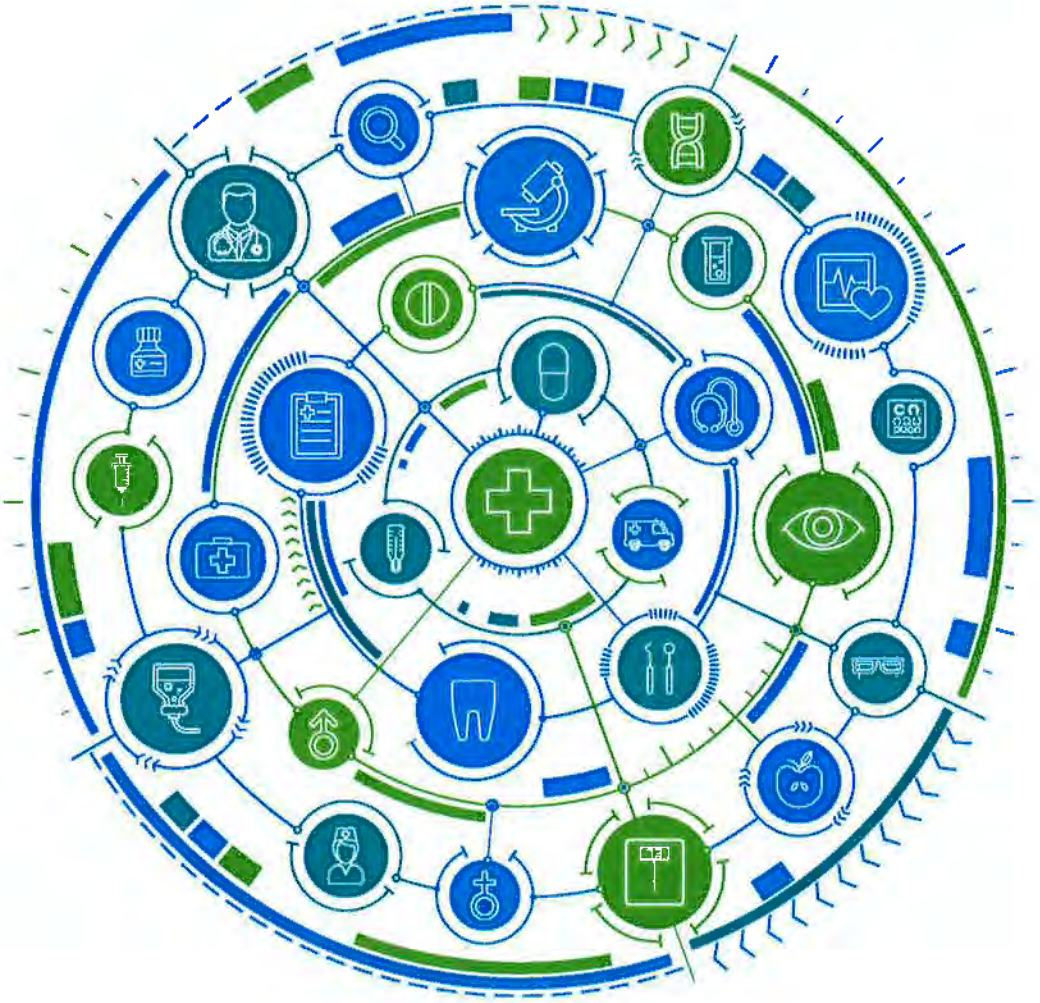
Deloitte.



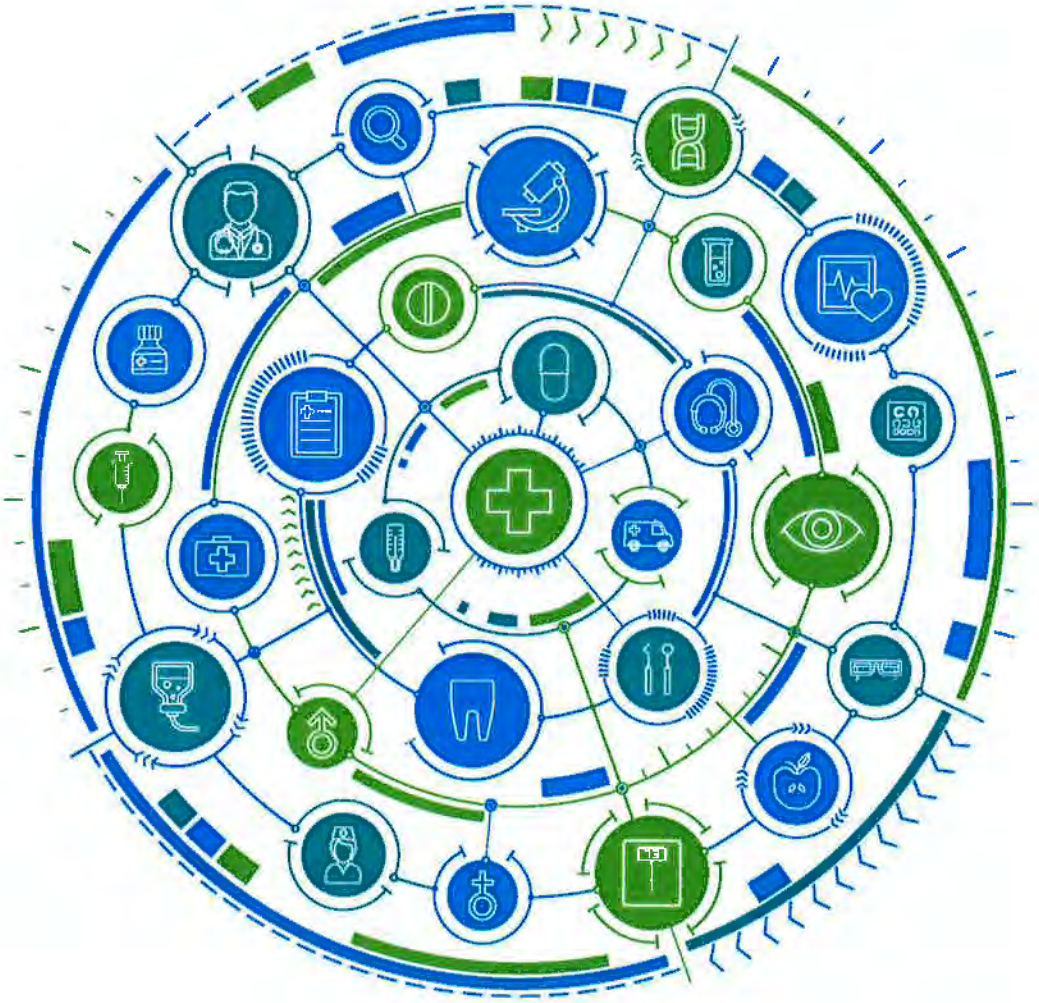
The State of Nebraska Department of Administrative Services (DAS)

Medicaid Managed Care Actuarial and Consulting Services

Technical Proposal - ORIGINAL

RFP # 5868 Z1 | July, 13, 2018

Deloitte.



The State of Nebraska Department of Administrative Services (DAS)

Medicaid Managed Care Actuarial and Consulting Services

Technical Proposal - ORIGINAL

RFP # 5868 Z1 | July, 13, 2018

Deloitte.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: +1 612 397 4000
www.deloitte.com

July 12, 2018

Nancy Storant/Teresa Fleming
State Purchasing Bureau, State of Nebraska
1526 K Street, Suite 130
Lincoln, NE 68508

RE: Request for Proposal for Medicaid Actuarial and Consulting Services (RFP 5858 Z1)

Dear Ms. Storant and Ms. Fleming:

Deloitte Consulting LLP (Deloitte) is pleased to submit this proposal to the State of Nebraska, Department of Health and Human Services to provide Medicaid Actuarial and Consulting Services for RFP 5868 Z1. We have reviewed the requirements in your RFP and have assembled a team with the depth of experience and skills to meet your needs.

We are providing one (1) original copy of the Technical Proposal; one (1) original copy of the Cost Proposal; and one (1) separately sealed copy of our Proprietary Information.

We have organized our responses per RFP requirements, as follows:

- **Section 1 – Request for Proposal Form**, which is responsive to RFP Section VI.A.1
- **Section 2 – Corporate Overview**, which is responsive to RFP Section VI.A.2
- **Section 3 – Technical Approach**, which is responsive to RFP Section VI.A.3
- **Cost Proposal**, which is responsive to RFP Section VII

The State of Nebraska has been, and continues to be a very important and valued client to Deloitte. We look forward to working with you and building off the successes of our ongoing Data Management and Analytics (DMA) engagement. We appreciate this opportunity to continue our relationship.

As used in this document, "Deloitte" means Deloitte Consulting LLP, a subsidiary of Deloitte LLP.
Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries.

Very truly yours,

Deloitte Consulting LLP

By: 

Tim FitzPatrick
Principal

Table of Contents

Request for Proposal Form

Section 1

RFP Reference: Section VI.A.1, Page 30

REQUEST FOR PROPOSAL FORM

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

The RFP for Contractual Services form must be signed using an indelible method (not electronically) and returned per the schedule of events in order to be considered for an award.

Sealed proposals must be received in the State Purchasing Bureau by the date and time of the proposal opening per the Schedule of Events. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.

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

Further, Sections II through VII must be completed and returned with the proposal response.

Following is our signed Request for Proposal for Contractual Services form, our completed Bidder Contact Sheet (Form A), acknowledgement of the RFP addenda, and our responses to RFP Section II, Terms and Conditions, RFP Section III, Contractor Duties, and RFP Section IV, Payment.

For the remaining responses to RFP Section V, Project Descriptions and Scope of Work and RFP Section VI, Proposal Instructions, please refer to Section 2, Corporate Overview and Section 3, Technical Proposal of our response.

For the response to RFP Section VII, Cost Proposal Requirements, please refer to Section 4, Cost Proposal, submitted under separate cover.

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the procedures stated in this Request for Proposal, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder maintains a drug free work place.

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.

__X__ 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.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED USING AN INDELIBLE METHOD (NOT ELECTRONICALLY)

FIRM:	**Deloitte Consulting LLP**
COMPLETE ADDRESS:	**50 South Sixth Street, Minneapolis, MN 55402**
TELEPHONE NUMBER:	**612-397-4650**
FAX NUMBER:	**612-692-4650**
DATE:	**07/09/2018**
SIGNATURE:	
TYPED NAME & TITLE OF SIGNER:	**Tim FitzPatrick, Principal**

Form A
Bidder Contact Sheet

Request for Proposal Number 5868 Z1

Form A should be completed and submitted with each response to this RFP. 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.

Preparation of Response Contact Information	
Bidder Name:	Deloitte Consulting LLP
Bidder Address:	50 South Sixth Street, Minneapolis, MN 55402
Contact Person & Title:	Tim FitzPatrick, Principal
E-mail Address:	tfitzpatrick@deloitte.com
Telephone Number (Office):	612-397-4650
Telephone Number (Cellular):	651-247-2039
Fax Number:	612-692-4650

Each bidder should 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:	Deloitte Consulting LLP
Bidder Address:	50 South Sixth Street, Minneapolis, MN 55402
Contact Person & Title:	Tim FitzPatrick, Principal
E-mail Address:	tfitzpatrick@deloitte.com
Telephone Number (Office):	612-397-4650
Telephone Number (Cellular):	651-247-2039
Fax Number:	612-692-4650

Acknowledgement of Addendum 1

Deloitte acknowledges the following RFP addendum.

ADDENDUM ONE
REVISED SCHEDULE OF EVENTS

Date: June 27, 2018

To: All Bidders

From: Nancy Storant / Teresa Fleming, Buyers
AS Materiel Purchasing

RE: Addendum for RFP Number 5868 Z1

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. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

	ACTIVITY	DATE/TIME
3.	State responds to written questions through RFP "Addendum" and/or "Amendment" to be posted to the Internet at: and/or http://das.nebraska.gov/materiel/purchasing.html	~~June 26 2019~~ TBD
4.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	July 11, 2018
5.	Review for conformance to RFP requirements	July 11, 2018
6.	Evaluation period	July 13, 2018 Through July 20, 2018
7.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
8.	Post "Intent to Award" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	August 1, 2018
9.	Contract finalization period	August 1, 2018 Through August 31, 2018

ACTIVITY		DATE/TIME
10.	Contract award	September 1, 2018
11.	Contractor start date	September 1, 2018

This addendum will become part of the proposal and should be acknowledged with the RFP

Acknowledgement of Addendum 2

Deloitte acknowledges the following RFP addendum.

ADDENDUM TWO
QUESTIONS and ANSWERS

Date: June 29, 2018

To: All Bidders

From: Nancy Storant, Buyer
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5868 Z1 to be opened July 11, 2018 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 as 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.	Section I, Part J	Page 3	How many copies of the Technical Proposal and Cost Proposal, respectively, are required in addition to the one (1) ORIGINAL Technical and one (1) separate ORIGINAL Cost proposal? Are any electronic (e.g., compact disk) copies required?	Bidders should submit **one** proposal marked on the first page: "ORIGINAL". If multiple proposals are submitted, the State will retain one copy marked "ORIGINAL" and destroy the other copies. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.

2.	Section I, Part V	Page 6	This part references "...evaluate proposals and award **contract(s)** in a manner...." (emphasis added). Is the State intending to select one vendor for the total/all SOWs or will the State make multiple awards to different vendors for different SOWs?	The State's intent is to award to a single contractor for RFP 5868 Z1. However, Section I. V. states that "The State reserves the right to evaluate proposals and award contracts in a manner utilizing criteria selected at the State's discretion and in the State's best interest."
3.	Section II, Part J	Page 10	Will the State consider a proposed mutually agreeable limit of liability for this contract (e.g., one times fees or a fixed dollar amount)?	No. The limitation of liability prohibition stems from the operation of Article XIII sections 1 and 3 of the State Constitution. Section 1 prohibits the State from extending the State's credit and Section 3 limits the State's cumulative indemnification on all State contracts to $100,000 (since the State has thousands of contracts, effectively, we can indemnify no one). By agreeing to a limitation of liability the State, as a matter of law, could be violating both sections. If the State were damaged in the amount of $5M, but we have agreed to a $2M limitation of liability we are indemnifying the contractor for the other $3M and since the State would have to pay the other $3M we are extending the State's checkbook (credit) for the $3M. Attorneys often argue that these sections do not address limitations of liability, and while it is true that they do not mention limitations of liability directly, oftentimes statutes have a second and third order effect that may or may not have been intended. The State's interpretation of its own law is that it is an issue, and we have to live with that interpret of our laws until a court tells us that we are wrong.
4.	Section V, Part B.4	Page 24	If Nebraska chooses to pursue a managed long term care initiative, will that optional work be considered under Scope of Work (SOW) 8 Special Projects?	Yes

5.	Section V	Pages 25-29	Can the State please specify the current rating/upper payment limits (UPLs) periods (i.e., the 12-month period, which could be a calendar year, state fiscal year or other 12-month period) for which the applicable rates/UPLs are prospectively set for the following programs: 1. Heritage Health 2. Program of All-Inclusive Care of the Elderly (PACE) 3. Dental Prepaid Ambulatory Health Plan (PAHP) Does the State have any plans to change these current rating/UPL time periods to a different prospective time period in the foreseeable future?	The current rating period for Heritage Health Program is based on the Calendar Year (CY). The current UPL rating/contract period for the PACE program is for State Fiscal Year (SFY). The current rating period Dental Benefit Program is set from October-September. The State is exploring changing the rating period to align with Heritage Health program (CY).
6.	Section V, Part C and Section VI, Part A.3	Page 25 and Page 33	Section V Part C contains a list of items in a-j related to "minimum requirements to be performed." However, in Section VI Part A.3 (page 33) the specific Proposal Instructions specify that the Technical Approach should consist of/address items a-e, which is similar to the 2013 RFP. To ensure the evaluation process is not "overly time consuming" (page 3), can the State please clarify/confirm that all Vendors are to structure their technical proposals to explicitly address the Technical Approach items a-e from page 33 in response to each scope of work (SOW), and that items a-j on page 25 are for general informational purposes to be incorporated in the technical response as applicable?	The bidder should respond to each item in Section V.C.6.a-j separately, when applicable, while incorporating Technical Approach requirements in Section VI.A.3.

7.	Section V, Part C	Page 25	Can the State please provide the amounts paid in SFY 16-17 (i.e., July 2016 to June 2017) and SFY 17-18 year-to-date (July 2017 to June 2018) respectively, to the current Actuary for each SOW item in contract #55789 O4 and contract #58451 O4, respectively?	Contract 55789 O4: FY 16-17 SOW 1: $ 54,354.93 SOW 2: $126,550.00 SOW 3: $ 34,175.00 SOW 4: $ 29,000.00 SOW 5: $142,473.35 FY 17-18 SOW 1: $259,063.16 SOW 2: $ 63,275.00 Contract 58451 O4 FY 16-17 SOW 2: $120,326.79 SOW 3: $102,416.12 SOW 4: $352,200.54 FY 17-18 SOW 2: $368,448.06 SOW 3: $194,698.88 SOW4: $416,887.78

8.	Section V, Part D, SOW 1	Page 25	SOW 1 reads similarly to SOW 2 in terms of the steps to be completed except SOW 2 includes work to develop a new base data set. However, the Cost Proposal indicates that the State would pay for both SOW 1 and SOW 2 to be completed in the same year (in the year that the State undertakes SOW 2). Can the State please elaborate on the differences between SOW 1 and SOW 2 and why the Vendor might be paid for developing rates under both SOW 1 and SOW 2 in a given year if the only difference is developing the new base data step covered in SOW 2?	Rebasing of rates generally refers to using base data from a more recent time period to develop capitation rates along with updating assumptions and/or revisiting the variables that went into developing the original rates. Updating of rates involves adjusting existing rates to reflect the impacts of any program, benefit, population, trend, or other changes between the rating period of the existing rates and the rating period of the updated rates. The State does not intend to remove SOW 2 from this RFP.
9.	Section V, Part D, SOW 1	Page 25	Has the State already implemented a diagnostic-based risk adjustment process (e.g., Chronic Illness and Disability Payment System (CDPS), CDPS+Rx, Adjusted Clinical Groups (ACGs), Clinical Risk Groups (CRGs), Diagnostic Cost Groups (DCGs), Episode Treatment Groups/Episode Risk Groups (ETGs/ERGs), Medicaid Rx, Diagnostic-related Groups (DRGs), Hierarchical Condition Categories (HCCs), Other)?. If so, what model was selected, when was it implemented, and how frequently are the risk scores updated to adjust managed care organization (MCO) payment rates (e.g., annually, semi-annually, quarterly)?	For calendar year 2018 capitation rates development, the State risk adjusted for certain populations by applying the following UCSD (a diagnostic classification system) risk score tools: Medicaid Rx, Chronic Illness and Disability Payment System (CDPS), Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) The CY2018 capitation rates are currently under CMS's review. Since this was just implemented in January 2018, the frequency of updating risk scores has not been determined.
10.	Section V, Part D, SOW 1	Page 25	Implementing diagnostic-based risk adjustment often requires running mock data runs, deciding on a number of policy issues, trainings/orientation with the Heritage Health MCOs, and other factors that can be a large one-time implementation cost until the process becomes a normal part of the workflow	The State anticipates the diagnostic-based risk adjustment to be an integral part of SOW #1 Capitation Rate setting. For instance, as part of CY2018 rate setting process, the State risk adjusted for certain populations by applying the following UCSD (a diagnostic classification system) risk score tools:

			cycle. If a diagnostic-based risk adjustment process (e.g. CDPS, CDPS+Rx, ACGs, CRGs, DCGs, ETGs/ERGs, Medicaid Rx, DRGs, HCCs, Other) has not been implemented yet, in what plan year(s) is this development/implementation work expected to occur?	Medicaid Rx, Chronic Illness and Disability Payment System (CDPS), Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx). The process of exploring/analyzing the possibility of changing and/or adding new diagnostic-based risk adjustment methodology/software should be categorized under SOW #8, until adopted by the State, then implemented later under SOW #1 at no additional cost.
11.	Section V, Part D, SOW 1	Page 25	If risk adjustment is not already implemented, when the State decides to develop, test, implement, and operationalize a diagnostic-based risk adjustment model/process (e.g., CDPS, CDPS+Rx, ACGs, CRGs, DCGs, ETGs/ERGs, Medicaid Rx, DRGs, HCCs, Other) will those activities be considered a SOW 8 Special Project?	Please see response to Question #10.
12.	Section V, Part D, SOW 1	Page 25	Does the State require the Actuary to intake, process, and use detailed person-/claim-level encounter data (i.e., protected health information) to support rate development or is summary-level data provided by the State and/or the Heritage Health MCOs for use by the Actuary? If detailed protected health information-level data is required, will the State and/or your Medicaid Management Information System (MMIS) vendor provide detailed file layouts, data dictionaries, validation totals, and any other required elements to ensure the accuracy and completeness of the data provided to the Actuary?	At a minimum, claims and member data will be at the detail level. Additional data may be at the detail or aggregate level, as appropriate. It is required that the contractor will store and maintain the Nebraska data in a secure data warehouse. The managed care entities are contractually required to provide accurate, valid encounter data. The data will be a combination of FFS and encounter records. The provision of data will be decided by the State, after coordinating data sources with the contractor.

13.	Section V, Part D, SOW 1, Item 2.j	Page 26	SOW 1, item 2.j says "Develop or assist in development of rate methodology for any new program(s) that may be implemented during the contract period." If there are any new program(s) implemented during the contract period, will related rate development activities be considered a SOW 8 Special Project?	Please see response to Question #10. All new programs requested will be implemented through the Change Order process.
14.	Section V, Part D, SOW 1	Page 26	Can the State please describe the expected process the State will use to arrive at final contract rates with each Heritage Health MCO during the contract period? For example, does the State conduct several meetings with each MCO to negotiate final rates or does the State make a "take it or leave it" offer to each MCO? How many meetings per rate cycle does the State anticipate will be needed with the Actuary and the MCOs to finalize rates?	Traditionally, over several on-site and webinar meetings, the actuary provides several rate options with their recommendation to the State. The actuary will then present the State's proposed rates to the MCOs. Feedback from the MCOs and the state are then evaluated which could result in additional rate presentations/discussions. The State will determine on the final rates with respect to SOW1.3.g The State anticipates 3-5 meetings with the MCOs per rate cycle to finalize rates. Additional meetings may be scheduled as necessary.
15.	Section V, Part E, SOW 2 and Attachment A Cost Proposal	Pages 26-27 and Attachment A	SOW 1 requires a price for every year of work and SOW 2 is only once during the initial 5 year contract period (and once per each optional 2-year renewal). It seems duplicative for SOW 2 to cover the full price of the entire rate development process (e.g., new base data, trend, program changes, assumptions, other) and in the same work year have SOW 1 cover the same rate development process/steps price excluding updating the new base data.	Rebasing of rates generally refers to using base data from a more recent time period to develop capitation rates along with updating assumptions and/or revisiting the variables that went into developing the original rates. Updating of rates involves adjusting existing rates to reflect the impacts of any program, benefit, population, trend, or other changes between the rating period of the existing rates and the rating period of the updated rates. CMS recommends a rebasing every 3-5 years. The initial contract term is five (5) years and rebasing is likely to occur. Rebasing may or may not be requested each optional renewal period but a pricing is required in the event rebasing is required.

			Is SOW 2 limited to only to the price for work associated with developing a new/updated base data and all other Heritage Health rate development steps/processes are to be included in the price for SOW 1?	SOW 2 is only associated with Rebasing activities that are not included in SOW 1 Rate Setting activities and are priced separately.
16.	Section V, Part E, SOW 2, Item 1	Pages 26-27	SOW 2, Item 1 "Policy and Financial Management Consulting Services" includes an array of very different activities. As it relates to avoiding an "overly time consuming" (page 3) effort to evaluate, does the State want Vendors to respond to each and every item in this list separately and incorporate the Technical Approach requirements a-e from page 33 in each item separately **or** can the Vendor respond to this group of services collectively?	Please see response to Question #6.

17.	Section V, Part E, SOW 2	Pages 26-27	SOW 2 includes several work topics under item 1 labeled "Policy and Financial Management Consulting Services". However, the Cost Proposal (Attachment A) does not include a separate line for "Policy and Financial Management Consulting Services" pricing. Therefore, are the "Policy and Financial Management Consulting Services" only to be done once per applicable contract period as noted in Attachment A like the other part of SOW 2?	Yes, Policy and Financial Management Consulting Services are an integral part of SOW 2 and are only to be completed once per applicable contract period during the Rebasing. Although the State will separately score the Policy and Financial Management Consulting Services (Part E 1. a-j) from the Rebasing Activities (Part E. a.-g)., the bidder should submit a combined total pricing in Attachment A Cost Proposal for all services under SOW 2.
18.	Section V, Part E, SOW 2 And Cost Proposal	Pages 26-27 and Attachment A	SOW 2 includes "Capitation Rate Rebasing" and "Policy and Financial Management Consulting" services which are very different services with separate deliverables and likely separate timing. The Cost Proposal does not allow for separate pricing of these Policy and Financial Management Consulting services. Would the State be willing to allow for separate pricing of the Policy/Financial Management work as a subcomponent(s) to SOW 2 similar to the structure used in the Cost Proposal for SOW 1? If this approach is acceptable to the State, can the State please revise the Attachment A Cost Proposal form?	Please see response to Ouestion #17.

19.	Section V, Part E, SOW 2 And Cost Proposal	Pages 26-27 and Attachment A	SOW 2, Item 1 "Policy and Financial Management Consulting Services" covers a diverse array of different activities in items a-j. From a Cost Proposal perspective, can the Vendor submit a dollar amount for this collective piece of work and then work collaboratively with the State to prioritize and decide which specific activity(ies) to undertake in the applicable plan year within the parameters of the work budget? What, if any, is the maximum budget for each plan year for **all** of the variety of activities listed in items a-j under the "Policy and Financial Management Consulting Services" in SOW 2?	Please see response to Question #17 There is no established budget.

20.	Section V, Part G, SOW 4	Page 27	Nebraska's Medicaid State Plan indicates that the Programs of All-inclusive Care of the Elderly (PACE) capitation rates are set as a percentage of the Upper Payment Level (UPL). This is a common approach used by states to set their PACE capitation rates and avoids the need for states to incur the additional time/cost of developing separate PACE rates (which are not required by the Centers for Medicare and Medicaid Services (CMS) to be actuarially sound). Is the Actuary/Vendor responsible to set the PACE UPLs only (as indicated on Attachment A) and the rates will then be determined as a percentage of this UPL through negotiation with the respective PACE site(s)? If not, what is the process the State expects of the Actuary/Vendor?	The contractor will be responsible for setting the PACE UPLs. The contractor will assist the State in determining the appropriate percentage of the UPL for the PACE final rates.
21.	Section V, Part G, SOW 4	Page 27	Is Immanuel Pathways the only current PACE site operating in Nebraska? Does Nebraska expect to implement additional PACE sites in geographic service/catchment areas outside of the geographic area(s) covered by the current structure of the PACE UPLs during this actuarial services contract period?	Yes No, not at this time.
22.	Section V, Part G, SOW 4	Page 27	Are PACE UPLs also required to be completed five months/150 days prior to their effective date? If not, when does the State prefer to receive the final PACE UPLs?	The PACE UPLs are not required to be completed five months/150 days prior to their effective date. The decision regarding the timeline of the submission of the final PACE UPLs will be made by the State with input from the contractor.

23.	Section V, Part H, SOW 5	Page 27	The CMS website does not list a current 1115 waiver for Nebraska. 1115 waivers usually require an extensive stakeholder process, strategy/planning sessions, complex budget neutrality calculations, concept papers, and potentially resource-intensive negotiations with CMS. What is the status of Nebraska's 1115 waiver and is it limited to a Substance Use Disorder (SUD) Waiver only? When is this 1115 SUD waiver expected to be submitted to CMS? Has Nebraska completed the stakeholder process for the 1115 SUD waiver?	The State currently is in the process of drafting an 1115 waiver, limited to SUD services. The 1115 SUD waiver is only in the drafting phase and there is no official CMS submission deadline. No, there is no stakeholder process completed at this time.
24.	Section V, Part I, SOW 6	Page 28	For the Dental Prepaid Ambulatory Health Plan (PAHP) program, item c in SOW 6 says "Develop a risk adjustment methodology". Since the State uses a single statewide Dental PAHP (per the State's 1915b waiver), what is expected from the Vendor in terms of a risk adjustment methodology for this SOW? If in the future, the State contracts with multiple, competing DBM PAHPs, would the State consider developing a dental-specific risk adjustment methodology as a Special Project under SOW 8?	No risk adjustment has been incorporated into the current Dental capitation rates, since this is the first contract year for the DBPM in Nebraska Medicaid. However, the State requires the contractor to identify or assess the risk differences across the dental population and recommend the appropriate risk score tools in developing the risk adjustment methodology. No, the dental specific risk adjustment activities are included in SOW 6 Dental Rate Setting.

25.	Section VI, Part A. 2.b	Page 30	Can the Vendor provide a web link to our public company's audited financial reports and statements or does Nebraska require these rather lengthy documents be included in an Appendix to the Technical Proposal?	No. Please provide documentation per the requirements of the RFP.
26.	Section VI, Part A.2.i	Page 32	Does the State expect references for all staff including office support staff/junior analysts proposed for this contract or is it acceptable to include references only for key staff: Principal, Consultant, and Analyst (meeting minimum requirements), actuaries, and project managers, etc.?	Bidders may submit references for only key staff members.
27.	Section VI, Part A.2.j	Page 32	This section indicates "Each Consultant or Analyst must have a minimum of five (5) years' experience in the SOW project they are assigned. The Bidder must identify the Consultant or Analyst assigned to each project." Is it acceptable to the State for each project to include staff that meet this minimum requirement but also include other staff with lesser experience to support the SOW project? This will allow the vendor to produce high quality work and still be cost effective for the State.	Yes
28.	Section VII, Part A and Attachment A	Page 34 and Attachment A	Given the potential 11 year duration of this contract, will the State work with the awarded Vendor to modify related SOWs or utilize SOW 8 – Special Projects to address significant State or Federal changes impacting the services required of this RFP?	All State and Federal regulation changes will be implemented through the Change Order process.

29.	Attachment A Cost Proposal and Section V, Part E, SOW 2	Attachment A and Page 26	In the Cost Proposal, SOW 2 – Capitation Rate Rebasing is specifically listed as happening "One (1) time for contract duration." However, in the description of SOW 2 in Section V Part E on page 26 the RFP says "The rebasing activity will occur at least once annually." Can the State please confirm/correct the language in Section V Part E SOW 2 on page 26 that the rate rebasing activity will occur once per contract period to align with the Attachment A Cost Proposal?	Rebasing will occur at least once per contract period. The last sentence in paragraph one (1) of Section V. E. is hereby amended to read as follows: The rebasing activity will occur at least once per contract period.
30.	Attachment A Cost Proposal	Attachment A	In the Cost Proposal, the line labeled "SOW 3 – 1915(b) Waiver" includes an "x" in every plan year. Given the waiver covers a two-year period, what work is the State expecting related to the waiver in each plan year?	The State does not anticipate an update every year given the waiver does cover a two year period however certain monitoring and activities are required to be performed on an ongoing basis.
31.	Attachment A Cost Proposal	Attachment A	In the Cost Proposal, the line labeled "SOW 5 – 1115 Waiver" includes an "x" in every plan year. Given most 1115 waivers cover a five-year period, what work is the State expecting related to the waiver in each plan year?	The State requires the contractor to accomplish activities including, but not limited to the monitoring, tracking, reporting of expenditures to meet 1115 Waiver budget neutrality and any State and/or federal compliance requirements regarding 1115 Waiver.

32.	Attachment A Cost Proposal	Attachment A	SOW 6 requires a price for every year of work and SOW 7 is only once during the initial five year contract period (and once per each optional two-year renewal). It seems duplicative for SOW 7 to cover the full price of the entire Dental PAHP rate development process (e.g., new dental base data, trend, program changes, assumptions, other) and in the same work year have SOW 6 cover the same Dental PAHP rate development process/steps price excluding updating the new dental base data. Is SOW 7 limited to <u>only</u> to the price for work associated with developing a new/updated Dental PAHP base data and all other PAHP rate development steps/processes are to be included in the price for SOW 6?	Rebasing of rates generally refers to using base data from a more recent time period to develop capitation rates along with updating assumptions and/or revisiting the variables that went into developing the original rates. Updating of rates involves adjusting existing rates to reflect the impacts of any program, benefit, population, trend, or other changes between the rating period of the existing rates and the rating period of the updated rates. No, SOW 7 is only associated with Rebasing activities and are not included in SOW 6 Rate Setting activities and are priced separately.
33.	R. EVALUATION OF PROPOSALS	4	Please provide examples of "such other information that may be secured and that has a bearing on the decision to award the contract."	If additional information or issues are identified during the reference check process the State reserves the right to investigate further or ask for clarification from the bidder.
34.	U. REFERENCE AND CREDIT CHECKS	6	Are reference and/or credit checks conducted at the corporate, individual employee level, or both?	Corporate level only
35.	REQUIRED INSURANCE COVERAGE CYBER LIABILITY	19	Are the complete definitions for the following publicly available and referenced in the context of the State of Nebraska or related division? "Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties"	The State of Nebraska has not defined these terms. The definitions would be based upon the insurance industry standard definitions.

36.	D. SOW 1 – CAPITATION RATE SETTING 1. Rate Data Analysis and Manipulation c. Analyze medical and pharmacy service utilization and cost profile patterns by category of service for all Managed Care cohorts	25	What is the source of medical and pharmacy data? Is this encounter data? Is it provided directly by the State or Department, or a third party intermediary?	Truven/Advantage Suite and or MMIS are the source of medical and pharmacy encounter data. The decision regarding extracting encounter data will be made by the State with input from the contractor.
37.	D. SOW 1 – CAPITATION RATE SETTING 3. Capitation Rate Finalization f. Attend, participate, and provide support in the Department's rate setting discussions and meetings with CMS.	26	How often does the Department anticipate having Contract resources onsite?	The State anticipates 3-5 onsite visits on an annual basis.

38.	E. SOW 2 – CAPITATION RATE REBASING 1. Policy and Financial Management Consulting Services a. Work collaboratively with the Department in the exploration of various Value Based Payment (VBP) models for the Department's Medicaid program as an alternative to the current reimbursement structure. Models include the use of Managed Care Organizations (MCOs), Accountable Care Organizations (ACOs), and Independent Practice Associations (IPAs) to incorporate shared savings, bundled payment mechanisms based on an episode of care rather than an individual visit, and other total cost of care models.	26	Does the Department implement an existing total cost of care (TCOC) methodology today? Does the Department desire to use technologies and algorithms that support alternative payment models such as PROMETHEUS® Analytics? Is there a different incumbent vendor providing this SOW rather than the incumbent actuary? What is required for the on-site plan audit reviews? What portion of the cost proposal do the Policy and Financial Management Consulting Services fall under?	No No, the State does not intend to utilize Prometheus as a payment (emphasis added) model. No. This decision will be made by the State with input from the contractor. Refer to SOW 2 in Section V.E.

39.	E. SOW 2 – CAPITATION RATE REBASING 1. Policy and Financial Management Consulting Services f. Develop dashboard reporting with benchmark comparisons by category of service for the Managed Care programs;	27	Does the Department currently use or desire to use (if not currently used) data visualization tools such as Tableau for dashboards and analytics reporting needs?	The State anticipates using data visualization tools for dashboards.
40.	h. Summary of Bidder's Corporate Experience i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this RFP. These descriptions should include: e. Experience with risk adjusted rate setting techniques in general and specifically with various risk group models, such as the Clinical Risk Group (CRG), Hierarchical Condition Categories (HCCs), etc.	31	Does the Department currently use 3M (CRGs), HCCs or both for risk-adjustment? Is the Department evaluating or considering the use of other risk adjustment technologies (i.e. groupers)?	No, the State does not currently use 3M CRGs, or HCCs, but the State is currently exploring those and other risk-adjustment Technologies.
41.	Section I.C – Schedule of Events	Page 2	The RFP states that the contract will be awarded 9/1/18. Will the winning vendor be responsible for development of CY19 capitation rates, or will that be completed by the current vendor?	Current Contractor is responsible for CY19 Rate Setting.

42.	Section I	Page 3	Subsection J states "Proposal responses should include the completed Form A, "Bidder Contact Sheet"". The RFP does not specify where this should be included in the response. Does the State have a desired section for including Form A?	The State does not have a desired section to include Form A.
43.	Sections II-IV	Pages 7-23	Does the state require original signature initials indicating acceptance of contract terms, or is a digital signature sufficient?	The bidder can note their response in any way that they would like, either with a typed initial, check mark, or a "wet" original.
44.	Section V	Page 24	Subsection B.4 mentions an optional Long-Term Care Managed Care delivery system. Long-Term Care Managed Care is not mentioned in the subsequent Scope of Work sections. Is the winning vendor expected to perform Long-Term Care Managed Care rate setting work on behalf of the Department?	Please note that Section V.B.4, Long-Term Care Managed Care, indicates **optional.** The State currently does not have a Long-Term Care Managed Care Program. Should the State opt to implement such program, the awarded contractor would perform these services under SOW 8.
45.	Section V	Page 26	Subsection 3.g. notes that final rates must be submitted 150 days or 5 months prior to their effective date. Given CMS' requirement of rates being submitted 90 days in advance of the effective date, is the 150 days noted in the RFP reflective of when rates need to be finalized and submitted to the Department, or when they need to be submitted to CMS?	The 150 days noted in the RFP are prior to submission to CMS.
46.	Section V	Page 26	Subsection E notes that SOW 2-Capitation Rate Rebasing will occur at least once annually. The Cost Proposal indicates that SOW 2 will occur once during the contract duration. How often will this service be performed under the contract?	Please see response to Question #29

47.	Section VI	Page 32	Subsection A.2.j states "The proposed Principal must have a minimum of ten (10) years actuarial consulting experience in the public sector and must have a Bachelor's Degree in Actuarial Science...". Are degrees in related fields such as Mathematics and Statistics acceptable in place of an Actuarial Science degree? If not, can the Principal be an Associate or Fellow of the Society of Actuaries (ASA or FSA) and a Member of the American Academy of Actuaries (MAAA) to fulfill the Actuarial Science degree requirement?	Yes
48.	Cost Proposal	Attachment A	We do not see a specific section for the Long-Term Care Managed Care (optional) program noted in the RFP. Is it expected that any MLTSS rate setting work would be reimbursed via the hourly rates submitted in response to the Optional Services section of the cost proposal?	Please see response to Question #44.
49.	V.C Scope of Work (SOW)	26	For SOW 2 please confirm that Capitation Rate Rebasing and Policy and Financial Management Consulting Services are both included in the same scope of work.	Yes
50.	V.C Scope of Work (SOW)	25-26	How does the department differentiate between the project activities outlined in SOW 1 (Annual Capitation Rate Setting) compared to SOW 2 (Capitation Rate Rebasing)?	Please see answer to Question #8.
51.	Attachment A Cost Proposal	First page	Please confirm the frequency of Capitation Rate Rebasing. Attachment A reads "one (1) time for contract duration". For a five-year contract this is not compliant with CMS regulations. SOW 2 on page 26 also indicates that the rebasing project will occur at least once annually	Please see answer to Question #29.

