services, Administration on Aging, Policy Academy State Profile; U.S. Census Bureau, 2009 Projections.

- Care coordination, i.e., improving person-centeredness, and reducing any conflicts of interest and challenges of care management for dual-eligible individuals.
- Service array and authority, i.e., evaluating any duplication of services, potential use of alternate waiver or State plan authorities, additional services and supports, revision of policies, and means of monitoring utilization.
- Provider management and reimbursement, i.e., enhancing provider reimbursement structures and level of reimbursement, claims management, and service/provider tracking processes.
- Measurement and promotion of quality, i.e., integrating data-driven performance measures specific to LTSS in the current quality improvement function, and identifying a manageable set of measures that fit the State's LTSS redesign goals.
- Delivery system, i.e., identifying key considerations and options for delivery of Medicaid-funded LTSS.

The goal of this solicitation and the resulting program(s) is to improve Nebraska's LTSS service delivery system, maintain compliance with Federal requirements, promote administrative efficiencies, and maximize program resources. MLTC is most interested in the creation of a system responsive to the needs of Nebraskans that will be sustainable for future generations.

It will be critical for the consultant to engage stakeholders and consider their input in all LTSS program redesign efforts, as described in the following section, Project Scope of Work.

C. PROJECT SCOPE OF WORK

1. RESEARCH, SERVICE DELIVERY SYSTEM ASSESSMENT, AND PRELIMINARY RECOMMENDATIONS

a. Upon contract award, the consultant must work with MLTC staff to design the research and service delivery system assessment portion of the project. The purpose of this project phase is to review the State's current services delivery system, determine its strengths and challenges, examine what other states have done to improve LTSS services delivery, and review federal requirements for program options and limitations.

b. This research and service delivery assessment must be fully described in the bidder's draft project work plan that is required with the proposal, and the final project work plan that is due to MLTC 15 business days after the contract start date.

c. Upon approval of the final project work plan, the consultant must review Nebraska's current LTSS delivery system against CMS guidelines, federal regulations, federal authorities for delivery of LTSS, and other states' best practices. PAS review has previously been conducted and must include only the study of other states' best practices.

d. Nebraska's Medicaid funded LTSS include:

- State Plan benefits provided in home and community-based settings (PAS, home health, hospice, private duty nursing, targeted case management, and optional rehabilitative services)
- Institutional services, including nursing facilities and ICF-DD
- HCBS 1915(c) waiver programs (A&D, TBI, DD Adult Day, DD Adult Comprehensive, and DD Children's waivers)
- MFP transition services

The consultant must work with the State to determine if any other programs should be included in the review.

e. At the conclusion of the research and assessment phase, the consultant must provide a report of its findings, including preliminary recommendations for improving MLTC's current LTSS service delivery system.

2. ENGAGEMENT OF STAKEHOLDERS

a. A key component to the success of this initiative is the involvement of stakeholders in the program assessment and redesign processes. The contractor must have demonstrated expertise

and experience in working with stakeholder groups, including the ability to guide a discussion and collect information, analyze the information, and provide actionable reports.

b. The consultant must facilitate community meetings and focus groups statewide, develop presentation and educational materials for these meetings, prepare and conduct brief participant surveys, and provide MLTC with a summary report of the stakeholder engagement process. At a minimum, stakeholder meetings must be held in Fremont, Gering, Grand Island, Hastings, Kearney, Lincoln, Norfolk, North Platte, and Omaha. At least two meetings must be held in these locations, one during business hours and one in the evening. Additional meetings may be held at the consultant's discretion, but at least these 18 sessions must occur. The stakeholder groups that must be represented include individuals receiving LTSS and family members/informal caregivers, and providers of community-based and institutional LTSS. Meetings must be held in accessible locations. The consultant may provide the capability for web-enabled participation, but meetings must be held in person.

c. The consultant must develop a plan for engaging stakeholders. For each stakeholder group, the stakeholder engagement plan must include a plan for the events, rationale for methods of communication and engagement, the meeting format, and information that the consultant expects to obtain from each meeting.

d. The consultant must work with MLTC to identify individuals and organizations who can provide a diversity of perspectives, meeting venues, meeting agendas, and plans. The contractor is responsible for all meeting logistics, including scheduling, preparation, and presentation materials. All proposed materials to be used as part of the stakeholder meetings must be submitted to MLTC for approval as part of the engagement plan.

e. At the conclusion of the meetings, the consultant must provide a summary report with a description of the stakeholders' input, and an analysis of findings. The report must include, for each meeting, a list of the participants, including names, organizations represented (if applicable), and role (for example, individual or his/her representative, advocate, or provider).

3. DEVELOPMENT OF A REDESIGN PLAN

a. With input from MLTC, the consultant must develop a detailed plan for redesign of the State's LTSS service delivery system. The plan must address all components of the LTSS service delivery system, consider the input of stakeholders, and include internal and external communications strategies. It must include an impact analysis, including operational, fiscal, and stakeholder considerations.

b. The consultant must explore opportunities to advance the State's MITA maturity status through shared services and data, collaboration, and use/reuse of systems.

c. The consultant should align all activities and recommendations with other DHHS initiatives. The consultant must include consideration of managed care models that align with CMS requirements and reflect lessons learned and best practices from other states. The consultant may propose additional services associated with implementing the plan.

d. Once the plan is approved, the consultant must provide training to appropriate DHHS staff on the plan. This training must include, but must not be limited to, the plan, its timeline, federal opportunities, and other states' best practices.

4. IMPLEMENTATION OF REDESIGN PLAN

The consultant should include implementation tasks in its technical and cost proposals. MLTC reserves the right to award or not award this portion of the scope of work.

D. BUSINESS REQUIREMENTS

1. BUSINESS LOCATION

a. All work sites where work is performed to fulfill the requirements of this RFP must be located in the United States (including its territories).

b. The consultant must provide toll-free communications with MLTC staff to conduct business operations.

2. MERGER, REORGANIZATION, AND CHANGE OF OWNERSHIP

The consultant must submit notification to MLTC of a merger, reorganization, or change of ownership at least 180 days prior to its effective date. The consultant must also submit a detailed merger, reorganization, or transition plan to MLTC for review at least 90 calendar days prior to the effective date of the proposed change. The purpose of the plan's review is to evaluate the new entity's ability to maintain and support the contract requirements.

E. STAFFING REQUIREMENTS

Each bidder must propose staff to work on this project with the following capabilities and experience:

1. Project Manager

This individual will lead the consulting team in the completion of the work activities described in this RFP. The Project Manager must provide expert advice on best practices; identify and quantify risks, challenges, and opportunities; and suggest ways to leverage these opportunities to meet MLTC's goals. This individual will oversee and synthesize the work performed by other team members and be responsible for final work products delivered to MLTC.

The proposed Project Manager should have a minimum of ten years' experience leading the design and development of Medicaid delivery systems. The bidder's proposal must prove that this individual has demonstrated experience in Medicaid LTSS services delivery systems, Medicaid long-term care services, both facility and community-based; Medicaid managed care delivery systems; federal and state Medicaid regulatory analysis; Medicaid reimbursement; and federal and state Medicaid operations.

2. Medicaid Regulatory Specialist(s)

This individual or individuals must review federal and State statutes, regulations, and guidance to analyze, evaluate, and identify the benefits, risks, and impacts of LTSS program changes. The Medicaid Regulatory Specialist must provide analysis and recommendations on federal statutes and regulations for which to request waiver authority and any State regulations that may require modification.

The proposed Medicaid Regulatory Specialist(s) should have a minimum of five years' experience in the analysis and evaluation of federal and state regulations and the design of Medicaid managed LTSS waiver programs.

3. Medicaid Program Analyst(s)

This individual or individuals must develop proposals for new LTSS program initiatives, including, but not limited to, program participants, services, and service delivery. The Medicaid Program Analyst must draw on financial, regulatory, and program research to analyze and evaluate the program's cost effectiveness, impact on affected individuals, and feasibility (in terms of obtaining federal and State approval, implementing State regulations, and making necessary staffing and system changes within recommended time frames.

The proposed Medicaid Program Analyst(s) should have a minimum of four years' experience in the analysis, evaluation, and design of Medicaid LTSS service delivery systems, including managed care models. They should also demonstrate experience conducting stakeholder meetings in at least three projects of similar scope.

F. DELIVERABLES

The consultant must submit the following deliverables as part of this project. Due dates are also provided but may be subject to change after contract award. Actual deliverable due dates will be provided to the consultant upon the contract start date.

Deliverable	Due Date
Final project work plan	15 business days after contract start date
Stakeholder engagement plan	30 calendar days after contract start date

Deliverable	Due Date
Presentation materials for stakeholder meetings	60 calendar days after contract start date
Assessment of Nebraska's LTSS service delivery system with preliminary recommendations	60 calendar days after contract start date
Completion of stakeholder meetings as required by IV.2.b	90 calendar days after contract start date
Summary report of stakeholder engagement	120 calendar days after contract start date
Draft redesign plan	6 months after contract start date
Final redesign plan	8 months after contract start date
Monthly status reports	15 calendar days after end of month

G. PERFORMANCE REQUIREMENTS

1. The consultant must ensure that all required deliverables, which may include documents, plans, or reports, as stated in this RFP or required at a future date, are submitted to MLTC in a timely manner for review and approval.

2. If MLTC requests any revisions to the deliverables already submitted, the consultant must make the changes and re-submit the deliverable, according to the time period and format required by MLTC. A 60 calendar day notice will be given on changes in format to any ongoing reports.

V. PROPOSAL INSTRUCTIONS

This section documents the mandatory requirements that must be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of “Project Description and Scope of Work” clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State’s comparative evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions:

A. TECHNICAL PROPOSAL REQUIREMENTS

The technical proposal should consist of the following subsections:

- Table of contents;
- Request for Proposal form;
- Corporate overview, as described in V.A.3;
- Draft project work plan; and
- Technical approach.

1. REQUEST FOR PROPOSAL FORM

By signing the “Request for Proposal for Contractual Services” form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions stated in this Request for Proposal unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

The Request for Proposal for Contractual Services form must be signed in ink and returned by the stated date and time in order to be considered for an award.

Further, Section III. Terms and Conditions must be returned with the proposal response.

2. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder must provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

b. FINANCIAL STATEMENTS

The bidder must provide financial statements applicable to the firm. If publicly held, the bidder must provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder’s financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

The State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

e. RELATIONSHIPS WITH THE STATE

The bidder shall describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any party named in the bidder's proposal response is or was an employee of the State within the past thirty-six (36) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

g. CONTRACT PERFORMANCE

If the bidder or any proposed Subcontractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other party's name, address and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder must address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Request for Proposal. These descriptions must include:

- **a)** The time period of the project;
- **b)** The scheduled and actual completion dates;
- **c)** The Contractor's responsibilities;
- **d)** For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
- **e)** Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion

date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. Contractor and Subcontractor(s) experience must be listed separately. Narrative descriptions submitted for Subcontractors must be specifically identified as Subcontractor projects.

iii. If the work was performed as a Subcontractor, the narrative description shall identify the same information as requested for the Contractors above. In addition, Subcontractors shall identify what share of contract costs, project responsibilities, and time period were performed as a Subcontractor.

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder must present a detailed description of its proposed approach to the management of the project.

The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles (as described in Section IV.D Staffing Requirements) of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder shall provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

j. SUBCONTRACTORS

If the bidder intends to Subcontract any part of its performance hereunder, the bidder must provide:

i. Name, address, and telephone number of the Subcontractor(s);
ii. Specific tasks for each Subcontractor(s);
iii. Percentage of performance hours intended for each Subcontract; and
iv. Total percentage of Subcontractor(s) performance hours.

3. DRAFT PROJECT WORK PLAN

The bidder must provide a draft work plan, preferably in Microsoft Project, that describes each task the bidder will conduct to complete the scope of work described in Section IV. Task begin and end dates must be included that comply with the deliverable due dates described in Section IV.F.

4. TECHNICAL APPROACH

In its technical approach, the bidder should fully address each statement in Attachment 1 Technical Approach, in order, based upon Section IV. Scope of Work. The bidder's responses should consider Section IV.B Background and Vision for LTSS Program Design.

B. COST PROPOSAL REQUIREMENTS

This section describes the requirements to be addressed by bidders in preparing the Cost Proposal. The bidder must submit the Cost Proposal in a section of the proposal that is a separate section or is packaged separately as specified in the RFP from the Technical Proposal section.

The component costs of the fixed price proposal for providing the services set forth in the Request for Proposal must be provided by submitting forms substantially equivalent to those described below.

1. PRICING SUMMARY

a. The bidder must complete and submit Attachment 2 Cost Proposal Worksheet in its cost proposal.

b. The bidder must include detailed spreadsheets to support the proposed costs recorded on Attachment 2 Cost Proposal Worksheet. These spreadsheets must include, at a minimum, detailed descriptions and/or specifications of the goods and/or services to be provided, quantities, and timing and unit costs, if applicable. For each staff person proposed to work on the project, the bidder must include the hourly rate that was used to determine the cost of each phase of the project, as well as the hours proposed, and any other expenses. Every proposed hourly rate must be inclusive of travel.

c. The State reserves the right to review all aspects of the Cost Proposal for reasonableness and to request clarification of any proposal where the cost component shows significant and unsupported deviation from industry standards or in areas where detailed pricing is required.

2. PRICES

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the Request for Proposal. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

Form A

Bidder Contact Sheet

Request for Proposal Number 2016-LTSSZ1

The Bidder Contact Sheet should be completed and submitted with each response to this Request for Proposal. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response. Each bidder shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Preparation of Response Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

Each bidder shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

ATTACHMENT 1
TECHNICAL APPROACH

Section IV.C.1
Research, Service Delivery System Assessment, and Preliminary Recommendations

1. Considering the projects for which the bidder provided narrative project descriptions in its corporate overview, describe the successes and challenges with LTSS projects of this type and scope.