52.	Attachment A Cost Proposal	First page	Please clarify how costs should be proposed for SOW 1 (Annual Capitation Rate Setting) and SOW 6 (Dental Rate Setting). There is an "x" indicated for each project task, as well as an "x" for the overall SOW line in the grid.	The proposed cost of the overall SOW 1 line (Capitation Rate Methodology Development Determination) should be reflective of the activities of developing the methodology (ies) framework for Capitation Rate Setting. Each project task aligns with other activities listed in SOW 1 and priced separately. The Capitation Rate Updates (2x or more per year) reflect the cost of some, but not all, of SOW 1 activities completed each additional time within the calendar year. The SOW 6 is structured the same way.
53.	VI.A.h. Summary of Bidder's Corporate Experience	31-32	The corporate overview section includes items related to risk adjustment, encounter data, prepaid inpatient health care, PACE, and Managed Long Term Care experience. Please provide clarification on whether the RFP response needs to address all of these items for the same 3 states in the narrative response, or whether the response may reference different states to highlight our experience in these areas.	The bidder may reference different States to highlight their experience in the narrative project response.
54.	General	N/A	Does the State have a proposed budget for this engagement?	No, the State does not have an established budget.
55.	I.R. Evaluation of Proposals	4	Can the State please clarify how the cost proposal will be evaluated? Specifically, will the combination of the base years and all optional years be included in the evaluation as one combined cost? Additionally, how will the rate card submitted for the optional services be evaluated?	Refer to the Evaluation Criteria Part 4 – Cost Proposal Points for the initial contract period. Renewal Periods and the Hourly Rate will not be scored.
56.	V.C. Scope of Work	25	Can the State please clarify which programs and populations are in scope of this contract and how many separate rate certifications are required? Additionally, how many rate	The covered programs are those approved through the Nebraska State Plan (Title XIX) in addition to the PACE and Waiver programs referenced in this RFP. The State's Medicaid program currently serves the following populations:

			amendments typically occur on an annual basis?	• Aged, Blind, and Disabled (AABD) • Children's Health Insurance Program (CHIP) • Family – Adults and Children (Family) • Foster Care/Wards (Foster Care) • Katie Beckett • Healthy Dual • Dual LTC • Non-Dual LTC • Dual Waiver • Non-Dual Waiver Some cohorts are further split by age and/or gender when appropriate. The State has historically submitted two certification letters to CMS per calendar year. Rate adjustments are subject to State and Federal mandates.
57.	V.C. Scope of Work	25	Can the State please clarify the number of onsite meetings and/or visits that are anticipated for this engagement on an annual basis?	Please see the answer to Question #37
58.	V.C. Scope of Work	25	Can the State please clarify which of the requested services within this RFP are currently being performed by the incumbent vendor?	Refer to Contract 58451 O4
59.	V.D. SOW 1 – Capitation Rate Setting	25	In regards to risk adjustment: a. Can the State please confirm the risk adjustment methodologies to be utilized for the fiscal year 2019 rates? b. Does the State expect the contactor to utilize a consistent methodology?	Nebraska Heritage Health Managed Care program's risk adjustment is fully risk adjusted (no phased in scores) capitation rates and on a prospective basis. The Risk adjustment methodologies aim to align MCO capitation rates with the relative health risk profiles of their membership mix. The State reserves the right to adjust risk scores for MCO's annually, semi-annually, or more frequently if warranted. The State anticipates reasonable changes to occur in the methodology with changes in the Managed Care program, policies, and membership. Changes to methodology

				would be approved by the State, actuarially sound, and approved by CMS as part of rate certification. The State will consider the feedback from the MCOs when making changes to the risk adjustment methodology.
			c. Will the State obtain the appropriate licenses for the risk adjustment software (if applicable)?	No – it is the responsibility of the contractor to purchase all necessary software to perform SOW in the RFP.
60.	V.D. SOW 1 – Capitation Rate Setting	25	Can the State please comment on the quality of the available encounter data and the State's expectations of the credibility of the data being utilized for the upcoming rate development processes?	The Managed Care entities are contractually required to provide accurate, valid encounter data.

61.	V.D. SOW 1 – Capitation Rate Setting	25	Can the State please clarify how the data will be made available to the vendor and what level of detail? Specifically, a. Is it expected the vendor will store data in a data warehouse or access the necessary data for rate setting on State systems? b. Will the data provided include MCO encounters, fee-for-service, and/or other MCO financial data? c. Will the data provided by the State be aggregated? d. Does the State anticipate the data to include protected health information (PHI) and/or personally identifiable information (PII)? e. What frequency will the data be provided to the vendor?	At a minimum, claims and member data will be at the detail level. Additional data may be at the detail or aggregate level, as appropriate. It is required that the contractor will store and maintain the Nebraska data in a secure data warehouse. Please see Section II.R, Business Associate Agreement (BAA). The managed care entities are contractually required to provide accurate, valid encounter data. The data will be a combination of FFS and encounter records. The provision of data will be decided by the State, after coordinating data sources with the contractor. Yes This decision will be made by the State with input from the contractor
62.	V.D.2. Interim Reporting and Other Deliverables for Rate Setting Functions	26	Many of these requested services under 'Interim Reporting and Other Deliverables for Rate Setting Functions' appear to be ad hoc in nature and/or may vary in time and effort depending on the nature of the request by the State. Does the State have an expected level of effort (total hours) or anticipated budget to perform these services?	No, there is no established budget or expected level of total hours spent for these required services included in SOW 1 Rate Setting.

63.	V.E. SOW 2 – Capitation Rate Setting	26	Can the State please clarify how the services in requested SOW 2 vary from SOW 1? It is our understanding the base period data would be rebased every year and the required rate development activities for SOW 2 would overlap the SOW 1 services.	Please see response to question #8
64.	V.E.1 Policy and Financial Management Consulting Services	27	Many of these requested services under 'Policy and Financial Management Consulting Services' appear to be ad hoc in nature and/or may vary in time and effort depending on the nature of the request by the State. Does the State have an expected level of effort (total hours) or anticipated budget to perform these services?	These services (Items in Section V.C.6.a-j) are ad hoc in nature and may or may not be applicable to each rebasing.
65.	V.E.1.f	27	Can the State please clarify how often the dashboards will be refreshed? Does the State have a preferred software format?	The dashboard will be refreshed upon receiving MCO reports. There is no specific timeframe. The software decision will be made by the State with the input of the Contractor.
66.	V.E.1.h	27	Can the State please clarify how many on-site reviews are anticipated to be performed on an annual basis?	Please see response to question #37
67.	V.E.1.i	27	Can the State please clarify what populations are anticipated to transition from a service-based payment arrangement to managed care, and the timing of each transition?	Heritage Health, the State's managed care program, went into effect January 1, 2017. No additional populations are anticipated to join managed care at this time.
68.	V.H. SOW 5 – 1115 Waiver Development and Submission	27	The underlying effort to support an 1115 waiver submission may vary based on the requested services. Does the State have an expected level of effort (total hours) or anticipated budget to perform these services?	Please see response to question #23. There is no established budget for this service.
69.	V.H. SOW 5 – 1115 Waiver Development and	27	Does the state have a target timeline/roadmap for submitting the 1115 application and	Please see response to question #23.

	Submission		implementing the waiver upon subsequent approval?	
70.	V.I. SOW 6 – Dental Capitation Rate Setting	27	Can the State please comment on the quality of the available dental data and the State's expectations of the credibility of the data being utilized for the upcoming rate development processes?	The dental managed care entity is contractually required to provide accurate, valid encounter data.
71.	V.I.2. Interim Reporting and Other Deliverables for Rate Setting Functions	28	Many of these requested services under 'Interim Reporting and Other Deliverables for Rate Setting Functions' appear to be ad hoc in nature and/or may vary in time and effort depending on the nature of the request by the State. Does the State have an expected level of effort (total hours) or anticipated budget to perform these services?	Please see response to Question # 62.
72.	V.J. SOW 7 – Dental Capitation Rebasing	29	Can the State please clarify how the services in requested SOW 7 vary from SOW 6? It is our understanding the base period data would be rebased every year and the required rate development activities for SOW 7 would overlap the SOW 6 services.	Please see response to questions #32
73.	Attachment A – Cost Proposal	1	The line item for 'SOW 2 – Capitation Rate Rebasing' requests one price for the contract duration and indicates the rate rebasing will only occur one time during the contract duration. However, per the language in Section V.E on page 27 of the RFP, it states the rebasing will occur at least annually. Can the state please confirm that the rates will be rebased annually and clarify how the fees should be quoted in the cost proposal?	Please see response to question #29
74.	Attachment A – Cost Proposal	1	The line item for 'SOW 7 – Dental Rebasing' requests one price for the contract duration and indicates the Dental rate rebasing will only occur one time during the contract duration. Can the State please confirm if the Dental rates are in fact only to rebased one time and clarify what length of time is considered	Yes, CMS recommends a rebasing every 3-5 years. The initial contract term is five (5) years and rebasing is likely occur. Rebasing may or may not occur each optional renewal period but a pricing is required in the event rebasing is performed.

			for "contract duration"? For example, does the State expect to rebase one time during the first five years under the base year of the contract, and then once every two years during each of the three optional renewal periods?	

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal response.

Acknowledgement of Addendum 3

Deloitte acknowledges the following RFP addendum.

ADDENDUM THREE
REVISED SCHEDULE OF EVENTS

Date: July 2, 2018

To: All Bidders

From: Nancy Storant / Teresa Fleming, Buyers
AS Materiel Purchasing

RE: Addendum for RFP Number 5868 Z1

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. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

	ACTIVITY	DATE/TIME
4.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	~~July 11, 2018~~ July 13, 2018
5.	Review for conformance to RFP requirements	~~July 11, 2018~~ July 13, 2018
6.	Evaluation period	July 13, 2018 Through July 20, 2018
7.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
8.	Post "Intent to Award" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	August 1, 2018
9.	Contract finalization period	August 1, 2018 Through August 31, 2018
10.	Contract award	September 1, 2018
11.	Contractor start date	September 1, 2018

This addendum will become part of the proposal and should be acknowledged with the RFP

Terms and Conditions

Section 1.II

RFP Reference: Section II, Page 7

Bidders should complete Sections II through VI as part of their proposal. Bidder is expected to read the Terms and Conditions and should initial either accept, reject, or reject and provide alternative language for each clause. The bidder should also provide an explanation of why the bidder rejected the clause or rejected the clause and provided alternate language. By signing the RFP, bidder is agreeing to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the proposal. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the proposal. The State of Nebraska is soliciting proposals in response to this RFP. The State of Nebraska reserves the right to reject proposals that attempt to substitute the bidder's commercial contracts and/or documents for this RFP.

The bidders should submit with their proposal any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the Contract. The State will not consider incorporation of any document not submitted with the bidder's proposal as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one Party has a particular clause then that clause shall control;
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

Following is our response to all RFP Section II, Terms and Conditions, requirements.

A: General

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section II, Page 7

The contract resulting from this RFP shall incorporate the following documents:

1. Request for Proposal and Addenda;
2. Amendments to the RFP;
3. Questions and Answers;
4. Contractor's proposal (RFP and properly submitted documents);
5. The executed Contract and Addendum One to Contract, if applicable ; and,
6. Amendments/Addendums to the Contract.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future 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 the executed Contract with the most recent dated amendment having the highest priority, 2) executed Contract and any attached Addenda, 3) Amendments to RFP and any Questions and Answers, 4) the original RFP document and any Addenda, and 5) the Contractor's submitted Proposal.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B: Notification

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section II, Page 8

Contractor and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract 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 below, 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.

C: Governing Law (Statutory)

RFP Reference: Section II, Page 8

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state and federal laws, ordinances, rules, orders, and regulations.

D: Beginning of Work

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section II, Page 8

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.

E: Change Orders

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section II, Pages 8 – 9

The State and the Contractor, upon the written agreement, may make changes to the contract within the general scope of the RFP. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Contractor may not claim forfeiture of the contract by reasons of such changes.

The Contractor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. 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, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Contractor's proposal, were foreseeable, or result from difficulties with or failure of the Contractor's proposal or performance.

No change shall be implemented by the Contractor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

F: Notice of Potential Contractor Breach

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		✓	We would like to discuss the deletion of this provision, as it was not in our prior contract with the State.

RFP Reference: Section II, Page 9

If Contractor ~~breaches the contract or~~ anticipates breaching the contract, the Contractor shall immediately give written notice to the State. The notice shall explain the ~~breach or~~ potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

G: Breach

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		✓	We suggest a clarification to reflect the fair cost of cover as the difference between the contract price for the terminated portion of the services and the actual and reasonable cost of the services from other sources. Further, we request a reasonable limitation of liability, as previously agreed to in our DMA contract. Lastly, we would like to clarify that the State's failure to may be a material breach.

RFP Reference: Section II, Page 9

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or

longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the 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 difference between the contract price for the terminated portion of the services and the actual and reasonable cost of the service from other sources for the terminated services ~~excess cost~~ occasioned thereby. The State's failure to make payment may ~~shall not~~ be a material breach, and the Contractor shall retain all available statutory remedies and protections.

To the extent allowed by Nebraska law, Contractor, its subsidiaries and subcontractors, and their respective personnel shall not be liable to the State for any claims, liabilities, or expenses relating to the contract or its performance ("Claims") for an aggregate amount in excess of 1.5 times the fees paid by the State to Contractor in the immediate 12 months prior to the Claims' arising, except to the extent resulting from their recklessness, bad faith or intentional misconduct. In no event shall either party, its subsidiaries or subcontractors, or their respective personnel be liable to the other for any loss of goodwill, revenues or profits (whether or not deemed to constitute a direct Claim), or any consequential, special, indirect, incidental, punitive or exemplary loss, damage, or expense relating to this engagement. In circumstances where this limitation on damages provision hereunder is legally unavailable, the aggregate liability of each party, its subsidiaries and subcontractors, and their respective personnel for any Claim shall not exceed an amount that is proportional to the relative fault that their conduct bears to all other conduct giving rise to such Claim. This limitation of liability shall be exclusive of insurance claims filed for personal injury, death, or property damage, indemnities, bonds, and any other express liability of the contractor contained herein for claims not involving contract performance.

H: Non-waiver of Breach

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section II, Page 10

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

I: Severability

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section II, Page 10

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 provision held to be invalid or illegal.

J: Indemnification

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		✓	We propose some clarifications that align with our prior contract with the State.

1. General

RFP Reference: Section II, Page 10

The Contractor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party 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 for personal injury, death, or real or tangible personal property loss or damage, to the extent directly caused by ~~arising out of, resulting from, or attributable to~~ the willful misconduct, negligence, or negligent error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, ~~resulting from this contract,~~ 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 Party

RFP Reference: Section II, Pages 10 - 11

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 shall not have any indemnification obligations to the extent that infringement or misappropriation arises from (i) modifications to the subject item made by anyone other than Contractor, its agents, assigns, or subcontractors, or use of the subject item in a manner not contemplated or permitted by this Contract,(ii) the failure of the indemnified party to use any combination with any platform, product, network or data not provided by Contractor. 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. In the event Contractor cannot reasonably procure, replace, or modify such subject material in accordance with the immediately preceding sentence, Contractor may require State to cease use of such subject material and refund State a pro rata portion of the fees paid by the State for the applicable subject material. The foregoing provisions of this paragraph constitute the sole and exclusive remedy of the indemnified parties, and the sole and exclusive remedy obligation of Contractor, relating to any claim of infringement or misappropriation of any patent, copyright, or other intellectual property right of a third party. 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 exercise its rights provided under this contract ~~receive the remedies provided under this RFP~~.

3. Personnel

RFP Reference: Section II, Page 11

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, including subcontractor's and their employees, provided by the Contractor.

4. Self-insurance

RFP Reference: Section II, Page 11

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. Attorney General to represent State's Legal Interests

RFP Reference: Section II, Page 11

The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

K: Attorney's Fees

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section II, Page 11

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if order by the court, including attorney's fees and costs, if the other Party prevails.

L: Assignment, Sale, or Merger

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section II, Page 11

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Contractor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Contractor's business. Contractor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Contractor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

M: Contracting with Other Nebraska Political Sub-divisions

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section II, Page 12

The Contractor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. §81-145, to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

N: Force Majeure

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section II, Page 12

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event"). The Party so affected shall immediately make a written request for relief to the other Party, and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

O: Confidentiality

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section II, Page 12

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their 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 by 5 U.S.C. 552a (m)(1), provides that any officer or employee, 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.

P: Office of Public Counsel (Statutory)

RFP Reference: Section II, Page 12

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.

Q: Long-term Care Ombudsman (Statutory)

RFP Reference: Section II, Page 13

Contractor must comply with the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq. This section shall survive the termination of this contract.

R: Business Associate Agreement (BAA)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		✓	We agree in concept with the BAA but would like to discuss further applicability and certain provisions of the BAA to align with the services provided under this contract.

RFP Reference: Section II, Page 13

In the provision of any service under this contract, the Contractor must comply with all applicable law, including but not limited to federal and state: statutes, and rules and regulations~~, and guidance documents~~. Compliance includes, but is not limited to:

1. The Health Information Protection and Portability Act (HIPAA), as set forth in Attachment B - BAA; and
2. The Medicaid-specific, above-and-beyond-HIPAA privacy protections found at 42 CFR Part 431, Subpart F

S: Early Termination

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section II, Page 13

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; and,
i. In the event funding is no longer available.

T: Contract Closeout

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		✓	We propose changes that ensure payment for completed and partially completed deliverables and to clarify that partially completed deliverables are provided on an as-is basis.

RFP Reference: Section II, Page 14

Upon contract closeout for any reason the Contractor shall within 30 days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State for which payment is made by the State, provided that any partially completed deliverables shall be provided on an as-is basis, without warranty or indemnity of any kind;
2. Transfer ownership and title to all completed or partially completed deliverables to the State for which payment is made by the State;
3. Return to the State all information and data, unless the Contractor is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data 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;
4. Cooperate with any successor Contactor, person or entity in the assumption of any or all of the obligations of this contract;
5. Cooperate with any successor Contactor, person or entity with the transfer of information or data related to this contract;
6. Return or vacate any state owned real or personal property; and,
7. Return all data in a mutually acceptable format and manner.

Nothing in this Section should be construed to require the Contractor to surrender intellectual property, real or personal property, or information or data owned by the Contractor for which the State has no legal claim.

Contractor Duties

Section 1.III

Following is our response to all RFP Section III, Contractor Duties, requirements.

A: Independent Contractor/Obligations

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section III, Page 15

It is agreed that the Contractor is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Contractor is solely responsible for fulfilling the contract. The Contractor or the Contractor's representative shall be the sole point of contact regarding all contractual matters.

The Contractor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Contractor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

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

All personnel assigned by the Contractor to the contract shall be employees of the Contractor or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor or the subcontractor respectively.

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

1. Any and all pay, benefits, and 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 that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law; and
5. Determining the hours to be worked and the duties to be performed by the Contractor's employees.
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Contractor, its officers, agents, or subcontractors or subcontractor's employees)

If the Contractor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the bidder'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.

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

Contractor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Contractor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

B: Employee Work Eligibility Status

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			

RFP Reference: Section III, Page 16

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 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 RFP 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.

C: Compliance with Civil Rights Laws and Equal Opportunity Employment/Nondiscrimination (Statutory)

RFP Reference: Section III, Page 16

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, compensation, 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 RFP.

D: Cooperation with Other Contractors

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		✓	We propose deletion of this last sentence to protect our preexisting and independently developed intellectual property

RFP Reference: Section III, Page 16

Contractor may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Contractor shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the performance of work by any other contractor or individual. ~~Contractor is not required to compromise Contractor's intellectual property or proprietary information unless expressly required to do so by this contract.~~

E: Permits, Regulations, Laws

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			

RFP Reference: Section III, Page 17

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Contractor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

F: Ownership of Information and Data/Deliverables

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		✓	We made a few clarifications around the State's ownership of deliverables, including an exception to ownership for Contractor's IP.

RFP Reference: Section III, Page 17

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or derived ~~obtained~~ by the Contractor on behalf of the State pursuant to this contract so long as the State meets is applicable obligations as found in this contract.

Upon full payment, the State shall own and hold exclusive title to any deliverable developed as a result of this contract, except for any Contractor Intellectual Property contained therein, and Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the ~~design, specifications, concept, or~~ deliverable, except for any Contractor Intellectual Property contained therein. Contractor Intellectual Property means all intellectual property created prior to or independently of the performance of the services, or created by Contractor or its subcontractors as a tool for their use in performing the services, plus any modifications or enhancements thereto and derivative works based thereon.

G: Insurance Requirements

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		✓	We have edited to reflect our current industry-standard insurance policies

RFP Reference: Section III, Pages 17 – 18

The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor;
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Contractor has verified that each subcontractor has the required coverage; or,
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Contractor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within One (1) year of termination or expiration of the contract, the contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and one (1) year following termination or expiration of the contract.

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.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

G.1: Workers' Compensation Insurance

RFP Reference: Section III, Page 18

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. The policy shall include a waiver of subrogation in favor of the State, unless prohibited by law. The COI shall ~~contain~~ evidence the mandatory ~~COI~~ subrogation waiver language found hereinafter, unless prohibited by law. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

G.2: Commercial General Liability Insurance and Commercial Automobile Liability Insurance

RFP Reference: Section III, Pages 18 - 19

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 for insured contracts. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s) with respect to acts or omissions in performance of services as defined under this contract. This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory with respect to additional insured status. The COI shall contain the mandatory COI liability waiver language found hereinafter. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE
COMMERCIAL GENERAL LIABILITY

General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
Independent Contractors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
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
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000 per occurrence
PROFESSIONAL LIABILITY	
All Other Professional Liability (Errors & Omissions)	$1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$1,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$10,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	

"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."
MANDATORY COI LIABILITY WAIVER LANGUAGE
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."

If the mandatory COI subrogation waiver language or mandatory COI liability waiver language on the COI states that the waiver is subject to, condition upon, or otherwise limit by the insurance policy, a copy of the relevant sections of the policy must be submitted with the COI so the State can review the limitations imposed by the insurance policy.

G.3: Evidence of Coverage

RFP Reference: Section III, Pages 19 - 20

The Contractor shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

Agency

Attn: Managed Care Finance Program Specialist

Address Medicaid and Long-Term Care / Rates & Reimbursement

City, State, Zip 301 Centennial Mall South, Lincoln, NE 68509

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.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G.4: Deviations

RFP Reference: Section III, Page 20

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.

H: Antitrust

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section III, Page 20

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.

I: Conflict of Interest

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section III, Page 20

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

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

The Parties shall not knowingly, for a period of two years after execution of the contract, recruit or employ any employee or agent of the other Party who has worked on the RFP or project, or who had any influence on decisions affecting the RFP or project.

J: State Property

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section III, Page 20

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.

K: Site Rules and Regulations

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section III, Page 21

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 in writing between the State and the Contractor.

L: Advertising

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section III, Page 21

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. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

M: Nebraska Technology Access Standards (Statutory)

RFP Reference: Section III, Page 21

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 the contract comply with the changed standard at a cost mutually acceptable to the parties.

N: Disaster Recovery/Back Up Plan

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section III, Page 21

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

O: Drug Policy

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section III, Page 21

Contractor certifies 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.

Payment
Section 1.IV

Following is our response to all RFP Section IV, Payment, requirements.

A: Prohibition Against Advance Payment (Statutory)

RFP Reference: Section IV, Page 22

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

B: Taxes (Statutory)

RFP Reference: Section IV, Page 22

The State is not required to pay taxes 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.

C: Invoices

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section IV, Page 22

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Managed Care Finance Program Specialist, Medicaid and Long-Term Care/Rates & Reimbursement, 301 Centennial Mall South, 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.

D: Inspection and Approval

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section IV, Page 22

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.

E: Payment

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section IV, Pages 22 - 23

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. (Neb. Rev. Stat. Section 73-506(1)) 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 of the contract, and the Contractor hereby waives any claim or cause of action for any such services.

F: Late Payment (Statutory)

RFP Reference: Section IV, Page 23

The Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408).

G: Subject to Funding/Funding out Clause for Loss of Appropriations

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
✓			NONE

RFP Reference: Section IV, Page 23

The State's obligation to pay amounts due on the Contract for a fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) 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 termination. All obligations of the State to make payments after the termination date will cease. 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.

H: Right to Audit (First Paragraph is Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		✓	We made a slight clarification because as aa private firm, we are not required to follow GAAP. However, we do materially utilize these accounting principles.

RFP Reference: Section IV, Page 23

The State shall have the right to audit the Contractor's performance of this contract upon a 30 days' written notice. Contractor shall materially utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. The State may audit and the Contractor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Contractor shall make the Information available to the State at Contractor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Contractor so elects, the Contractor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Contractor be required to create or maintain documents not kept in the ordinary course of contractor's business operations, nor will contractor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to contractor.

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one and one-half percent (1.5%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Contractor, the Contractor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety days of written notice of the claim. The Contractor agrees to correct any material weaknesses or condition found as a result of the audit.

Section 2 :
Corporate Overview

Corporate Overview

Section 2

RFP Reference: Section VI.A.2, Page 29

The corporate overview section of the Technical Proposal should consist of the following subdivisions:

Following is our response to all RFP Section VI.A.2, Corporate Overview, requirements.

A: Bidder Identification and Information

RFP Reference: Section VI.A.2.a, Page 29

Following is our response to all RFP Section VI.A.2.a, Bidder Identification and Information, requirements.

RFP Requirement	Deloitte's Response
Full Company Name	Deloitte Consulting LLP
Company Headquarters Address	30 Rockefeller Plaza New York, NY 10112
Entity Organization	Deloitte Consulting LLP is a Limited Liability Partnership
State of Incorporation or otherwise Organized to do Business	Deloitte USA LLP, Deloitte LLP, and the subsidiaries of Deloitte LLP (one of which is Deloitte Consulting LLP) are each separate and distinct legal entities. Each of the subsidiaries listed above is organized under Delaware law, is separately capitalized, has its own Chairman, CEO, and Board of Directors, and provides a distinct array of services.
Year in which the Bidder first Organized to do Business and whether the Name and form of Organization has changed since first organized	Deloitte's parent company was founded in 1845 and has since undergone many changes, but has consistently provided professional services for over 150 years. Deloitte LLP and its subsidiaries are not corporations but rather limited liability partnerships and there are no dates or states of "incorporation". Deloitte LLP and most of its subsidiaries went live as follows: • Deloitte LLP–1994 • Deloitte & Touche LLP–1997 • Deloitte Consulting LLP–1996 • Deloitte Tax LLP–2003 • Deloitte Financial Advisory Services LLP–2003

Figure 2-1. Bidder Identification and Information.

B: Financial Statements

RFP Reference: VI.A.2.b, Page 29

"Deloitte" is the brand under which tens of thousands of dedicated professionals in independent firms throughout the world collaborate to provide audit, consulting, financial advisory, risk management and tax services to selected clients. These firms are members of Deloitte Touche Tohmatsu Limited (DTTL), a UK private company limited by guarantee. Each member firm provides services in a particular geographic area and is subject to the laws and professional regulations of the particular country or countries in which it operates.

Following are some key facts and figures about our Global Organization:

- A globally connected network of 34 member firms in more than 150 countries and territories
- Largest professional services provider in the world (based on global revenues and headcount)
- More than nearly 264,000 employees and more than $38.8 billion in revenues in FY17
- Serving 80 percent of the world's largest companies (Global Fortune)
- Offer audit, tax, consulting, and financial advisory services

In the United States, Deloitte LLP and Deloitte USA LLP are member firms of DTTL. The subsidiaries of Deloitte LLP provide industry-leading audit, consulting, tax, and advisory services to many of the world's most admired brands, including 80 percent of the Fortune 500. Our people work across more than 20 industry sectors with one purpose: to deliver measurable, lasting results. We help reinforce public trust in our capital markets, inspire clients to make their most challenging business decisions with confidence, and help lead the way toward a stronger economy and a healthy society. As part of the DTTL network of member firms, we are proud to be associated with the largest global professional services network, serving our clients in the markets that are most important to them.

Following are some key facts and figures regarding our US firms:

- Largest professional services firm in the U.S. in terms of revenue and headcount
- More than 85,000 people, including more than 5,300 partners, principals and directors
- 115 offices in 97 cities
- More than $18.5 billion in revenue in FY17
- Ranked No. 1 on BusinessWeek magazine's "50 Best Places to Launch a Career"
- Ranked as one of Fortune magazine's "100 Best Companies to Work for" 19 times since 1998
- 24 consecutive years on Working Mothers magazine's 100 Best Companies list

Deloitte LLP and its subsidiaries (the "U.S. Firms") provide audit, advisory, tax, and consulting services through over 84,000 people in 97 U.S. cities. For the most recent fiscal year ended June 3, 2017, the U.S. Firms had revenue of U.S. $18.6 billion. See more detailed information in the chart below.

Since the U.S. Firms are privately owned partnerships, they do not have audited financial statements nor do they file other corporate financial information such as a 10-K.

Should you have additional questions regarding the financial information, please contact John Peirson, Deputy Chief Financial Officer of Deloitte LLP, at (612) 397-4714 or Graham Cowie, U.S. Firms' Controller of Deloitte Services LP, at (615) 882-7270.

Further, although the U.S. Firms do not have a rating from one of the nationally recognized credit rating agencies, their privately placed debt is assigned a designation by the National Association of Insurance Commissioners ("NAIC"). The U.S. Firms' privately placed debt carries an NAIC 1 designation; NAIC's highest designation, which is comparable to an A or better rating from one of the nationally recognized rating agencies.

Detailed information regarding Deloitte LLP in the U.S. is provided in the chart below:

Source: Deloitte LLP, New York

Figure 2-2. Deloitte LLP Financial Information.

The above financial information was prepared for internal purposes. This financial information has not been audited and does not present the financial position, results of operations, or other financial information in accordance with generally accepted accounting principles.

The use of this information is restricted to your consideration in providing you professional services. Any other use or circulation of this information is prohibited.

C: Change of Ownership

RFP Reference: Section VI.A.2.c, Page 29

Deloitte does not anticipate a change in ownership or control of the firm during the 12 months following the proposal due date.

D: Office Location

RFP Reference: Section VI.A.2.d, Page 30

We currently serve 44 of 50 U.S. states as well as the Commonwealth of Puerto Rico and the District of Columbia and have offices in 28 of the State capitals. We have offices throughout Nebraska, including in Lincoln and Omaha. We already have an onsite presence working with the State and are looking to grow our Nebraska analytics and actuarial team locally. In addition to the onsite support in Nebraska, the office location overseeing performance pursuant to this contract is as follows:

50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
Tel: +1 612-397-4000

E: Relationships with the State

RFP Reference: Section VI.A.2.e, Page 30

The following figure lists our team's work with the State (to include awarded contracts) over the previous ten (10) years.

Vendor	Contract	Title
Deloitte Consulting LLP	78047 04	Data Management and Analytics
Airam Actuarial Consulting, LLC (subcontractor to TriWest Group LLC)	69568	Rate development for Family Navigator and Family Peer Support Services

Figure 2-3. Relationships with the State.

F: Bidder's Employee Relations to State

RFP Reference: Section VI.A.2.f, Page 30

No members of the Deloitte Team (including our subcontractors) have been employed by the State of Nebraska within the past 12 months.

G: Contract Performance

RFP Reference: Section VI.A.2.g, Page 30

Deloitte is one of the world's leading providers of consulting services, and has a particularly significant position in respect of large-scale projects in the public sector. Some of those projects involve direct contractual relationships with public entities, but others are established as subcontracts with large-scale system developers. Large-scale systems projects frequently evolve during the course of implementation with revised objectives or systems enhancements grafted onto the original commitments. Occasionally, those conditions create disagreements over contract requirements.

We are proud of our record and reputation in anticipating, addressing and resolving issues of this sort. These matters represent a very small portion of our major systems consulting engagements in recent years, and all disputes remain in the preliminary stage. There has been no determination by a court or an independent evaluator that we have defaulted on any contract. We are confident that these matters will be resolved to our satisfaction, and that none of these matters will have an adverse effect on Deloitte's ability to serve the State of Nebraska.

Airam Actuarial Consulting, LLC has not had a contract terminated for default within the last ten (10) years.

H: Corporate Experience

RFP Reference: Section VI.A.2.h, Page 30

State Health Practice Overview

SECTION HIGHLIGHTS

- Deloitte has a rich history of effective service delivery to 49 states and commonwealths and the District of Columbia, as well as to the federal government.
- 4500+ practitioners in the Public Sector Industry with 1,500+ serving the State Sector.
- Consistently serving U.S. public sector state government clients for more than 40 years.

Our diverse work with state, federal and commercial health care organizations enables us to offer innovative and holistic perspectives that are grounded in practical experience. In serving Nebraska, we draw on our extensive experiences in the federal and state government–more specifically with State health organizations and the Centers for Medicare & Medicaid Services, where we support the Center for Medicare & Medicaid Innovation, the Center for Medicare, and the Center for Consumer Information & Insurance Oversight–as well as the commercial market–including health care plans, providers and life sciences organizations.

- Deloitte's State Health practice has aided states in improving population health through Medicaid transformation, analytics, provider-incentive programs, waiver/policy design and related services. The State Health team has deep knowledge of state government, Medicaid agencies and essential strategies to help states achieve their desired outcomes for their Medicaid program. Our state health practitioners work closely with our broader Health and Human Services practice to deliver active projects in 24 states and British Columbia
- Our Medicaid program experience includes business process redesign and organizational transformation, data warehousing, HIPAA and operational assessments, actuarial rate setting, waiver strategy support, MITA assessments, MMIS-related projects, Medicaid eligibility system development, procurement strategies and assistance, program transformation, Health Information Technology (HIT) planning and IV&V and Quality Assurance.
- Deloitte Federal Health experience includes providing extensive support to CMS in program management, program integrity and organizational design. Deloitte has also provided value to other Federal agencies and offices, including the Office of the National Coordinator (ONC) for Health Information Technology, the Centers for Disease Control (CDC) and other quasi-Federal organizations, including the Patient-Centered Outcomes Research Institute (PCORI) by integrating our health care expertise across both Federal and Commercial practices, as well as bringing our stakeholder engagement, technology and subject matter experience to meet the demands of a complex and fast-paced environment

Deloitte in Nebraska

Deloitte has the benefit of a local presence in Omaha with an active Deloitte office as well as an active onsite team supporting the ongoing Data Management and Analytics (DMA) engagement. Based on our experience, the benefits of having the ability to work together in person fosters a collaborative partnership between the State and contractor.

As an example of recent success with this approach for an actuarial, financial, and policy focused contract similar to this RFP, we have established an onsite team working in the New York DOH office. This arrangement has provided the State with continual contact with our team who have the ability to join strategic discussion sessions or respond to requests at the speed of normal business which has allowed for significantly better team integration. Our onsite team consists of data analysts, an onsite actuary and overall project coordinator, policy consultants, and other staff to support the wide range of tasks required by the State. Finally, having the onsite team allows direct data warehouse access to team members, removes the necessity to maintain detailed client data offsite and significantly reduces data exposure risk.

Based on the immense impact this approach has had in New York, the Deloitte team would be willing to discussing the potential for establishing an onsite team for the DHHS Actuarial and Consulting Services contract and review the best practices developed with New York to gain efficiency and integrate effectively across all required tasks.

Experience Overview

The Deloitte team is highly qualified to provide exceptional value to DHHS with a team that has a number of professionals with more than 20 years of experience servings state governments focused on Medicaid programs. Deloitte as a firm also has nearly 50 years of experience in health and human services working with a multitude of state, Federal, and commercial health care organizations to successfully achieve their business goals.

The information below illustrates a number of diverse experiences where our team has assisted in delivering innovative solutions for Medicaid programs and managed healthcare plans. We have chosen to highlight direct and relevant experience to the work required in this RFP. Our track record of proven results demonstrates our deep experience and competence in delivering RFP tasks.

Capitation Rate Setting

The Deloitte team brings DHHS extensive experience with setting and reviewing Medicaid Managed Care Capitation Rates as well as development and implementation of risk adjustment methodologies across all programs and populations.

- [redacted]
- [redacted]


CHCS

Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations

Figure 2-4. Developing Capitation Rates for Medicaid Long Term Services and Supports Programs: State Considerations.

- [redacted]
- [redacted]

Waiver Support

The Deloitte team works with a number of state agencies to provide strategic, policy, and financial support for 1115, 1915 (b), and 1915 (c) waivers across various populations as well as conduct independent waiver evaluations.

- [redacted]

- [redacted]

Policy and Financial Management Consulting Services

Deloitte has routinely been recognized as an industry leader in the design and implementation of value based care methodologies across state government, health plan and provider groups.

- [redacted]

[redacted]

- [redacted]
- [redacted]

Below we have included three specific project narratives similar to this RFP in size, scope, and complexity for Deloitte, and three specific project narratives for Airam Actuarial Consulting LLC as primary qualifications. We've provided additional narratives to further illustrate the breadth and depth of the Deloitte team's experience.

Deloitte Team Experience

Project Description #1: [redacted]

[redacted]

Project Description

[redacted]

Figure 2-4. Deloitte's Project Description #1 – [redacted].

Project Description #2: [redacted]

[redacted]

[redacted]

Figure 2-5. Deloitte's Project Description #2 – [redacted].

Project Description #3: [redacted]

[redacted]

[redacted]

Figure 2-6. Deloitte's Project Description #3 – State of Maine.

Subcontractor - Airam Actuarial Consulting, LLC Experience

[redacted]

Project Description #1: [redacted]

[redacted]

Figure 2-7. Airam Actuarial Consulting Project Description #1.

Project Description #2: [redacted]

[redacted]

Figure 2-8. Airam Actuarial Consulting Project Description #2.

Project Description #3: [redacted]

[redacted]

Figure 2-9. Airam Actuarial Consulting Project Description #3.

Additional Deloitte Team Experience

Project Description #4: [redacted]

[redacted]

Figure 2-10. Deloitte's Experience in the [redacted].

Project Description #5: [redacted]

[redacted]

Figure 2-11. Deloitte's Experience with [redacted]

Project Description #6: [redacted]

[redacted]

Project Description

[redacted]

Figure 2-12. Deloitte's Experience with the [redacted].

I: Summary of Proposed Personnel/Management Approach

RFP Reference: Section VI.A.2.i, Page 31

The Deloitte team is prepared to provide DHHS with the critical thinking, diverse experience and knowledge required to effectively support all Medicaid program and populations related to actuarial, financial, and data analytics. An integrated Deloitte team brings together an experienced group of professionals with extensive experience in Medicaid, state and federal health care, value-based care reimbursement, Medicaid reform initiatives, and the Affordable Care Act. Additionally, we deliver team members who also support the ongoing Nebraska Data Management Analytics engagement, who will support our team and DHHS in aligning rate development activities with data and analytics initiatives.

Our team's deep Medicaid knowledge, specialized experience in large project management, top tier thought leadership related to value based care, and focus on data analytics & reporting will be of significant benefit to DHHS. The Deloitte team has a proven track record of bringing the best team to deliver projects actuarial rate setting and assisting organizations to advance their missions. Our approach to staffing and organization is based on years of experience successfully delivering projects for HHS clients and is regularly updated with lessons learned to provide the most efficient approach to staffing and managing our team throughout all project phases.

Our team is comprised of staff with the requisite skills to meet the requirements of this RFP and who are committed to the success of this project. We manage project staffing levels to be aligned with the planned work in each phase such that there are sufficient numbers of resources assigned to meet project timelines and workload. In assessing the personnel for the project, the Deloitte team looked at the following core competencies for potential project staff:

- **Experience and Knowledge**. Direct experience, knowledge and skills relevant to actuarial rate development and consulting, how it fits into the State's vision and the processes necessary for successful rate development.
- **Communication.** Ability to communicate and work together as a team–with Deloitte staff, subcontractors, DHHS staff, data source vendors and other stakeholders–using our effective project management methodology to achieve common objectives and goals.
- **Understanding and Managing Expectations**. Proven ability to complete tasks and activities based on project plans similar in size and scope to the project.

The Deloitte team brings a strong combination of complimentary skillsets and experience in delivering actuarial rate development to the Department. The unmatched breadth and depth of knowledge of Deloitte's practitioners, as well as our long history of experience delivering complex solutions, is bolstered by our Nebraska-specific program knowledge and expertise.

Deloitte recognizes the importance of staffing the engagement with the appropriate staff and key personnel with the right mix of skills needed to deliver the solution within the specified time frame. We understand that defining clear roles and responsibilities as well as selecting the right team members leads to a more effective project team. Working with the Deloitte team, a partner that shares your vision and is committed to helping you attain your goals, is a critical element of the project's overall success.

How Deloitte will work with DHHS

Deloitte understands that a project's success depends substantially on selecting the right team to support the project. Working with a team that shares your vision - and is committed to helping you attain your goals - is a critical element of a project's overall success. Deloitte's approach to staffing this project demonstrates our understanding of DHHS' needs and goals by providing an experienced team of personnel, led by our Lead Executive, Tim FitzPatrick, who possess significant knowledge and experience in Medicaid rate development, value-based care, and project management. Supporting Tim is our Project Coordinator, Tim Egan, who will manage day-to-day aspects of the engagement and be the primary point of contact with DHHS. Supporting Tim and Tim we have assembled leads who will oversee various components of the engagement, including actuaries, policy specialists, a clinician, pharmacist, and value-based reimbursement specialists. We will draw from a team over 120 health actuaries (over 60 credentialed) and 3,000 Deloitte practitioners support our State Health clients to support each initiative, as necessary.

With our approach, we bring a blend of resources that know your solution, bring a national perspective on Medicaid and other HHS programs and have deep technical experience to support DHHS in your upcoming Medicaid reform initiatives. In addition, our current DMA team in 350A of the Gold Building has space to accommodate our actuarial support and we would be prepared to establish an onsite team over the course of the engagement to work alongside DHHS. We have successfully implemented an onsite delivery model for the State of New York Medicaid rate setting engagement and our clients have found it to be very beneficial to work with us side-by-side. We look forward to continuing the collaborative and inclusive environment established with the DMA work. We would be happy to discuss this opportunity further with you during the initial kick-off stages of the engagement.

Deloitte consistently delivers quality work products

Service delivery excellence is a driving force behind Deloitte's quality control plan. Our project implements these standards for you today with the DMA and we will continue this high level of quality through our next project experience with you. You will get consistency and the quality you have come to expect from Deloitte deliverables through our standard processes. Our Office of Quality and Risk Management oversees quality and risk management for all Deloitte Consulting engagements and programs, which are frequently reviewed and audited for risk and compliance. Issues that arise during an engagement are escalated internally and discussed with the client as part of our plan.

Having a solid quality control plan framework in place increases our ability to deliver high quality results. We focus on continuous improvement to help our professionals enhance the value delivered to our clients and lower our cost of quality.

Core to assessing quality and risk are engagement reviews. These reviews use a specific framework to prepare lead engagement reviewers for the upcoming review and focus them on areas and topics where risks or quality issues most often occur on projects. We follow this same process for the Data Management and Analytics (DMA) project as well. The framework is divided into categories and captures quality issues and risks within four dimensions of risk: contract, client, solution, and team. Reviews are conducted by principals and directors, who are assigned by our Quality Leadership team.

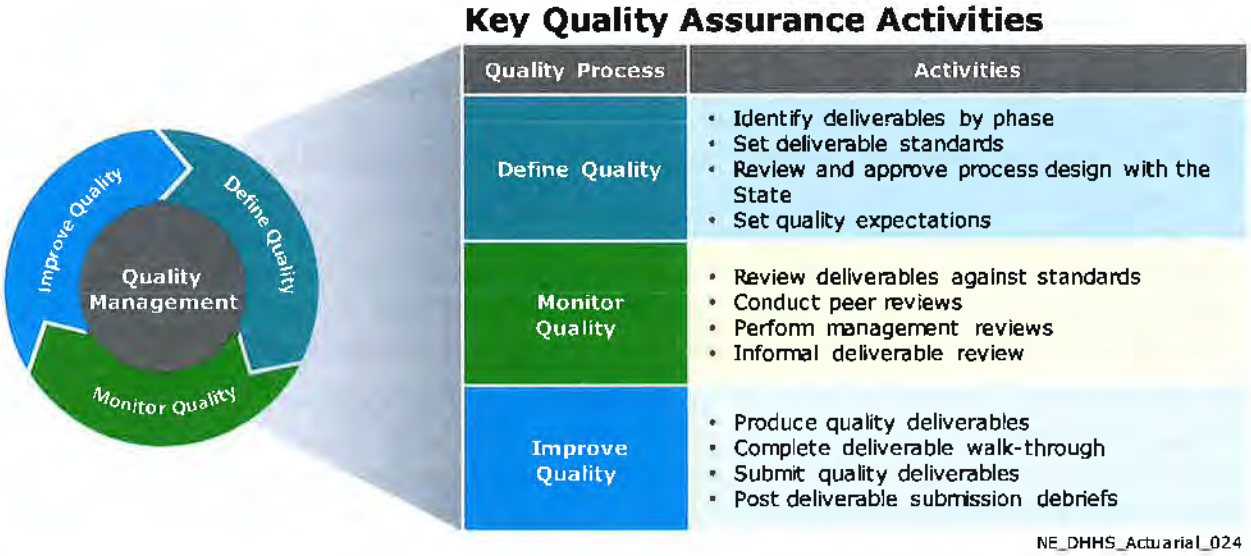


Figure 2-13. Key Quality Assurance Activities.

The Deloitte team understands the importance of providing quality deliverables on time and within budget both to meet the DHHS expectations as well as the applicable actuarial standards of practice. Our leadership team will enhance communication, collaboration and understanding of the requirements for each task. Our approach to the RFP tasks involves a number of levels of actuarial review and quality assurance reviews prior to the release of final deliverables.

Deloitte is committed to quality, with an underscore of two main components: technical excellence and customer service excellence. Our quality structure is supported by four pillars: client service standards, the people dimension, performance standards, and process.

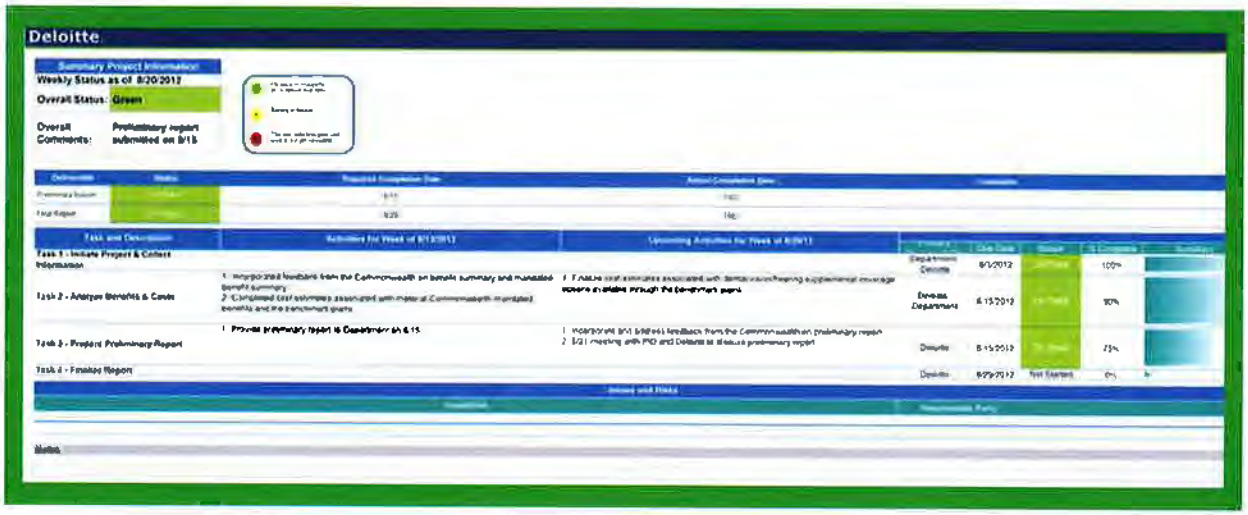
1. **Client Service Standards will be set with the DHHS.** Deloitte and DHHS need to reach a mutual agreement regarding timelines, deliverables, interim milestones, expectations, assumptions, and important communications to deliver a quality product

2. **The People Dimension.** We understand the nature of the Nebraska Medicaid programs and this project. Deloitte has brought together a team with diverse technical and personal backgrounds in order to bring a well-rounded team to DHHS
3. **Performance Standards.** Our actuarial team members are held to very high professional standards including the Actuarial Standards of Practice and Actuarial Practice Notes. Additionally, Deloitte adheres to published standards (e.g., the CMS Rate Development Guide) in the rate-setting process
4. **The Process.** Deloitte's Project Coordinator manages a day-to-day process for each of the tasks to be completed for the DHHS. This process tracks that work products are on time and receive proper quality reviews prior to finalizing

Deloitte manages to success

Our team employs a standardized project management framework to maintain the appropriate level of communication and cooperation with the DHHS as a component of our daily project management activities. Our Project Coordinator will provide direct point of contact between our teams and the DHHS, with our project and program leaders providing oversight of the responsibilities of the contract.

The Deloitte team will hold monthly status meetings with the DHHS and will provide a monthly status report, (example provided in the figure that follows) that provides an update on the overall progress of the project.



NE_DHHS_Actuarial_023

Figure 2-14. Sample Status Report.

In addition, to effectively monitor and control the delivery of services the Deloitte team offers a transparent approach to project management enabling the DHHS to gain up-to-date access to project metrics and status. To assist the DHHS with the process and requirements of planning, executing, and monitoring activities for this engagement, the Deloitte team will use standardized project management tools, methods and project management approaches.

Our approach incorporates established tools and techniques for components such as managing project plans; coordinating across dependencies; disseminating information on project progress; and managing issues, risks, scope, actions, decisions, and tasks.

As required, the Deloitte team will provide a Problem Identification Report used to identify, analyze and manage risks and issues. Our methodology for risk and issues management is based on the principles defined by the Project Management Institute (PMI), and characterized by proactively planning for risks and issues on the project, and holistic consideration of risks that are both internal and external to the project. The Deloitte team will approach problems and track issues as a team activity and work closely with DHHS project staff to help monitor these problem areas, mitigate risks and resolve issues.

The Deloitte Team

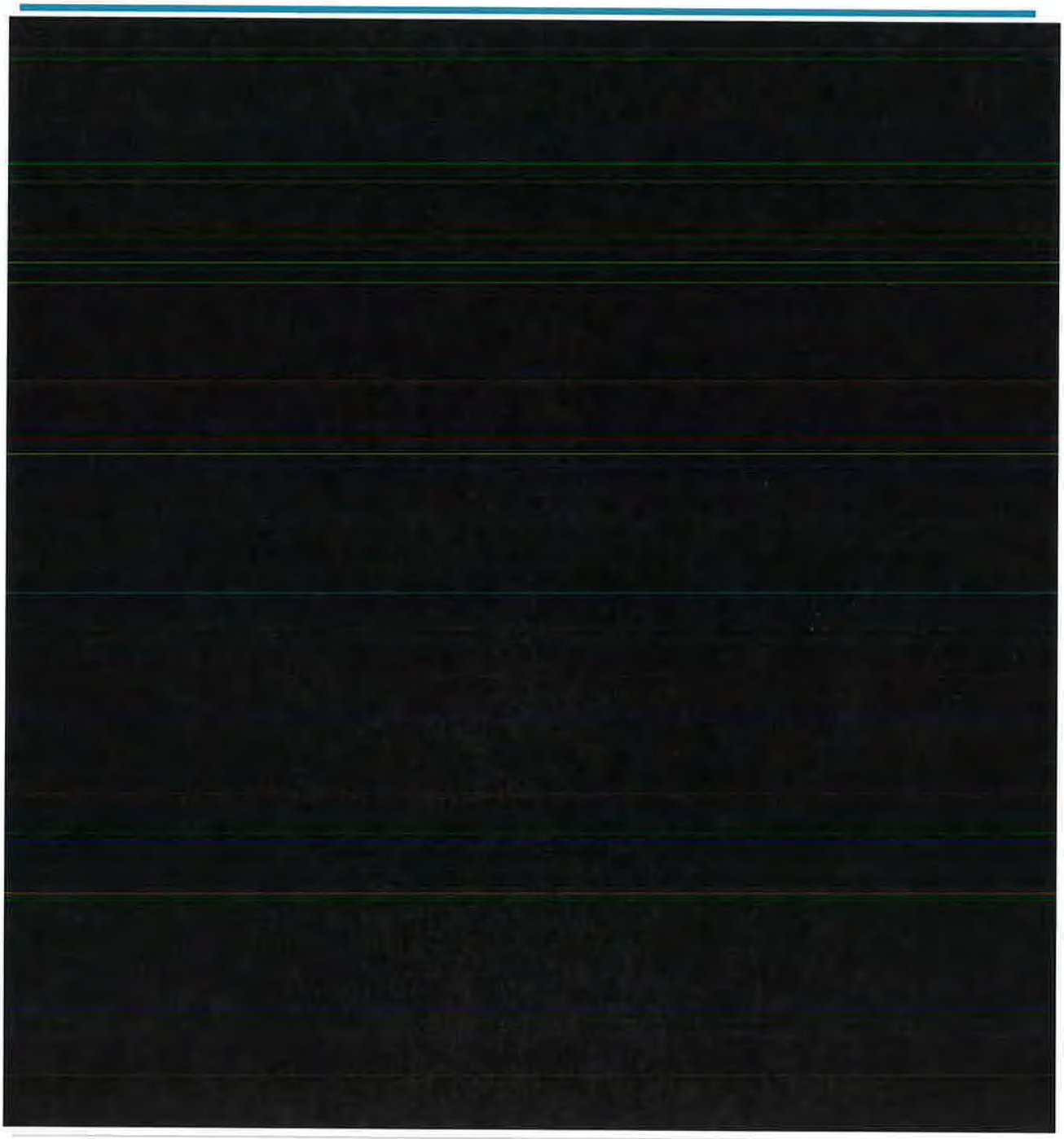
As highlighted in Section 2.H, we have assembled a team with significant experience supporting one or more of the tasks requested in this RFP, including physical health, behavioral health, prescription drug, and dental rate setting; PACE rate development; waiver development, including waiver strategy, cost effectiveness, and budget neutrality; and a variety of Medicaid reform initiatives, including value-base care reimbursement, data analytics and visualizations, and encounter data quality reviews. Our team brings this experience across state government, but also commercial payer and provider experience.

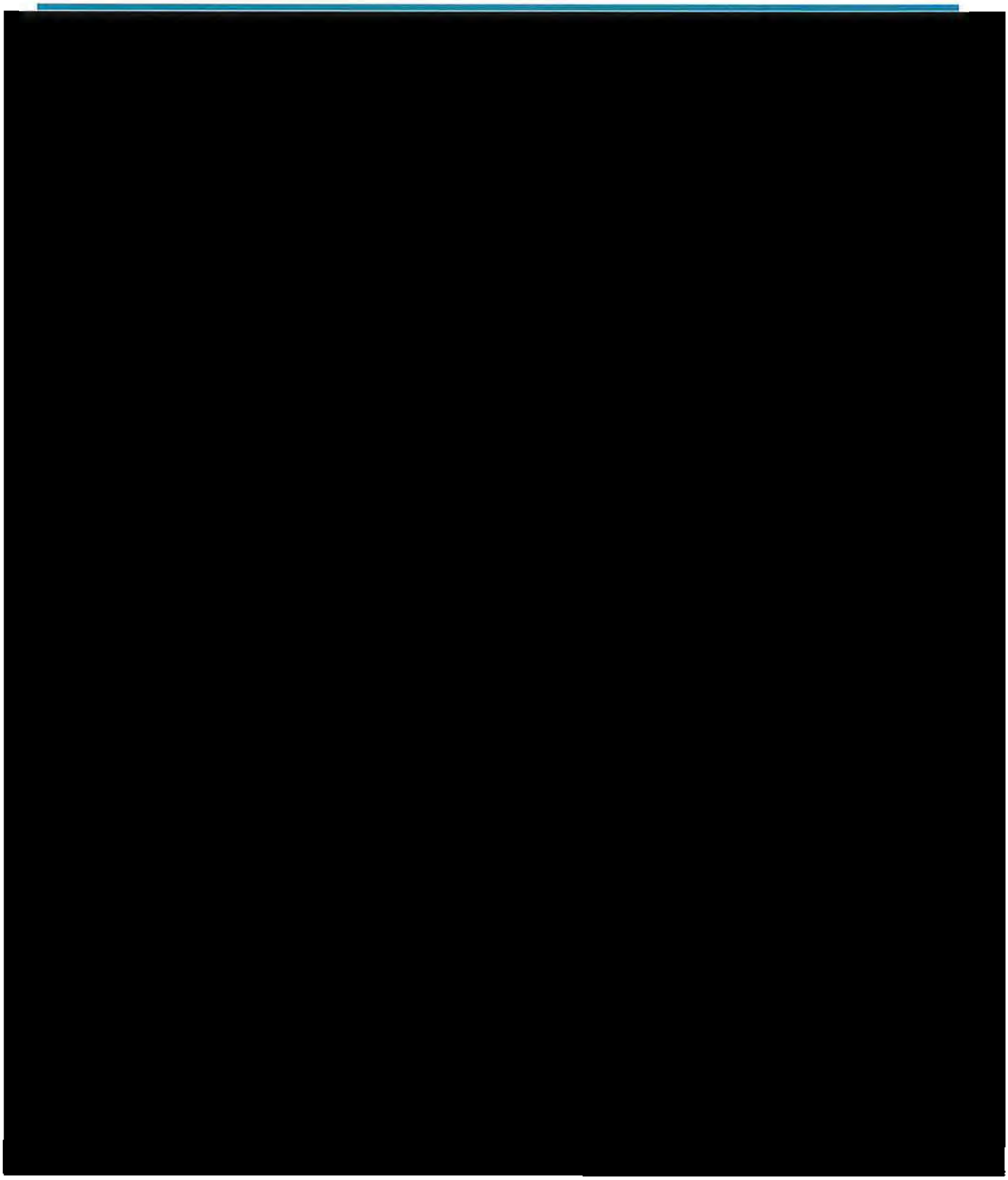
A summary of our project team structure is outlined in the organizational chart below.

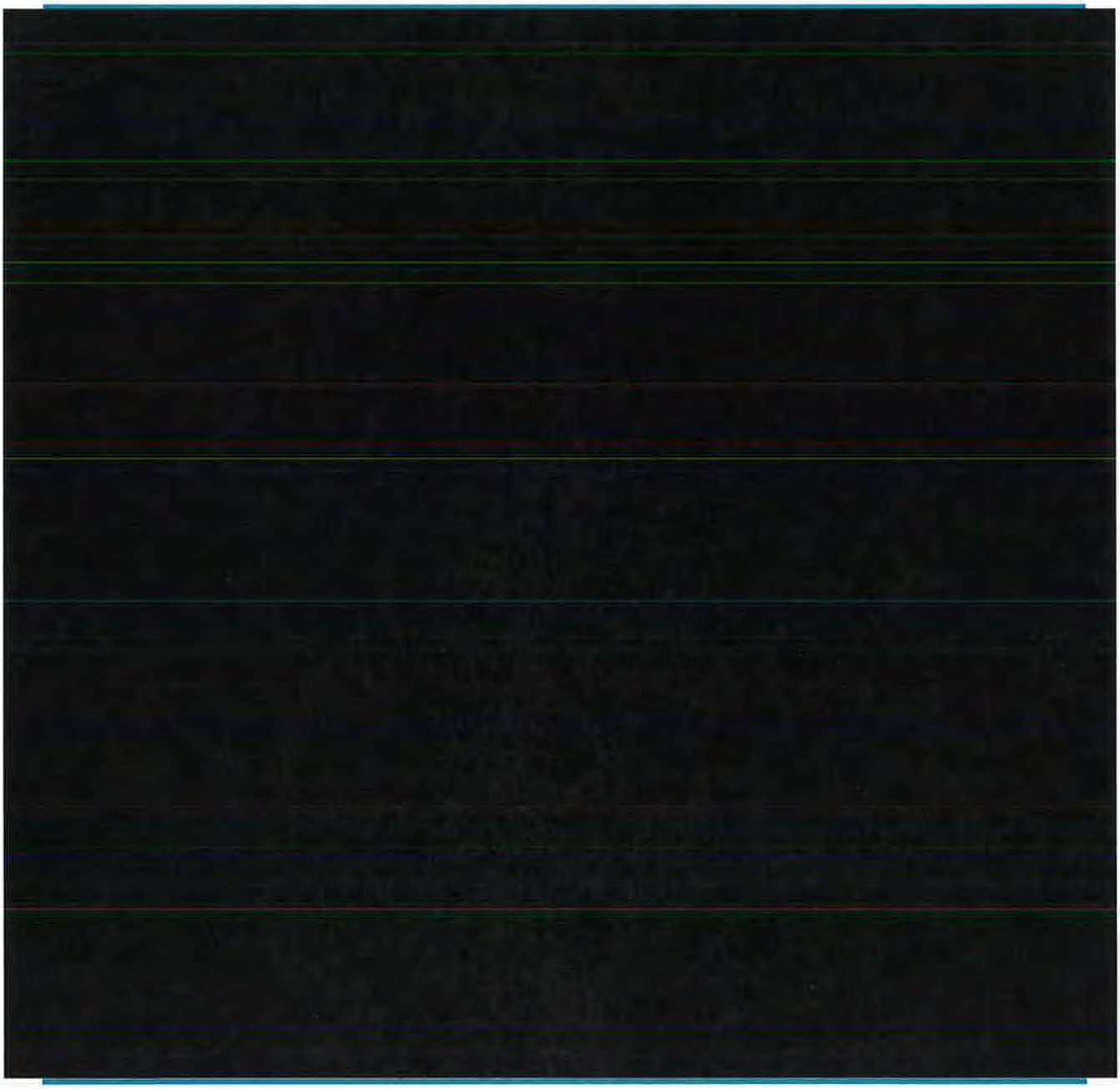
Project Organization Chart

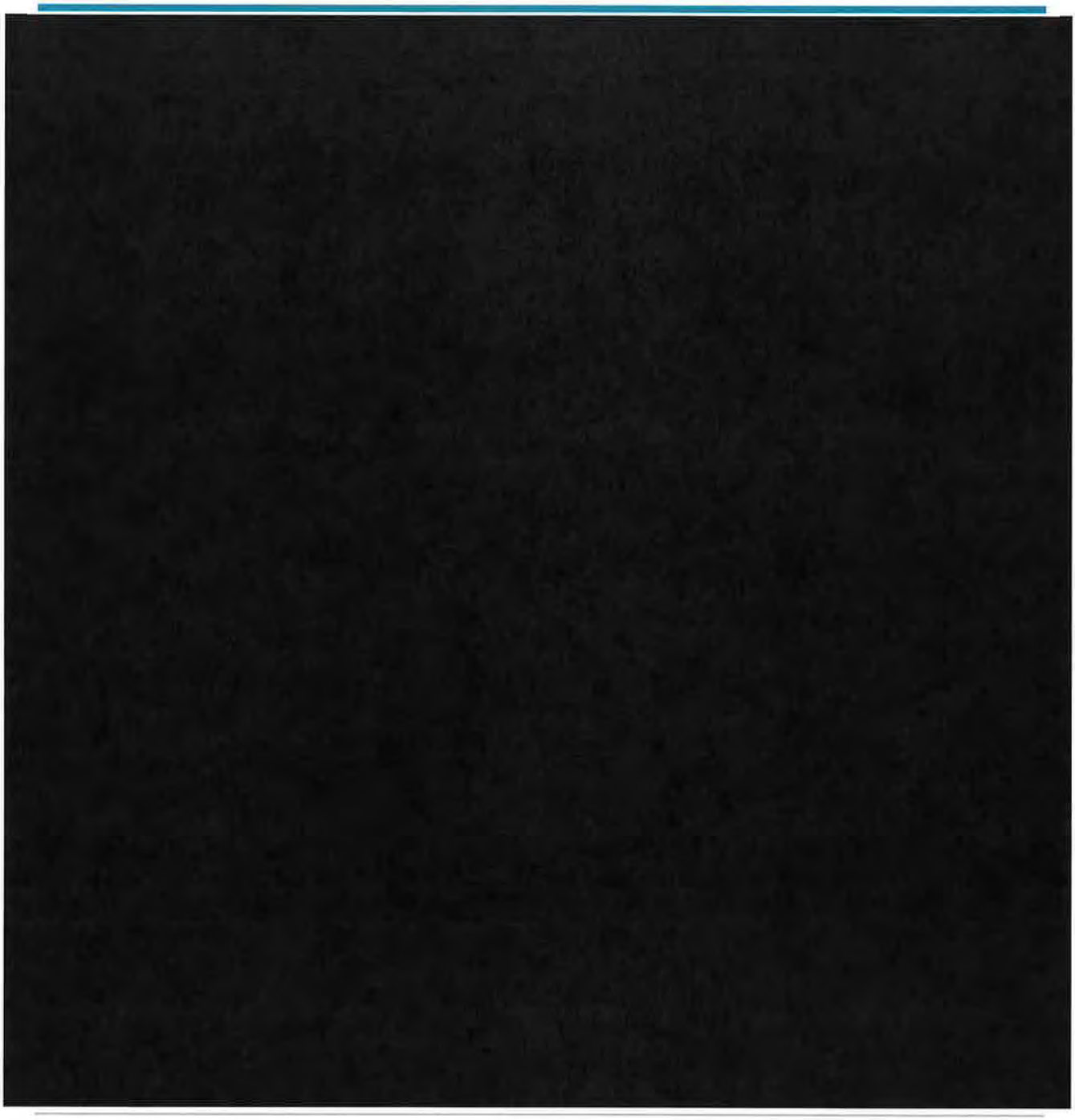
Resumes

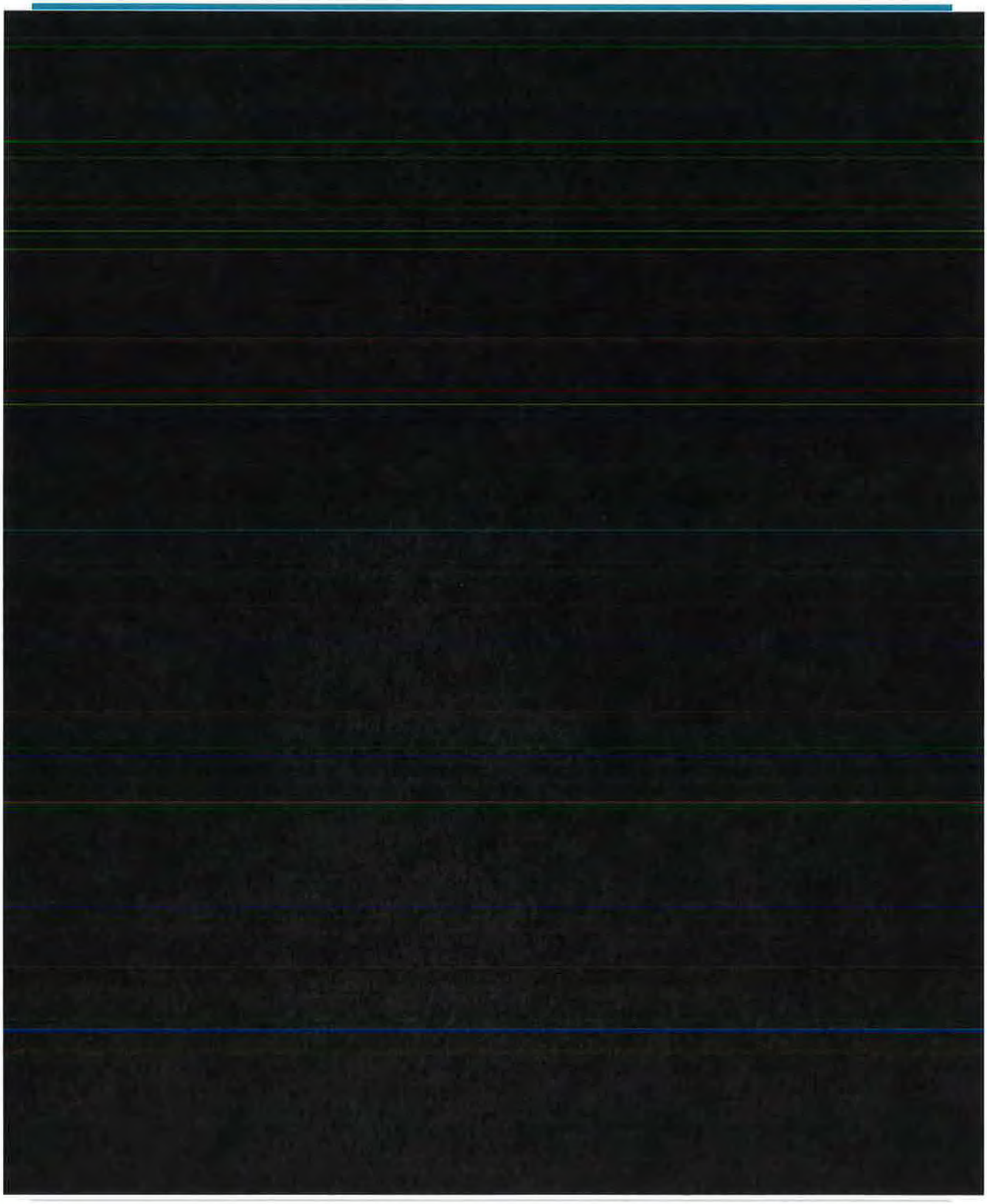
Following are resumes for all key personnel proposed by Deloitte to work on the project. Also included are bios for our subject matter advisors that will be available to the team and DHHS, as necessary.