2. Describe the bidder's understanding of Nebraska's LTSS delivery system and the solutions that will be considered to make improvements.

3. Describe how the bidder proposes to complete the research and service delivery system assessment part of this project and what resources will be used.

4. Describe how CMS LTSS guidelines and regulations will be reviewed and incorporated into the research, service delivery system assessment and preliminary recommendations part of the project.

5. Provide a proposed work plan that covers all the activities required in the RFP, including start and completion dates and the staff person(s) to complete each specified task.

6. Provide a sample work product for a project similar in scope and size to this project, and that includes research, a program assessment, and program recommendations. A LTSS project is preferred but not mandatory.

Section IV.C.2
Engagement of Stakeholders

7. Describe the bidder's proposed approach to engaging and communicating with stakeholders.

8. Provide sample reports and presentations from previous, similar contracts that demonstrate the bidder's capabilities and qualifications for effective stakeholder engagement.

9. Provide a tentative list of stakeholders suggested to be included in the stakeholder meetings.

10. Describe three projects that the bidder completed for which stakeholder meetings were included. Discuss how adequate attendance was ensured.

Section IV.C.3
Development of a Redesign Plan

11. Describe the bidder's proposed approach to completing the redesign plan, including redesign of the current program and then the possible incorporation of delivery system changes.

12. Describe how the bidder will ensure that its final recommendations and redesign plan will improve affordability, access to care, individual choice of setting/provider, quality of care, and the State's MITA maturity level.

13. Describe how the bidder will ensure that its final recommendations and redesign plan will improve integration of care for dually-eligible individuals.

14. Describe the bidder's proposed plan to involve MLTC's contracted MCOs and all other stakeholders in the development of its redesign plan.

15. Describe how the bidder proposes to train MLTC staff about the redesign plan and resources that will be involved.

Section IV.C. 4
Implementation of a Redesign Plan

16. Describe the bidder's proposed approach to the implementation of its LTSS redesign plan. Describe any potential risks to plan implementation and how they will be mitigated.

17. Describe bidder's proposed plan to involve MLTC's contracted MCOs and all other stakeholders in the implementation process.

18. Describe how the bidder proposes to train and work with MLTC staff for plan implementation and resources that would be involved. Describe other potential audiences for training and resources that would be involved.

ATTACHMENT 2
COST PROPOSAL WORKSHEET
RFP 2016-LTSSZ1

Bidder Name:

Deliverable	Year 1	Year 2	Year 3	Total Cost
Final project work plan				$0.00
Stakeholder engagement plan				$0.00
Presentation materials for stakeholder meetings				$0.00
Assessment of Nebraska's LTSS service delivery system with preliminary recommendations				$0.00
Completion of stakeholder meetings as required by IV.2.b				$0.00
Summary report of stakeholder engagement				$0.00
Draft redesign plan				$0.00
Final redesign plan				$0.00
LTSS redesign implementation				$0.00
Status reports				$0.00
Total Cost	**$0.00**	**$0.00**	**$0.00**	**$0.00**

COMPLETE YELLOW HIGHLIGHTED CELLS ONLY. NO FORMATTING OR FORMULA CHANGES PERMITTED.

ATTACHMENT 3
VENDOR GRIEVANCE PROCEDURE

This policy is used to protest a service contract awarded through the Department of Health and Human Services. If a service is bid directly by Health and Human Services, the Director of Health and Human Services is responsible for handling protests. All protests/grievances are to be forwarded to the Director of Health and Human Services.
Grievances/Protests will only be accepted from vendors who have submitted a timely bid response in connection with the award in question. Administrative procedures for grievances/protests are as follows:

1. Grievances/protests must be expressed in writing, directed to: Director, Department of Health and Human Services, Centennial Mall South (5th Floor), Lincoln NE 68509. Grievances/protests should (1) reference the bid number; (2) include specific issues that are disputed; and (3) provide a point of contact and mailing address to which a response can be sent. All grievances/protests must be received within ten (10) business days of the posting of the award (commodity) or intent to award (service), in order to be considered a valid grievance/protest.

2. A response will be made in writing to the point of contact provided in the grievance/protest by the Department of Health and Human Services Director, generally within ten (10) business days of receipt of the grievance/protest.

3. If the response from the Department of Health and Human Services Director has not satisfied the grievance of the vendor, the vendor may make a written request for a meeting with the Director of Health and Human Services or a designee of the Director's choosing, by directing such request to: Director of Health and Human Services, Department of Health and Human Services, Centennial Mall south (5th Floor), Lincoln NE 68509. Such request should (1) reference the bid number; (2) include the specific issues disputed; and (3) provide a point of contact and mailing address. All meeting requests must be received within ten (10) business days of the date of the Director of Health and Human Services Director's response in order to be considered a valid request.

4. A meeting will be scheduled and held with the vendor, Director of Health and Human Services, or the Director's designee for the vendor, to present their issues.

5. A written final decision will be sent to the vendor, generally within ten (10) business days, unless additional time is necessary to fully examine the issues presented.

ATTACHMENT 4
REVISED COST PROPOSAL WORKSHEET
RFP 2016-LTSSZ1

Bidder Name:

Deliverable	Year 1	Year 2	Year 3	Total Deliverable Cost
Final project work plan				$0.00
Stakeholder engagement plan for Research, Delivery System Assessment, and Preliminary Recommendations				$0.00
Stakeholder meeting presentation materials for Research, Delivery System Assessment, and Preliminary Recommendations				$0.00
Completion of stakeholder meetings prior to completing the assessment of Nebraska's LTSS delivery system with preliminary recommendations				$0.00
Summary report of stakeholder engagement prior to completing the assessment of Nebraska's LTSS delivery system with preliminary recommendations				$0.00
Assessment of Nebraska's LTSS service delivery system with preliminary recommendations				$0.00
Draft redesign plan				$0.00
Stakeholder engagement plan for soliciting feedback to draft redesign plan				$0.00
Stakeholder meeting presentation materials for soliciting feedback to draft redesign plan				$0.00
Completion of stakeholder meetings for soliciting feedback to draft redesign plan				$0.00
Summary report of stakeholder engagement following the draft redesign plan				$0.00
Final redesign plan				$0.00
Status reports				$0.00
Total Deliverables Cost	**$0.00**	**$0.00**	**$0.00**	**$0.00**

COMPLETE YELLOW HIGHLIGHTED CELLS ONLY. NO FORMATTING OR FORMULA CHANGES PERMITTED.