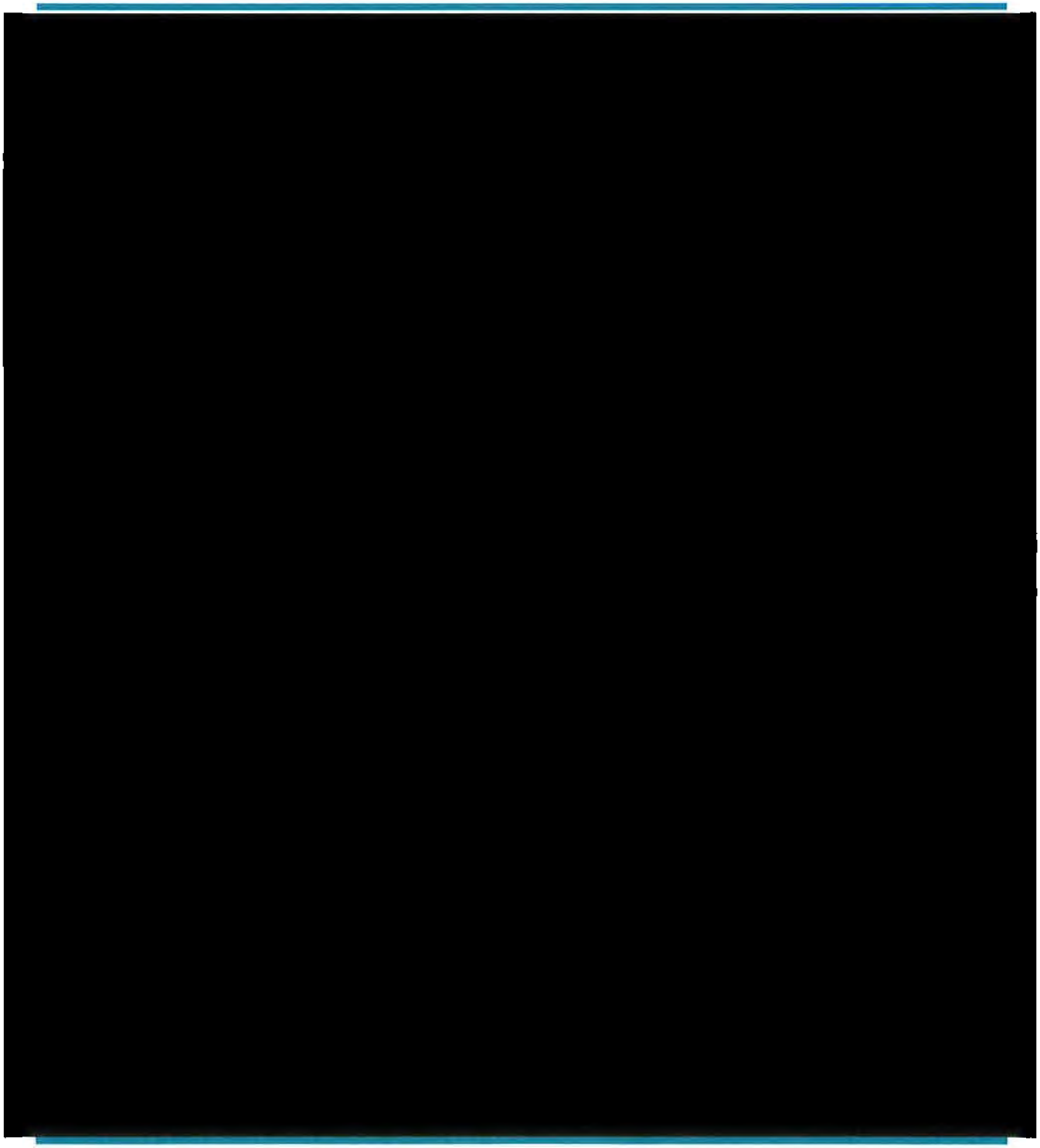


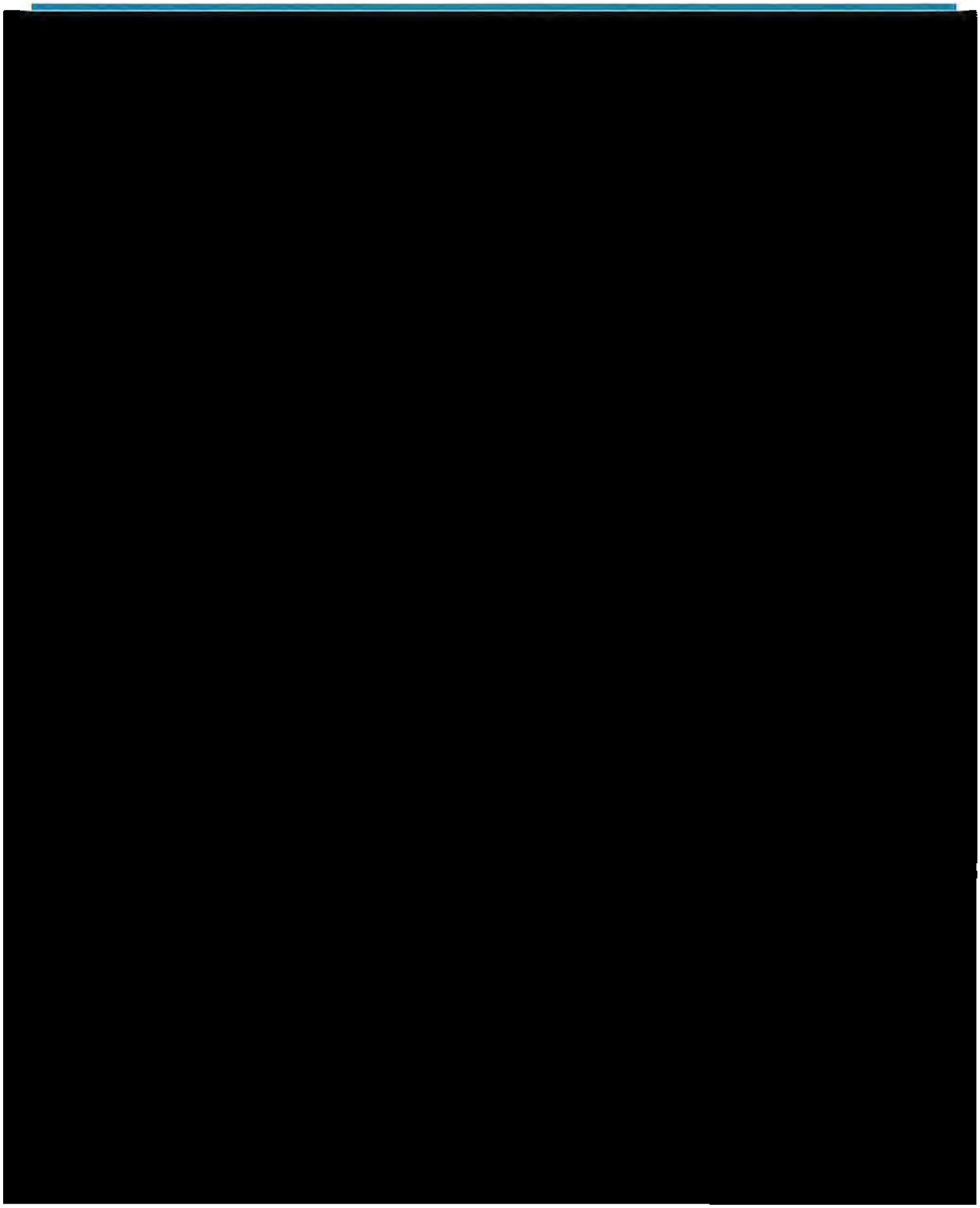


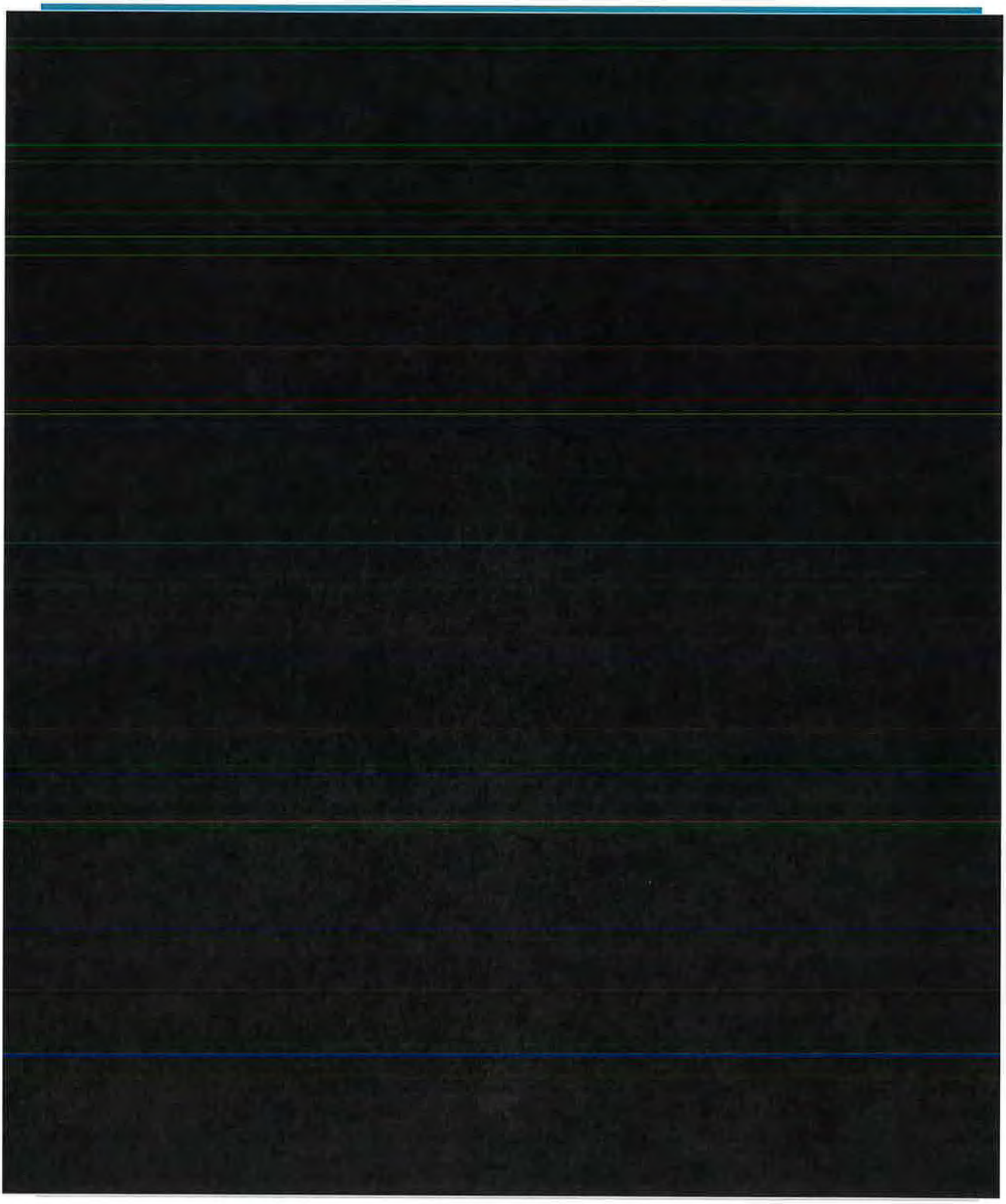


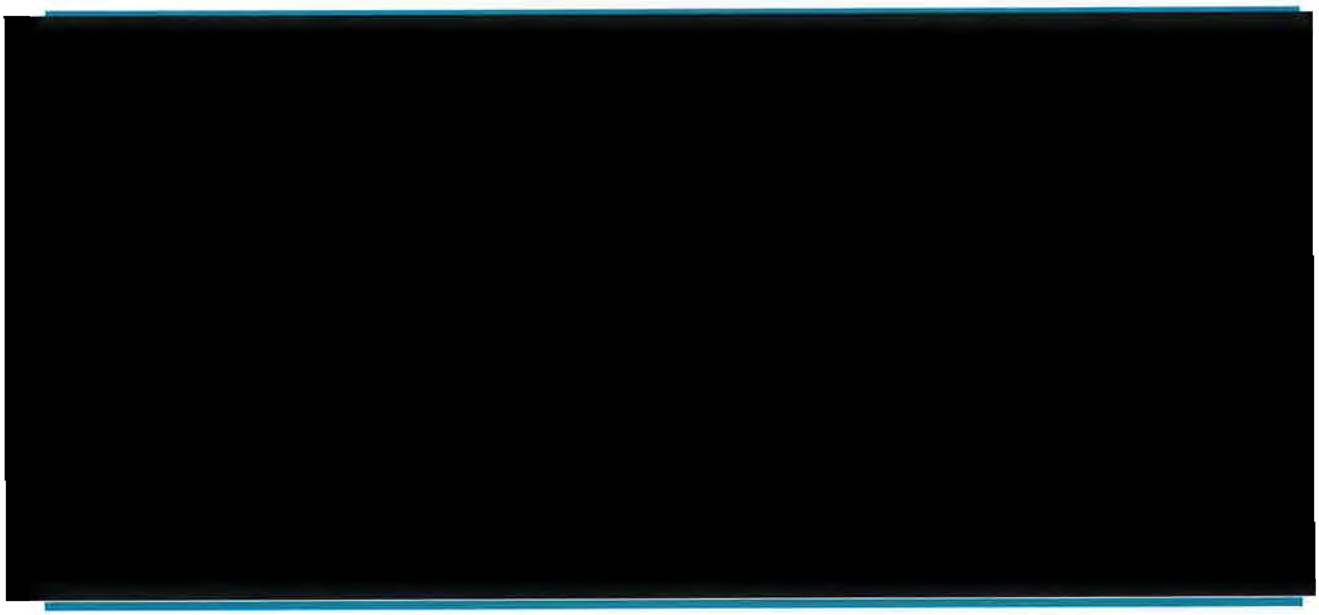


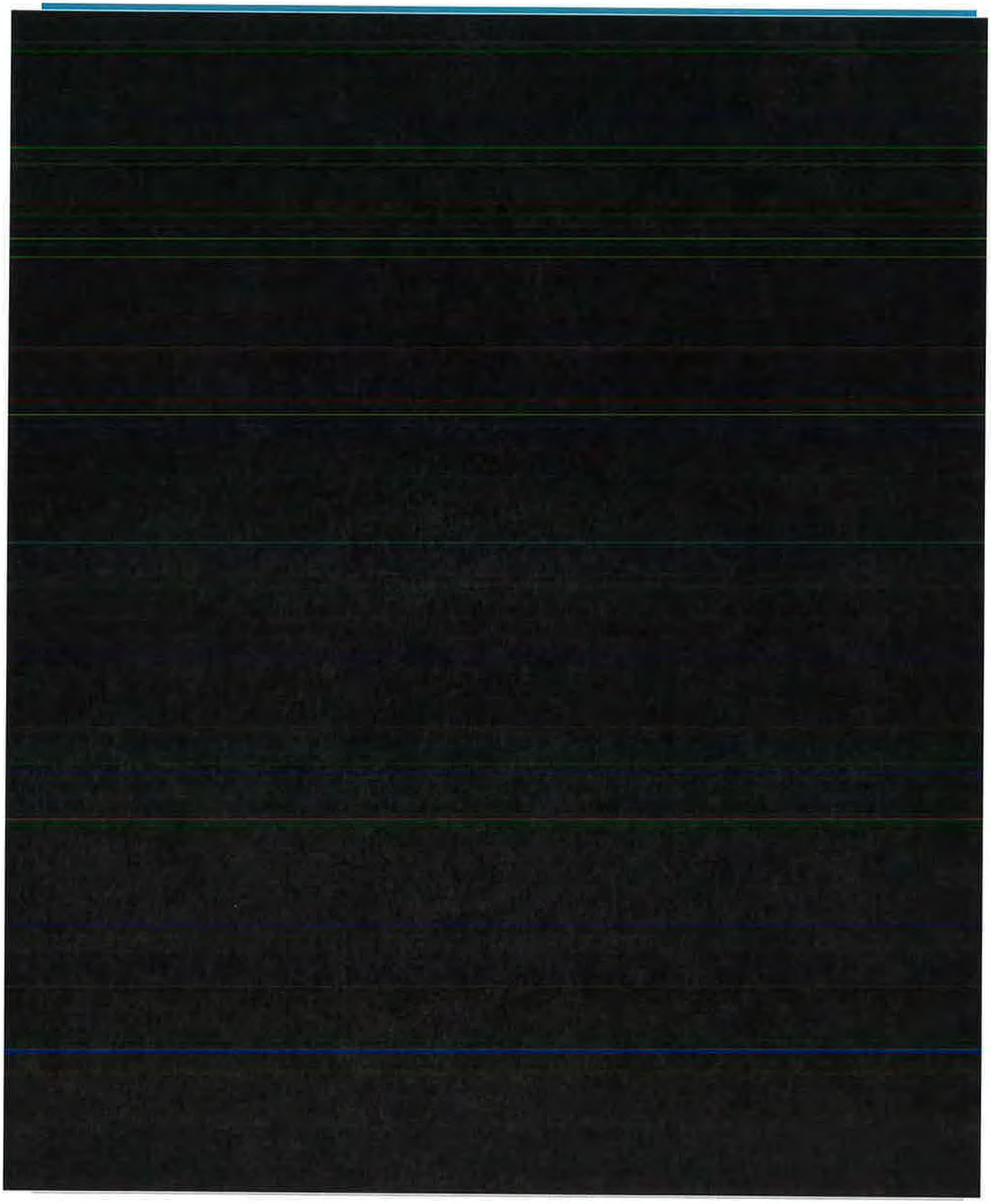


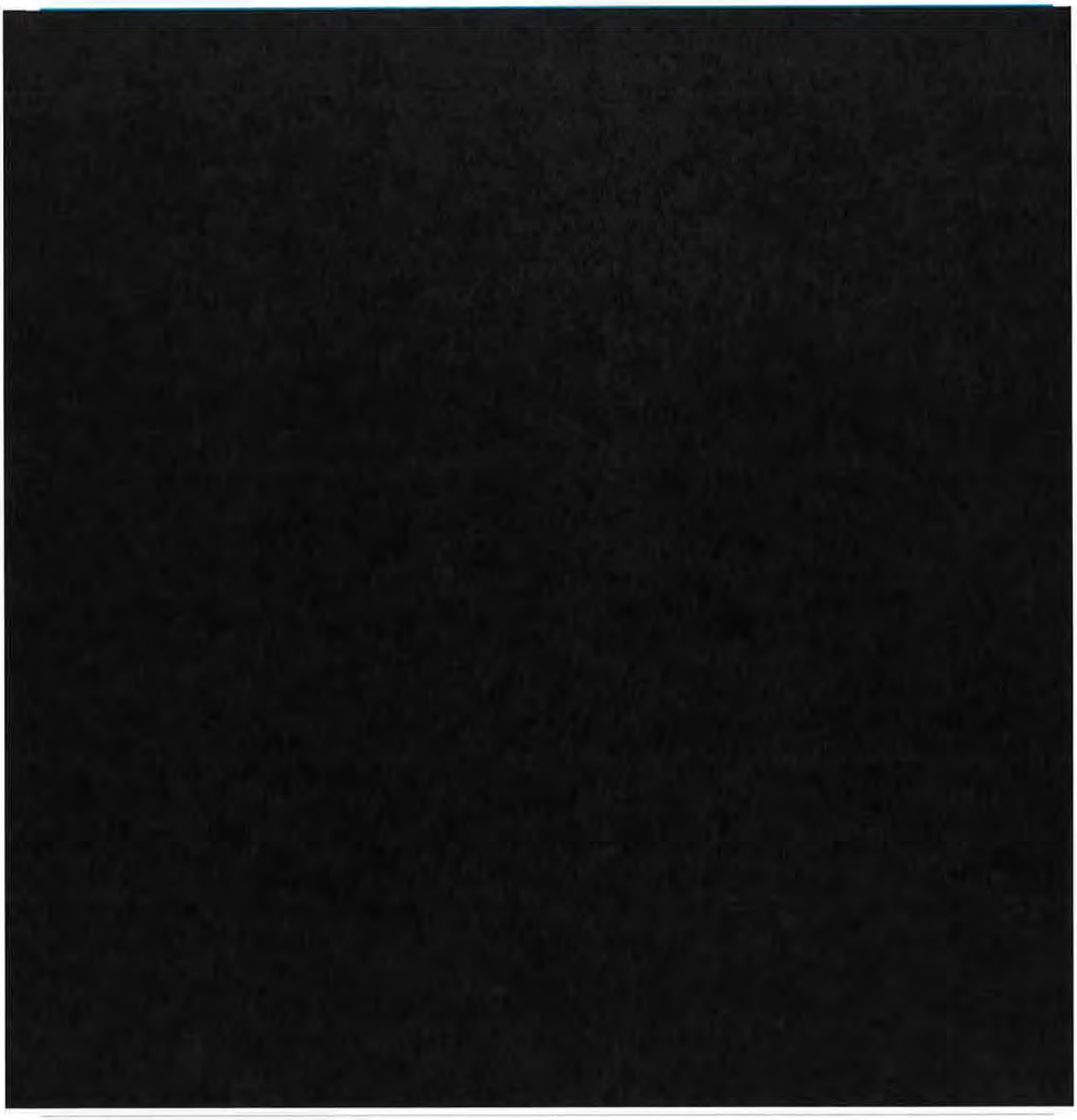


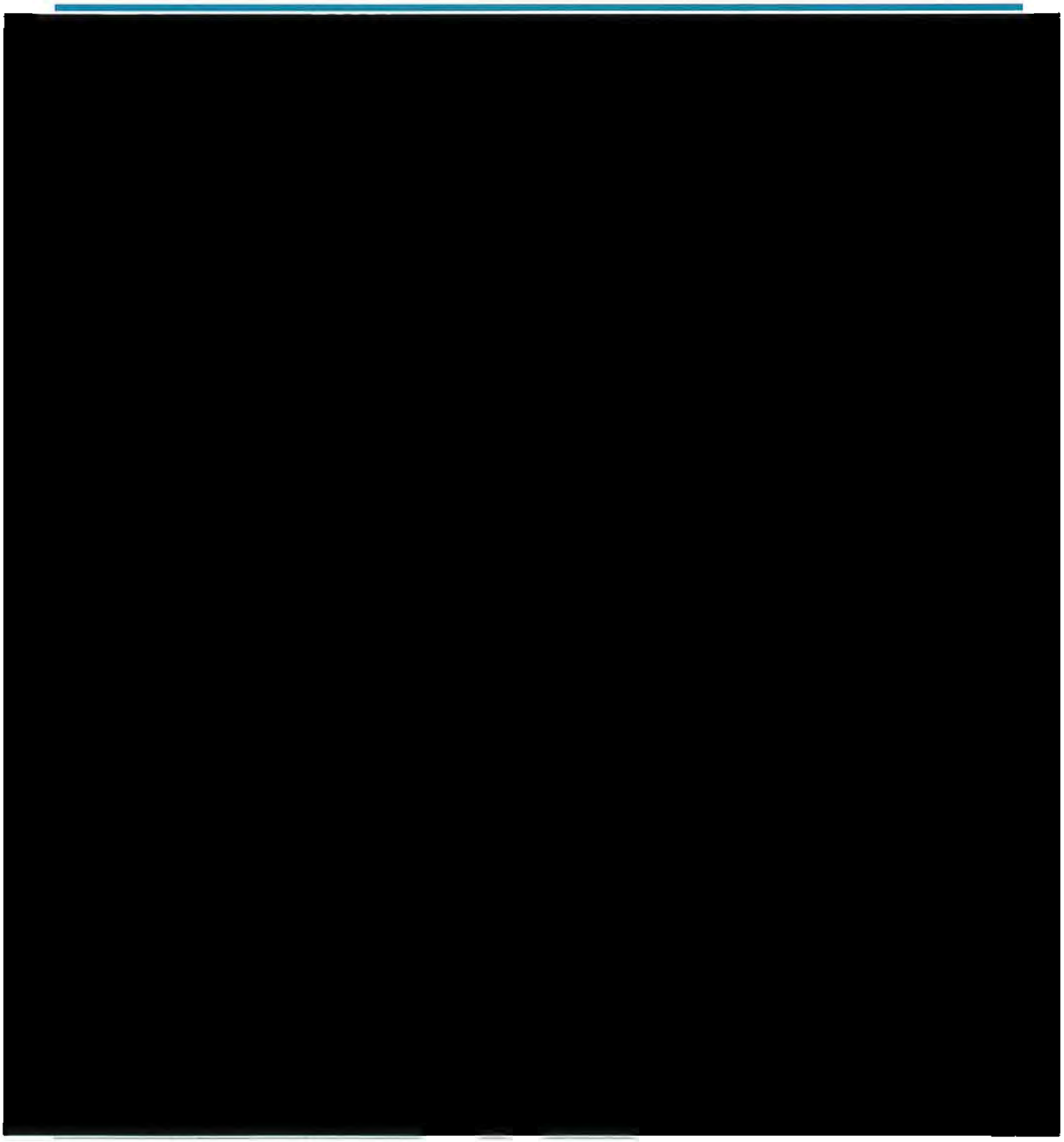


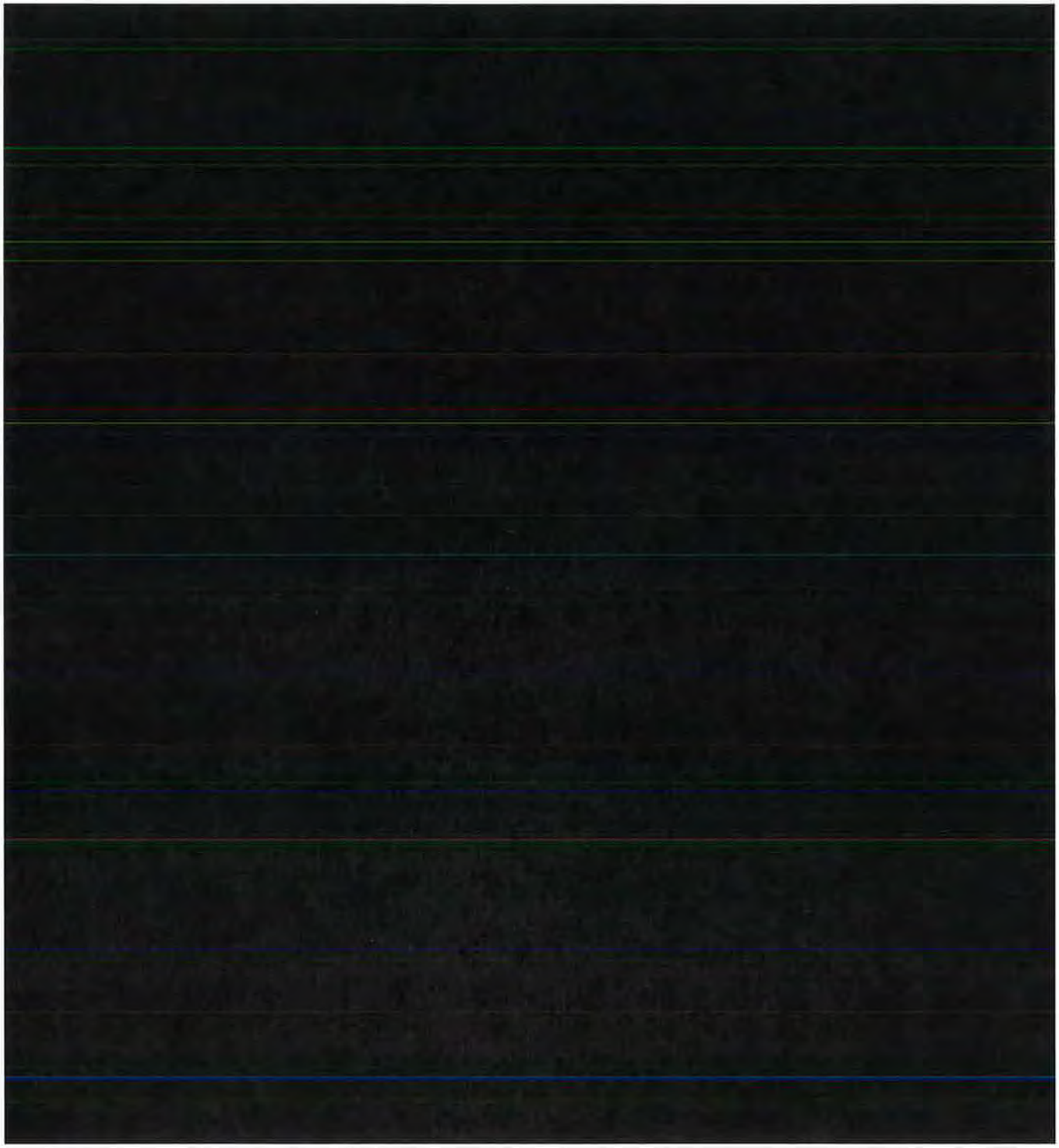


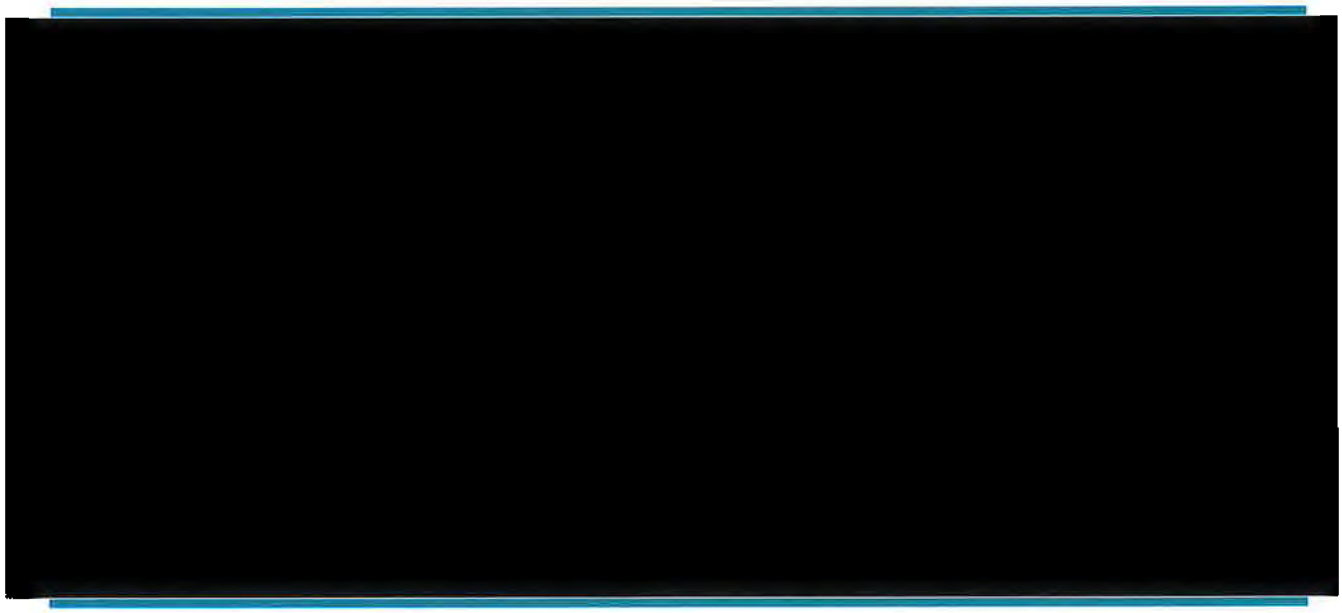


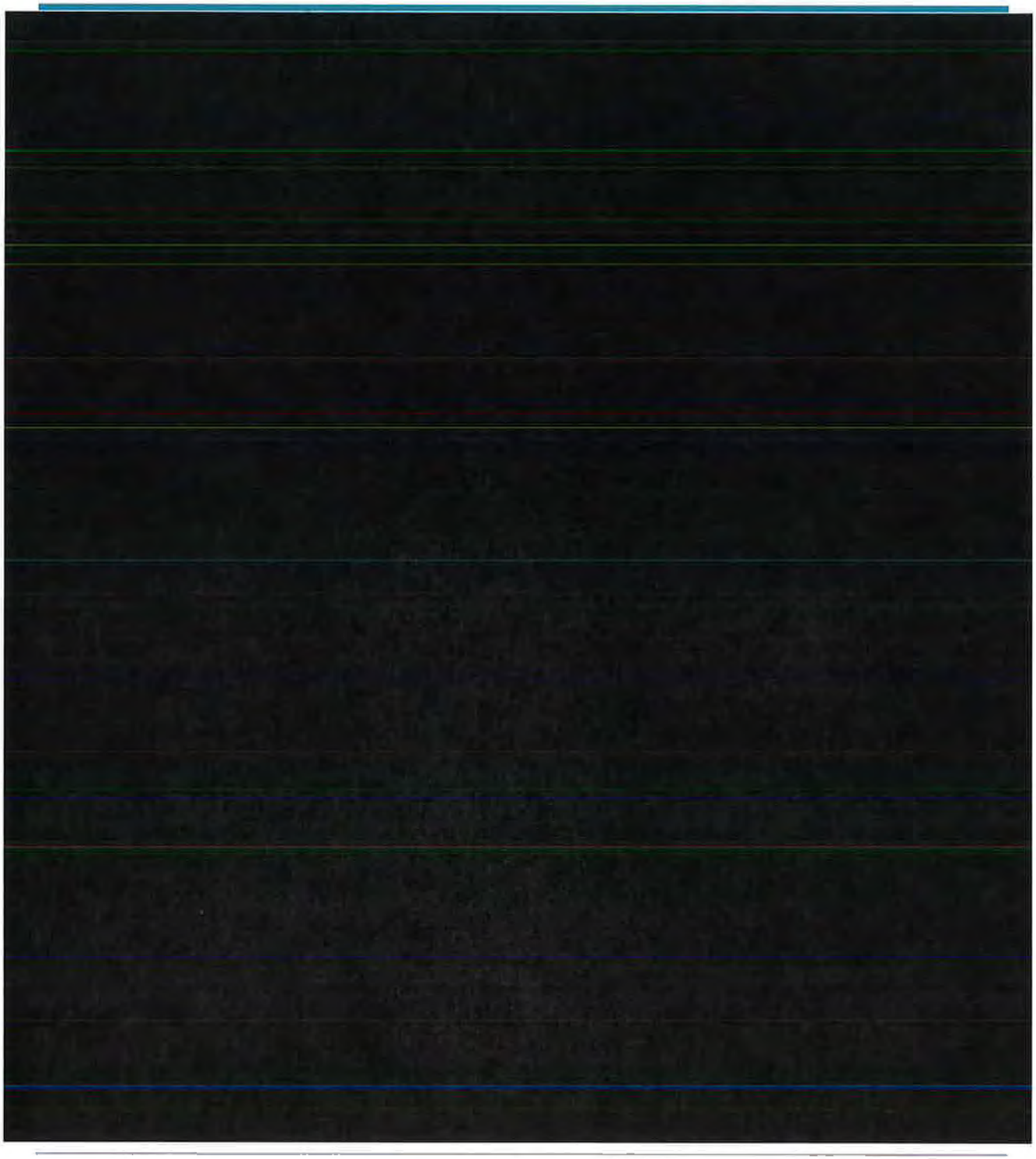


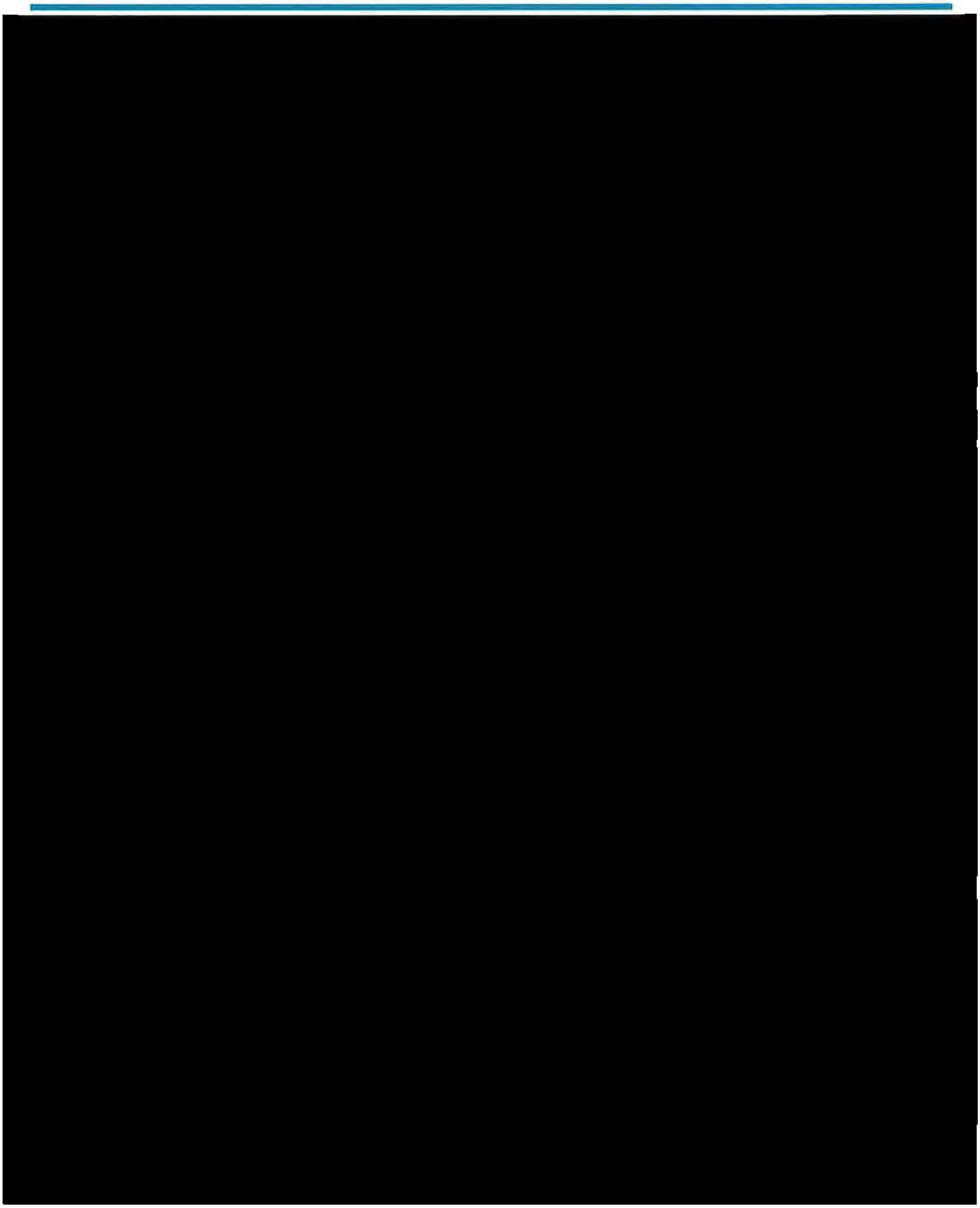


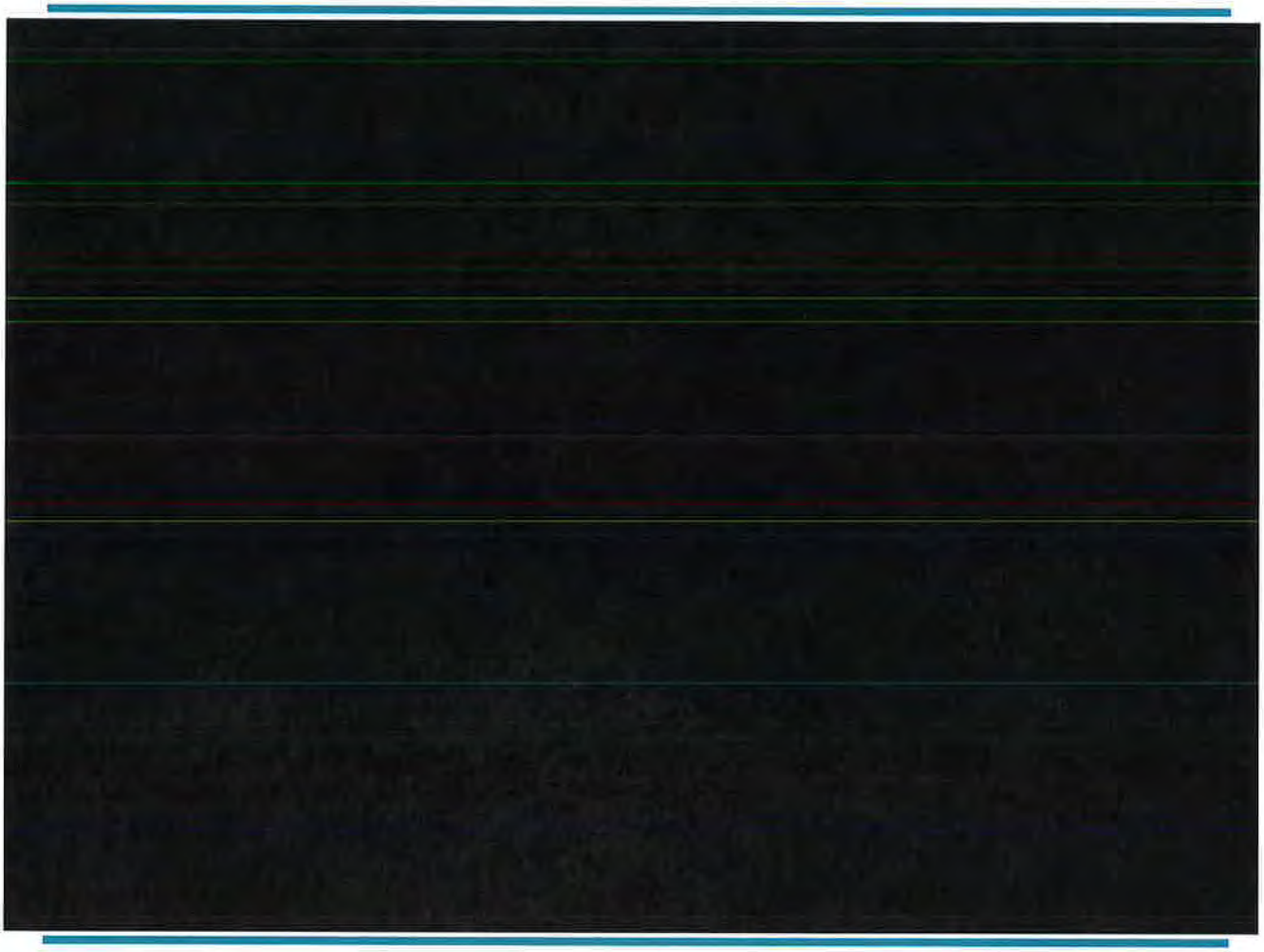


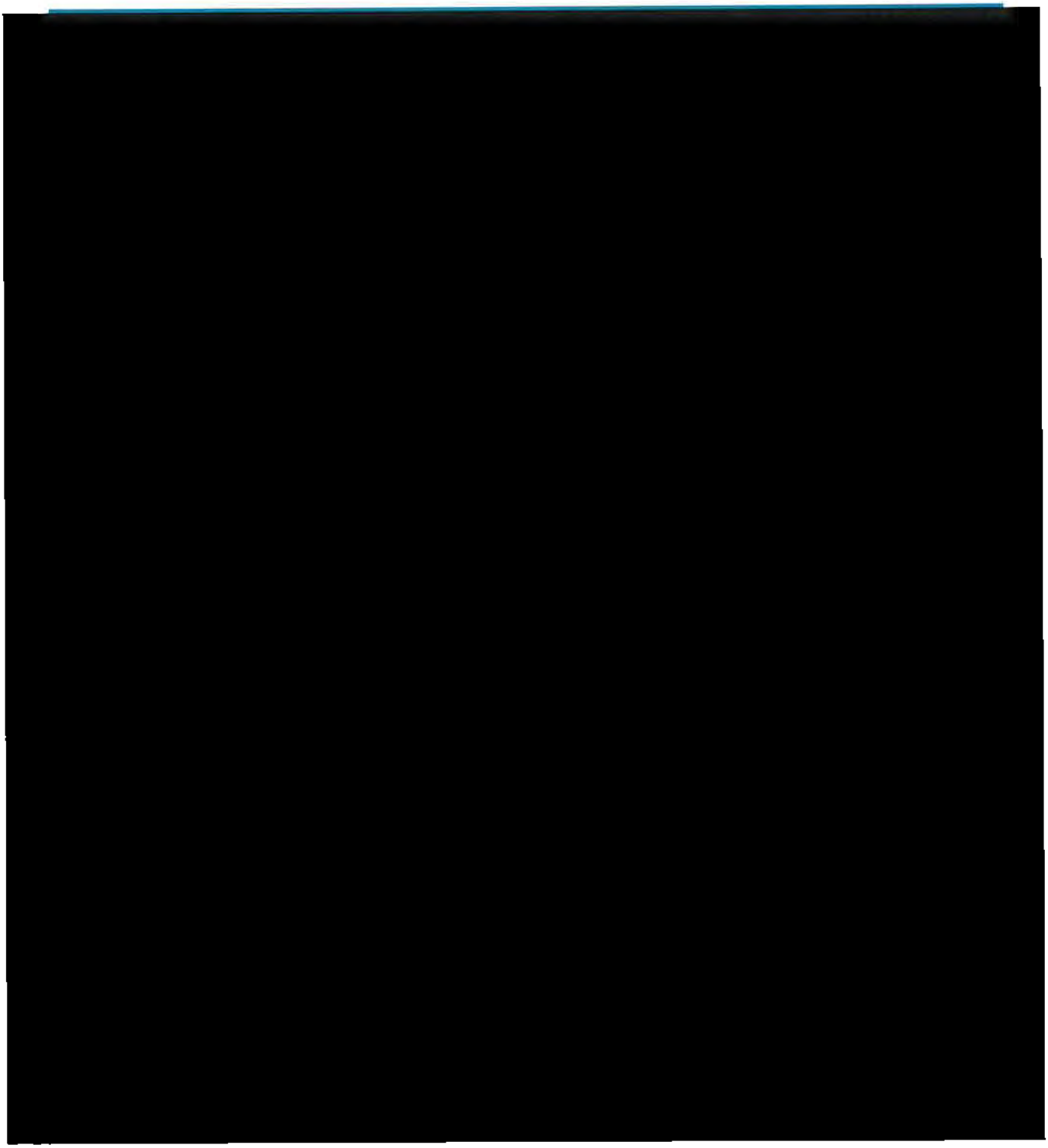


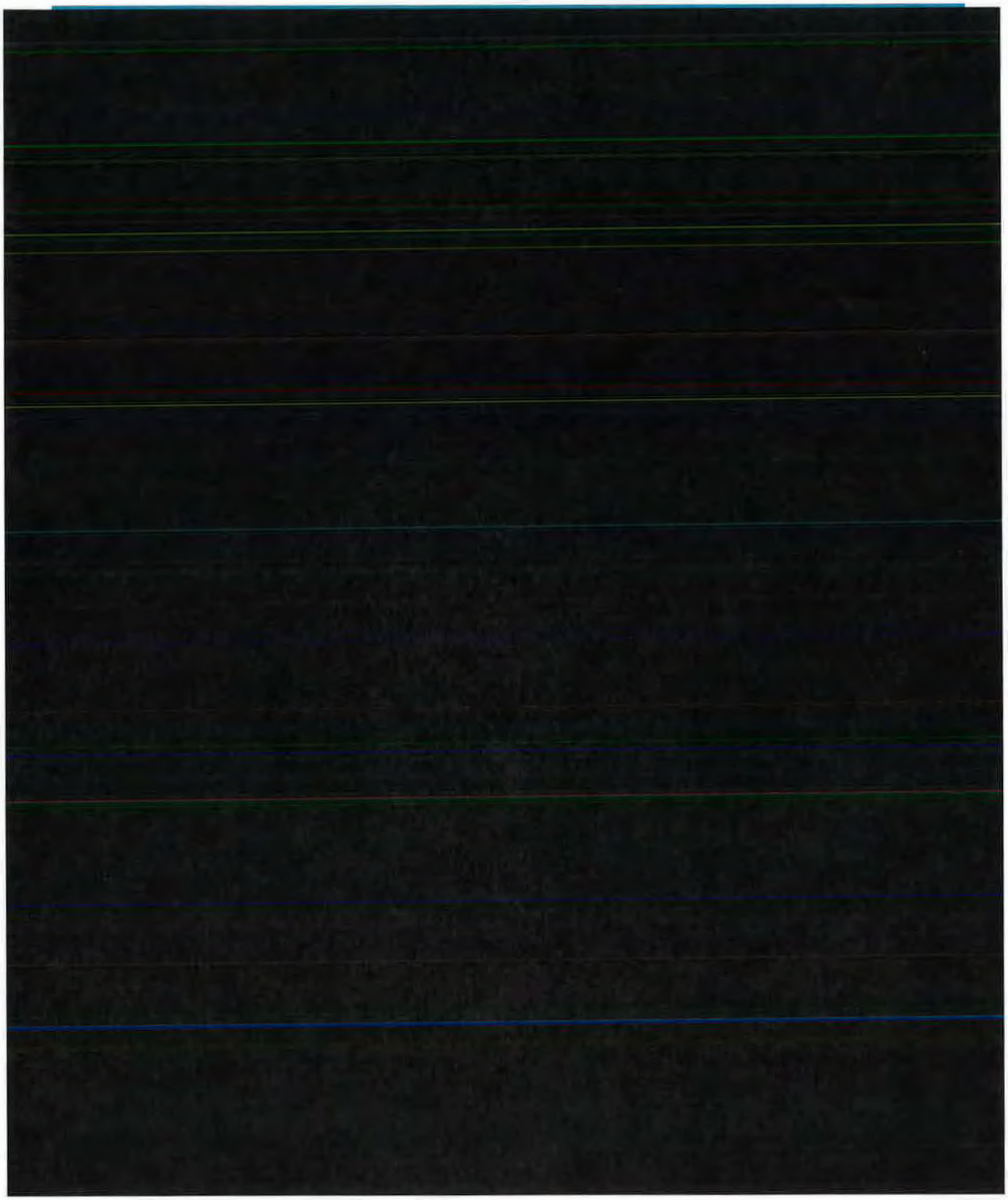


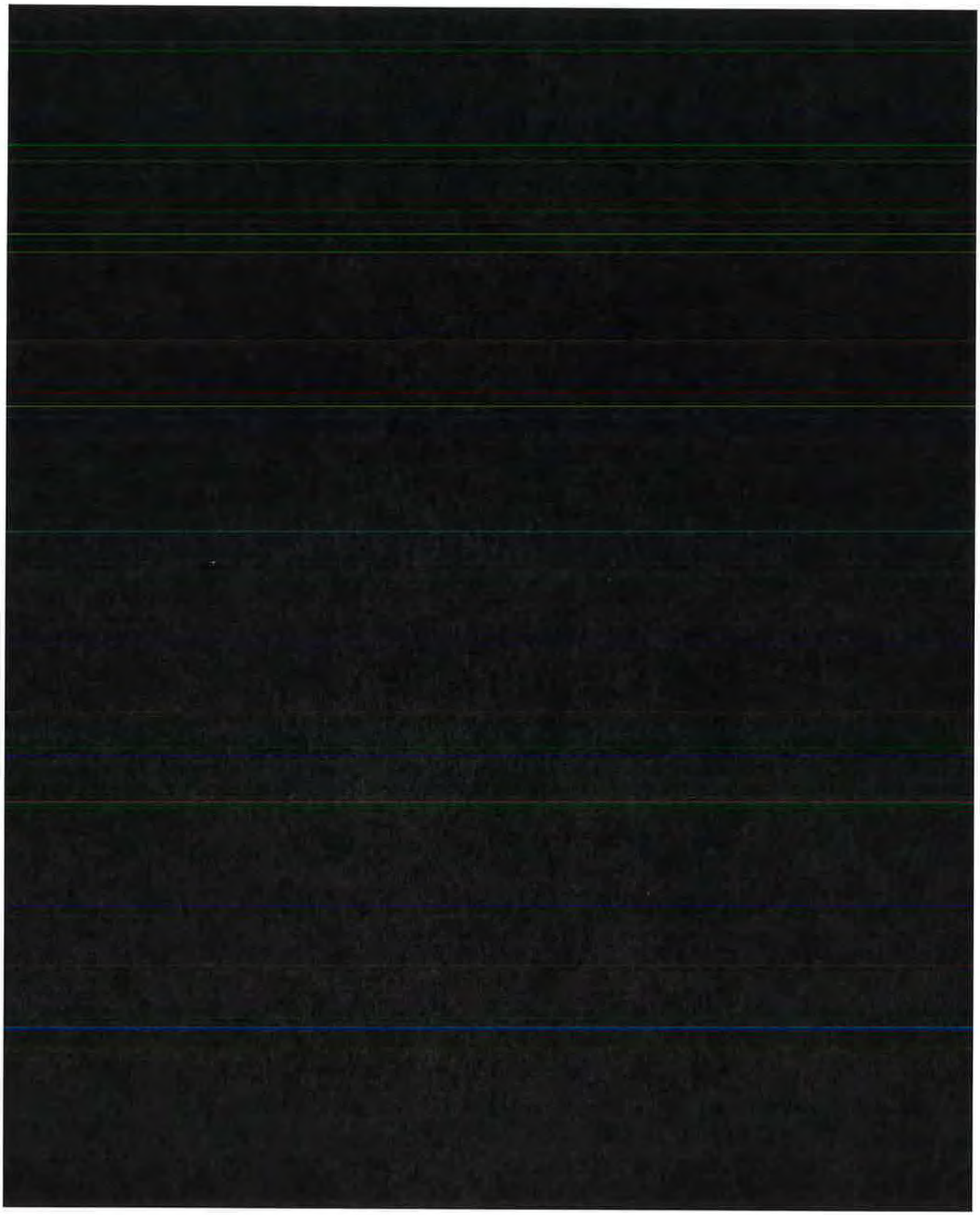












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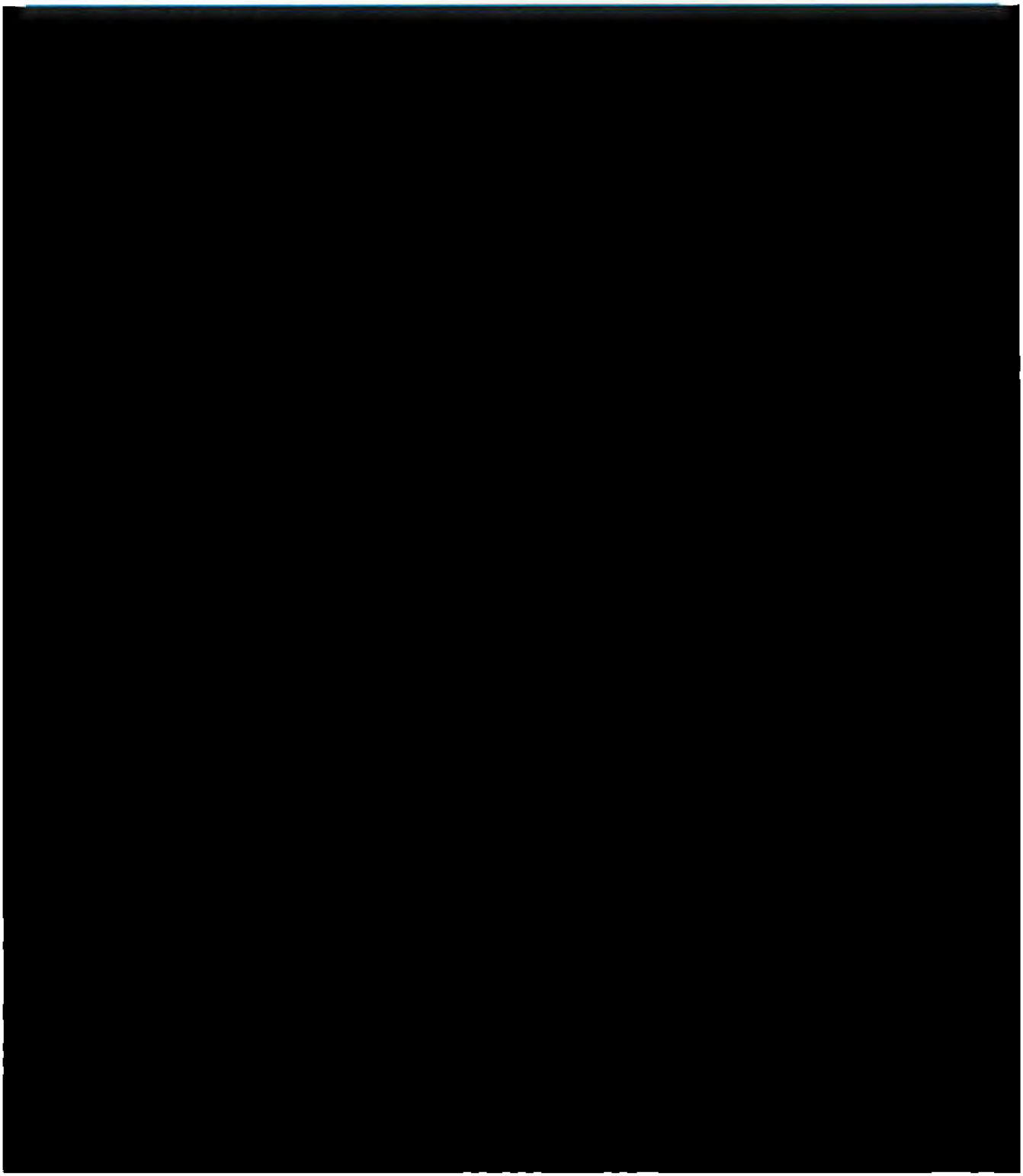