ADDENDUM ONE
REVISED SCHEDULE OF EVENTS

Date: March 17, 2016

To: All Bidders

From: Julie Gillmor, Buyer
Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care

RE: Addendum for Request for Proposal Number 2016-LTSSZ1 to be opened April 7, 2016 at 2:00 p.m. Central Time

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

	Activity	Date/Time
2.	Last day to submit written questions	~~**March 22, 2016**~~ **March 28, 2016**
3.	State responds to written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~March 29, 2016~~ **April 6, 2016**
4.	Proposal opening Location: Nebraska Department of Health and Human Services Division of Medicaid and Long-Term Care 301 Centennial Mall South, ~~Lower Level D~~ 3rd Floor Conference Room 3A (Check in with 3rd floor reception desk) Lincoln, NE 68509	~~**April 7, 2016**~~ **April 13, 2016** 2:00 p.m. Central Time
5.	Review for conformance of mandatory requirements	~~**April 7-8, 2016**~~ **April 13-14, 2016**
6.	Evaluation Period	~~**April 11-14, 2016**~~ **April 15-22, 2016**
8.	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~**April 18, 2016**~~ **April 26, 2016**
9.	Contract finalization period	~~**April 18-28, 2016**~~ **April 26-May 12, 2016**
10.	Contract award	~~**April 29, 2016**~~ **May 13, 2016**
11.	Contractor start date	~~**May 2, 2016**~~ **May 16, 2016**

ADDENDUM TWO
REVISIONS TO THE RFP

Date: April 6, 2016

To: All Bidders

From: Todd Baustert, Buyer
Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care

RE: Addendum for Request for Proposal Number 2016-LTSSZ1

The following is hereby amended:

Document	Section	Change From:	Change To:
RFP	Request for Proposal for Contractual Services Form – Procurement Contact	Procurement Contact: Julie Gillmor	Procurement Contact: Todd Baustert
RFP	Request for Proposal for Contractual Services Form	RETURN TO: DHHS-MLTC Attn: Julie Gillmor	RETURN TO: DHHS-MLTC Attn: Todd Baustert
RFP	II.A Procuring Office and Contact Person	Name: Julie Gillmor	Name: Todd Baustert
RFP	II.E Written Questions and Answers	Questions may also be sent by facsimile to (402) 742-1155, but must include a cover sheet clearly indicating that the transmission is to the attention of Julie Gillmor, Buyer, showing the total number of pages transmitted, and clearly marked "RFP Number 2016-LTSSZ1; LTSS Redesign Consultation Questions."	Questions may also be sent by facsimile to (402) 742-1155, but must include a cover sheet clearly indicating that the transmission is to the attention of Todd Baustert, Buyer, showing the total number of pages transmitted, and clearly marked "RFP Number 2016-LTSSZ1; LTSS Redesign Consultation Questions."
RFP	V.A Technical Proposal Requirements	Corporate overview, as described in V.A.3;	Corporate overview, as described in V.A.2;
RFP	IV.C.4 Implementation of Redesign Plan	The consultant should include implementation tasks in its technical and cost proposals. MLTC reserves the right to award or not award this portion of the scope of work.	The consultant should include implementation tasks in its technical proposal. MLTC reserves the right to award or not award this portion of the scope of work.

			Should MLTC choose to award this portion of the scope of work, the role of the consultant during this phase will be to augment MLTC staff implementing the redesign plan. MLTC will request and approve Contractor resources at a specific staff level based upon assigned task(s). Contractor compensation for the implementation phase will be based on the hourly rate identified in the bidder's response to V.B.1.b.
RFP	III.II Invoices	Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Invoices must classify the contract deliverable (per IV.F Deliverables) associated with each expense. Invoices are to be submitted no later than 30 calendar days following MLTC's approval of deliverable(s). A final invoice must be submitted within 30 days of the last day of the contract period.	Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Invoices must classify the contract deliverable (per IV.F Deliverables) associated with each expense. Invoices are to be submitted no later than 30 calendar days following MLTC's approval of deliverable(s). Should the State decide to award the scope of work in IV.C.4, the Contractor shall invoice DHHS monthly for actual hours worked on the 5th of the month following the month the work occurred. Invoices must provide at a detailed level, the work produced by individual personnel and the hours worked. All invoices submitted for deliverables other than work conducted within IV.C.4 must follow the requirements set forth in the first paragraph of Section III.II. A final invoice must be submitted within 30 days of the last day of the contract period.
RFP	IV.C.2.b	The consultant must facilitate community meetings and focus groups statewide, develop presentation and educational materials for these meetings,	The consultant must facilitate community meetings and focus groups statewide, develop presentation and

		prepare and conduct brief participant surveys, and provide MLTC with a summary report of the stakeholder engagement process. At a minimum, stakeholder meetings must be held in Fremont, Gering, Grand Island, Hastings, Kearney, Lincoln, Norfolk, North Platte, and Omaha. At least two meetings must be held in these locations, one during business hours and one in the evening. Additional meetings may be held at the consultant's discretion, but at least these 18 sessions must occur. The stakeholder groups that must be represented include individuals receiving LTSS and family members/informal caregivers, and providers of community-based and institutional LTSS. Meetings must be held in accessible locations. The consultant may provide the capability for web-enabled participation, but meetings must be held in person.	educational materials for these meetings, prepare and conduct brief participant surveys, and provide MLTC with a minimum of two summary reports of the stakeholder engagement process. The initial report should summarize stakeholder engagement prior to the assessment of Nebraska's LTSS delivery system with preliminary recommendations. The second report should summarize stakeholder engagement and feedback to the draft redesign plan. In order to produce the initial stakeholder engagement report, a minimum of 18 stakeholder meetings must be held in Fremont, Gering, Grand Island, Hastings, Kearney, Lincoln, Norfolk, North Platte, and Omaha. At least two meetings must be held in each of these locations, one during business hours and one in the evening. In order to produce the stakeholder engagement report summarizing stakeholder feedback to the draft redesign plan, a minimum of 18 stakeholder meetings must be held in Fremont, Gering, Grand Island, Hastings, Kearney, Lincoln, Norfolk, North Platte, and Omaha. At least two meetings must be held in each of these locations, one during business hours and one in the evening. The stakeholder groups that must be represented include individuals receiving LTSS and family members/informal caregivers, and providers of community-based and institutional LTSS. Meetings must be held in accessible locations. The consultant may provide the capability for web-enabled

			participation, but meetings must be held in person. Additional meetings may be held at the consultant's discretion, but at least these 36 sessions must occur.
Attachment 2			Attachment 2 is replaced with Attachment 4

RFP section IV.F Deliverables is hereby amended as follows:

Deliverable	Due Date
Final project work plan	15 business days after contract start date
Stakeholder engagement plan for Research, Delivery System Assessment, and Preliminary Recommendations	30 calendar days after contract start date
Stakeholder meeting presentation materials for Research, Delivery System Assessment, and Preliminary Recommendations	30 calendar days after contract start date
Completion of stakeholder meetings prior to completing the assessment of Nebraska's LTSS delivery system with preliminary recommendations	60 calendar days after contract start date
Summary report of stakeholder engagement prior to completing the assessment of Nebraska's LTSS delivery system with preliminary recommendations	75 calendar days after contract start date
Assessment of Nebraska's LTSS service delivery system with preliminary recommendations	90 calendar days after contract start date
Draft redesign plan	6 months after contract start date
Stakeholder engagement plan for soliciting feedback to draft redesign plan	8 months after contract start date
Stakeholder meeting presentation materials for soliciting feedback to draft redesign plan	8 months after contract start date
Completion of stakeholder meetings for soliciting feedback to draft redesign plan	10 months after contract start date
Summary report of stakeholder engagement following the draft redesign plan	15 calendar days following final stakeholder engagement meeting
Final redesign plan	12 months after contract start date
Status reports	15 calendar days after end of month

ADDENDUM THREE
QUESTIONS and ANSWERS

Date: April 6, 2016

To: All Bidders

From: Todd Baustert, Buyer
Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care

RE: Addendum for Request for Proposal Number 2016-LTSSZ1
to be opened April 13, 2016 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
1.	IV.C.2.a	31	Does the State require that stakeholder meetings in all identified locations be complete prior to the redesign phase, or should meetings take place within both the assessment and redesign phases? If the State wishes to collect input during both phases, does the State have a proposed structure for which locations to meet with during the assessment vs. redesign phase?	Stakeholder input should be collected during the assessment and redesign phases. See Addendum Two and Attachment 4.
2.	IV.C.2.d	31	Does MLTC have established stakeholders to meet each of the required stakeholder group representatives within each of the locations identified in IV.C.2.b, or will it be expected that the contractor recruit these individuals?	The Department will provide a list of established stakeholder groups to the awarded Contractor. The Contractor should also recruit additional stakeholders.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
3.	IV.F	32-33	Can the State provide more information about the expected timeline for completing deliverables? The contract appears to be for three years; can the State provide information about the types of activities it anticipates occurring in years 2 and 3?	The Department anticipates that implementation-related activities will occur in the contract's second and third years.
4.	V.B	36	Should the contractor's proposal for conducting the outreach meetings include funds to cover the costs of: • Rooms for meetings • Accessibility – translators, materials in braille, etc.? • Stipends for participants with disabilities • Funds for respite, transportation, or other costs for individuals with disabilities and/or family members to participate If stipends are desired, does the State have an anticipated amount per person that should be factored into the cost proposal?	Each bidder's cost proposal should include all appropriate costs for conducting stakeholder meetings. The Department will not provide participant stipends or other reimbursement for meeting attendees or their family members.
5.	V.B	36	Can the State provide any guidance on its expectation regarding how much it anticipates the overall scope of work will cost?	No.
6.	IV.C.1.	30	To what extent will the State be able to respond to data requests, such as summary data on expenditures and recipients for different programs and different sets of recipients? If the contractor were to develop data requests would the State have staff that could pull the data? If so, how quickly could those request be processed?	Summary data is subject to availability and will generally be released within five (5) working days of an approved data request.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
7.	IV.C.4.	31	Can the State give more guidance regarding the types of implementation activities the contractor should prepare bids on? Given the lack of a current LTSS redesign plan and the wide variety of approaches for reforming systems, it may be challenging to develop tasks that are specific enough to cost out. Instead, could the contractor simply supply hourly rates to that could be applied to implementation tasks?	During the implementation phase, the Contractor should operate in a staff augmentation role. See Addendum Two.
8.	V.B	36	Does the State anticipate that the stakeholder input will primarily be about the draft plan (therefore, they would occur after the outline of the plan had been developed)?	See response to question 1.
9.	Pg. 1 Scope of RFP – "will be issued approximately for a period of three (3) years effective the date of the award". Pg. 33 – Final Redesign Plan – "due date is 8 months of contract start date" yet the cost proposal worksheet assumes costs for this deliverable into year 2.	1 and 33 Attachment 2 – cost proposal worksheet	Can you confirm the timeline that C1, C2 and C3 will occur in the initial eight months of the contract with C4 exercised upon approval of the redesign plan?	See Addendum Two and Attachment 4. All deliverables should be completed within the first year of the contract, except status reports which the Contractor should provide on a monthly basis through the end of the contract. Should The Department elect to utilize the Contractor's services in a staff augmentation role as described in Section IV.C.4, these activities are expected to take place in years two (2) and three (3) of the contract.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
10.	Pg. 33 – Assessment of Nebraska's LTSS service delivery system with preliminary recommendations Attachment 1 – Technical Approach	33 and Attachment 1	Can you provide more detail on the scope of quantitative analysis anticipated within the assessment and the data that will be made available?	See Section IV.C.1 of the RFP and response to question 6.
11.	Pg. 33 – Assessment of Nebraska's LTSS service delivery system with preliminary recommendation Attachment 1 – Technical Approach	33 and Attachment 1	Given that the assessment is due within 60 days of contract start, should we assume minimal quantitative analysis?	See response to question 6.
12.	Development of a Redesign Plan – "The consultant must explore opportunities to advance the State's MITA maturity status through shared services and data, collaboration, and use/reuse of systems."	31, 3.b.	Given that the assessment deliverable is due within 60 days of contract start, what is the state's expectation regarding this exploration? Is the state anticipating that this exploration occur within the initial 60 days or can such exploration occur throughout the initial six months of the project and be included within the draft redesign plan?	This exploration may occur within the first six (6) months of the project and be included in the draft redesign plan.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
13.	IV.B. Background	29-30	Can the Department provide any additional clarification regarding the role of managed care in the LTSS redesign?	The role of managed care in LTSS should be assessed by the contactor and addressed during stakeholder meetings. The contractor should then provide a recommendation regarding managed care in LTSS in Nebraska.
14.	IV.C. Scope	30-31	Please clarify the role, if any, of the DHHS Division of Developmental Disabilities in the contract activities.	Section IV.C.1.d of the RFP lists the State programs that will be included in the project's scope of work which includes waivers and services administered by the Division of Developmental Disabilities.
15.	IV.C.2	30-31	For the Stakeholder engagement meetings, can the Department offer any additional information regarding the State's preference and history regarding stakeholder alignment and whether separate meetings would be expected for different populations (ie, DD vs aging vs IL)?	Separate meetings are not required for different populations. See response to question 2.
16.	IV.C.4	31	Does the State have a timeline goal for beginning LTSS redesign implementation, and if so, when?	The Department anticipates that the implementation period will begin no later than May 2017.
17.	IV.B.	29-30	Does the Department anticipate any interdependencies between implementation of the HCBS Statewide Transition Plan and the LTSS Redesign? Can you offer any clarification regarding this alignment?	The Department does anticipate interdependencies between the implementation of the HCBS Statewide Transition plan and the LTSS Redesign. An updated draft of the State Transition Plan, posted for public comment on March 28, 2016 can be found at: http://dhhs.ne.gov/Pages/Transition.aspx
18.	Section II.K. Evaluation of Proposals	5	This section indicates that "Evaluation criteria weighting will be released with the Request for Proposal. Evaluation criteria weighting and a list of respondents will be posted to the Internet at: http://das.nebraska.gov/material/purchasing.html" The evaluation criteria does not appear to be posted. Do you have an estimated date when the evaluation criteria weighting will be posted?	The evaluation criteria was posted on March 30, 2016.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
19.	Section IV.C.2. Engagement of Stakeholders	30-31	Is the Consultant responsible for payment of venue facility fees, if required, for stakeholder meetings? Additionally, is the Consultant required to pay any stakeholder attendees for travel to the meetings?	See response to question 4.
20.	IV, C, 2, a. Engagement of Stakeholders	30	Will the consultant be expected to provide formal presentations to select NE official meetings/legislative committees? Will there be the establishment of dedicated external stakeholder advisory committee(s) to oversee the LTSS redesign effort? If yes, will the Consultant be expected to assist in the formation of these committee(s) and possibly assist in staffing them?	The Contractor may be expected to provide formal presentations for select NE official meetings/legislative committees. The Department will establish a LTSS advisory committee to address reform issues. The committee will meet for the first time in the second quarter of calendar year 2016. The Contractor will not be expected to assist in the formation of this committee or staff it, but may be asked to provide a project update at each meeting.
21.	IV, C, 2, b. Engagement of Stakeholders	31	The State notes in its concept paper that stakeholders would include individuals receiving LTSS, advocacy organizations, providers, managed care organizations, care coordination agencies, legislators, among others. Of these groups, has the state identified which of these groups should be targeted for participation in the 18 required meetings? Is the State open to alternative approaches to conduct of stakeholder input to assure each of these groups has input into the process? Are there any prohibitions to having webinar-only public meetings as long as the mandatory 18 face-to-face meeting requirement is met?	See Addendum Two. The Contractor should target all stakeholders, as listed in the concept paper, for participation in the stakeholder meetings.
22.	Section IV.C.3. Development of a Redesign Plan	31	For the impact analysis, does MLTC have existing reports and information the Consultant will use? Does MLTC expect the Consultant to conduct original data analyses?	MLTC will provide existing reports and information to the awarded Contractor. The Contractor should conduct analysis on data acquired as a result of its stakeholder feedback efforts and incorporate this analysis into appropriate deliverables set forth in Section IV.F of the RFP as amended in Addendum Two.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
23.	Section IV.C.4. Implementation of Redesign Plan	31	As written, MLTC will likely receive proposals with a wide variation in proposed implementation tasks resulting in a wide range of cost proposals, particularly given the implementation tasks may vary based on the final redesign (e.g., an 1115 demonstration proposal may or may not be needed). Would MLTC consider revising the Cost Proposal template to allow for submission of hourly rates for this set of tasks instead of a full cost proposal since the redesign plan and associated tasks/activities are unknown at this time?	See response to question 7.
24.	Section IV.C.4. Implementation of Redesign Plan	31	Further to the above question, if the State requires a fixed price for the Implementation Phase, please clarify the State's approach and methodology for evaluating and scoring Cost Proposals for the implementation phase of the project.	See responses to questions 7 and 18.
25.	Section IV.E. Staffing Requirements	32	Please confirm if the State's expectation is that *all* staff proposed within the designated staffing categories meet *all* competencies listed. If so, would the State consider providing flexibility in the requirements to better allow for a full complement of experience and assignment across a team to accomplish the given tasks? For example purposes only, we would anticipate that all Medicaid Program Analysts will not need to be involved in stakeholder meetings. Additionally, team members with MITA expertise may or may not meet (or need) the required qualifications of four to five years of experience in Medicaid LTSS delivery systems. Would the State consider, for example, establishing core competencies outside of the actual position categories and allow the Consultant to identify core team members who satisfy those requirements?	All staff proposed should meet the competencies required in Section IV.E of the RFP.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
26.	Section V.A.2.h.i. and ii. Summary of Bidder's Corporate Experience	35	We understand that "The State will use no more than three narrative project descriptions submitted by the bidder during its evaluation…" Our question is whether the State would consider a narrative project description for a project performed by a subcontractor as satisfying one of the narratives? Or, relative to the above question, does the state require that all three narrative project descriptions be for projects performed by the **prime** contractor?	Project narratives submitted in response to requirements set forth in Section IV.A.2.h of the RFP must describe the Contractor's completed projects, not Subcontractors. Bidders may include project narratives in which they acted as a Subcontractor, provided requirements in Section V.A.2.h of the RFP are met.
27.	Section V.A.2.h.i. and ii. Summary of Bidder's Corporate Experience	35	Are three narrative project descriptions also required for subcontractors?	See Section V.A.2.h of the RFP. The Department will evaluate no more than three narrative project descriptions. Also, see response to question 26.
28.	V, A, 2, i, Summary of Bidder's Proposed Personnel / Manageme nt Approach	36	The RFP states that one of the resume requirements is that resumes include "understanding of the process." What is required to be responsive to this requirement?	All proposed staff should meet the requirements of their respective staffing category described in Section IV.E of the RFP.