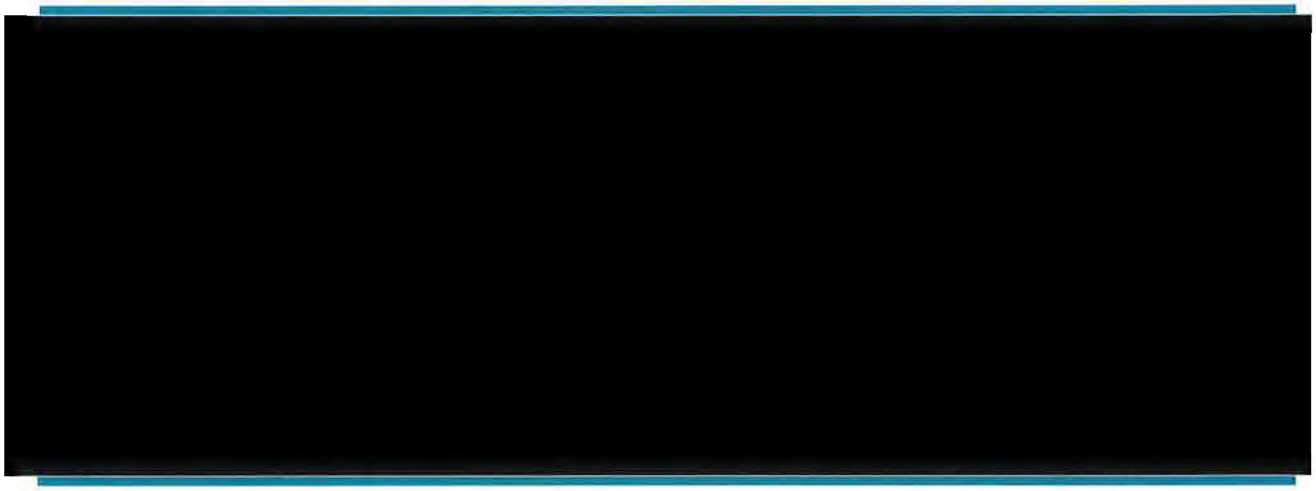

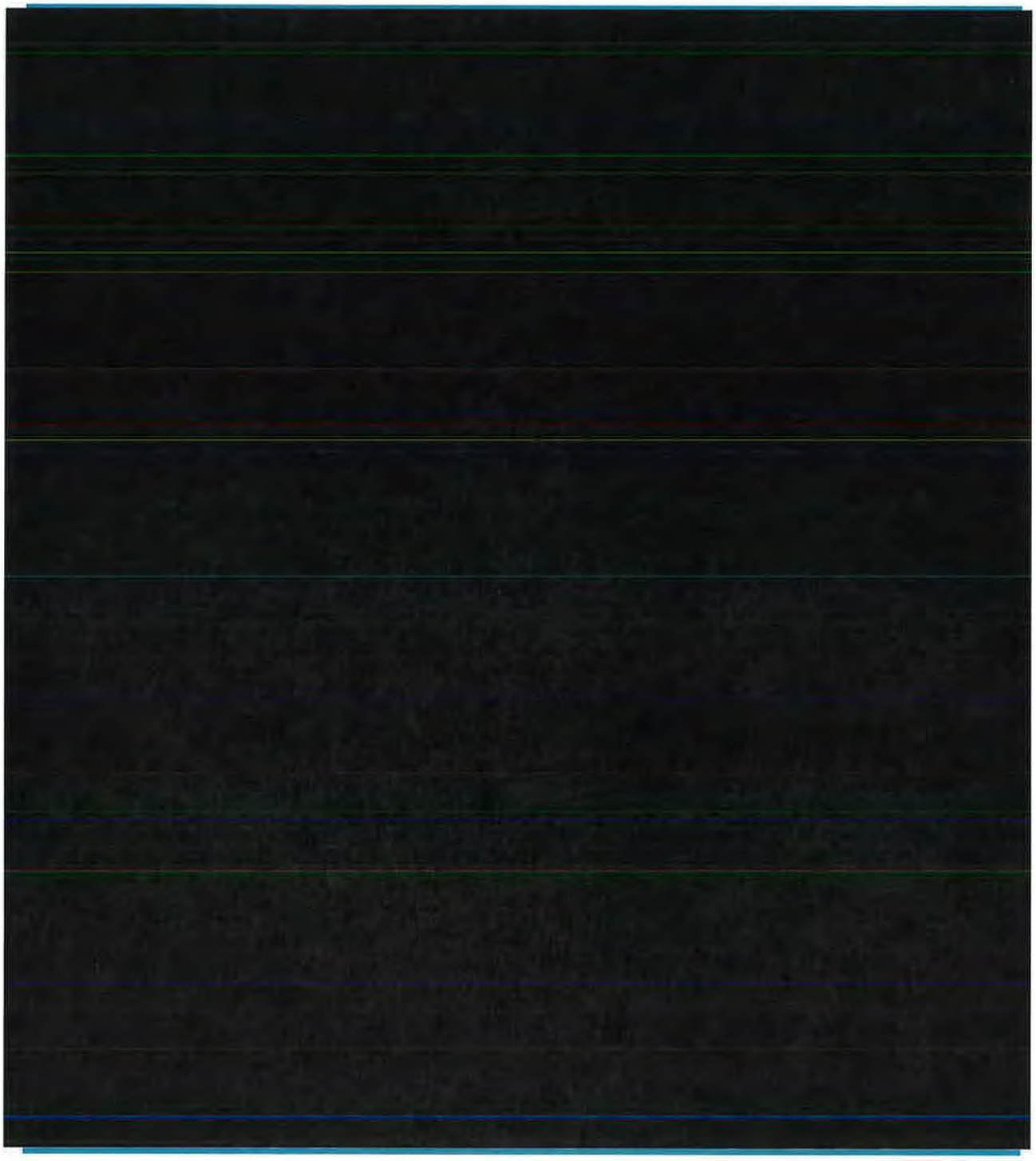

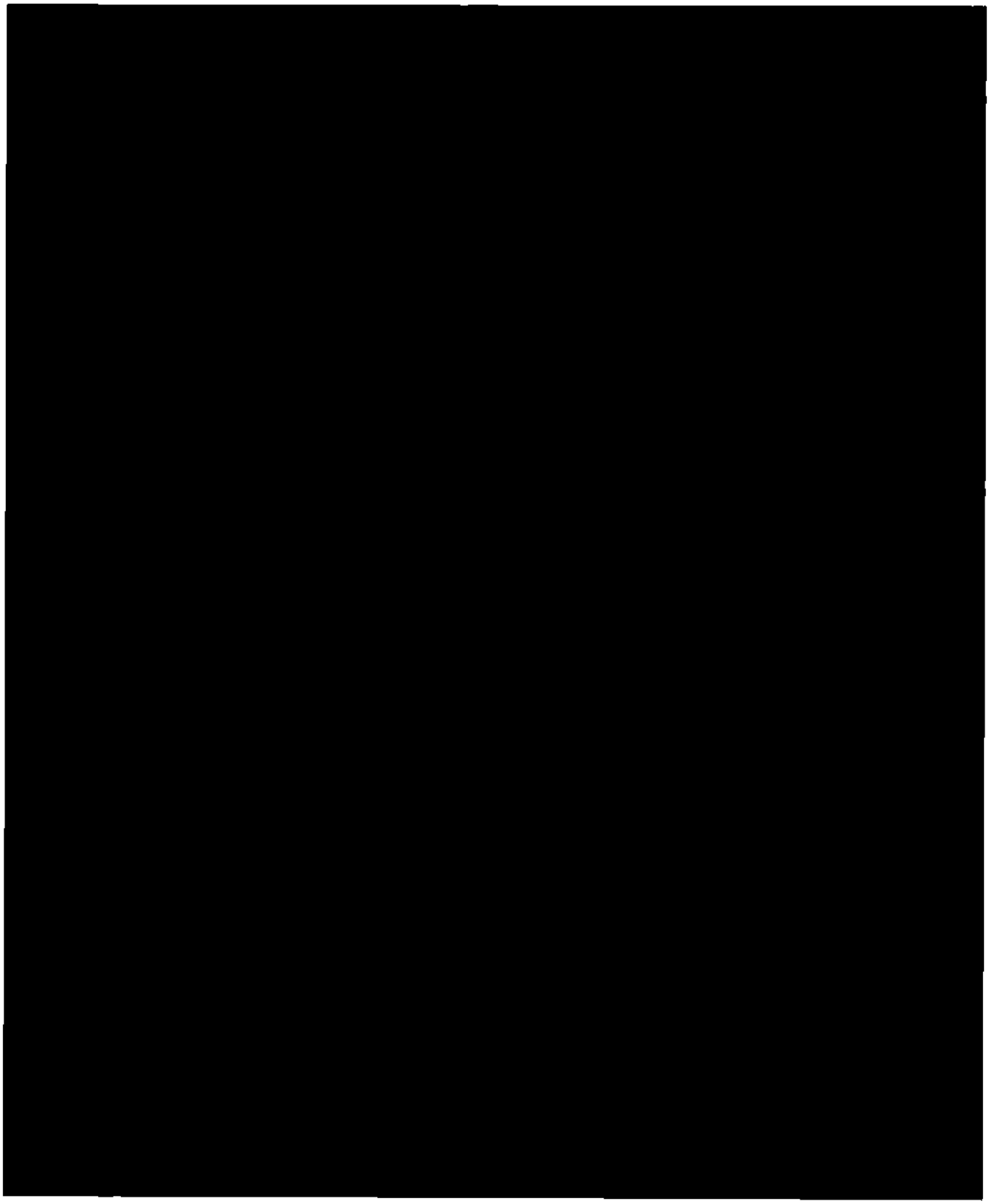

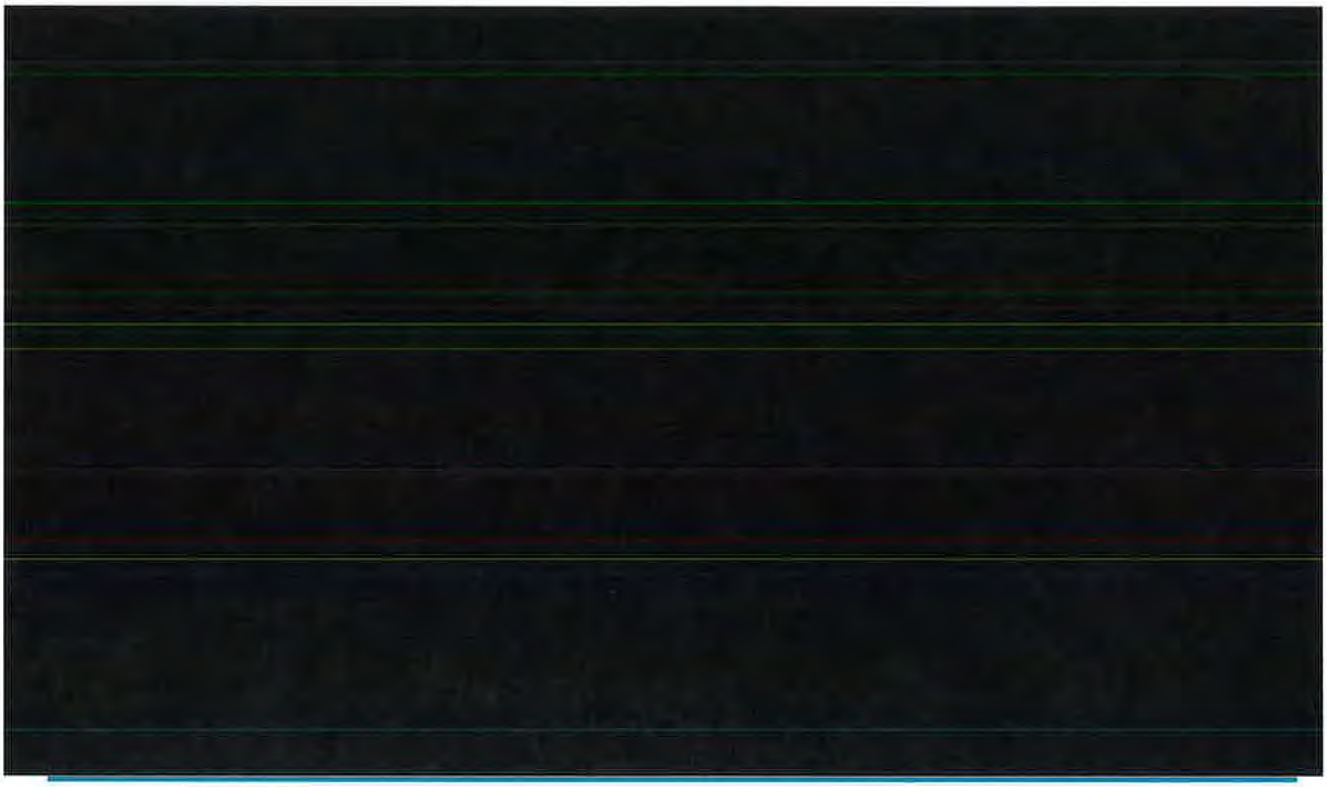

Bios for Subject Matter Advisors

[redacted]

[redacted]

J: Project Planning and Management

RFP Reference: Section VI.A.2.j, Page 31

Per the requirements of the RFP, Deloitte confirms that the Deloitte team will be led by Tim FitzPatrick, ASA, MAAA, a credentialed actuary with over 15 years of relevant health actuarial experience, and over 10 years' experience serving public sector clients. As documented further in Tim's resume, Tim meets the minimum education requirements and has supported Medicaid managed care programs of similar size of Nebraska.

Additionally, Deloitte confirms that each task lead shown in our organizational chart in Section 2.I has at least five years' experience in the tasks they are assigned. Additional supporting staff will be leveraged, as necessary, to support our leadership team.

K: Subcontractors

RFP Reference: Section VI.A.2.k, Page 32

Deloitte intends to use one subcontractor for this project, Airam Actuarial Consulting, LLC.

Airam Actuarial Consulting, LLC

RFP Requirement	Deloitte's Response
Subcontractor Name	Airam Actuarial Consulting, LLC
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Figure 2-15. Subcontractor Information.

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Section 3 :
Technical Approach

Technical Approach

Section 3

RFP Reference: Section VI.A.3, Page 32

Following is our response to all RFP Section VI, Technical Approach, requirements.

Our Understanding

We understand the DHHS is looking to transform their organization into a data and analytics-driven organization that makes sound decisions based on high quality and consistent information. Rate setting is another prime example of this vision to use data to make better decisions and analyze the effectiveness of program policy. With the use of standardized and consistent data collected through DMA and across DHHS, the Department can make the most effective use of existing investments, while also using data to make the most informed decisions about rate development, payment reform, and program policy.

Our team's approach to supporting the DHHS takes into consideration the current challenges Medicaid programs and the health care market face and your program goals of reducing of cost, increasing access to quality services, and informing decisions through the use of analytics with efforts like DMA.

SECTION HIGHLIGHTS

Our implementation plan delivers:

- Approaches founded upon our breadth of actuarial, policy, and financial experiences across the marketplace, and hands-on knowledge supporting the DHHS Data Management and Analytics (DMA) engagement
- Data-driven insights to support value based payment initiatives for Medicaid reimbursement
- Bench capacity to address the RFP services required by the DHHS
- A team committed to delivering innovative methods and ideas for the complex issues facing DHHS
- Our experience capturing, cleansing, standardizing, and consolidating your Medicaid program data

We are at the forefront of managed care innovation such as value based payment methodologies, data analytics, and data visualizations, and consumerism to support the DHHS' needs. We are able to leverage our experience with your staff, data, and systems through the DMA project in order to make the most efficient use of your staff time and deliver this work for you in a timely and cost-efficient manner. With the data cleansing work being done through DMA, the tools our projects collectively bring to you, our understanding of your staff time commitments, and the knowledge we have gained of your current claims and encounters interfaces, we can deliver to DHHS the greatest benefit in the rate setting project.

"I am very excited to have the opportunity to work with the State of Nebraska. As your Lead Client Executive for this engagement, I bring over 15 years of health and Medicaid actuarial experience working with states, the federal government, and health plans across the nation."

Tim FitzPatrick, ASA, MAAA
Project Executive

Project Description and Scope of Work
Section 3.V

RFP Reference: Section V, Page 24

The bidder should provide the following information in response to this RFP

Following is our response to all RFP Section V, Project Description and Scope of Work, requirements. Within our response, we summarize our understanding of the project requirements, our proposed approach, technical considerations, work plans, and anticipated deliverables and due dates.

3.V.A: Project Overview

RFP Reference: Section V.A, Page 24

Deloitte confirms that the RFP is requesting actuarial and consulting services in support of Nebraska's Medicaid managed care program and other services. Our actuarial services will follow the applicable actuarial standards of practice, CMS' rate setting managed care rate development guide, and the requirements of CFR 438. Our approach will incorporate methods and tools that can be readily replicated across programs and initiatives.

3.V.B: Project Environment

RFP Reference: Section V.B, Page 24

Deloitte understands the scope of this project will support the following managed care delivery systems:

- **Heritage Health Managed Care Program** – which incorporates an integrated package of physical health, behavioral health, and pharmacy services through managed care organizations.
- **Dental Managed Care Program** – which provides dental services through a single, statewide dental benefits manager.
- **PACE** – which provides comprehensive coordinated long-term services and supports benefits to dually eligible Medicaid and Medicare beneficiaries

We also understand if the Department elects to implement a long-term care managed care program, those services will be conducted under SOW 8 – Special Projects.

3.V.C: Scope of Work

RFP Reference: Section V.C, Page 25

We understand the DHHS is seeking a partner to provide actuarial and consulting services across 12 core tasks, some with corresponding sub-tasks. We believe it is in DHHS' best interest to perform this work with a vendor who is already providing extensive data cleansing and standardization for your FFS claims and encounters through DMA, who better understands the current incongruences of your data and your vision for its consolidation and analysis. In fact, this rate setting project is a logical progression of the goals for DMA by providing another outlet where timely and accurate data will allow DHHS to make sound decisions for the Medicaid program based on data-backed analysis.

Our approach is derived to meet the tasks that support the needs of the DHHS and the populations you serve. We are equipped with the appropriate, dedicated resources to effectively and efficiently meet the requested services and the staff needed to complete those tasks.

Deloitte's approach to RFP tasks:

- Offers flexibility in addressing the DHHS' evolving needs
- Incorporates our experience supporting other state Medicaid agencies
- Provides sound rate development in compliance with actuarial standards of practice
- Incorporates innovative thinking to support reimbursement transformation and value based payment principles
- Leverages our existing understanding of your unique data challenges
- Limits re-work or new interface development by using DMA interfaces and historical data

Within our detailed approach to each task, we have further described the benefits we bring to the DHHS. The methodologies for rate setting, risk adjustment, financial monitoring, data analysis, reporting, and other DHHS tasks are repeatable across programs to provide the most efficient use of resources. We understand that while these methodologies are repeatable, there is uniqueness to each program and the populations served. Our proposed team brings the appropriate knowledge and experience to understand the specific considerations and approach differences by program.

For further information on our team's experience, please refer to our response in **Part 2 – Corporate Overview**. In addition, our proposed fees for these services are included under separate cover within our response to **Part 4 – Cost Proposal**.

Within this section we outline our approach to the RFP tasks as depicted in the figure that follows.

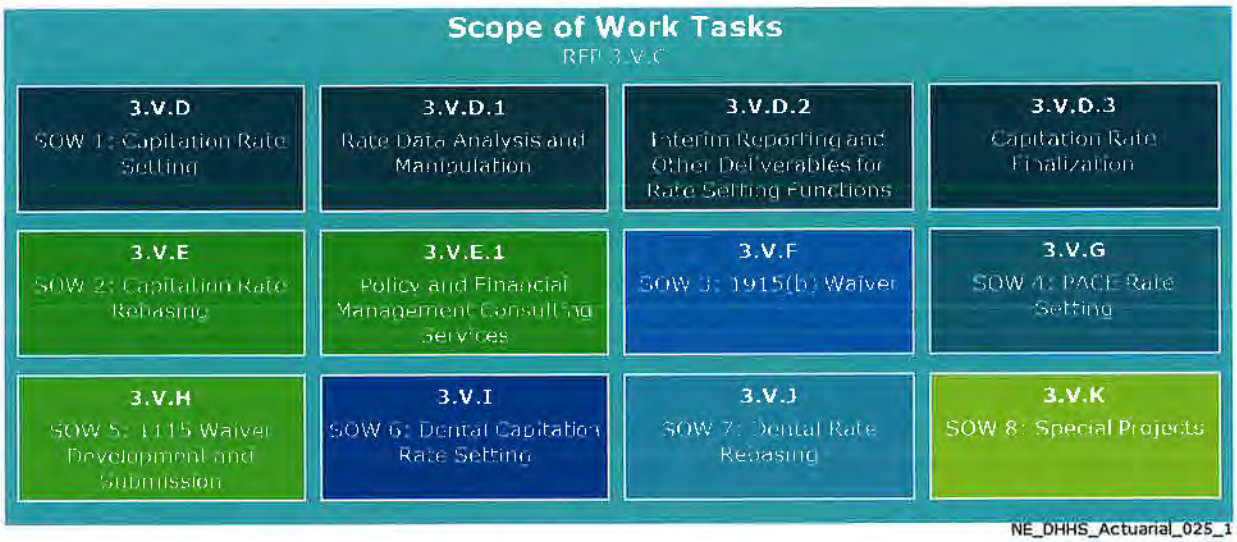


Figure 3-1. Technical Approach Core Tasks.

Deloitte Brings a Proven Approach to Core RFP Tasks

Deloitte recognizes that each task accomplishes critical initiatives to support the management of the Nebraska healthcare programs. Our team will be responsive to the challenges and drivers of the DHHS's vision and objectives. Deloitte approaches supporting the DHHS through clear processes that enhance data-driven decision making.

The following figure summarizes our key differentiators for each task.

Why Deloitte? Deloitte Team Delivers a Proven Approach to Core RFP Tasks

Task 3.V.D: SOW 1 - Capitation Rate Setting

- The Deloitte team implements a comprehensive and actuarially sound process for developing capitation rates
- Our team focuses on unique process components that may be required by program
- Our methodology is stepwise to include the DHHS in each component
- The Deloitte team's rate development approach incorporates reimbursement transformation requirements and value-based payment principles

Task 3.V.D.1: Rate Data Analysis and Manipulation

- We focus on data quality and use tools and techniques to identify opportunities for data improvements, including the opportunity to leverage our DMA analytics and data visualization capabilities to support decision making
- We leverage our analytical capabilities to review and analyze program trends, develop cost profile patterns, review MCO performance, and develop rate adjustments

Task 3.V.D.2: Interim Reporting and Other Deliverables for Rate Setting Functions

- Our documentation structure clearly describes our rate setting process to the DHHS and applicable parties
- Our team leverages proven communication techniques and software to support staff trainings, online webinars, computer-based trainings, and stakeholder discussions
- Our customized project management framework is tailored to meet the DHHS communication requirements and work closely with DHHS stakeholders to monitor and communicate progress on RFP tasks

Why Deloitte? Deloitte Team Delivers a Proven Approach to Core RFP Tasks

Task 3.V.D.3: Capitation Rate Finalization

- The final capitation rates will encompass our thorough rate development progress, program and market considerations, and DHHS objectives, in compliance with actuarial standards of practice
- We deliver a thorough documentation process in compliance with the protocols prescribed by the American Academy of Actuaries, applicable actuarial standards of practice, and DHHS specifications
- We leverage communication techniques and software to support stakeholder discussions, including MCO training, final rate discussions with CMS, and DHHS staff training

Task 3.V.E: SOW 2 – Capitation Rate Rebasing

- Focus on data quality and underlying credibility in selecting the most appropriate base data sets for the rebasing process
- Bring innovative ideas to the DHHS on new rate setting methodologies, including efficiency adjustments, rate cohort groupings, reimbursement methods
- We deliver a through documentation process in compliance with the protocols prescribed by the American Academy of Actuaries, applicable actuarial standards of practice, and DHHS specifications

Task 3.V.E.1: Policy and Financial Management Consulting Services

- Deloitte delivers a team with deep actuarial, policy, and financial experience in state reimbursement transformation methodologies and developing value based payment arrangements
- Our team brings a focus on Nebraska goals of achieving 50 percent of payment systems reimbursed through value based arrangements over the next five years
- Deliver leading data analytics, data visualizations, and data management to support decision making in alignment with the ongoing DMA initiative

Task 3.V.F: SOW 3 – 1915(b) Waiver

- Deloitte delivers a team with experience supporting waiver strategy, waiver development, and cost effectiveness calculations across a number of states
- Detailed approach in developing cost effectiveness calculations and supporting waiver documentation

Task 3.V.G: SOW 4 – Program of All-Inclusive Care for the Elderly (PACE) Rate Setting

- A comprehensive process that will reflect the specific needs of Nebraska's PACE program
- Useful insights on drivers affecting Nebraska's PACE UPL and capitation rates
- Proactive consideration of unique challenges and factors inherent in PACE rate setting as the State plans to transition LTSS benefits into managed care

Task 3.V.H: SOW 5 – 1115 Waiver Development and Submission

- Deloitte delivers a team with experience supporting waiver strategy, waiver development, and budget neutrality calculations across a number of states
- Deliver innovative ideas related to opioid use and substance use disorder services
- Detailed documentation to support budget neutrality calculations, including historical data development, without waiver and with waiver PMPM estimates

Task 3.V.I: SOW 6 – Dental Capitation Rate Setting

- The Deloitte team implements a comprehensive and actuarially sound process for developing capitation rates
- Our methodology is stepwise to include the DHHS in each component
- Incorporates the unique attributes of dental services

Why Deloitte? Deloitte Team Delivers a Proven Approach to Core RFP Tasks

Task 3.V.J: SOW 7 – Dental Capitation Rate Rebasing

- Focus on data quality and underlying credibility in selecting the most appropriate base data sets for the rebasing process
- Bring innovative ideas to the DHHS on new rate setting methodologies
- We deliver a through documentation process in compliance with the protocols prescribed by the American Academy of Actuaries, applicable actuarial standards of practice, and DHHS specifications

Task 3.V.K: SOW 8 – Special Projects

- Experienced team capable of scaling to meet the DHHS needs
- Deliver data analytics and appropriate documentation to support managed care procurement edits
- Innovative ideas to address encounter data challenges

Figure 3-2. Deloitte Team Delivers a Proven Approach to Core RFP Tasks.

Deloitte and our partners have provided health actuarial, advisory, and consulting services to states, health plans, and Federal agencies. We have highlighted examples of our experience throughout our response to the core RFP tasks. Our team has the tools, methodologies, and experience to support your RFP tasks.

Starting on the next page, we address our response to core Tasks 3.V.D. through 3.V.K., and the corresponding sub-tasks.

3.V.D: SOW1 – Capitation Rate Setting

RFP Reference: Section V.D, Page 25

Understanding of Project Requirements

SECTION HIGHLIGHTS

The Deloitte team's approach to capitation rate development includes:

- Implementing a comprehensive and actuarially sound process for developing capitation rates
- Our team's focus on unique process components that may be necessary for each DHHS program
- A proven methodology that is stepwise and includes the DHHS in each component
- Delivering a documentation structure that clearly lays out the rate setting process to the DHHS and applicable parties

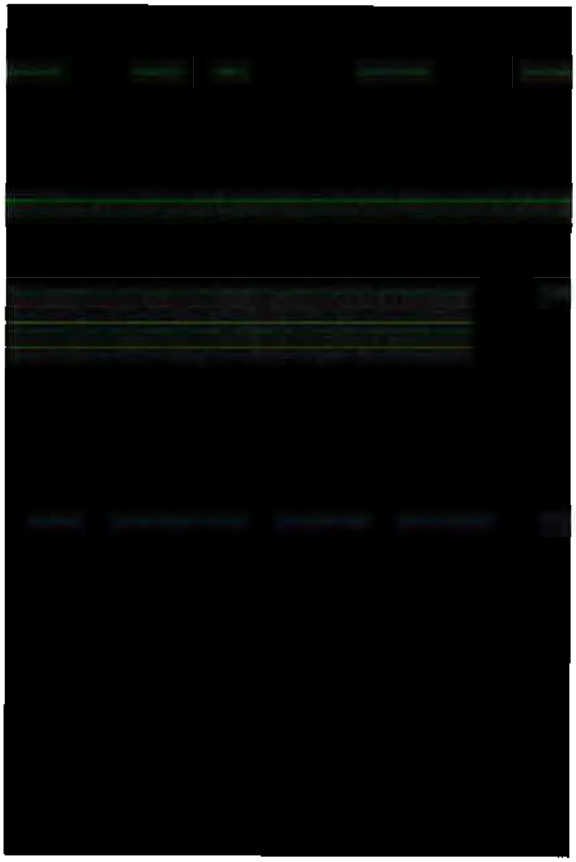
The Deloitte team is well qualified to assist the DHHS in the development of its actuarially sound rates and rate ranges, and to analyze pricing alternatives for risk adjustment and risk mitigation techniques. We bring in-depth knowledge of the rate setting process and hands-on experience with large Medicaid programs, including New York. Our rate setting methodology follows the documentation protocols laid out by the Academy of Actuaries, CMS certification requirements, and the DHHS specifications.

Our documentation includes assumptions, adjustments, and calculations made to arrive at the rates and provides a narrative description of each factor. For new adjustments such as recent changes made to Nebraska's Medicaid benefit package for new behavioral health services of multisystemic therapy (MST), family functional family therapy (FFT) or peer support services we will provide documentation through the process of implementing new services in the managed care rates to reflect the new benefits accurately.

We are prepared to provide required technical support to the DHHS, MCOs, PIHPs and other interested stakeholders. Our support encompasses rate development, data analysis, participation in rate meetings, providing technical support for rate negotiations, and technical discussions around emerging rate issues such as trend development, programmatic changes, service utilization, and medical and administrative efficiency. As the vast majority of Nebraska's Medicaid population is now receiving care through Heritage Health managed care, it is increasingly important that we collaborate across interested stakeholders in Nebraska throughout the rate setting process.

Aided by our ongoing DMA initiative, our advanced analytic techniques provide the targeted analytics that enable the DHHS to make informed decisions about its program's future. We are at the forefront of assisting our clients with integrating innovative solutions such as value based payments to better align managed care programs to the future of health care administration. These innovations can help increase program efficiency, improve program quality, and better manage program costs as the statewide managed care program continues to mature.

Proposed Development Approach



The Deloitte team develops actuarially sound rates and rate ranges following the applicable actuarial standards of practice, CMS' rate setting managed care rate development guide, and the requirements of CFR 438. We calculate rates for all managed care cohorts and any applicable geographic regions. We will thoroughly review with the DHHS rate calculations and rate methodologies to provide a complete understanding of the base data used, the adjustments made, and assumptions applied. Premium efficiency and/or medical management adjustments are discussed in detail with the DHHS prior to application.

We discuss risk mitigation approaches and reinsurance arrangements with the DHHS as part of our processes to employ risk management assistance. We thoroughly document the base encounter and financial data, assumptions and adjustments in a detailed summary that breaks down cost and utilization information by program, geography, and category of service based on the goals of the DHHS.

We certify that the resulting rates are actuarially sound under CFR 438, the Federal regulation covering capitation rates, and provide analytic support during negotiations with CMS, as needed. Our team's experience supporting other state programs such as New York, as well as CMS, provides the DHHS and its stakeholders with the confidence in our processes, models, methodologies, and, ultimately, the rates.

A detailed description of our rate setting process is found in **Section 3.V.D.a** below.

The following table summarizes our high-level understanding of the subtasks. Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

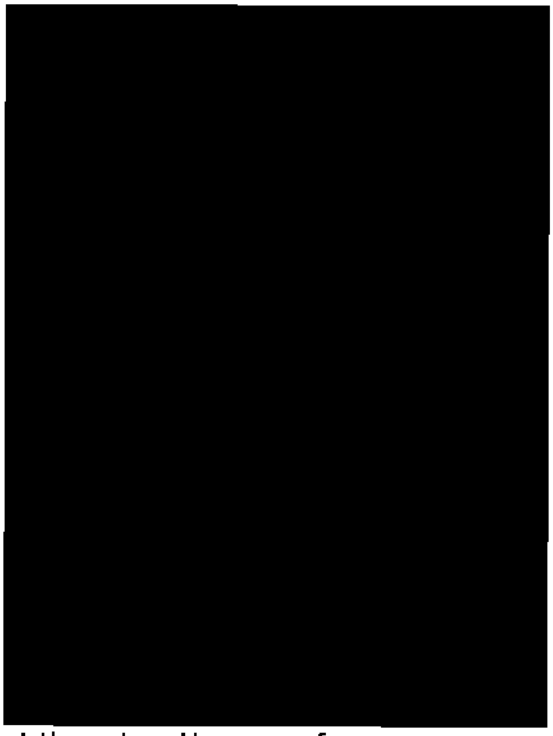
Subtask	The Deloitte team's Understanding of the Subtasks
3.V.D.a	Utilize capitation rate methodology to develop capitation rates for the DHHS program
3.V.D.b	Develop rates based on the defining characteristics of each managed care cohort
3.V.D.c	Assist in the risk adjustment methodology applicable for the given DHHS program
3.V.D.d	Calculate actuarially sound capitation rate range bounds

Figure 3-3. Task 3.V.D Subtasks.

Technical Considerations

While our team is responsible for updating the actuarial capitation rates and rate ranges for each period, there are key items we collaborate with DHHS to collect in the rate setting process including:

Base Data for Rate Setting



Deloitte works with DHHS and our DMA team to collect the necessary base data items for rate setting. This data collection includes financial reports, eligibility data, encounter data, historical FFS data, data dictionaries, methodology to analyze categories of services, cohorts, covered populations and other key items to analyze base data. Deloitte reviews base data items for reasonability. This review includes comparison of financial data to encounter data to determine encounter data completeness and comparison of emerging managed care data to FFS data for populations and services that have recently moved to managed care.

The State of Nebraska has a very mature physical health managed care program as these services have been covered in managed care since 1995. For these services that have been long-standing in the state's managed care program, we utilize managed care encounter data and/or plan submitted financial data to set the rates. However, for newer services such as behavioral health services that have recently been added to the state's benefit package, as credible emerging managed care experience may not be yet available for the entire benefit package covered by the state, we may leverage additional data sources such as FFS data to utilize a credible data source in the rate setting process.

As outlined in the new managed care regulations, CMS requires states and their actuaries to analyze the most recent three years of data available when developing managed care capitation rates annually. Often times, only one or two years of data is selected as the base data and that is updated each year with the new actuarial certification. Through the data review process, we can coordinate with the DHHS on the appropriate base data sets to utilize for the rate setting process.

Additionally, through Deloitte's efforts on the DMA initiative, we understand there may be other challenges that arise in the data collection process. For example, the MMIS may not collect all of the 837 form base data submitted by the MCOs, and systems such as CONNECT and NFOCUS have not historically submitted all claims to the MMIS. These types of situations may impact the soundness of the underlying encounter data and are important items our team will work with DHHS and our DMA team members to resolve.

Data Security and Storage

In collecting the data, the Deloitte team treats all sensitive data, including Personal Health Information (PHI) in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations. As a result, we only collect the minimum amount of data necessary to complete the analysis. Where possible, risk can be mitigated by encrypting identifiers such as Claim ID and Member ID or by reducing the specificity of data (e.g., including the month and year of service rather than the day of service). We also have strict internal guidelines related to the collection and destruction of sensitive data. External data with sensitive information provided to Deloitte are required to be uploaded to our secure FTP.

After data is provided to our team via the secure FTP, the data is warehoused in our encrypted SQL server environment. The SQL server environment allows for team members to run queries on the large claim sets and eligibility records to gather insights on the State of Nebraska's Medicaid program. Additionally, the Deloitte team maintains highly secured access to its server infrastructure that employs industry-accepted procedures and tools that are designed to safeguard portions of the network and servers.

Where possible, data can be utilized directly through the DMA initiative to reduce state staff time in gathering the required data for rate setting. Additionally, the noted data security considerations above are an important aspect of the DMA effort and the work performed and processes implemented to date can be leveraged for the rate setting engagement.

Rate Setting Considerations

To develop the capitation rates and rate ranges, we work with DHHS to collect detailed background information used in the consideration of the rate setting approach for the program. Examples of this include model contracts, historical certifications and actuarial memorandums, risk sharing arrangements, MLR requirements, Stop-Loss documentation, historical payment rates, historical managed care efficiency adjustments, historical correspondence with CMS and rate presentations. Deloitte works with DHHS to collect the detailed documents for the state to provide an easy transition in developing the capitation rates in the upcoming rating year. The data discovery sessions done by the DMA team for items including data dictionaries, system documents, and financial reports, will aid as an accelerator to the rate setting team during this collection process.

Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Detailed Project Work Plan

We have been through this process before with many clients and are skilled at applying the nuances that contractors bring to the actuarial rate setting process. We also bring a deep understanding of the medical assistance and health care environments. We understand state and federal policies and have resources at our disposal to deepen our understanding of the unique circumstance of DHHS.

We will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval.

A high-level project timeline is included in Appendix 1. We will work closely with the DHHS in the beginning stages of the engagement to develop detailed work plans for each managed care program.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we may provide for the capitation rate setting effort. We will work closely with DHHS in the beginning stages of the engagement to develop the detailed work plan and deliverable due dates.

Deliverable	Our Understanding of Capitation Rate Setting Deliverables
Actuarially Sound Capitation Rate(s) and Rate Ranges	Using our Capitation Model, we calculate actuarially sound capitation rates that comply with CFR 438, the actuarial standards of practice, and the CMS rate development guide.
Data Book	Data book supporting the development of the capitation rates as needed for the applicable program
Actuarial memorandum, Actuarial certification and CMS rate guide index	Actuarial memorandum with detailed descriptions of how the rates were developed from base data, program changes, trend, non-medical loads, etc. An actuarial certification certifying the rates as actuarially sound. A detailed index for each item requested as documentation by CMS in the managed care rate development guide to expedite CMS' review of the capitation rate development.
Risk Adjustment Factors	MCO-level risk adjustment factors and the supporting documentation are produced using the appropriate risk adjustment software
Program Change Rate Impact	Leverage encounter data analytics to assess the effect on current program rates to understand the impact of program changes

Figure 3-4. Potential Deliverables for Capitation Rate Setting.

3.V.D.a – Capitation Rate Methodology Development and Determination

RFP Reference: Section V.D. a, Page 25

Developing actuarially sound capitation rates and rate ranges that meet the certification requirements of CFR 438, CMS' rate setting managed care rate development guide, the American Academy of Actuaries' (AAA) standards of practice and the DHHS's responsibilities requires a rigorous and tested process. The Deloitte team has developed a detailed process based on many years of experience working with state managed care programs which we will customize based on the DHHS's program requirements. Our proposed rate setting process is outlined in the following figure.