29.	Section V.B. Cost Proposal Requireme nts	36	What is the project budget allocated or approved for this effort?	See response to question 5.
30.	RFP Attachment 1. Technical Approach	1-2	For any question that requests sample work product or project work, must this work have been conducted by the prime contractor? Or, is subcontractor work acceptable for activities they will support?	Either is acceptable, but the work project should be identified as being performed by a Prime Contractor or Subcontractor.
31.	Section IV.C.1.d	30	This section indicates that the State will determine if other programs should be included in the review. Please confirm that bidders should consider the LTSS services listed in preparing their RFP response. How will the State address changes to the programs to be reviewed with the Contractor in terms of scope, timelines and budget?	Section IV.C.1.d of the RFP identifies the programs expected to be included in the Contractor's assessment. Additional programs may be considered as a result of the Contractor's recommendations provided in the redesign plan. The Department does not anticipate that the inclusion of one or more programs will affect the project's scope, timelines, or budget.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
32.	Section IV.C.2.d	31	This section notes that all proposed materials to be used as part of stakeholder meetings must be submitted to MLTC for approval as part of the stakeholder engagement plan, which is due 30 calendar days after the contract start date. However, the deliverables chart on page 33 (IV.F) indicates that presentation materials for stakeholder meetings are due 60 calendar days after the contract start date. Please confirm when presentation materials for stakeholder materials must be submitted for approval, 30 calendar days or 60 calendar days after contract start date.	See Addendum Two.
33.	Section IV.C.4.	31	The State requests that implementation tasks be included in the technical and cost proposals and will reserve the right to award or not award this portion of the scope of work. Please indicate how this piece of the technical and cost proposal will be evaluated in awarding this work and provide any additional detail regarding the expectations of the State associated with the implementation tasks.	See responses to questions 7 and 18.
34.	Section IV.D.1.b	32	The section indicates that toll-free communications are to be used for MLTC staff communications. Is this referring to group conference calls or does this extend to all communications?	This requirement refers to group conference calls.
35.	Section IV.F.	33	Based on the deliverable schedule presented in this section, please confirm that the Contractor has 30 days to complete the stakeholder meetings (to happen between 60 and 90 days after contract start date)? Will the State provide approval of the presentation by the 60th day after contract start? When will the materials need to be provided to the State in order to secure approval by this time? Finally, confirm that the stakeholder meetings that need to happen in this time period are the minimum 18 meetings outlined in Section IV.C.2.b. on page 31 of the RFP.	The Contractor has 30 days to complete the stakeholder meetings. The Department will review materials for stakeholder meetings for approval within five (5) business days of receipt. The Contractor may submit draft materials earlier than the 60 deliverable timeframe. As indicated in Section IV.F of the RFP, all required meetings set forth in Section IV.C.2.b of the RFP must take place within 90 calendar days of the contract start date.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
36.	Attachment 2	Cost Proposal Worksheet	Given the Final Redesign Plan is due to the State eight months after the contract start date, what tasks are expected around the Final Redesign Plan following this period and into Year 2 of the contract that necessitates additional costs as reflected in the Cost Proposal Worksheet?	See Addendum Two and Attachment 4. Final Redesign Plan is due within the first year of the contract.
37.	II.B	2	What is MLTC's budget for this project?	See response to question 5.
38.	II.O	5	Are there two requirements for this section? First is a Certificate of Good Standing, which must be completed prior to award? Second is certificate for transacting business in the State of Nebraska which must be submitted with the bid?	No, this requirement is one and the same.
39.	II.O	5	If a business transaction certificate is required and we are not the successful bidder, will the State of Nebraska still require us to submit a tax return even though no business was conducted?	The Department does not understand the question and is therefore unable to respond.
40.	III. F.4	10	Can the Evidence of Coverage be provided prior to award rather than with the RFP response?	Yes.
41.	III. GG/HH/II	18	Are progress payments permitted under this contract or are payments restricted to contract deliverables?	See Section III.II of the RFP and Addendum Two.
42.	III.PP	21	If requested, will the state deem proprietary the financial statements (required on page 34) of privately held companies?	Yes, provided that proposal conforms to the proprietary information submission instructions set forth in Section III.PP of the RFP.
43.	IV.B	29	Under Program Administration, there is a discussion of developing an individual assessment process and instrument for eligibility determination, assessment of needs, care planning, etc. Is the state intending a single or multiple instruments be developed? Are different instruments to be developed for each service (i.e. HCBS, ICF-DD, MFP transition services)?	None of these tasks are part of this project's scope of work.
44.	IV.C.2.b	31	Does MLTC anticipate that stakeholder meetings will be separately conducted by providers (i.e. Medicaid, DD, and MCOs)? Will meetings held with families/caregivers be separate from provider meetings?	See response to question 15.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
45.	IV.C.2.d	31	Will MLTC send invitations to the stakeholders? If invitations are the responsibility of the contractor will MLTC provide the email addresses for the stakeholders?	No, invitations are the responsibility of the Contractor. The Department will work with the Contractor to identify stakeholders and provide email addresses. The Contractor may need to conduct additional research to obtain some email addresses.
46.	IV.C.3.a	31	Will MLTC provide claims data to allow for the completion of the fiscal analysis?	Yes.
47.	IV.C.4	31	Can the cost proposal for the Implementation of Redesign Plan be submitted after the approval of the Redesign Plan? It is not feasible to develop a fixed cost proposal when the scope of the redesign has not been developed or approved.	See responses to questions 7 and 18.
48.	IV.F	31	The Completion of Stakeholder Meetings should be extended to 120 days after contract date and the Summary Report of Stakeholder Engagement should similarly be extend to 150 days. If the submittal of the presentation materials for the stakeholder meeting are required 60 days after contract start date, it is not practical to conduct a minimum of 18 stakeholder meetings statewide in 30 calendar days.	Due dates are set forth in Section IV.F of the RFP.
49.	V.A.2.i	36	Should resumes be submitted for key personnel rather than all personnel? There will be junior and support personnel on this project and their resumes would not be relevant to assessing the skills and expertise necessary to successfully complete this project. Additionally, it would be impracticable to get three references for the junior and support personnel.	The Department should receive resumes for all client-facing consultants who will be involved in the completion of this project.
50.	V.A.2.i	36	In describing the contents required in the resumes, the RFP states the requirement of "understanding of the process". Will you please explain what the state is expecting here?	See response to question 28.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
51.	Attachment 2	1	Are the "Year" columns a contract or state fiscal year? The reason for the question is the spreadsheet allows for a cost for the Final Redesign Plan in Year 2 but this deliverable is due 8 months after the start of the contract.	See Attachment 4.
52.	II C	2, Customer Service	In this section it states, "Contractor will develop or provide technology an business procedures designed to enhance the level of customer satisfaction and to provide the customer appropriate information given their situation." Can DHHS provide a more detailed description of the types of technology or procedures it anticipates falling into this description of deliverables?	Per Section II.C of the RFP, the Contractor, its employees, Subcontractors and agents must be accountable, responsive, reliable, patient, and have well-developed communication skills as set forth by the customer service industry's best practices and processes.
53.	II K	5, Evaluation of Proposals	Could DHHS provide us with a copy of the "evaluation criteria weighting" as indicated on page 5 of the RFP?	See response to question 18.
54.	II M	5, Mandatory Requirements	Is it acceptable to include a transmittal letter with a bidder's proposal?	Yes, as long as all other required materials are included in the order specified in the RFP.
55.	IV-C2b	31, Project Scope of Work – Engagement of Stakeholders	Under stakeholder community meeting requirements, will the vendor be expected to secure accessible meeting spaces to meet this requirement as well as pay for any expenses associated with these spaces?	See response to question 4.
56.	V	33, Proposal Instructions	Can DHHS further explain where "Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals." Is this to take place under the Corporate Overview or in the Technical	All proposals should follow the format identified in Section V of the RFP.
57.	V A1	34, Technical Proposal Requirements	Section III Terms and Conditions - can this document be included with a bidder's proposal at the end of the technical proposal document as an attachment?	No. See response to question 56.
58.	V A	34, Technical Proposal Requirements	Could you please clarify whether the reference to the Corporate overview, as described in V.A. bullet three as referring to V.A.3 should instead refer to V.A.2 or whether it is correct as stated in the RFP?	See Addendum Two.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
59.	V A2h	35, Summary of Bidder's Corporate Experience	Would DHHS like a list of all similar projects in this matrix with the top three highlighted for use in evaluation?	See Section V.A.2.h of the RFP. A summary matrix should be provided. Narrative project descriptions should also be provided. No more than three (3) narrative project descriptions submitted by the bidder will be considered in the proposal evaluation.
60.	V B	36, Cost Proposal Requirements	Does DHHS have a specific dollar amount set aside in the budget for this scope of work and if so, can you provide us with this dollar amount?	See response to question 5.
61.	Form A	38, Bidder Contact Sheet	Would it be appropriate to place this form directly following the Request for Proposal for Contractual Services Form in the Technical Proposal submission?	The Bidder Contact Sheet should be included in the bidder's proposal after the Terms and Conditions document.
62.	IV c 1	Attachment 1, Technical Approach	Section IV.c.1 has the following language in number 5: "Provide a proposed work plan that covers all the activities required in the RFP, including start and completion dates and the staff person(s) to complete each specified task." Section V.A.3 also requests a Project Work Plan. Would providing a work plan in Section V.A.3 be sufficient or does the state wish to see two separate work plans, one in Section V.A.3 and a second in response to item number 5?	One work plan is sufficient. It should be included in the bidder's proposal after the Corporate Overview section.
63.	V.A.2.d	34	Is an office located within the State of Nebraska required?	No.
64.	V.B.1.a	36	Addendum One Revised Schedule of Events says the Contract Start Date is May 16, 2016. What is the Contract Period end date for this RFP? Is the Contract Period May 16, 2016 through May 15, 2017, one year from the Start Date?	See Section I of the RFP.
65.	IV.B.	29-30	The State has identified reduction of duplication as a potential area of opportunity. Will the State please provide an example of duplication that has been identified?	The Department anticipates that the Contractor will be responsible for assessing current services to ensure that they are not duplicative, and that waiver services enhance state plan services.
66.	IV.B.	29	What is the status of the State's plan to include LTSS in Heritage Health managed care in 2018?	See response to question 13.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
67.	IV.B.	29	Has the State received feedback on LTSS Program Redesign Concept Paper to date? Will the State make the feedback available to bidders now, or will the contractor have access to it upon award?	Feedback on the concept paper will be made available to the awarded Contractor.
68.	IV.C.2.	30-31	What role will the State play in notifying stakeholders of community meetings and other stakeholder events?	See response to question 45.
69.	V.B.1.	36-37	Does the State anticipate that accessible meeting locations will be available at no cost, or should the contractor assume meeting facility costs in its cost proposal?	See response to question 4.
70.	V.B.1.	36-37	Does the State have a target budget for this RFP, either in dollars or hours of labor?	See response to question 5.
71.	V.B.1	36	Regarding Attachment 2, Cost Proposal Worksheet, is the period of performance for 3 years starting on May 16, 2016 and ending on May 15, 2019?	Yes. See Attachment 4.