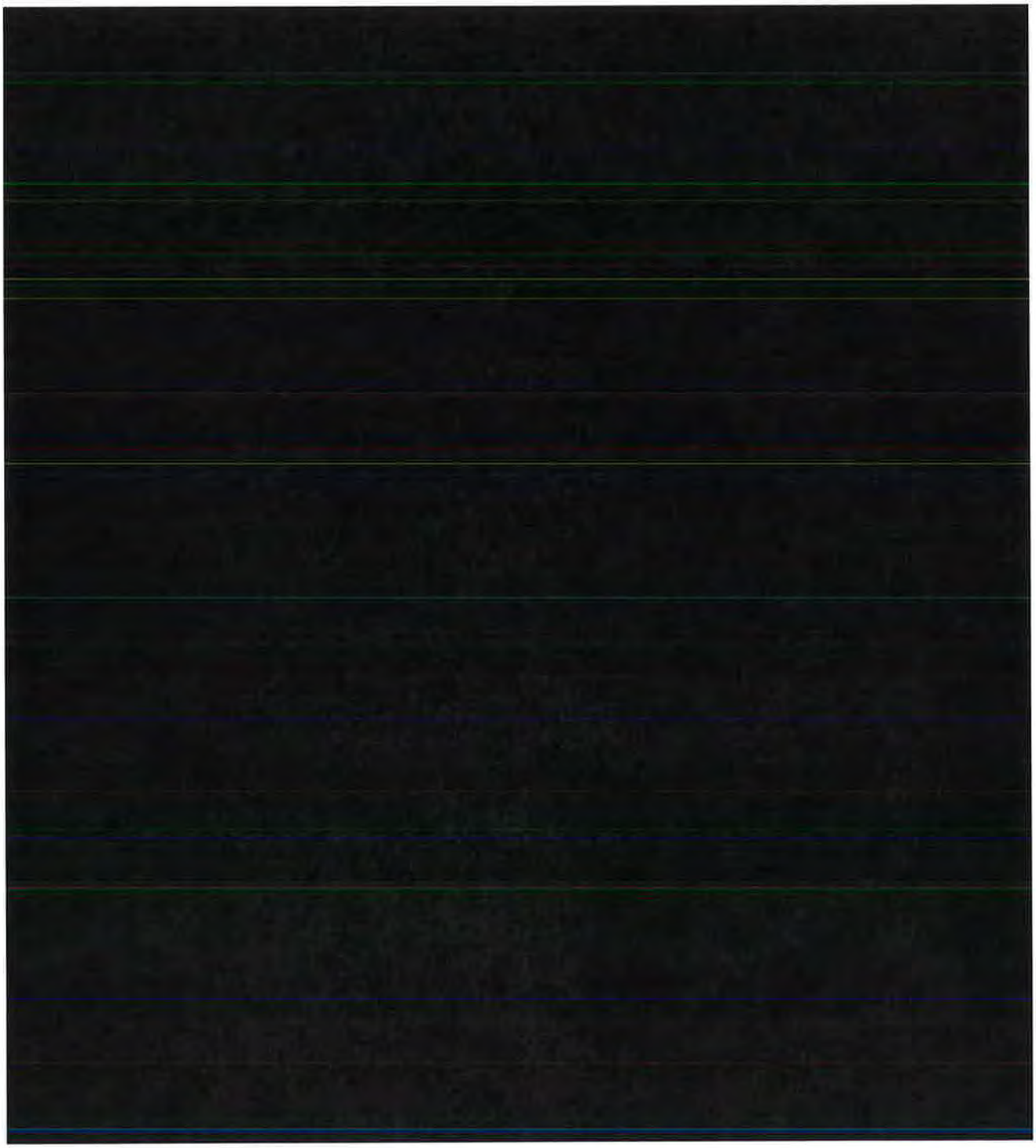


Figure 3-5. Rate Setting Process.

To develop actuarially sound rates, the Deloitte team will collect data across various rating periods and geographies for the DHHS programs. These data sources will include FFS data, encounter data, MCO financial data, policy and programmatic changes, managed care trends, managed care assumptions, market trends, other state information and other

applicable sources. MCO administrative costs will also be collected. Once this information is compiled, we will work with the DHHS to determine the best way to develop the rate ranges and calculate actuarially sound rates or rate ranges. Discussed below are some of the key steps in rate setting that we will review with the DHHS during the rate setting process.

Review Methodology, Assumptions, and Calculations

[redacted]

Base Data Collection and Validation. As mentioned above, actuarially sound rates are highly dependent on accurate, complete, and timely data. This data can take many forms and generally depends on the maturity of the program and sophistication of the participating health plans. As the program matures and the health plans gain experience, fee-for-service data can largely be replaced by encounter data. However, encounter data raises new issues in that there is no longer a direct one-to-one correlation with a claim and a payment.

To validate that the encounter data submitted is complete, we propose that supplemental data in the form of health plan financial data be gathered in coordination with our team and DHHS. By performing a detailed financial review of this data and comparing it to the reported encounter data, we can identify potential issues with the encounter data and bring those to the attention of the errant plan for process improvement and revision. This process would be similar to the process in place with DMA today. Our team of actuaries and health plan financial reviewers has the experience and knowledge needed to determine where a health plan's encounter data reporting is deficient or when a plan's financial data does not support its reported level of service. We use this knowledge to identify opportunities for improvements in encounter data and financial data reporting by health plans that will ultimately improve the accuracy, completeness, and timeliness of the base data used to set rates.

Additionally, as noted above, our Deloitte team is currently working to develop the Data Management and Analytics (DMA) system for DHHS which we will utilize throughout the base data collection process in order to remove some of the reliance on DHHS staff to help provide Deloitte was the base data sources as well as better coordinate efforts between the rate setting team and the analytics team and the underlying data being used in both efforts.

Data Adjustments. Adjustments to the base data generally take four forms: normalizing the data for known issues (such as prior program changes, unusual past experience due to fluctuations in services or changes in delivery systems, the impact of unexpected changes in eligibility or demographics); trending the data for anticipated changes in cost and utilization; other assumptions covering planned or proposed changes in medical management, efficiency, eligibility or demographics, and health plan administration; and risk adjusting the data to reflect geographic and MCO specific variations in costs. We address the key adjustment issues in more detail below. These processes and adjustments can also be incorporated through the data governance process with DMA for continuous improvement of the data:

Programmatic Changes. The data underlying actuarially sound rates should reflect those programmatic changes brought on by implemented changes in the policy or operation of the DHHS programs. These program changes can be widespread affecting nearly all eligibility categories due to changes in provider reimbursement levels or the inclusion or exclusion of certain medical services, or they can be narrowly focused and affect only a single program or geographic area. To underpin the actuarially sound rate calculations, we adjust the base data to reflect those program changes put in place during the historical experience period. The Deloitte team's broad experience with many different programs brings the requisite program knowledge to carefully assess the cost and/or utilization impact of such programmatic changes.

Trend. Health care inflation, or trend, stems from the annual changes in both the cost and the number of services provided. While trend is often represented by a complex logarithmic projection of past experience, this approach only serves to explain historical experience. Our actuaries use their judgment based on a complete and thorough understanding of the applicable program, combined with knowledge of the health care delivery system, to arrive at a credible projection of trend. Trend estimates are often developed at the category of service level for medical services, and by drug type for prescription drugs. Additional considerations may include the impact of high cost drugs, drugs coming off patent, and new medical treatments and procedures. The Deloitte team's experience with setting rates in New York and other states provides the DHHS with the confirmation that trend adjustments are as accurate as possible.

MCO and Other Assumptions. Other adjustments to the base data include assumptions for upcoming program changes or planned changes due to expected improvements in medical management, service substitutions, or administrative cost allowances. With the exception of planned changes in a plan's allowed administrative costs, these types of adjustments are usually projections based on the actuaries' knowledge and understanding of the program and health care delivery system. The Deloitte team has experience developing these and other programmatic factors in New York and elsewhere, and has established credibility within the health plan community.

Risk Adjustment. The data must also be adjusted to reflect the regional and MCO specific risk variation based on the distribution of services. Our actuaries have experience with a variety of diagnostic based risk adjustment models including risk adjustment models that have been developed by the University of California at San Diego (UCSD). Currently, the DHHS utilizes all three UCSD risk adjustment models of Chronic Illness and Disability Payment System (CDPS) and the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) and Medicaid RX (MRX). The UCSD risk adjustment models were specifically built for Medicaid populations and allow risk scores for members to be calculated based on conditions corresponding to major body systems or chronic diseases as well as the types of drugs the members are receiving. Our team utilizes eligibility and claims data for each member to develop a risk score at the member level utilizing the models indicated above. Next, we roll up these risk scores to a combination of regional and MCO-specific levels to reflect the relative risk experienced by each MCO in a given geographical region. These regional health plan relative risk scores are then applied in the rate setting process. Deloitte will coordinate with the DHHS on obtaining the appropriate risk adjustment licenses for the CDPS, CDPS+RX and MRX risk adjustment software.

Additionally, we understand through the Question and Answer responses for this RFP that the DHHS may be considering alternate risk adjustment models. We can support the DHHS in that process within SOW 8 – Special Projects. We are familiar with other risk adjustment models, including the Clinical Risk Group (CRG) model which members of our team are utilizing currently in New York.

Developing Actuarially Sound Rate Ranges. Our actuaries comply with federal regulations (CFR 438) which require an actuary developing rates for a managed care program to do so following actuarially sound principles. CMS had outlined what it considers to be the approved process in its Capitation Rate Development Guide. The American Academy of Actuaries (AAA) developed a practice note addressing the issue of actuarial soundness. The purpose of the practice note was to provide nonbinding guidance to an actuary when certifying rates or rate ranges for capitation of managed care programs. Effective July 1, 2018, actuaries may still develop actuarial rate ranges, but will need to certify to specific point estimates within that range.

Our team's actuaries are members of the AAA and are very familiar with the applicable requirements and actuarial practices. The Deloitte team's actuaries have developed actuarially sound rates under the applicable regulations for many years. We will validate the base data as described above, apply the required adjustments, trend, and assumptions developed in cooperation with the DHHS, to arrive at actuarially sound rates.

Finalize Capitation Cohort Rates and Rate Ranges. Following the rate development methodology we describe in detail above, we finalize and recommend rate ranges by managed care cohort and geographic rating area. In doing so, we take into account the unique characteristics of each program and region and may develop separate adjustments for programmatic changes, trend, medical management practices, or other assumptions, in conjunction with the DHHS. DHHS can then determine final payment rates by cohort based on the recommended rate ranges we have developed.

Review Rate Setting Process with the DHHS. We will review aspects of our rate development with the DHHS. The sources of the base data, what data adjustments should be applied and why, the impact of programmatic changes, how trend was calculated and applied, MCO administration allowances, and the level of efficiency or medical management adjustments applied are discussed to provide understanding and consensus in approach.

Attest to Actuarial Soundness. Our team certifies the rates we develop as meeting the federal requirements for actuarial soundness as specified under CFR 438. Our rate certification is documented in a certification letter that can be sent to CMS as well as a CMS response guide to the CMS managed care rate setting guide. This letter provides details on the data, adjustments, assumptions, and methodology used to arrive at the actuarially sound rate ranges. Further, we are available for discussions with CMS on our certification.

Develop Financial Summary. An important component in enhancing the participating MCO's understanding and acceptance of the calculated capitation rates is the provision of a data book or financial summary. We publish a summary that lays out in detail the cost and utilization statistics from the historical data used to form the base data for rate setting. It provides data and narrative explanation of the adjustments, trend, and assumptions used. Detail can be provided at a program, eligibility, geographic, and service level and includes unit cost and utilization information.

3.V.D.b – Develop Managed Care cohorts and capitation rates, using a variety of parameters, including but not limited to, recipients' age, gender, category of eligibility, level of care, and geographic location

RFP Reference: Section V.D. b, Page 25

Deloitte has the knowledge required so that the costs and characteristics associated with managed care cohorts are accurately reflected. We understand that medical and pharmacy costs vary by parameters such as but not limited to age, gender, eligibility group, level of care and geographic region. The base data sets used to develop capitation rate ranges should be divided into cohorts that represent consolidated groupings which inherently represent differing levels of risk or geographic cost variation. Developing cohorts involves the following steps:

As the State's eligibility system transitions to NTRAC, new data elements may be added that could assist in the rate setting process. This information is also planned to move into DMA and may continue to evolve throughout the course of this engagement.

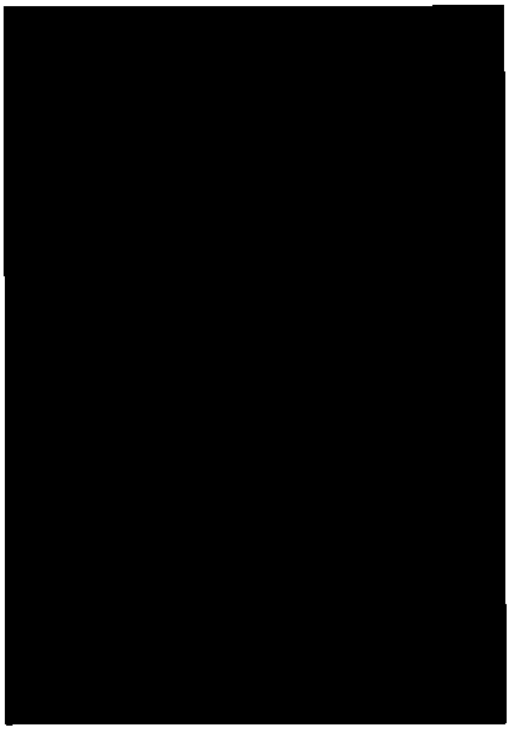
1. Start with a base period eligibility and medical and pharmacy expense data
2. Develop the cohort by working with DHHS to determine the necessary logic for managed care cohorts to be credible but reflect appropriate levels of cost variation
3. Review methodology with DHHS
4. Reviewing and evaluate data adjustments as required

Deloitte understands and appreciates the importance of establishing appropriate rates for each cohort in the Medicaid program. As time passes by, these cohorts may need to change. We will assist the state to develop and refine the logic to define these cohorts as described in **Task 3.V.E.c.**

3.V.D.c – Develop a risk adjustment methodology

RFP Reference: Section V.D.c, Page 25

The Deloitte team brings the required experience, technical skills, and credibility to provide information, advice, and recommendations related to risk adjustment. Our team has the needed risk adjustment experience and has implemented some of the leading risk adjustment strategies in the public and private sectors.



We have worked with a number of state Medicaid agencies on a variety of risk adjustment programs using risk adjustment models including ACG, CDPS, CRG, DCG and the HHS-HCC model. For example, members of our team are currently analyzing the impact of CRG version changes in New York.

If DHHS elects to implement or adopt a different risk adjustment process in the future or add risk adjustment to a program that does not currently use it, our history of analyzing model appropriateness for a given program and then administering state risk adjustment using the leading risk adjustment models gives us the needed knowledge and experience to assist DHHS in the transition for either circumstance.

For purposes of this response, we have assumed that DHHS plans to continue utilizing the three UCSD risk adjustment models of CDPS, CDPS+RX and MRX that were originally implemented in Nebraska in 2018. However, as requested Deloitte will work with the DHHS to implement or consider new risk adjustment models as further highlighted in SOW 8 – Special Projects.

Creating Regional Plan specific risk scores utilizing UCSD models

The UCSD risk adjustment model package includes three different risk adjustment models, the CDPS model utilized to indicate what major categories members have based on medical diagnosis, the MRX model which assigns members into multiple different therapeutic categories based on pharmacy NDC codes and the CDPS+RX model which is a hybrid version of the CDPS and MRX models. The UCSD models are specifically built for Medicaid

populations and have different risk adjustment models for disabled, TANF adult and TANF Children populations.

To develop member level risk scores, our team utilizes eligibility and claims data to create the necessary eligibility, diagnosis and claims inputs for each of three models. The models then develop a member specific risk score based on the diagnostic and claims inputs as well as the model parameters selected. After the member level risk scores are developed, an average case-mix score, often times called the regional health plan relative risk score, is created at a combination of regional and plan specific levels to reflect the relative risk experienced by each plan in a given geographical region. These regional health plan relative risk scores are then applied in the rate setting process.

As the UCSD models allows for customization of certain model parameters, there are multiple considerations that need to be made when utilizing these models which Deloitte will work with DHHS to determine the appropriate parameters to utilize for the state's population. Decisions on these model parameters include:

- Utilizing concurrent or prospective weights.
- Creating custom Nebraska weights or utilizing standard CDPS weights
- Deciding what versions of the UCSD models to utilize
- Deciding what combination of UCSD models to utilize when selecting the final plan relative risk scores

3.V.D.d – Develop a range of rates that are actuarially sound

RFP Reference: Section V.D.d, Page 25

The Deloitte team will use the rate development process discussed in the beginning of this section to determine actuarially sound rate ranges based on the appropriate range of assumptions and adjustments. The low and high bounds of the rate range are intended to represent the levels at which appropriately managed care would be able to meet the levels of access and care as specified under the program.

In developing these low and high bounds rates by rate cell, the Deloitte team makes multiple actuarial assumptions. As these assumptions are estimates of various impacts of the given component, our team applies a range to the assumptions and uses multiple sources such as program-specific experience, industry research, Deloitte actuarial tools and models to apply ranges for these assumptions that are actuarially sound. Typical adjustments that have a range include program changes, physical and behavioral trends, pharmacy trends, efficiency, administrative costs, taxes and risk margin.

Our team will provide documentation on how the ranges were developed. We will specify which assumptions had low/target/high estimates applied to the base rates to develop the ranges. Additionally, we will document the low/target/high values of these assumptions and provide the source material as well as a description of the data utilized.

In the most recent version of the managed care rate development guide from CMS applicable for Rating Periods beginning from July 1, 2017 to June 30, 2018, CMS requires that each individual capitation rate be certified as actuarially sound. Deloitte will work with DHHS to follow this guideline and will certify that each final rate is within the actuarial sound rate range developed.

3.V.D.1: Rate Data Analysis and Manipulation

RFP Reference: Section V.D.1, Page 25

Understanding of the Project Requirements

Through our experience, we recognize the development of rates is not simply a calculation exercise; rather it is an ongoing process involving data analysis and reporting, actuarial rate calculations, development of assumptions, evaluations of MCOs and their reported data, proper documentation and communication, technical assistance with providers, and strategy support with the State as we work to deliver innovative ideas and efficiencies into the Medicaid program.

We understand the importance of data quality and its impact on the ability to develop actuarial sound rates. Therefore, we believe that the State needs a partner who truly understands how Medicaid health care data is collected, validated and manipulated, using analytics to develop actuarially sound rates. To accomplish this, the ability to look at, understand, and manipulate data in more sophisticated ways is needed and our experience with your specific data through the DMA project provides our team with significant insight into your MMIS data composition and challenges.

The Deloitte team's approach to rate data analysis:

- Considers quality and attributes of various sources of MCO program data
- Provides useful insight on drivers of cost of care by analyzing utilization and cost profile patterns by different cohorts and service categories
- Evaluate and include relevant medical and non-medical adjustments to base period data
- Monitor external factors such as inflation, economic and health related trends affecting MCO program risks and reflect these factors in calculated trend
- A suite of tools, methods, and accelerators to enhance the rate setting process and drive data-driven decisions

Proposed Development Approach

Deloitte will work under the guidance of Actuarial Standards of Practice #23 on Data Quality and section 438.6 of the Code of Federal Regulations (CMS Medicaid Rate Development Guide) when carrying out data analysis tasks. As depicted in the following figure, our approach to rate data analysis and manipulation at a high level involves the following steps:

- Select base data
- Verify and validate data

- Adjust data
- Normalize data
- Analyze data
- Review external factors

Figure 3-6. High Level Steps for Data Analysis and Manipulation.

Select Base Data

The objective of this step is to gather base data that reflects program goals and program risks. We will to confirm that data is accurate, comprehensive and appropriate for developing actuarially sound rates for services to be furnished under the contract. Data relied upon should be based only upon services covered under the state plan and only cover program eligible individuals. As noted earlier, we anticipate leveraging DMA as the primary data source for the base data.

When appropriate, the Deloitte team can integrate data from multiple sources using techniques such as credibility weighting. Our team can carry out analyses to determine the degree of reliability of data to be used for this purpose. Each selected data source should be sufficiently current as new CMS guidance states that actuaries must utilize the most recent one to three years of available data annually when certifying capitation rates.

We believe that multiple years of data from various sources should be considered to confirm that base data is comprehensive so historical trends can be calculated and effects of programmatic changes are captured. This is particularly important for capitation rate cells that have fewer members or recently integrated services, such as pharmacy or behavioral health, and are therefore less credible. Typically, enrollment data, FFS data, MCO encounter data, and MCO Financial statements data are reliable sources for this purpose. We will review these data sources for credibility and appropriateness to determine sources to use as base data. These data sources are discussed in detail later in our response to this task.

For new program initiatives without appropriate or credible historical data, we will need to use other data sources for rate development. We will work with the State and our DMA team members to determine which sources of data to use, based on which source is determined to have the highest degree of reliability specific to the program and rate development requirements.

Verify and Validate Data

Once data is selected, the Deloitte team verifies that data is accurate and reliable for actuarially sound rate development. We carry out reasonableness and consistency checks by reviewing each data element, identifying questionable data values and reviewing current

data for consistency with data used in prior analyses. Our team can carry out standard checks such as but not limited to: range checks, missing value tests, checking for internal and external consistencies, checking that data is sufficiently recent and verifying sample records to raw source files.

In order to confirm completeness of data, we shall evaluate utilization and volume metrics to benchmark statistics. In cases where material defects are identified, we will carry out practical steps to improve the quality of data. This will include, but is not limited to, obtaining additional or corrected data. The data discovery and data cleansing efforts previously performed for the DMA initiative will help accelerate the data validation effort.

Adjust Data

The objective of this step is to confirm that data from base period reflects program risks and characteristics in the projection period. Programmatic changes include benefit changes (carve-ins and carve-outs), changes in the eligible population, or other programmatic changes in the managed care program (or FFS program that affected the managed care program) not reflected in the base period and outlined in the regulation. In cases where, base utilization and cost data are not derived from the Medicaid population, our team can adjust the data to make them comparable to the Medicaid population.

The adjustment process may include the following:

- **Large Claim Adjustments.** In order to smooth any potential volatility as a result of an abnormal distribution of catastrophic claims, we review large medical claims for irregular payments. We typically redistribute claims in excess of the selected amount evenly based on membership and verify the adjustment is cost-neutral
- **State Plan Services Only Adjustments.** Per the CMS Medicaid Rate Development Guide, it is required that payment rates be based only upon services covered under the state plan. If required, adjustments to data will be made to reflect FFS state plan services only. For example, adjustments may need to be made to encounter data to remove services an MCO offers to the members but are not part of the state plan services
- **Incurred But Not Reported (IBNR) Adjustments.** In order to account for any claims that may still be outstanding in the base data, we use IBNR adjustments to complete the data
- **Third Party Liability (TPL) Adjustments.** If any additional TPL data is received, the base data is adjusted to properly reflect the appropriate impact of TPL payments
- **Retroactivity Adjustments.** Claims for clients who are retroactively eligible for Medicaid must be excluded from the fee-for service base if the MCO is not obligated to cover the cost incurred in this period. Appropriate adjustment for retroactivity confirms that the MCO capitation rates properly match risk with payment. Additionally, it is sometimes necessary to adjust (or prorate) the capitation rate to account for enrollment of less than a full month

- **Pharmacy Rebate Adjustments.** This adjustment is necessary to account for the drug rebates received by the MCOs
- **Medicare Adjustments.** Determining the impact of Medicare payments and cost sharing on claims data, if included, for dual-eligible enrollees
- **Financial Experience Adjustments.** This adjustment may be required for rates that are updated by adding a year of trend rather than based on new base data
- **Other Adjustments.** Other adjustments as required such as investment income adjustments, reinsurance adjustments, capitated expenses that are not in encounter data, etc.

Normalize Data

The Deloitte team understands that our overall objective is to develop rates that reflect managed care program risks in the contract period. Base period data must therefore be normalized for a number of factors such as demographic mix, geographic area, benefit plan, group characteristics, utilization management efforts and provider reimbursement arrangements. This normalization step results in data for a common benefit plan which reflects standard program characteristics. Normalized data from multiple sources can then be combined and used to calculate rates which are then adjusted to reflect characteristics specific to the group expected in the contract period.

The Deloitte team considers the following when normalizing data:

- **Required Payment Rate Adjustments.** Adjustments to account for legislative or executive action results in changes to state FFS or capitation payment rates
- **Duration Adjustments.** Adjustments to reflect the relative cost of members based upon the length of time between the first Medicaid member month and the beginning of the member's MCO start date
- **Policy Change Adjustments.** Adjustments to account for rate, benefit, or eligibility changes occurring after the base period
- **Population Change Adjustments.** Adjustments to account for a difference in membership reflected in the base data and the current Medicaid managed care program. Area factors as well as age/gender factors will be considered
- **Benefit Change Adjustments.** Adjustments to account for a difference in benefits reflected in the base data and the current Medicaid managed care program
- **Cost Sharing Adjustments.** Adjustments to account for a difference in cost sharing reflected in the base data and the current Medicaid managed care program
- **Efficiency Adjustments.** This adjustment reflects savings as a result of more effectively managing care.

Analyze Data

Our team understands that quality analysis of data can provide useful insights upon which the State can make impactful decisions. We can analyze utilization and cost profile patterns by evaluating various standard metrics. Such metrics include but are not limited to trends in costs, utilization and intensity per enrolled member. We can calculate benchmarking statistics from the data and analyze the results in relation to previous years' data, and external benchmarks.

We can carry out analyses to determine the true financial picture of the health plans by analyzing their care and administrative overheads. We will develop expense load assumptions to be applied when calculating health plan rates after evaluating plan size, efficiency, level medical claims costs, risk assumed by the plan, state and federal taxes, profit, risk and contingency margins.

We plan to leverage the tools used within DMA to support this effort. As discussed further in **Task 3.V.E.1.f**, additional dashboards within DMA can be developed using pre-built, existing connectors into HealthInteractive for reporting and querying against DMA.

Review External Data

Medicaid programs are affected by many external factors that need to be carefully evaluated and reflected in the rate development process. The Deloitte team will leverage its unique tools and knowledge to monitor inflation, economic and health related trends statewide and nationwide. Sources for reviewing these external trends include Industry research on CPI index, NHE, and other health related trend surveys.

The following table summarizes our high-level understanding of the subtasks. Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Deloitte's Understanding of the Subtasks	
3.V.D.1.a	Appropriate base period membership and claims information can be sourced from Enrollment rosters, FFS databases, MCO encounter data and MCO financial data. Cross validation can occur amongst these sources. We can validate and verify data relied upon for completeness, comprehensiveness, reliability and accuracy.
3.V.D.1.b	The Deloitte team will analyze new regulatory requirements or program changes and develop factors to adjust capitation rates to reflect changes.
3.V.D.1.c	Our team can analyze base period data to develop utilization and cost profile patterns by managed care cohorts and service categories to provide valuable insights into the data which can help to determine trend drivers, completeness of data and material defects in the source data.
3.V.D.1.d	The Deloitte team will be prudent to understand and analyze specific and necessary claim and non-claim adjustments to the base period data of each MCO and discuss these items with state Medicaid personnel.
3.V.D.1.e	We can measure and reflect changes in the Medicaid environment that have an impact on program characteristics and, consequently, rates. Our team has access to national databases and benchmark metrics to compare State Medicaid performance.

Figure 3-7. 3.V.D.1 Subtasks.

Technical Considerations

Deloitte understands the data challenges that occur in the development of Medicaid managed care capitation rates. Therefore, we believe that the State needs a partner who truly understands how Medicaid health care data is collected, validated and manipulated, using analytics to develop actuarially sound rates.

Data Quality

Not all reported data is free from error and any errors can impact the results of any actuarial analysis. When using any data, we operate under the guidance of Actuarial Standards of Practice #23 on Data Quality to facilitate quality results.

Before using any data, we carry out reasonableness and consistency checks by reviewing each data element, identifying questionable data values and reviewing current data for consistency with data used in prior analyses. In order to confirm completeness of data we shall evaluate utilization and volume metrics to benchmark statistics. In cases where material defects are identified, we will carry out practical steps to improve the quality of data. We understand that the metadata and business rules documentation is available from DMA to identify the quality rules, exception rules of processing, and lineage of where data is sourced from.

Collecting high quality data starts with a well-conceived and executed data collection plan. To address potential issues, we will work with Department staff to review the state's current data collection practices, and potentially recommend changes to strengthen data accuracy.

Lack of Credible Data

For new populations and services without appropriate or credible historical data, we will utilize other data sources for rate development. We will work with the State to determine which sources of data to use, based on which source is determined to have the highest degree of reliability specific to the program and rate development requirements. As the new populations or services mature, we will evaluate the encounter data specific to these populations and services to determine if this data is credible to be used in rate development.

Additionally, the CMS Medicaid Rate Development Guide indicates that utilization and unit cost trends should be analyzed separately. This requires reliable encounter data to perform these analyses. Deloitte's trend approach includes analyzing multiple data sources to utilize the most credible trend data.

Sparse Data Available for Programmatic Changes

Often new benefits or new high cost drugs covered under managed care will have very little, if any, actual experience on which to base the programmatic change adjustment. Programmatic changes may also include little background information necessary to development and adjustment for the capitation rates. We have experience incorporating these new services into the managed care capitation rates and understand the nuances

involved with these new services and drugs. We will work with the State to determine the most appropriate and reliable data sources to utilize in the cost estimates of these new services.

Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Detailed Project Work Plan

We will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval.

A high-level project timeline is included in Appendix 1. We will work closely with the DHHS in the beginning stages of the engagement to develop detailed work plans for each managed care program.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we may provide for the Rate Data Analysis and Manipulation effort. We will work closely with DHHS in the beginning stages of the engagement to develop the detailed work plan and deliverable due dates.

Deloitte's Understanding of the Deliverables	
Base Data Summaries	Summaries of the base data PMPMs utilized in the actuarially sound capitation rates will be produced. These summaries will include category of service level information and be specific to each rate cell. These summaries may also include applicable adjustments made to the base data. Base data utilized will comply with Actuarial Standard of Practice #23 on Data Quality and 42 CFR 438.5(c).
Programmatic Change Adjustment Summaries	Summaries of the impact of the programmatic change adjustments utilized in the actuarially sound capitation rates will be produced. These summaries will include the impact on capitation rates at the level of detail applied in capitation rate development specific to each rate cell on either a PMPM or percentage basis. Programmatic change adjustment development will be consistent with 42 CFR 438.5(f) and applicable actuarial guidance.
Trend Summaries	Summaries of the trends utilized in the actuarially sound capitation rates will be produced. These summaries will include selected trends specific to each rate cell at the level applied in capitation rate development. Trend development will be consistent with 42 CFR 438.5(d) and applicable actuarial guidance.
Actuarial Memorandum	An actuarial memorandum will be produced documenting actuarial assumptions made, as well as the data, materials, and methodologies used in the development of each component of the capitation rates.

Figure 3-8. Potential 3.V.D.1 Deliverables.

3.V.D.1.a – Analyze the financial statement data of managed care plans with focus on relevant issues affecting capitation rate development

RFP Reference: Section V.D.1.a, Page 25

The Deloitte team can provide a holistic review of reports to identify opportunities to condense data points and sources necessary to meet reporting requirements, in addition to identifying opportunities for process automation. Standardization of data collection tools may also be important.

As stated earlier, our knowledge in business intelligence tools and team's experience with the DMA initiative presents an opportunity to provide technical assistance in dashboard generation and performance measurement visualization. In addition, Deloitte business intelligence experienced resources are able to provide support in designing confirming analysis methods for statistical accuracy.

Deloitte developed the managed care capitation rates in New York State and utilized MCO financial data for:

- Medical base data
- Base data adjustments
- Trend analysis
- Non-medical expense development

We will carefully analyze the following Medicaid program data sources and other relevant sources:

MCO Financial Statements

Deloitte can assist the State to review MCO financial information by using the health plans' reported financial data. Financial data provides a detailed view of cost and utilization experienced by health plans and is submitted to the State on a periodic basis. Financial data includes information such as medical loss ratio (percentage of premium spent on medical care compared to administrative expenses), plan spending in different care settings, amount of capitation rate spent on administrative expenses compared to services, the types, level and cost of various services provided to members, and the number of members receiving different types of services or no services.

Deloitte can review submitted information for accuracy and completeness by analyzing plan's membership and revenue data against those collected by the State's other tracking systems. We can also review the data by analyzing membership information, medical expenses, and administrative costs by different cohorts in order to understand MCO's financial performance.

The following table shows some components of financial data and the approach for reviewing each component:

Deloitte's Approach for Reviewing Financial Data	
Membership	Review for accuracy and completeness by comparing to state enrollment data
Premium	Verify the premium information reflects underlying capitation payments reported in the State's tracking system
Claim Costs	Compare per capita rates by cohort to benchmarks and historical levels to determine if large variances
Utilization	Review utilization rates and trend compared to benchmarks
Admin	Consider plan efficiency when reviewing admin expense, particularly focusing on medical management staffing and costs compared to benchmarks
MLR	Review reasonableness by comparing if plans' MLR is within benchmark range. Amounts above or below the range may indicate denial of services, insufficient capitation rates etc. and will need for further evaluation

Figure 3-9. Financial Data Review Components.

Enrollment Data

Medicaid Managed Care Enrollment Report shows the number of Medicaid recipients currently enrolled and the number of Medicaid recipients eligible to enroll in Nebraska's Medicaid managed care program.

The data is presented for each MCO by county and Medicaid Aid Category. These reports are generated from primary and secondary roster reports. These reports provide enrollment counts as of the 1st of the month thereby allowing the report to be posted the same month of enrollment. We can review these numbers against other data sources such as DMA.

FFS Data

Some Medicaid enrollees in Nebraska are served through a fee-for-service delivery system where health care providers are paid for each service. Medicaid FFS databases are an appropriate source of base data for both utilization and cost information for certain Medicaid population. Certain benefit packages recently carved into managed care will rely on their historical FFS data as their base data for rate development. With movement towards value based payments for Medicaid programs, FFS data will be summarized and analyzed for new services without fully credible encounter data to understand key trends and whether additional members can be transitioned to managed care settings.

MCO Encounter Data

The State requires all full risk and partial capitation managed care plans which serve Medicaid recipients to collect and submit data on encounters for all contracted services. DMA data is a valuable source of information for monitoring MCO performance within and across counties and MCOs. In addition, the patient level data available provides the opportunity to conduct a variety of outcomes research, and fiscal analyses.

Deloitte will collaborate with the State in gathering, analyzing and exploring ways to further use encounter data in rate setting. Deloitte will conduct validation and completeness checks on encounter data to confirm that it was properly loaded and is reliable for rate setting purposes. Completeness check will be evaluated using metrics such as:

- Proportion of members using services
- Utilization rate per thousand members
- Encounters per member

Where appropriate, Deloitte will estimate incurred-but-not-reported (IBNR) encounters in order to complete validated encounter data. Encounter data will then be summarized by cohort and service category level so as to provide insight into utilization and cost profile patterns. The data discovery and data cleansing efforts under the DMA initiative will accelerate the encounter data review efforts for the rate setting project.

Other Data Sources

Deloitte will consider other data sources with relevant information for actuarially sound rate development. Examples include, but are not limited to: National Medicaid databases, data from research and consulting firms, intercompany experience studies, etc.

3.V.D.1.b – Analyze any programmatic changes that will be effective in the state fiscal year and utilize the data to calculate adjustment factors to be applied to the existing capitation rate ranges, as applicable

RFP Reference: Section V.D.1.b, Page 25

We work diligently to monitor, incorporate and update the rate setting process such that the rates are compliant and consistent with new programmatic or legislative changes on an ongoing basis. We make adjustments as required, request appropriate data and make potential methodology changes. Following the process below, we work with the State to quantify the impact of such changes and develop innovative solutions while balancing the financial stability of the managed care organizations. To address changes, our adjustments can be made by county or zone, to specific managed care organizations, and by phases to dampen the impact of significant policy changes on the organizations and their members.

Figure 3-10. Process to Analyze and Quantify Program Changes.

We are currently working with other states to incorporate new programmatic and legislative changes as the managed care program changes. For example, within the past year we have worked to incorporate numerous program changes into the New York managed care capitation rates including services recently covered by managed care, new populations, and changing program parameters. Our process to determine, analyze and quantify the impacts of program changes follows these steps:

- **Data Gathering.** Our policy specialists closely monitor the policy and legislative changes and efficiently gather the proper information for analysis. We will leverage the available managed care and FFS data and request additional information from the managed care organizations as needed to perform our assessment.
- **Impact Analysis.** The Deloitte team develops a model of the impact of the policy and legislative changes, including a close examination of on the impact on the rate setting methodology and encounter, financial, and FFS data. The impact analysis includes an evaluation of the proposed changes against existing policies and procedures, assessment of the impact on the managed care organization program, its population being served, and an assessment of the impact on the Nebraska health care market. Using our suite of tools, we:

- Conduct an analysis to determine likely changes to consumer consumption patterns and impact on benefits
- Assess potential changes in utilization, pricing, and quality as well as project impacts to eligibility given the revised MCO program benefit structure and the underlying risk of the new population
- In collaboration with the State, make the appropriate adjustments to the base data to reflect anticipated changes in health care delivery, utilization, cost, and eligibility expected under the new policy based on the analysis performed above. This tool will allow for detailed and aggregate reviews of the impact to individual claims, MCOs and the overall Medicaid programs, depending on the data utilized within the analysis
- Apply agreed upon assumptions within the model. These may include assumptions on trend, utilization, unit cost, or eligibility
- Run the model to calculate the projected impact on costs, utilization, access, quality, and providers
- Run a sensitivity analysis by adjusting assumptions to reflect potential variations in expected results such as the impact of higher or lower trend, increased or decreased woodwork effect

- **Develop Solutions.** Once the impact has been analyzed and the model completed with agreed upon assumptions, the Deloitte team's health care specialists work in collaboration with our actuaries and the State to identify efficiencies and areas for innovation and improvement. This process takes into account leading practices in health care, population trends, as well as an understanding of Nebraska's health care landscape. Our team will provide insights into options such as the impact of enhanced payments for evidence based and emerging practices and structuring authorization requirements.
- **Document.** At each stage of the impact analysis and solution development work products will be reviewed with the State's staff and approved prior to applying the outcome to the next stage. The final product of each analysis will be presented to the State and key stakeholders as requested by the State, or if indicated a report will be developed.
- **Implementation.** Once the State selects a course of action the Deloitte team will support the State's implementation. The Deloitte team of actuaries, Medicaid and health care specialists will provide knowledge and assistance, as desired in implementation activities including but not limited to, rate negotiations or policy modifications. For example, with a policy modification, we can help the State implement the change in a variety of ways, such as writing the modified language to be sent to stakeholders and calculating the rate impact and negotiating the new rate with the MCOs.

3.V.D.1.c – Analyze medical and pharmacy service utilization and cost profile patterns by category of service for all Managed Care cohorts

RFP Reference: Section V.D.1.c, Page 25

Deloitte believes that studying medical and pharmacy cost trends is very useful not only to aid in development of actuarially sound rate, but also for opportunity identification. Deloitte team has strong skills that will analyze medical and pharmacy data to identify abnormalities and to determine reasons and implications of inconsistencies. These analyses will be used to evaluate and certify reasonableness and credibility of FFS data, MCO encounter data or financial data.

We typically calculate benchmarking statistics from the data and analyze the results in relation to previous years' data, and/or external benchmarks. Such metrics include but are not limited to trends in cost, utilization, & intensity per enrolled member. Analysis will be done by specialty, service category, therapeutic class, & condition (disease).

Deloitte will analyze utilization and cost profile patterns by evaluating metrics such as but not limited to:

- Cost PMPMs by service category
- The rate of hospital admissions
- Average length of stay per admission
- Bed day usage rate
- Unit price such as average costs per admission
- Average drug prices by generic, brand and specialty categories
- Cost per script across therapeutic classes

These analyses will help to identify differences between and within medical and pharmacy care, variations in specialties and diagnosis categories, changes in products and markets, and impact of new high cost drugs. Outcomes of these analyses will enable accurate assessment of trends specific to each MCO program, cohort and health plan and the State to use fact-based information to manage their health care costs.

Utilization metrics measure incidences of using healthcare goods and services and count of units of healthcare goods and services being used. Analyzing changes in these metrics over time will reveal important information in the operations of a MCO program. For example, we can review utilization by demographic, geographic, provider and service categories to determine:

- Services or goods that are key drivers of healthcare costs
- The availability of new products and services
- Changes in member's behavior, e.g., healthier lifestyles, increased use of preventative or screening regimens
- Ease of access to existing services
- Shifting of utilization to generic drugs when brand drugs lose patent protection

To assess the current costs of an MCO program we can **leverage our ability to access the Medicaid and other public health data** that will help us analyze actual historical data. Through our facet analysis capabilities, we are able to promptly define and analyze cost and utilization across types of service, populations, and provider groups to understand the current costs of the programs.

In addition to DMA, Deloitte can also leverage the following additional tools:

- **Benefit Models.** This is a flexible benefit model that tests the financial and beneficiary impact due to changes in cost sharing structure and utilization limits for specific benefit categories across various benefit plan designs
- **Customizable Cost Model.** This is a model that analyzes service category allowed cost per unit, PMPMs, utilization/1000 and average LOS where appropriate to track MCO and program changes upon data updates

3.V.D.1.d – Provide technical assistance in the evaluation of individual MCOs, including areas such as IBNR claims adjustments, administrative overhead, care management overhead, and appropriateness of medical costs incurred

RFP Reference: Section V.D.1.d, Page 26

Deloitte understands the importance of complete and accurate MCO financial data. Deloitte can review the financial reporting information to determine if calculations and amounts appear reasonable. We further perform analytical procedures and potentially review a sample of supporting documents to determine if information stated appears reasonable and whether further evaluation of MCO financial reporting is needed.