ADDENDUM FOUR
REVISED SCHEDULE OF EVENTS

Date: April 26, 2016

To: All Bidders

From: Todd Baustert, Buyer
Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care

RE: Addendum for Request for Proposal Number 2016-LTSSZ1

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

	Activity	Date/Time
8.	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~**April 18, 2016**~~ ~~**April 26, 2016**~~ **May 2, 2016**
9.	Contract finalization period	~~**April 18-28, 2016**~~ ~~**April 26-May 12, 2016**~~ **May 2-12, 2016**
10.	Contract award	~~**April 29, 2016**~~ **May 13, 2016**
11.	Contractor start date	~~**May 2, 2016**~~ **May 16, 2016**

ADDENDUM FIVE
REVISED SCHEDULE OF EVENTS

Date: April 28, 2016

To: All Bidders

From: Todd Baustert, Buyer
Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care

RE: Addendum for Request for Proposal Number 2016-LTSSZ1

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

	Activity	Date/Time
8.	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~**April 18, 2016**~~ ~~**April 26, 2016**~~ ~~**May 2, 2016**~~ **May 13, 2016**
9.	Contract finalization period	~~**April 18-28, 2016**~~ ~~**April 26-May 12, 2016**~~ **May 13-30, 2016**
10.	Contract award	~~**April 29, 2016**~~ ~~**May 13, 2016**~~ **May 31, 2016**
11.	Contractor start date	~~**May 2, 2016**~~ ~~**May 16, 2016**~~ **June 1, 2016**

EVALUATION CRITERIA

RFP NUMBER 2016-LTSSZ1
Opening Date: April 13, 2016, 2:00 p.m. Central Time

Mandatory Requirements
The proposals will first be examined to determine if all mandatory requirements listed below have been addressed to warrant further evaluation. Proposals not meeting mandatory requirements will be excluded from further evaluation. The mandatory requirement items are as follows:

1. Request for Proposal For Contractual Services form, signed in ink;
2. Completed Section III. Terms and Conditions;
3. Corporate Overview;
4. Technical Approach; and
5. Cost Proposal.

Evaluation Criteria
All responses to this Request for Proposal, which fulfill all mandatory requirements, will be evaluated. Each category will have a maximum possible point potential. Areas that will be addressed and scored during the evaluation include:

Evaluation Criteria	Possible Points
Part 1 — Corporate Overview	100
Part 2 — Technical Approach	750
Part 3 — Cost Proposal Points	300
Total Points without Oral Interviews	1150
Oral Interviews (If necessary)	100
Total Points with Oral Interviews	1250

Part 4 – Cost Proposal Points

Cost points will be calculated as follows:

1. Establish lowest cost submitted – lowest cost submitted receives the maximum points.
2. To assign points to all others, the following formula will be followed:
   Lowest Cost Submitted ÷ Cost Submitted x Maximum Possible Cost Points = Cost Points to Award (see samples below)

	Formula	Sample	Sample	Sample
	Lowest Cost Submitted	$100,000	$100,000	$100,000
÷	Cost Submitted	$100,000	$200,000	$150,000
x	Maximum Possible Cost Points	300	300	300
=	Points To Award	300	150	200

NOTIFICATION OF INTENT TO AWARD

Date: May 5, 2016

To: All Vendors

From: Todd Baustert, Buyer
Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care

Subject: Request for Proposal Number 2016-LTSSZ1

This is to notify all vendors who responded to the above-referenced Request For Proposal that the State of Nebraska intends to award the contract for long-term supports and services redesign consultation services to Mercer Health & Benefits LLC.

Thank you for your interest in doing business with the State of Nebraska.

FINAL EVALUATION DOCUMENT

RFP Number 2016-LTSSZ1
Long-Term Supports and Services Redesign Consultation Services
Opening Date: April 13, 2016

Evaluation Criteria	Possible Points	Mercer Health & Benefits LLC	Navigant Consulting, Inc.	Public Consulting Group, Inc.
Part 1.0 Corporate Overview	100	91.25	86.25	74.75
Part 2.0 Technical Approach	750	632.25	623.25	495.25
Part 3.0 Cost Proposal	300	250	198	300
Total Points without Oral Interviews	**1150**	**973.5**	**907.5**	**870**
Oral Interviews (if required)	100			
Total Points with Oral Interviews	**1250**			
Ranking		**1**	**2**	**3**

Invalid Proposal - Truven Health Analytics Inc. - Did not comply with mandatory requirements