Deloitte can provide technical assistance to help the State to examine and evaluate reasonableness of MCO's medical and non-medical components of its health care costs in their financial statements. We will assist the State to analyze IBNR, admin, and medical costs.

IBNR

An efficient and thorough analysis of insurance reserves requires the appropriate actuarial professionals. We have several actuaries that have specific experience in reviewing health plan reserves. As part of this process our actuaries comment on reserve adequacy, observations regarding emerging trends that may affect the program, and the appropriateness of the IBNR methodology employed compared to Actuarial Standards of Practice #5, Incurred Health and Disability Claims.

In order to understand reserve adequacy, our actuaries may develop an independent estimate of health plan reserves and validate if the MCO's reserves are within a range of reasonableness. Below describes the general methods we use to develop an independent estimate.

Deloitte uses the following methodologies to calculate reserves:

Reserve Methodologies

Completion Factor Method	This method applies observed historical claim payment patterns to recent paid claim experience. • Example of historical claim payment patterns: 5% of all claims paid in the 1st month, 50% by the 2nd month, 90% by 3rd month etc.
Loss Ratio Method	In this method, one estimates the loss ratios (incurred claims ÷ earned premiums) by comparing historic loss ratios of similar products. • Estimated Loss Ratio x Earned Premiums = Estimated Incurred Claims • Estimated Incurred Claims – Paid Claims = IBNR

Reserve Methodologies	
Tabular Method	This method applies factors to items such as individual claims, waived rates, or other volume measures based on previous experience in order to estimate the IBNR for known claims
Projection Method	This method projects recent experiences based on historical experiences • Historical Experience x Trend Rates = Projected Experience
"Hybrid" Method	At Deloitte, we generally combine the completion factor method and the projection method • Completion factor method for older claims (usually >70% complete) • Overrides recent month experience with the projection method

Figure 3-12. Deloitte Reserving Methodologies.

Administrative and Care Management Overhead

Deloitte recognizes the importance of setting reasonable expectations for what administrative costs should be in a well-run MCO. We consider the effect of plan size, efficiency, risk assumed by the plan, state and federal taxes, profit, risk, contingency margins, and other factors listed below when determining if the administrative loads of the plan are reasonable.

Additional items that Deloitte may analyze include:

- Overall size across all lines of business
- Lines of business covered by the capitation
- Age of the health plan or years of participation in Medicaid
- Organizational structure
- Demographic mix of enrollees
- Marketing expenditures
- Claims processing expenditures
- Medical management expenditures:
  - Staff overhead expenses
  - Member services
  - Interpreter services

When evaluating care management overheads or medical management expenditures, Deloitte will analyze health plan's initiatives that increase quality of care, improve access and reduce medical spend. These may consist of programs such as:

- Complex Case Management
- Disease Management
- Utilization Management

- Behavioral Health Service
- Social Work Support
- Preventive Outreach Services
- Health Care Information & Analytics Services
- Provider Relations

For these programs, we can gather available benchmarks on staff salaries, staff-to-member ratios, benefits costs, etc. to determine an estimate of care management program cost and compare to the MCO's financial statement to evaluate the reasonability. We can also analyze historical levels of MCO care management costs and inquire about significant variances against statewide averages.

In the determination of an appropriate level of a profit and risk allowance, Deloitte may consider the following items:

- Contingency margin
- Contribution to surplus
- Investment rate of return
- Profit margin

Deloitte is fully capable of setting what reasonable expectation of administrative cost should be due to its insights in market wide benchmark values.

Appropriateness of Medical Costs Incurred

We understand that Medicaid involves the outlay of substantial public resource and therefore protecting the integrity of the program is paramount. We understand the challenges due to complexity involved in providing a broad list of benefits delivered by many participating providers to beneficiaries statewide.

Deloitte has the tools and required knowledge to run sophisticated models on data in order to detect inappropriate provider billing and individuals receiving benefits to which they were not entitled. These activities contribute a large component of Medicaid fraud and threatens fiscal and program integrity. This effort can be integrated into program integrity processes in DMA.

In addition to evaluating the potential for inappropriate expenditures, Deloitte can also summarize several years of historical financial data by category of service and rating cohorts to understand trends in MCO claims experience. We can evaluate these trends compared to publicly reported trend sources such National Health Expenditures, Kaiser, Consumer Price Indices etc. to determine reasonability.

3.V.D.1.e – Analyze inflation, economic, and health related trends

RFP Reference: Section V.D.1.e, Page 26

Deloitte understands that external sources of trend should be well understood, measured and reflected when determining MCO future costs. Deloitte has specialists that will analyze and support the State as opportunities or challenges surface due to market trends. Deloitte is fully capable of monitoring trends in the healthcare landscape nationally and within Nebraska.

The Deloitte Center for Health Solutions (DCHS) is the research division of Deloitte's Life Sciences and Health Care practice. The goal of DCHS is to inform stakeholders across the health care system about emerging trends, challenges, and opportunities. The Deloitte Center for Health Solutions regularly issues briefs on the impact of regulations to state health care programs.

We constantly scan the market for trends in economic factors such as changes in household income, general inflation, physician supply, demographics, and federal and state regulations. Some useful sources of trend information that we review include Medicare trends, National Health expenditure (NHE) of GDP, Medical Consumer Price Index (M-CPI) and trend surveys.

Deloitte develops benchmark statistics from these external data sources. These provide valuable metrics against which MCO programs in Nebraska can be compared to. In addition, Deloitte has the ability to access national databases to help review Nebraska results against national averages. Deloitte is best placed to analyze both historical and emerging forces of Medicaid trend. Following are some examples:

- **Demographic Changes.** Increase in elderly or disabled persons
- **Geographic Trends.** Population movement into higher or lower cost regions
- **Birth Rates.** Increase in fertility rates and maternity rates would lead to increased costs
- **Price Inflation.** Increase in drug unit costs in specialty therapy classes like Hepatitis C, HIV and inflammatory conditions have contributed to significant increased spending in specialty drug costs
- **New Drugs or Drugs Going On or Off Patents.** Patents protect a drug's original manufacturer from competition for a period of time leading to high claim costs
- **New Technologies.** These affect care delivery systems leading to reduced cost e.g. growth in virtual care and online health advisers lead to cost savings across the healthcare system
- **Provider Practice Patterns.** Changes in the structure of health plan's provider contracts have an impact on costs
- **Legislative Changes.** Introduction of new taxes or mandated benefits lead to increased medical costs

- **Benefit or Product Changes and their Impact.** Changes made to existing benefits package or introduction of new products e.g. Basic Health Plan may lead to shifts or increases in costs
- **Random Fluctuations.** Onetime events such as an expensive flu season could cause increase in claims costs
- **Health Plan Initiatives to Control Costs.** Activities such as disease management and cost containment protocols, historical claims auditing, service provider code auditing, coordination of benefits and reimbursement recovery lead to bending down the health plan's cost trend curve

Deloitte will analyze multiple years of data related to these healthcare factors and their impact on health care costs. Adjustments needed to reflect observed trends will be assessed and incorporated into capitation rate development process when developing prospective trend assumptions.

3.V.D.2: Interim Reporting and Other Deliverables for Rate Setting Functions

RFP Reference: Section V.D.2, Page 25

Understanding of the Project Requirements

Our team will collaborate with the State to clearly present our results, recommendations, and consultative guidance during each rate cycle of the capitation rate development. A clear communication process is important to the success of this engagement. Our team is prepared to support the State through consultations and meetings for the requested deliverables and follow actuarially sound practices when communicating and documenting our findings.

SECTION HIGHLIGHTS

The Deloitte team's approach to interim reporting and other rate setting support:

- Provide timely updates and present our results, recommendation, and consultative guidance from strategy to implementation during each rate cycle of the capitation rate development
- Facilitate successful program monitoring activities and set milestones for tasks associated with the capitation rate setting process
- Improve the accuracy and efficiency of the existing and new capitation rate development methodologies and the data source used
- Create an oversight manual and conduct training sessions on documentation requirements as specified in the manual

Proposed Development Approach

Produce Documents and Facilitate Meetings

The development and determination of capitation rates require a collaborative relationship between Deloitte and the State. Deloitte is fully committed to serving Nebraska as a valued client. Our team will be available during business hours to respond to questions from Department staff on an unscheduled basis, and we will designate a primary point of contact to address issues on a daily basis. Deloitte has a presence in Nebraska, and our practitioners will be available for regular, scheduled, onsite meetings. Additionally, our staff will have as many ad hoc meetings as required via phone and when requested, onsite.

The Deloitte team will follow up phone conversations related to the capitation rate development with an e-mail summary of items discussed and the results of those discussions. The email will follow a dedicated formatted template for clarity and consistency.

At meetings that Deloitte and the State attend, the Deloitte team will prepare a meeting agenda before meetings and will take minutes during the meeting. Following the meeting, we will distribute a final copy of those minutes to designated Department staff using a formatted template. We will work with the State to finalize the format of such communications during the transition phase of this engagement.

The Deloitte team will produce documents and data requested by Department staff to aid discussion at meetings. We will also provide documents that we believe may assist meetings

and communications. Furthermore, we will work with the State to determine the most appropriate document storage method. We currently use a variety of methods with our current clients such as SharePoint, eRooms, and Secure FTP Transfers, which can be accessible to Department staff. Documents available on the repository will be the most current version of the document available. The Deloitte team will make available on the repository project documents related to the services listed in this RFP. Some of the documents may include, but not be limited to the following examples:

- All draft and final deliverables
- Any records of meetings related to the services listed in the RFP
- Documentation for presentations related to the services listed in the RFP

Improve Accuracy of the Existing and New Capitation Rate Development Methodologies

Deloitte also has internal quality controls in place to confirm the accuracy and quality of the work delivered and supporting documents to be delivered to the Department. Deloitte will work closely with Department staff and other Department vendors to confirm that the most efficient and accurate capitation rate development methodologies are being utilized. Additionally, any report or memorandum created by Deloitte for public distribution will be submitted to the Department for review and approval prior to release. The reports will be developed in a manner consistent with the requirements of this contract.

Accurate and quality base data is essential to being able to deliver quality capitated rates. The ability to validate, store, and report essential data on a consistent basis is a major factor in the success of capitation rate development. Elimination of data errors starts with a well-conceived and executed data collection plan. To address potential issues, we will work with the Department staff to review the state's current data collection practices, and potentially recommend changes to strengthen data accuracy. Deloitte will employ data validation by performing statistical analyses on the data to identify concerns caused by technical or reporting issues.

Each time data is collected from a health plan, it is considered leading practice to perform quality assurance (QA) tests to confirm the data is reasonable and helps mitigate downstream data-related issues. Deloitte will help the Department develop a standardized QA protocol to be used for each data transfer from vendors.

With our long history of working with state Medicaid agencies and CMS, we have developed working relationships with many other Medicaid vendors and contractors including CMS's central office and regional offices, Medicaid managed care organizations, and fiscal agents. We will use these relationships or form new ones to work collaboratively with the State's vendors and contractors as needed.

Collaborate to Determine Communication and Work Plan

A clear communication process is important to the success of any engagement. The Deloitte team will work collaboratively with Department staff to determine the appropriate communication plan, with our assumption the current plan used for the DMA initiative can be replicated. We believe weekly status reports should be prepared in a standardized template (i.e. PowerPoint) and shared with Department staff to provide updates on the engagement status. In addition, conference calls, video conferences via WebEx, and other meetings will be planned accordingly to discuss approach, review results, and address questions throughout the engagement. The timing and format of such communications will be finalized prior to the start of the engagement.

In regards to planning, we will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval. Also, milestone dates will be provided in the work plans, and will be contingent on the Department's approval. Our success will depend on our ability to deliver on time, on budget, high quality work products and deliverables that meet your needs. Providing reports and deliverables within the agreed upon timeline is obviously one way we will track successful completion.

Develop Dynamic Rating Methodologies and Train Staff

Deloitte will work with the State to identify tasks within the capitation rate development process to create materials and conduct a training to educate Department staff. The training session will provide knowledge so that the users are capable of using programs and software materials developed for contracted services. We anticipate developing a presentation that can be presented to DHHS staff prior to completion of the rates.

Finally, the Deloitte team has been assembled to support the dynamic environment of healthcare. We are able to develop, or assist in the development of the rate methodology for new programs. Deloitte brings the on-demand knowledge in fiscal strategy, Medicaid rate setting, and healthcare to serve the Department in creating, analyzing, and/or responding to emergent trends and new initiatives in the Department. In addition, Deloitte can also provide the Department with access to our national innovative research and analysis teams such as the Deloitte Center for Health Solutions. Our team will be able to leverage this research to develop innovative models and accelerate research for the Department.

The following table summarizes our high-level understanding of the subtasks. Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Deloitte's Understanding of the Subtasks

3.V.D.2.a	Participate in periodic meetings with Department staff to discuss the parameters, priorities, methodology, timelines, and ongoing results of capitation rate development in each rate cycle
3.V.D.2.b	Provide documents and data, as directed by Department staff, to discuss at these meetings
3.V.D.2.c	Provide project management staff and project/timeline updates for all tasks associated with the capitation rate setting process
3.V.D.2.d	Work collaboratively with Department staff to improve the accuracy and efficiency of the existing data sources and new data sources used for capitation rate development
3.V.D.2.e	Work collaboratively with Department staff and other Department vendors to improve the accuracy and efficiency of capitation rate development methodologies
3.V.D.2.f	Provide the Department with exhibits, reports, and calculations in the format(s) specified by the Department, including all formulae, databases, data sets, analyses, and documents relevant to the capitation rate setting process
3.V.D.2.g	Develop work plans for rates to be determined including milestones for completion
3.V.D.2.h	Meet work plan milestones and timelines as agreed upon with the Department
3.V.D.2.i	Provide staff training in methodologies used to develop rates
3.V.D.2.j	Develop or assist in development of rate methodology for any new program(s) that may be implemented during the contract period

Figure 3-13. 3.V.D.2 Subtasks.

Technical Considerations

Deloitte understands the importance of meeting project milestones and delivering results in a timely manner. We will work with the State to comply with the agreed upon workplans and overcome challenges that arise to deliver high quality results.

Data Delays

Delays in receiving high quality data could present challenges to meeting the agreed upon timing. Data delays could be caused by many factors including late data submissions, longer than expected data cleansing, or data access issues. When data delays occur, Deloitte with work closely with the State to revise any impacted timelines and workplans and work to keep the overall progress on track with the project timeframe. We anticipate data delays can be mitigated by utilizing data from DMA.

Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Detailed Project Work Plan

We will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval.

A high-level project timeline is included in Appendix 1. We will work closely with the DHHS in the beginning stages of the engagement to develop detailed work plans for each managed care program.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we may provide for Interim Reporting and Other Deliverables for Rate Setting Functions. We will work closely with DHHS in the beginning stages of the engagement to develop the detailed work plan and deliverable due dates.

Deloitte's Understanding of the Deliverables	
Status Reports	Regular status reports, at the appropriate cadence, will be provided to the Department. These status reports may include timelines, lists of priorities, progress updates, exhibits detailing results of actuarial analyses including in the capitation rate development, and descriptions of methodologies used in the capitation rate development to discuss with the Department. These status reports will follow a standardized structure agreed upon by Deloitte and the State.
Workplans	At the outset of rate setting tasks, we will provide a workplan with anticipated tasks and expected project milestones for discussion with the Department. Progress on these workplans will be communicated through the status reports.
Actuarial Rate Package	In connection with the actuarial memorandum, the Deloitte team will provide a package of exhibits to be provided to the Department that detail base data, adjustments, trend, non-medical expenses, and final capitation rate estimates. These will be provided in a format agreed upon by Deloitte and the State and include formulae, databases, data sets, analyses, and documents relevant to the capitation rate setting process, as applicable.

Figure 3-14. Potential 3.V.D.2 Deliverables.

3.V.D.2.a – Participate in periodic meetings with Department staff to discuss the parameters, priorities, methodology, timelines, and ongoing results of capitation rate development in each rate cycle

RFP Reference: Section V.D.2.a, Page 25

Deloitte is fully committed to working closely with the State to confirm projects are successfully completed. As mentioned above, Deloitte will be available for regular, scheduled, onsite meetings. Deloitte will have ad hoc meetings as required and when requested, onsite or via phone. We will be available during business hours to respond to questions from Department staff, and Deloitte will designate a primary point of contact to address issues on a daily basis.

Deloitte developed the managed care capitation rates in New York State which included weekly status meetings where the following items were discussed regularly:

- Progress updates
- List of priorities
- Methodologies utilized
- Results of data analyses

A clear meeting cadence will be finalized prior to the start of the engagement. Regular status meetings will be scheduled to review the status report and discuss project risks. In addition,

conference calls, video conferences via Skype, and other meetings will be planned accordingly to the project timeline and on an as needed basis to discuss approach, review results, and address questions throughout the engagement.

A clear documentation trail will also be necessary. Each meeting will have an agenda created so that attendees can prepare in advance. Meeting minutes will be distributed in a standard template to document the discussion.

3.V.D.2.b – Provide documents and data, as directed by Department staff, to discuss at these meetings

RFP Reference: Section V.D.2.b, Page 26

The Deloitte team will produce documents and data requested by Department staff to aid discussion at meetings. Materials will be distributed an appropriate amount of time in advance of the meeting to maximize the time during the meeting to review results and answer questions.

3.V.D.2.c – Provide project management staff and project/timeline updates for all tasks associated with the capitation rate setting process

RFP Reference: Section V.D.2.c, Page 25

We will designate a project manager to be responsible for operation of the contract duties and will be responsible for consultation and assistance with the State's personnel. The project manager will serve as the daily point of contact should issues arise and need to be addressed.

In addition to the project manager, we will have dedicated staff members responsible for the coordination of various project management duties. This will include development of meeting templates which include agendas, meeting minutes, and status reports. Agendas will be developed and distributed in advance of meetings. Meeting minutes will be captured and distributed to meeting attendees. A weekly status report will be distributed on a regular basis to discuss key activities, project timelines, and risks.

Open communication with the Department is important to keep the engagement on track. Deloitte will hold frequent meetings with Department staff in order to provide updates on the engagement status. We will work closely with Department staff in the beginning stages of the engagement to determine the frequency of these meetings and develop a status report template that aligns with the detailed project plan and timeline to monitor progress throughout the engagement.

Our success will depend on our ability to deliver on time, on budget, high quality work products and deliverables that meet your needs. Providing reports and deliverables within the agreed upon timeline is obviously one way we will track successful completion. Timely

feedback from the Department will also be required for suggested changes to the reports or deliverables. We will work to promptly incorporate the suggested edits into the reports and deliverables. Department staff will notify Deloitte as to whether the deliverables are satisfactory.

If awarded this contract, we will be moving into familiar territory – we have a team of experienced leaders who have performed large-scale engagement transfers before. To be successful at this transition, we will bring leadership skills, project management skills, and functional and technical qualifications that are aligned with the Department's key objectives. This opportunity is very important to us and if awarded this contract we will be ready to deliver on day one.

3.V.D.2.d – Work collaboratively with Department staff to improve the accuracy and efficiency of the existing data sources and new data sources used for capitation rate development

RFP Reference: Section V.D.2.d, Page 25

Throughout our data analysis we will be reviewing the data for accuracy and actively seek out opportunities to improve the data. The ability to validate, store, and report essential data on a consistent basis is a major factor in the success of capitation rate development. We anticipate that by using DMA as a primary data source for rate setting, many of the data collection and data validation efforts can be accelerated.

Elimination of data errors starts with a well-conceived and executed data collection plan. Such a plan lays out in detail what data is to be formatted and reported. To address potential issues, we will work with the Department staff to review the state's current data collection practices, and potentially recommend changes to strengthen data accuracy. Some recommendations might include creating a data collection plan, providing training sessions for the health plans, and devising a data dictionary to codify terms and field definitions to support consistent data formatting. Deloitte will employ data validation by performing statistical analyses on the data to identify concerns caused by technical or reporting issues.

The steps Deloitte implements to evaluate data quality:

- Determine the appropriateness of the data utilized for rate setting
- Measure the credibility and validity of health plan financial and encounter data
- Evaluate whether data collected meets relevant requirements in the CMS Managed Care Rate Development Guide
- Work with health plans to address data concerns

In any engagement, it is crucial to have quality data; which may involve appropriately assessing and adjusting existing data sources to eliminate potential biases and data anomalies. Upon project initiation, Deloitte will verify the accuracy and reliability of the available data based on reporting provided from the Department and standard checks for

completeness. Additionally, we will perform high level validations of the data based on other available data sources whenever required.

Each time data is collected from a health plan, it is considered leading practice to perform quality assurance (QA) tests to confirm the data is reasonable and helps mitigate downstream data-related issues. Deloitte will help the Department develop a standardized QA protocol to be used for each data transfer from vendors. Regardless of the data collection plan used, the Department should prioritize security of data through secure servers and practice the industry standards of data security procedures.

Deloitte will follow the Actuarial Standards of Practice #23 on Data Quality. We will follow the guidance on a) selecting the data that underlie the actuarial work product; b) relying on data supplied by others; c) reviewing data; d) using data; and e) making appropriate disclosures with regard to data quality. Generally, data that are completely accurate, appropriate, and comprehensive are frequently not available. Deloitte will use their professional judgement to assess the data quality and take action to improve issues identified. If data limitations are identified, we will disclose the limitations and implications on our analyses.

3.V.D.2.e – Work collaboratively with Department staff and other Department vendors to improve the accuracy and efficiency of capitation rate development methodologies

RFP Reference: Section V.D.2.e, Page 26

Deloitte has internal quality controls in place to confirm the accuracy and quality of the work delivered and supporting documents to be delivered to the Department. Use of tools allows Deloitte to provide the Department with reports and documents that were produced using tested and validated processes and analyses on a timely basis. This will help Deloitte confirm that all such reports are accurate, correct, and complete to give the Department the analysis it needs for program management. Deloitte will work closely with department staff and any other Department vendors to confirm that the most efficient and accurate capitation rate development methodologies are being utilized.

Additionally, as a majority of our proposed team are credentialed actuaries and Members of the American Academy of Actuaries, we meet the Qualification Standards of the American Academy of Actuaries. The team is very experienced in rate setting, risk adjustment, data management and analytics, actuarial analysis, financial analysis, and quality assessment. Our actuarial methods, considerations, and analyses conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board.

Any report or memorandum created by Deloitte for public distribution will be submitted to the Department for review and approval prior to release. The reports will be developed in a manner consistent with the requirements of this contract.

3.V.D.2.f – Provide the Department with exhibits, reports, and calculations in the format(s) specified by the Department, including all formulae, databases, data sets, analyses, and documents relevant to the capitation rate setting process

RFP Reference: Section V.D.2.f, Page 26

The Deloitte team will make available project documents related to the services listed in this RFP, in the format requested by Department staff. Some of the documents would include, but not be limited to the following examples:

- All draft and final deliverables described in the RFP
- Any records of meetings related to the services listed in the RFP
- Documentation for presentations related to services listed in the RFP

As outlined in the introduction on our approach to delivery, the Deloitte team provides both a high-level review of the rate development process and develops a detailed document outlining the rate setting process including assumptions, adjustments and calculations as part of the capitation rate certification letter for submission to CMS. Other ad hoc documentation or descriptive data reports are available upon request, to provide the State with an understanding of the critical elements of the rate development process.

Documentation of Our Rate Development

Our rate documentation includes:

- A description of the rate calculation process used
- A description of the methodology used to develop and validate the base data
- A description and explanation of the adjustments made to the data
- A description of the trend calculation methodology and data
- A description of the assumptions used and supporting reasoning
- A table of year-over-year changes to the rates or rate ranges

The Deloitte team has assisted over 30 states with the development of actuarially sound rates for various programs and produced reports to thoroughly document the rate development process.

Provide Management Summary Materials

At the end of the rate setting process, we present our results to the State, and outline year over year rate changes. Additionally, in this presentation, the Deloitte team addresses anomalies in the year over year rate analysis, and provides documentation explaining why these anomalies exist and where there may be areas for process optimization. During the first year of the contract, existing reporting and data books are reviewed and evaluated

against the State's goals. We work collaboratively with the State to develop a reporting plan that maintains consistency while enhancing the information available to support the State and its strategic decision-making process.

Systematic Documentation

The Deloitte team produces a wide variety of rate certification letters, data books, financial review summaries, and other reports to communicate the results from analytics completed using our suite of methods, accelerators, and tools. As an example, we recently completed an analysis of the impact on premiums of introducing a risk adjustment model in a state. For this project, we had to create the methodology used, gather data, assess and adjust the data, create the model, run the model, produce the results, and distribute the results to the affected health plans and to state officials. At the end of the project, we developed a methodology document that laid out the process we followed, described the data we used, discussed the adjustments we made, and presented the findings. This documentation allowed both the state and the affected health plans to understand the impact of the proposed risk adjustment model on their premiums as well as illustrate the effect poor data submission practices had on their results. We bring this level of rigor to all our projects as we believe that systematic documentation increases transparency in our communications, and allow facilitated knowledge transfer.

3.V.D.2.g – Develop work plans for rates to be determined including milestones for completion

RFP Reference: Section V.D.2.g, Page 26

We will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval.

A high-level project timeline is included in Appendix 1. We will work closely with the State in the beginning stages of the engagement to develop detailed work plans for each managed care program.

3.V.D.2.h – Meet work plan milestones and timelines as agreed upon with the Department

RFP Reference: Section V.D.2.h, Page 26

Milestone dates will be provided in the work plans, and will be contingent on the Department's approval. The Deloitte project manager will track the progress of each deliverable via a deliverable dashboard which logs each milestone due date, as well as the delivered date, review dates, and approval dates. Refer to our responses to **Part 2, Section 2.i – Summary of Bidder's Proposed Management Approach**, for more information on our project management and quality control approach.

3.V.D.2.i – Provide staff training in methodologies used to develop rates

RFP Reference: Section V.D.2.i, Page 26

Our team will work with the State to provide a training session to Department staff. This session will assist the Department staff to gain understanding of the methodologies used to develop rates. We propose that the training session be conducted via an onsite meeting and a supporting presentation can be distributed for those who cannot attend.

The methodologies of developing the rates will be documented in detail and pulled into a manual to share with the State. To kick off the training process, the Deloitte team will host a general meeting and give an overview presentation of the rate development. This overview presentation is to help the Department staff set the stage and get the ground information. We would then conduct the in-person meeting to walk through the rate development process step by step:

- Describe the base data selection process
- Discuss the development of assumptions
- Explain the new modeling files in addition to the existing modeling tools the State has and the ways we used them to complete the rate development.

Our project manager will also be available to address questions that the Department staff may have throughout the process.

3.V.D.2.j – Develop or assist in development of rate methodology for any new program(s) that may be implemented during the contract period

RFP Reference: Section V.D.2.j, Page 26

Deloitte will work closely with the State to understand the project objectives, timeline, and work plan. We can develop, or assist in the development of the rate methodology for new programs. Deloitte brings the on-demand knowledge in fiscal strategy, Medicaid rate setting, and healthcare to serve the Department in creating, analyzing, and/or responding to emergent trends and new initiatives in the Department.

In addition, Deloitte can also provide the Department with access to our national innovative research and analysis teams such as the Deloitte Center for Health Solutions. Deloitte Center for Health Solutions researches and develops solutions to our nation's health care and public-health related challenges. The Center has conducted extensive research and published numerous articles in the areas of health care reform, consumerism, health insurance exchanges, electronic health records, as well as Accountable Care Organizations, and medical homes. Our team will be able to leverage this research to develop innovative models and accelerate research for the Department.

It is critical for these methodologies to be innovative and cost-effective in order for the new program to be properly positioned for the future of health care. Our approach to assist in development of rate methodology for new programs follows these steps:

Figure 3-15. Approach for Rate Methodology Development for New Programs.

Understanding Vision and Goal

To start, the Deloitte team will work with the State's program development team to gain a comprehensive understanding of the background, the strategic vision and the goals on the new program the State plans to implement.

Determine Payment Model

To develop actuarially sound rates, the Deloitte team will conduct a feasibility analysis to select the best payment model for the new program. We would determine the ROI of the program operating under managed care and compare the results to the ROI operating under the other potential value based care payment models, such as an ACO.

Collect and Adjust Data

Once the payment model is determined, appropriate data will be needed to estimate the total cost of care. We will review the current cohorts to select a data pool that mostly resemble the demographic and programmatic features of the new program. The Deloitte team would then collect a variety of data across the rating periods and zones within the data pool. These data sources will include FFS data, encounter data, MCO financial data, policy and programmatic changes, managed care trends, managed care assumptions, market trends, other state information and other applicable sources. Each data source will be reviewed and cross-validated and adjustments will need to be made to the data so that it is representative of the new program.

The adjustments to the base data generally take three forms: normalizing the data for known issues, trending the data for anticipated changes in cost and utilization, and other assumptions including demographics, geographic, risk, eligibility, etc. Trend will be an important component as there will be no historical data for the new program as it is not

implemented. The Deloitte team will use our knowledge to develop service and unit cost trends based on the population data that is more representative of the new program.

Other Analysis

Savings factors will need to be developed based on an estimate of the reduction to medical cost. We will conduct a review of the current care management programs as well as the service category summaries. The areas where increased management of the population may reduce higher costs to the average will be estimated. We will also review non-medical costs to understand the administrative requirements for the new program. Deloitte will follow the CMS Managed Care Rate Development Guide and the actuarial standards of practice when working with the State to develop this methodology.

3.V.D.3: Capitation Rate Finalization

RFP Reference: Section V.D.3, Page 26

Our response in this section provides a general overview of the final actuarial memorandum and supporting documentation provided to DHHS. Each task associated with finalizing the capitation rates, including the types of documentation created and how regulations are followed is specifically addressed.

Understanding of the Project Requirements

Through our experiences in setting Medicaid managed care rates across a wide array of clients with various goals and needs, we recognize that clear and detailed documentation of the rate setting process is critical to the success of our relationship with DHHS. Our credentialed and experienced actuaries follow the documentation protocols laid out by the Academy of Actuaries, CMS certification requirements, and DHHS specifications. The actuarial memorandum and other supporting documentation we produce will include assumptions, adjustments, and calculations made to arrive at the rates and will provide a narrative description of each factor.

We will provide required technical support to DHHS, MCOs, and other interested stakeholders. Our support encompasses maintaining data, participation in rate meetings, providing technical support for rate negotiations with CMS, and technical discussions around emerging rate issues such as trend development, programmatic changes, service utilization, and medical and administrative efficiency.

We are at the forefront of assisting our clients with integrating innovative solutions such as value-based payments and accountable care to better align Medicaid programs to the future of healthcare administration.

SECTION HIGHLIGHTS

The Deloitte team's approach to rate documentation includes:

- Produce a detailed actuarial memorandum documenting and detailing Deloitte's proven rate setting process
- Create a financial summary exhibiting the value of the adjustments made during rate development and demonstrating a high-level view of the rate calculations
- Certify that all developed rates are actuarially sound and compliant with the Balanced Budget Act, the CMS rate setting checklist, and CFT 438.6(c)
- Support DHHS in state rate setting discussions and negotiations with CMS
- Provide final rates to DHHS by requested deadline

The following table summarizes our high-level understanding of the subtasks. Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Subtask	The Deloitte team's Understanding of the Subtasks
3.V.D.3.a	Document our rate development process and provide a memorandum disclosing the data, assumptions, and methodology used in developing rates
3.V.D.3.b	Attest that the rate setting process is compliant with all rate setting requirements described in the BBA
3.V.D.3.c	Certify that the rates are actuarially sound and provide the documentation to support this certification
3.V.D.3.d	Provide documentation supporting that the rates were developed in accordance with CMS guidance
3.V.D.3.e	Prepare presentation materials to support discussions with DHHS rate setting meetings
3.V.D.3.f	Attend DHHS meetings with CMS and support DHHS as needed
3.V.D.3.g	Provide final rates and rate exhibits to DHHS by requested deadline, 150 days or 5 months before effective date

Figure 3-16. 3.V.D.3 Subtasks.

Proposed Development Approach

The Deloitte team has significant experience in over 30 states in developing actuarially sound rates and creating actuarial memoranda and data books thoroughly documenting our rate setting process. These memoranda and data books have covered a wide array of plans and programs including behavioral health, physical health, non-emergency medical transportation, and VBP programs. Our rate setting process follows the documentation protocols laid out by the Academy of Actuaries, the actuarial standards of practice, the CMS Rate Development Guide, the Balanced Budget Act of 1997 (BBA), and DHHS specifications.

Upon completion of the rate setting procedures, the Deloitte team will provide a memorandum which will include:

- A description of the rate calculation process used
- A description of the methodology used to develop and validate the base data
- A description and explanation of the adjustments made to the data
- A description of the trend calculation methodology and data
- A description of the assumptions used and supporting reasoning
- A description of the risk adjustment process, if applicable
- Supporting exhibits containing summarized base data, base data adjustments, trend assumptions, risk adjustment (if applicable), non-benefit expense assumptions, other adjustments, and final rates
- A table of year-over-year changes to the rates
- A certification that the capitation rates are actuarially sound and compliant with CMS guidelines and the requirements of the Balanced Budget Act (BBA)

The Deloitte team will discuss and justify in this memorandum our chosen rate setting methodology and will describe the assumptions behind and methodology used for the

development of trend factors, program changes, adjustments for changes in the managed care programs, adjustments for administrative changes, change in the population risk status, and adjustments for changes in the covered population, as well as other adjustments needed. The exhibits provided to support the memorandum will show the value of each adjustment applied in the development of the rates and demonstrate a high-level calculation of the rates.

The Deloitte team will document in the memorandum the different data sources used in rate development, including but not limited to Managed Care encounter data, FFS data, and financial data. We will document our validation of the data used in the rate setting process. A detailed discussion of our proven approach to rate setting and data is discussed in more detail in **Section 3.V.D** above.

We understand that in reviewing, designing, and implementing our capitation models, compliance with the relevant rate setting regulations and guidance is critical. Our actuaries comply with federal regulations (CFR 438.4) which require an actuary developing rates for a Medicaid managed care program to do so following actuarially sound principles. CMS has outlined what it considers to be the approved process in its Rate Development Guide. The American Academy of Actuaries (AAA) developed a practice note addressing the issue of actuarial soundness in Medicaid managed care rate setting. Our team's actuaries are members of the AAA and are very familiar with the applicable requirements and actuarial practices. We will validate the base data as described above, apply the required adjustments, trend, and assumptions developed in cooperation with DHHS, to arrive at actuarially sound rates. We will provide a certification that the rates were developed in compliance with relevant regulations and the guidance discussed here.

In addition to the memorandum, we will provide supplemental exhibits which document the value of the assumptions and adjustments used in developing the rates and provide a high-level view of the rate calculations. Additional exhibits and other supporting materials will be created as needed to summarize our process and support rate discussions. The Deloitte team will collaborate with DHHS to clearly present our results, recommendations, and consultative guidance. A clear communication process is important to the success of this engagement. Our team is prepared to support DHHS by travelling on-site periodically as needed and for key meetings to allow for flexibility and efficiency in communications as we partner with DHHS in the rate setting and rate negotiation process. The establishment of an onsite team would also aid in these discussions.

These supporting materials will be available for DHHS review to confirm that our processes and results are consistent with DHHS specifications. Subsequently, the supporting materials and our team will be available to support DHHS in its rate setting meetings and discussion with CMS, as required. Generally, this form of technical support involves an overview of the rates and detailed discussions on the data sources, data timing, data adjustments, trend calculations, programmatic adjustments, assumptions used, and the administrative loads applied. In addition to our team's extensive experience in working with CMS, members of the Deloitte team have previously worked at CMS and thus are familiar with the rate negotiation process from CMS' point of view.

Additionally, we are prepared to help DHHS comply with the CMS rule finalized in 2016 which requires new documentation to be developed and delivered to CMS. We will work collaboratively with DHHS to develop the required documentation for CMS as requirements become effective including but not limited to: enhanced MLR reporting, rate development methodology if requested, validated data used in capitation rate development, and compliance with new network adequacy standards and new rate certification standards.

Finally, Deloitte understands that timely rate setting procedures are critical in a managed care program, therefore final rates and final rate exhibits will be submitted to DHHS 150 days or five months prior to their effective data.

Technical Considerations

As the Deloitte team documents our rate development process and provides final rate exhibits, memorandum, and certifications, the following are potential technical aspects to consider.

CMS Rule Compliance. The CMS rule finalized in 2016 requires new documentation to be developed and delivered to CMS, as well as additional considerations in the rate development. The required documentation will need to be developed with DHHS as the requirements become effective. We will work collaboratively with DHHS to develop the required documentation and ensure the documentation and rate development meets the new standards.

Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Detailed Project Work Plan

We will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval.

A high-level project timeline is included in Appendix 1. We will work closely with the DHHS in the beginning stages of the engagement to develop detailed work plans for each managed care program.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we may provide for the programs in scope. We will work closely with DHHS in the beginning stages of the engagement to develop the detailed work plan and deliverable due dates.

Deliverable	Our Understanding of the Deliverables
Actuarially Sound Capitation Rates &	Using our rate setting model, we calculate actuarially sound capitation rates that take into account program specific considerations and comply with CFR 438.4, the AAA standards of practice, and the CMS rate setting checklist. As part of this, an actuarial

Deliverable	Our Understanding of the Deliverables
Actuarial Memorandum	memorandum will be produced documenting actuarial assumptions made, as well as the data, materials, and methodologies used in the development of the rates.
Certification Letter for Submission to CMS	We will produce a certification letter to CMS. This letter will provide details on the data, adjustments, assumptions, and methodology used to arrive at the actuarially sound rates. This certification letter will meet all requirements are stated in the CMS Rate Development Guide.
Presentation Material	We will provide supporting documentation and presentation material as requested by DHHS for DHHS rate setting discussions and meetings.

Figure 3-17. Potential 3.V.D.3 Deliverables.

3.V.D.3.a – Produce an actuarial memorandum that provides a detailed description of the methodology for developing the capitation rates along with all actuarial assumptions made and all other data, and materials used in the development of rates

RFP Reference: Section V.D.3.a, Page 26

As discussed above, the Deloitte team will provide a memorandum detailing our rate calculation process, the data and adjustments applied, the assumptions made, and a summary of year over year changes.

As discussed in **Section 3.V.D** above, our rate setting documentation provides the justification supporting each of our assumptions and adjustments. Our rate setting methodology adjusts for the following external factors:

- Programmatic changes brought on by implemented changes in the policy and operation of the DHHS programs
- Health care trend and unit cost inflation, based on assumptions developed from historical data by our credentialed actuaries and adjusted based on their knowledge of the Nebraska Medicaid program and the health care delivery system in general
- Other changes in population risk status, managed care programs, covered population, and other external factors

Our memorandum will be prepared under the supervision of Deloitte actuaries who are members of the AAA and have extensive experience certifying capitation rates for a multitude of states and a wide variety of Medicaid programs.

3.V.D.3.b – Certify that the rates comply with all requirements for managed care rate setting as described in the Balanced Budget Act (BBA) of 1997 including attestations of actuarial soundness and certification of plan rates in accordance to the BBA

RFP Reference: Section V.D.3.b, Page 26

In the memorandum discussed above, we will attest and certify that the methodology and assumptions used in our rate development comply with the requirements of the BBA as well as the Code of Federal Regulations section 438.4 and the CMS Rate Development Guide. We are experienced with these regulations and documents. We also follow generally accepted actuarial principles and practices by referring to the actuarial Code of Professional Conduct and the relevant Actuarial Standards of Practice (ASOP), such as ASOP #23 regarding data quality and ASOP #49 regarding Medicaid Managed Care Capitation Rate Development and Certification.

The Deloitte team's rate setting process follows actuarially sound practices

- Complies with CFR 438.4
- Complies with the CMS Rate Development Guide
- Extensively documented and factually based

3.V.D.3.c – Provide actuarial certification as to the soundness of the rates along with all associated exhibits supporting the development of capitation rates

RFP Reference: Section V.D.3.c, Page 26

Our actuaries comply with federal regulations (CFR 438) updated in 2016 which require an actuary developing rates for a Medicaid managed care program to do so following actuarially sound principles. CMS had outlined what it considers to be the approved process in its Rate Development Guide. When certifying our final rates, we will reference the practice note[1] from The American Academy of Actuaries (AAA) addressing the issue of actuarial soundness in Medicaid as well as the study[2] released by AAA discussing the definition of actuarial soundness. Our team's actuaries are members of the AAA and are very familiar with the applicable requirements and actuarial practices. We will validate the base data as described

[1] Medicaid Rate Certification Work Group of the American Academy of Actuaries "Health Practice Council Practice Note, Actuarial Certification of Rates for Medicaid Managed Care Programs", August, 2005

[2] The Actuarial Soundness Task Force, American Academy of Actuaries, "A Public Policy Special Report, Actuarial Soundness", May, 2012

above, apply the required adjustments, trend, and assumptions developed in cooperation with the DHHS, to arrive at actuarially sound rates.

Additionally, we recognize there were new elements introduced in the CMS rule approved in 2016. Under the rule, all rate cells must be submitted to CMS, provider-preventable conditions must be identified and reported, point estimate capitation rates must be developed and be certified in accordance with new network adequacy and MLR guidance, and value based payments under capitation are allowed. We are prepared to partner with DHHS to create and submit the additional required documentations as the requirements become effective and will certify that the rates were developed in accordance with new guidance.

Further, we will partner with DHHS to identify new opportunities presented by the allowance of value based payments. Based on our experiences supporting states in their efforts to save costs and innovate – such as supporting the State of Maine in designing and implementing their Accountable Communities program – we understand the challenges present when implementing and designing new programs as well as the potential efficiencies and savings opportunities which they represent.

3.V.D.3.d – Provide necessary certification to meet the requirements of the CMS rate setting consultation guide

RFP Reference: Section V.D.3.d, Page 26

The Deloitte actuarial team will certify the rates we develop as meeting the federal requirements for actuarial soundness as specified under 438.4. Our rate certification is documented in a certification letter that can be sent to CMS. This letter provides details on the data, adjustments, assumptions, and methodology used to arrive at the actuarially sound rates. Further, we will be available for related discussion with CMS on our certification.

Per the CMS Rate Development Guide, we will validate and document that payment rates are:

- Certified to be actuarially sound as described above
- Developed using generally accepted actuarial principles and practices
- Based only upon services covered under the State Plan (or costs directly related to providing these services, for example MCO administration)
- Reflective of adjustments for external factors discussed above in **Section 3.2.A.1**
- Provided under the contract to Medicaid-eligible individuals only

3.V.D.3.e – Prepare all presentation material, attend and participate in MCO meetings as requested to promote approved recommendations

RFP Reference: Section V.D.3.e Page 26

We intend to support you throughout the rate development and rate negotiation process in a manner that meets your needs. As discussed in the introduction, we will create all exhibits, memoranda, and other supporting documentation for DHHS rate setting discussions and meetings. Further, we are prepared to incorporate an onsite team, as necessary, to work efficiently with DHHS.

This team will attend, participate, and provide support at DHHS rate setting meetings. Deloitte has key experiences supporting rate development discussions across a wide array of clients, including conversations with managed care organizations, Medicaid directors, and CMS.

3.V.D.3.f – Attend, participate, and provide support in the Department's rate setting discussions and meetings with CMS

RFP Reference: Section V.D.3.f, Page 26

The Deloitte team brings experience in working with State Medicaid agencies, MCOs, and CMS in discussions related to the rate setting process, calculated rates, and changes to the Medicaid reimbursement structure. In fact, our team members have worked with CMS to develop CMS rate setting checklists. Additionally, team members have previously worked for CMS and are familiar with the rate negotiation process from CMS' point of view. This work has allowed us to gain insight into CMS' processes and practices.

We also have key experience working to support states in discussions with CMS, both with regard to managed care rate development and accountable care organization rates.

Based on our experiences working on rate setting with states including Kentucky, Maine, Minnesota, Texas, and New York, we have developed a deep understanding of State Medicaid programs and how we can best support them in discussions with CMS. These experiences position Deloitte's team to have significant impact while participating in DHHS meetings with CMS.

As discussed in the response to **Task 3.V.D.3.c** above, we are prepared to assist DHHS transition to the new reporting requirements described in the 2016 final CMS ruling as they are implemented. We will identify new opportunities for DHHS through the allowance of value based payments under capitation, and will provide support in discussions with CMS regarding these new opportunities.

3.V.D.3.g – Submit final rates and final rate exhibits 150 days or 5 months prior to their effective date

RFP Reference: Section V.D.3.g, Page 26

The timely development and finalization of rates is essential to operating an efficient managed care program. We will work closely with DHHS in the beginning stages of the engagement to develop detailed work plans for each managed care program so that final rates and supporting rate exhibits can be shared with DHHS in a timely manner before their effective date.

3.V.E: SOW 2 - Capitation Rate Rebasing

RFP Reference: Section V.E, Page 26

Understanding of the Project Requirements

The Deloitte team is well qualified to support DHHS in rebasing the rates for new emerging experience observed in the Medicaid program. Our team has extensive experience in accounting for new emerging data and how that data impacts different adjustments used in the initial rates and the trend applied to bring the base data forward to the rating period. Our team will work with the State to utilize new data as it is available to re-estimate the managed care rates applicable for the upcoming rating period.

SECTION HIGHLIGHTS

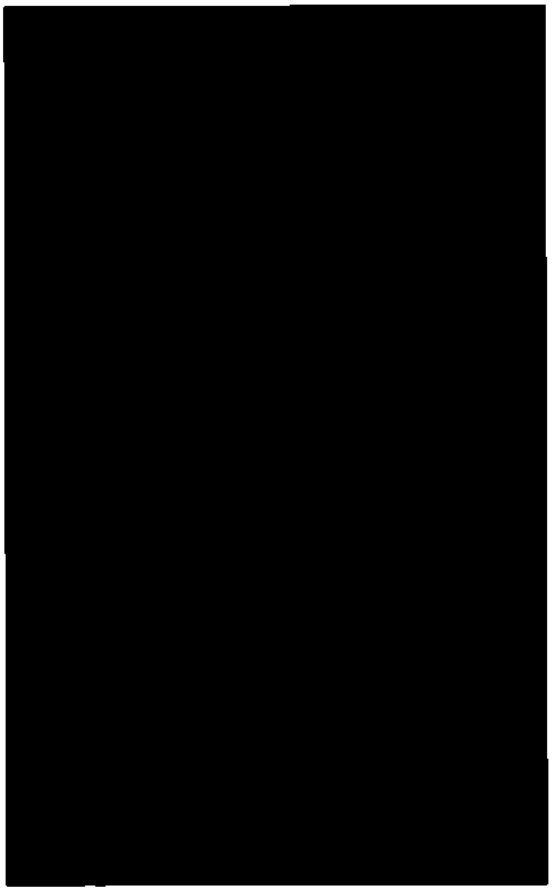
The Deloitte team's approach to rebasing the capitation rate development includes:

- Utilizing more recent experience in developing the managed care capitation rates
- Considering alternative methodologies for developing capitation rates
- Confirming alternative methodologies and rebased data proposed will be acceptable based on CMS guidelines
- Delivering a documentation structure that clearly lays out the impact of rebasing to DHHS and applicable parties

As the Department wishes to utilize new base data sources and new rate setting methodologies, the Deloitte team will assist the DHHS in analyzing different types of rate methodologies and models that can be utilized in the development of its actuarially sound rates and rate ranges. Through our team members, we bring in-depth knowledge of different methodologies used in the rate setting process and hands-on experience with utilizing a variety of different data sources used to set the rates. Additionally, our team has extensive knowledge of the CMS Regulations on rate setting laid out in CFR 438 and the managed care rate development published each year from CMS. In particular, recent CMS guidance requires states and their actuaries to utilize the most recent three years of data available on an annual basis for the capitation rate setting process. We will coordinate with the DHHS on the most appropriate data sources to utilize each year as part of the rate development process in light of these new managed care regulations.

We are prepared to provide required technical support to the DHHS, MCOs, PIHPs and other interested stakeholders throughout the capitation rate rebasing process. Our support encompasses rate development, data analysis, participation in rate meetings, providing technical support for rate negotiations, technical discussions around emerging trends, analysis of alternative rate cells, training for department staff and preparing presentation materials on the impact of capitation rate rebasing.

Proposed Development Approach



The Deloitte team develops actuarially sound rates and rate ranges following the applicable actuarial standards of practice, CMS' rate setting managed care rate development guide, and the requirements of CFR 438. As more recent data is collected our team can consider modifications to the rates developed through rebasing the data for more emerging experience.

As emerging experience becomes available and additional data sources such as encounter data continue to improve, Deloitte will work with DHHS to rebase the rates towards these new data sources.

Additionally, we will work with DHHS to implement new rate setting methodologies utilizing different base data sources, different data sources for program changes and different assumptions that may be applied to trend to reflect more recent data available.

A detailed description of our rate setting process is found in **Section 3.V.C.1.a.** The remainder of this section describes how rebasing would reflect that process.

The following table summarizes our high-level understanding of the subtasks. Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Subtask	The Deloitte team's Understanding of the Subtasks
3.V.E.a	Consider different rate setting methodologies and models to utilize in the rate development process
3.V.E.b	Analyze emerging data for considerations in rebasing the rates
3.V.E.c	Consider changes in potential cohorts for the managed care program
3.V.E.d	Confirm any revisions to the rate development methodology follow CMS guidelines
3.V.E.e	Provide documentation and training for department staff for new rate setting methodologies
3.V.E.f	Provide actuarial certification to the soundness of any rebased rates
3.V.E.g	Develop presentation materials for any rebased rates

Figure 3-18. 3.V.E Sub-tasks.

Technical Considerations

While our team is responsible for updating the actuarial capitation rate ranges for each period, there are key items we collaborate with DHHS to collect in the rate setting process including:

Base Data items for Rate Setting

Deloitte works with DHHS and the DMA team to collect the necessary base data items that may be used to rebase the managed care rates as part of SOW 1. This data collection includes financial reports, eligibility data, encounter data, historical FFS data, data dictionaries, methodology to analyze categories of services, cohorts, covered populations and other key items to analyze base data. When considering different base data sources to use to change the methodology to develop the rates, Deloitte does a detailed review of data sources against one another including comparing financial data to encounter data to determine encounter data completeness and comparison of emerging managed care data to FFS data for populations and services that have recently moved to managed care.

The State of Nebraska has a very mature physical health managed care program as these services have been covered in managed care since 1995. For these services that have been long-standing in the state's managed care program, we utilize managed care encounter data and/or plan submitted financial data to set the rates. However, for newer services such as behavioral health services that have recently been added to the state's benefit package, as credible emerging managed care experience may not be yet available for the entire benefit package covered by the state, we may leverage additional data sources such as historical FFS data to utilize a credible data source in the rate setting process. As the newer services have emerging managed care experience that can be deemed credible, we can rebase the rates to utilize these new sources.

Detailed Project Work Plan

We will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval.

A high-level project timeline is included in Appendix 1. We will work closely with the DHHS in the beginning stages of the engagement to develop a detailed work plan.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we may provide for the programs in scope. We will work closely with DHHS in the beginning stages of the engagement to develop the detailed work plan and deliverable due dates.

Deliverable	Our Understanding of Capitation Rate Rebasing Deliverables
Encounter Data and Financial Report Comparison	A detailed summary on how the different base data sources such as encounter data and financial reports compare for considerations in changing the methodology utilized to develop the rates
Impact of Rebasing Rates	Detailed summary and presentation materials of how changing the rating methodology would impact historical rates for considerations in modifying rate development methodology going forward.

Figure 3-19. Potential Deliverables for Capitation Rate Rebasing.

3.V.E.a – Analyze different types of rate methodologies and models used by governmental and commercial entities upon request

RFP Reference: Section V.E.a, Page 26

The Deloitte team has extensive experience in considering different rate methodologies and models that can be used in setting managed care rates for the DHHS and will work the Department to update for new models as they are requested. As different stakeholders gain familiarity with the DHHS Medicaid program and have suggestions on how to reflect certain program change adjustments differently or different sources that can be utilized, the Deloitte team has a process in place to collaborate with those departments and take into consideration other stakeholder feedback in the rate setting process.

Additionally, as requested, the Deloitte team will recommend different models for DHHS to consider that our team has implemented in other states or are newer methodologies or models that are being utilized by other states. In in the State of Maine, our team worked with the state to develop a unique ACO program that was tailored to the program goals and outcomes that the state was interested in implementing. This program included a unique attribution methodology, risk adjusted total cost of care targets, claim caps to address outliers, risk corridors that varied by ACO size, quality measures and targets, and a shared savings methodology between the ACOs and the state.

3.V.E.b – Analyze paid claims (both fee-for-service and managed care, managed care financial statement data, and managed care encounter data with a specific focus on developing a rate range of high/target/low full risk capitation rates

RFP Reference: Section V.E.b, Page 26

As discussed in **Section 3.V.D**, actuarially sound rates are highly dependent on accurate, complete, and timely data. This data can take many forms and generally depends on the maturity of the program and sophistication of the participating health plans. As services in the program mature, specifically behavioral health experience currently in Nebraska, and the health plans gain experience, fee-for-service data can largely be replaced by encounter data. However, encounter data raises new issues in that there is no longer a direct one-to-one correlation with a claim and a payment.

Throughout the capitation rate rebasing process, we will evaluate new data sources to consider if they can be utilized when rate setting and what their impact may be on the high, target and low capitation rates. For the encounter data, we propose that supplemental data in the form of health plan financial data be gathered by DHHS in coordination with our team. By performing a detailed financial review of this data and comparing it to the reported encounter data, we can identify potential issues with the encounter data and bring those to the attention of the errant plan for process improvement and revision. This process would be similar to the process in place with DMA today.

Our team of actuaries and health plan financial reviewers has the experience and knowledge needed to determine where a health plan's encounter data reporting is deficient or when a plan's financial data does not support its reported level of service. We use this knowledge to identify opportunities for improvements in encounter data and financial data reporting by health plans that will ultimately improve the accuracy, completeness, and timeliness of the base data used to set rates thus improving the accuracy of the high, target and low capitation rates.

3.V.E.c – Analyze rate cell alternatives for identification of various groupings for the population (e.g. age, gender, eligibility)

RFP Reference: Section V.E.c, Page 26

Deloitte has the knowledge required so that the costs and characteristics associated with managed care cohorts are accurately reflected. We understand that medical and pharmacy costs vary by parameters such as but not limited to age, gender, eligibility group, level of care and geographic region.

As part of the rebasing process, we will analyze if there are different ways to potentially divide the base data sets based on differing levels of risk or geographic cost variation. As part of this rebasing analysis, we will consider the following steps:

1. Start with the same base period eligibility and medical expense data used in the rate setting process
2. Analyze a potential range of cohort variations to determine the necessary logic for managed care cohorts to be credible but reflect appropriate levels of cost variation
3. Review potential cohort changes with DHHS
4. Adjust rate setting process in future for any agreed upon changes in the cohorts in the state

Deloitte understands and appreciates the importance of establishing appropriate rates for each cohort in the Medicaid program. Our experience assisting other state Medicaid programs with the review and development of rates for specific populations provides us with the knowledge to analyze any possible changes to the structure of cohorts in the state as part of the rebasing effort.

3.V.E.d – Assess compliance of rate methodologies and applications with Federal and State laws, rules, and regulations regarding reimbursement and budget-related issues

RFP Reference: Section V.E.d, Page 26

In rebasing rates, it is important that any changes to the methodology comply with the appropriate federal and state laws, rules and regulations. In the rebasing process, our actuaries comply with federal regulations (CFR 438) which require an actuary developing rates for a Medicaid managed care program to do so following actuarially sound principles. CMS has outlined what it considers to be the approved process in its Capitation Rate Checklist. The American Academy of Actuaries (AAA) developed a practice note[3] addressing the issue of actuarial soundness in Medicaid managed care rate setting. The purpose of the practice note was to provide nonbinding guidance to an actuary when certifying rates or rate ranges for capitation of Medicaid managed care programs. Recently the AAA released a study[4] discussing, in part, the definition of actuarial soundness. Our team's actuaries are members of the AAA and are very familiar with the applicable requirements and actuarial practices. The Deloitte team actuaries have developed actuarially sound rates under the applicable regulations for many years.

For any items that are rebased or changed as part of the rebasing process, we will validate the changes and assumptions developed in cooperation with DHHS, to arrive at rebased actuarially sound rates. We will provide a certification that the rates or rate ranges were developed in compliance with relevant regulations and the guidance set forth.

3.V.E.e – Provide documentation and training for Department staff on new capitation rate-setting methodologies and procedures. Documentation and training shall be easily understood, allowing the Department to implement and manage the execution of new capitation rate-setting methodologies

RFP Reference: Section V.E.e, Page 26

Deloitte team will work with DHHS to provide a training session to Department staff on any new methodologies resulting from the rebasing process. This session will assist the Department staff to gain understanding of the methodologies used to develop rates and

[3] Medicaid Rate Certification Work Group of the American Academy of Actuaries "Health Practice Council Practice Note, Actuarial Certification of Rates for Medicaid Managed Care Programs", August, 2005

[4] The Actuarial Soundness Task Force, American Academy of Actuaries, "A Public Policy Special Report, Actuarial Soundness", May, 2012

efficiently use the programs and software developed for contracted services, as agreed to in the final contract terms.

The methodologies of developing the rates will be documented in detail and pulled into a manual to share with DHHS. To kick off the training process, the Deloitte team will host a general meeting and give an overview presentation of the rate development. This overview presentation is to help the Department staff set the stage and get the ground information. We would then conduct an in-person meeting to walk through the rate development process step by step:

- Describe the base data selected as part of the rebasing process
- Discuss how assumptions are modified based on the rebasing
- Explain the new modeling files in addition to the existing modeling tools DHHS has and the ways we used them to complete the rate development using rebased rates.

Our project manager will also be available to address questions that the Department staff may have throughout the process.

3.V.E.f – Provide an actuarial certification as to the soundness of the rates the contractor develops

RFP Reference: Section V.E.f, Page 26

Our actuaries comply with federal regulations (CFR 438.4) updated in 2016 which require an actuary developing rates for a Medicaid managed care program to do so following actuarially sound principles. CMS had outlined what it considers to be the approved process in its Rate Development Guide. The American Academy of Actuaries (AAA) developed a practice note addressing the issue of actuarial soundness in Medicaid. The purpose of the practice note was to provide nonbinding guidance to an actuary when certifying rates or rate ranges for capitation of Medicaid managed care programs. Our team's actuaries are members of the AAA and are very familiar with the applicable requirements and actuarial practices. The Deloitte team's actuaries have developed actuarially sound rates under the applicable regulations for many years. We will validate the base data as described above, apply the required adjustments, trend, and assumptions developed in cooperation with the DHHS, to arrive at actuarially sound rates.

Additionally, we recognize there were new elements introduced in the CMS rule approved in 2016. Under the rule, all rate cells must be submitted to CMS, provider-preventable conditions must be identified and reported, rates must be developed in accordance with new network adequacy and MLR guidance, and value based payments under capitation are allowed. We are prepared to partner with DHHS to create and submit the additional required documentations as the requirements become effective and will certify that the rates were developed in accordance with new guidance.

Further, we will partner with DHHS to identify new opportunities presented by the allowance of value based payments. Based on our experiences supporting states in their efforts to save costs and innovate – such as supporting the State of Maine in designing and implementing their Accountable Communities program – we understand the challenges present when implementing and designing new programs as well as the potential efficiencies and savings opportunities which they represent.

3.V.E.g – Prepare all presentation material, and attend and participate in with MCO meetings as requested to promote approved recommendations

RFP Reference: Section V.E.g, Page 27

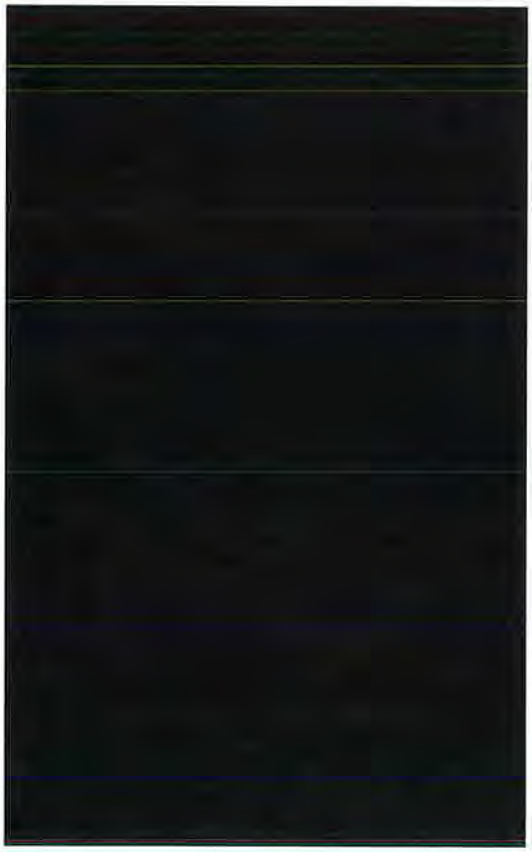
We intend to support you throughout the rate development and rate negotiation process in a manner that meets your needs. As discussed in the introduction, we will develop exhibits, memoranda, and other supporting documentation for DHHS rate setting discussions and meetings.

This team will attend, participate, and provide support at DHHS rate setting meetings. Our team is prepared to support DHHS by travelling on-site periodically as needed and for key meetings to allow for flexibility and efficiency in communications as we partner with DHHS in the rate setting and rate negotiation process. Deloitte has key experiences supporting rate development discussions across a wide array of clients, including conversations with managed care organizations, Medicaid directors, and CMS.

3.V.E.1: Policy and Financial Management Consulting Services

RFP Reference: Section V.E.1, Page 26

Understanding of the Project Requirements



Deloitte understands that the State has major efforts underway to transform the Medicaid healthcare delivery system into a financially sustainable care delivery system. This is evidenced by the Long-Term Care Redesign efforts as well as Heritage Health's commitment that MCOs implement value-based contracts with an increasing proportion of their network providers to reach a goal of value-based contracts for 50% of the MCOs' providers in five years' time.

In order to have long term success with these programs, DHHS needs a partner who understands how Medicaid eligibility and financial spend data can be collected, validated and manipulated, using analytics to empower the DHHS and allow program managers to use all the data that may be available to better manage its program while improving outcomes. The Deloitte team has the knowledge to transform analytics into actionable insights to respond to financial patterns impacting the Medicaid program and managed care.

Lastly, as new regulatory and legislative requirements are anticipated to be released in response to demands to improve the health care system, the DHHS seeks consulting and advisory services that will provide insight, guidance, and tools to help anticipate and prepare for these regulations and requirements. The Deloitte team is positioned to support the DHHS in its efforts to quantify the effect that policy changes will have on managed care and to analyze the impact of legislative mandates at the federal and statewide level. We are able to draw from our existing knowledge of payment reforms proposed and enacted in other states based on past and present experience working with other state Medicaid departments.

"Our team looks forward to partnering with the State to support your managed care programs. Data-driven decision making and accountable, outcome based design is a cornerstone of an innovative system of care and Nebraska's Medicaid managed care innovation."

Jim Jones
Policy and Financial Management Consulting Services Policy Lead

Value-Based Payments (VBP)

Our team brings deep VBP experience with both health plans, providers, and public sector agencies in establishing fair and transparent shared savings targets, establishing bundled payment mechanisms in high impact areas, and other total cost of care models across the risk spectrum. We have helped stakeholders reduce potentially avoidable readmissions, ER visits, and other complications in service to improving the patient experience.

As outlined in the Deloitte publication, The Road to Value-Based Care, the shift toward VBP presents unprecedented opportunities and challenges. Instead of rewarding volume, new VBP models reward better results in terms of cost, quality, and outcome measures. These models have the potential to upend health care stakeholders' traditional patient care and reimbursement models. The shift has already begun in some markets to build key capabilities around VBP. As organizations plan their route to VBP, it is important to understand that there is no single, "right" payment model that fits all situations.

A recent report surveying states on their activities to plan and administer alternative payment models, including value-based arrangements, found that:

- The most common alternative payment models in use by state Medicaid programs are payments based on care episodes, populations, and additional payments that support delivery system reform.
- Like Nebraska, states are pursuing enhancements in data portals to encourage collaboration under a value-based payment arrangement. Minnesota has developed a web-based data management portal to share data on provider risk, performance, and patient-level care coordination metrics.

Deloitte's experience gained in markets where the shift to VBP is underway shows that the transition is much like a road trip—different routes and modes of transportation can get travelers to their destination. By implementing a holistic process and leveraging robust supporting data—much like following a GPS system—the DHHS can develop payment model(s) that work for your populations and stakeholders.

Our approach will provide insight into charting which path to VBP is appropriate for the various stakeholders in Nebraska. Our approach evaluates the current state of payment reform initiatives already underway and reviews nationally recognized and evidence-based leading strategies throughout the health care industry. We can assess economic opportunities and identify payment model strategy options, each backed by a business case, data analytics, and with quantitative and qualitative costs, estimated program resource needs, and identified regulatory challenges. We can support DHHS in identifying optimal partners, reviewing contracts based on risk appetites, assist in configuring optimal low cost and high performing provider networks, and support build out robust monitoring tools and processes to support effectiveness of various risk share contracts and bundled payments.

Data Visualizations and Analytics

The DHHS seeks to improve on its financial management tools in a way that will support easy, accurate review of the financial and operational performance of the Medicaid program. Our analytical solutions are equipped to support, refine, and advance existing tools and ultimately enable data-driven decision making. Our DMA team is working with DHHS on transforming the MLTC program to be fundamentally data-driven by giving stakeholders access to quality data, appropriate tools and services. The knowledge gained and lessons learned from building this data platform will be used to further DHHS data management and analytic capabilities.

Deloitte is a recognized analytics leader in the marketplace

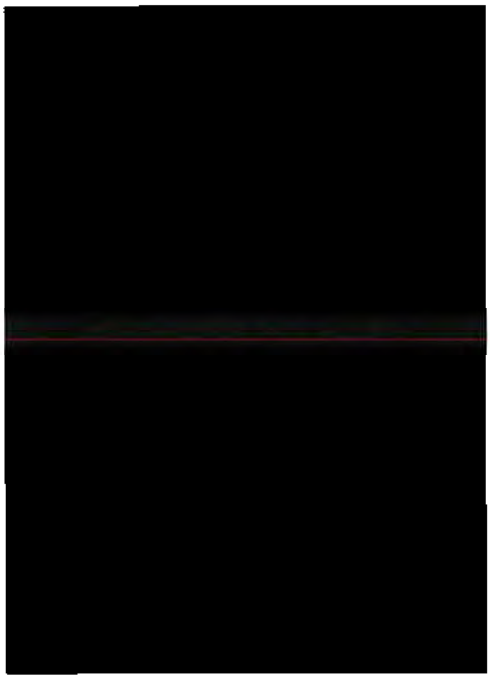
- Deloitte was named by Kennedy as a Leader in Analytics IT Consulting
- Leader in Business Intelligence Services Providers by Forrester
- "Strong Positive" in market scope BI and IM in North America by Gartner

To help the DHHS accomplish its goals around data management and analytics, the Deloitte team will use our national experience in analytics coupled with our large State Health practice. Deloitte employs a robust Analytics practice comprised of over 5,000 practitioners with significant experience advising our clients on data management and analytics and delivering analytics solutions.

Deloitte Analytics offers a broad suite of capabilities to help clients tap into the value of their data and enable insight-driven decision making. We are a recognized, leading provider of data management and analytics consulting services, focused on assisting clients with business transformations through data management and analytics. Deloitte Analytics brings a wide array of backgrounds in advanced analytics, statistical modeling, operational efficiency, data discovery, data science, and more to meet our clients most complex analytic needs. The figure below summarizes some of the benefits of a continued focus on data analytics and improved reporting capabilities through data visualizations:

Figure 3-20. Reasons for Refining Analytics and Reporting Capabilities.

Policy and Regulation Changes

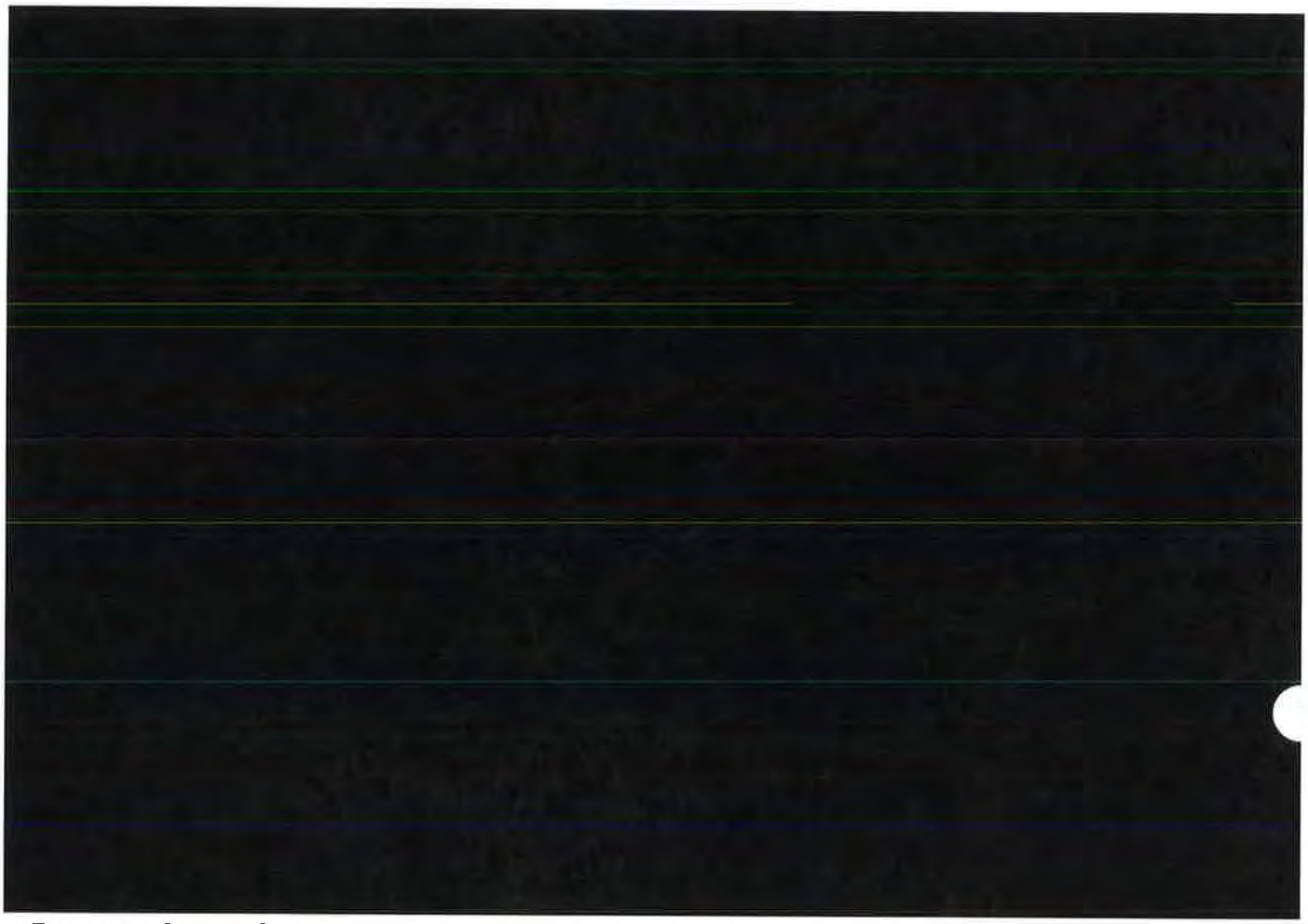


The DHHS is working to build a high-performance, financially sustainable Medicaid delivery and payment system, and the Deloitte team brings a strong background in both government policy and Medicaid program design to help the DHHS adapt major initiatives that will improve the delivery and payment of Medicaid services in the state. Deloitte will designate a team accountable to DHHS requests for information on policy and legislative activity. The responsibilities of this team will include, but not be limited to, the following:

- Analyzing proposed policy and legislative changes that will affect the transition to non-service based payments
- Consulting on the efficiency of the Managed Care delivery system
- Consulting on State budget proposals, Federal Medicaid waivers, and budget neutrality
- Supporting DHHS in onsite plan reviews as required
- Providing other ad hoc actuarial, consulting, and financial/accounting technical assistance services

Deloitte can serve the DHHS's needs for policy advisory services by using our Proactive Policy Analysis (PPA) solution which helps us to promptly take an in-depth look at the impact of legislation and policy to assess true impact and set expectations. This tool allows public sector agencies and departments to assess how changes impact budgets, operations, mission, technology assets, strategic planning and execution, preparing for pending legislation and policy changes.

As described in the figure below, the tool allows us to understand potential impacts of new legislation by capturing program information that may be impacted by legislative changes. The actual details of the potential legislation are then added to build a relationship model and map that shows an agency where in their organization the legislation has potential impacts against program goals and budgets.



Proposed Development Approach

The following table summarizes our high-level understanding of the subtasks. Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Subtask	The Deloitte team's Understanding of the Subtasks
V.E.1.a	Explore various Value Based Payment (VBP) models for the State's Medicaid program as an alternative to the current reimbursement structure
V.E.1.b	Analyze federal and state policies, provide technical support and analysis in the transformation of the State's Medicaid reimbursement system
V.E.1.c	Support the development and continued maintenance of total cost of care benchmarks and bundled payments
V.E.1.d	Provide technical assistance in evaluating management agreements, contracts, and cost sharing and cost allocation methods as they pertain to Managed Care plans
V.E.1.e	Support refinement of existing financial monitoring tools, on-site monitoring, and plan engagement techniques
V.E.1.f	Develop dashboard reporting with benchmark comparisons by category of service

Subtask	The Deloitte team's Understanding of the Subtasks
V.E.1.g	Analyze the accuracy of Managed Care Organization (MCO) premiums, retrospectively, based on overall MCO financial performance
V.E.1.h	Provide on-site financial, clinical and operational assessment
V.E.1.i	Track and analyze financial impacts of transition from service based payments programs to Managed Care
V.E.1.j	Develop annual MCO financial reports comparing financial and medical management efficiency, medical loss ratio, profitability and financial solvency, net worth per member, and other key metrics

Figure 3-22. Task 3.V.E.1 Subtasks.

Technical Considerations

Considerations for the underlying subtasks within this section will vary depending on the requested support. As the Deloitte team develops reports, tools, dashboards, and financial models related to the requested policy and financial management services it will be important to account for the following technical considerations:

- Confirming that any data provided to Deloitte by MCOs or by the DHHS is credible and accurate. DHHS should also ensure that any data passed to Deloitte for these services has been reviewed and validated for accuracy. Leveraging DMA as the primary data source should help expedite this process
- Ensuring that the DHHS understands the process that went into any financial analysis and the data behind it
- Documenting various procedures in the event that the DHHS or Deloitte needs to update any analysis

Additionally, while traditional service-based payment models have tended to increase the volume of services without guaranteeing either sufficient cost containment or improvements in the outcomes of patient care, it will be important to continue to monitor program results to determine if the initiatives and reimbursement methodologies are resulting in cost efficiencies, increased quality, and/or improved access.

Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Detailed Project Work Plan

The timeline and activities will vary by depending on the requested support. We will work closely with DHHS staff in the beginning stages of the engagement to determine the requested scope of services and develop a detailed work plan. The proposed work plan will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and other key dates will be contingent on DHHS's approval.

An illustrative example of a high-level project timeline we may develop in support of the requested Policy and Financial Management activities is included in Appendix 1.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we may provide for the policy and financial management subtasks. We will work closely with DHHS in the beginning stages of the engagement to determine the final scope of services, develop the detailed work plan, and deliverable due dates.

Deliverable	Our Understanding of the Deliverables
Payment Model Considerations	Develop a presentation that summarizes the end-to-end operational needs for selected payment models. This presentation will support DHHS in defining the VBP roadmap.
Payment Model Impact	Leverage encounter data analytics to assess the financial impact to the rate setting process of switching populations over to VBP payment models.
Contract Review Assessment Report	Develop a report that outlines our findings and recommendations based on our review of managed care contracts and agreements and how they align to proposed VBP initiatives.
MCO Financial Dashboards	Provide breakdowns of medical and pharmacy claims and utilization by population, region, and managed care organization, administrative and claim cost comparisons against contractual rates and rate ranges, as well as plan market share and performance
Pharmacy Cost and Utilization Dashboards	Provide breakdowns of pharmacy claims and utilization by population, region, and managed care organization.
Premium Adequacy Analysis	Analyze the adequacy of the premium rates for various MCOs during the course of the fiscal year and determine if rate setting adjustments are necessary.
MCO Financial Comparison Report	Prepare a report summarizing variances in cost components by MCO to aid in the development of a profit cap requirement

Figure 3-23. Task 3.V.E.1 Potential Deliverables.

3.V.E.1.a – Work collaboratively with the Department in the exploration of various Value Based Payment (VBP) models for the Department's Medicaid program as an alternative to the current reimbursement structure

RFP Reference: Section V.E.1.a, Page 26

With U.S. healthcare costs higher than other countries, it is important now more than ever to develop high quality, financially-sustainable healthcare delivery and payment models. Incorporating value based care and thereby value based payments into care delivery models provides opportunities for curbing costs while improving the quality of care and health outcomes for the Nebraska population.

Deloitte provides subject matter advisors with experience across the health care market through working with payers, providers, state governments, and the Federal government on value based care initiatives. Led by an actuarial team that has successfully designed and implemented value based care initiatives for dozens of clients spanning across providers,

integrated delivery systems, national and local/regional plans, and states, we will provide financial modeling support that aligns with the State's value based payment initiatives.

We will evaluate the selected models for applicability to the DHHS's objectives along with the associated cost impacts and potential savings. We will then help define the financial models and associated parameters that will move the State's programs to a value based payment system that supports collaboration amongst providers, promotes population health improvement, and leverages emerging population health improvement projects and data.

The figure that follows summarizes our modeling approach for reimbursement transformation and value based payment initiatives.

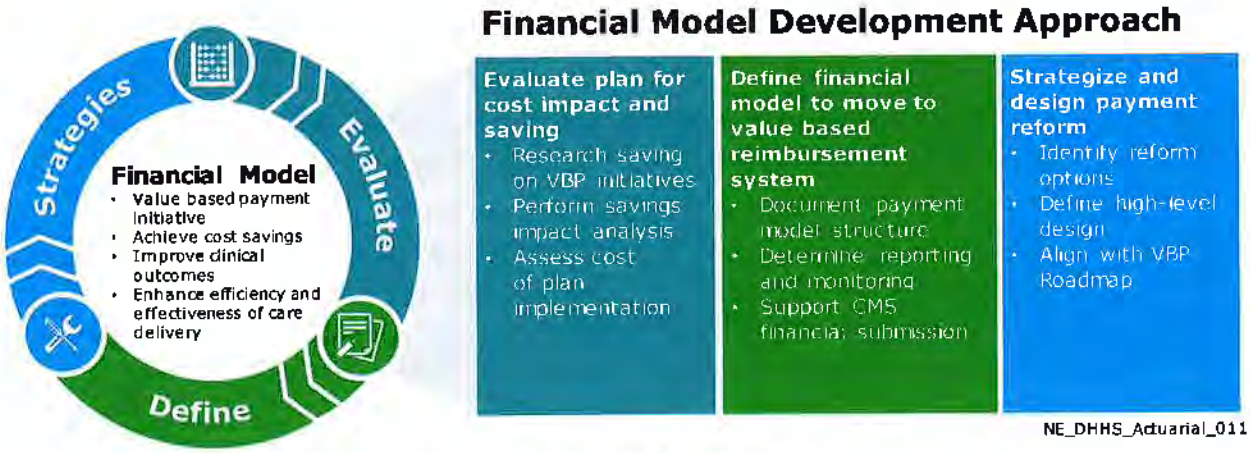


Figure 3-24. Reimbursement Transformation Financial Modeling Approach.

Strategize and Design VBP Reimbursement Options

When designing payment reform initiatives several considerations need to be addressed, such as the population being served, the prevalence of the services for the covered population, the demographics of that population, and the program goals.

Such considerations include, but are not limited to:

- **Overall Program Goals.** Payment methodology should align with the goals and objectives that the DHHS is trying to achieve and the included populations.
- **Prevalence of Service.** Services that account for most of the expenses are often included in risk-based reimbursement due to largest opportunities presented.
- **Overlapping Services.** The DHHS may want to consider excluding services that have already been managed via other initiatives or programs.
- **Potential for Cost-Shifting.** The DHHS may consider the potential for cost-shifting, especially if only certain populations or services are included in a risk-based reimbursement. For instance, providers may push more hospital care to long-term home and community based care if hospital care is included in risk-based reimbursement while

the latter is not. The shifted cost should be taken into account when measuring the "actual" savings.

- **Administrative Expenses.** Expenses that do not directly relate to the care delivered but improve the quality of care and operational efficiencies (e.g., care coordination, service monitoring, etc.) should be reflected in the payment methodology.
- **Provider and Plan Willingness and Capability to Take on Risks.** The DHHS may want to consider the potential financial burden of services to be included in payment methodology for the participating providers and plans in the program.
- **Prevalence of Existing Arrangements.** The DHHS may want to consider the current shared savings arrangements between MCOs and PPSs or other payer/provider organizations in determining the success of these arrangements.
- **Impact on Quality and Access.** Ultimately, the payment model should not negatively affect the quality of care and patient access, which will have a downward impact on population health.
- **Current Payer-Provider Landscape.** The DHHS may want to consider the prevalence, if any, of certain payer and provider groups. For example, Independent Practice Associations (IPAs) are often well suited to conform to an accountable care model if they are accustomed to capitated risk-sharing payment structures.

Identify Payment Reform Options

In accordance with the state's commitment to requiring contracted MCOs to enter value-based contracts with providers, we will help the State identify payment model options that align with the population covered and to improve population health and achieve predefined objectives. We will perform an opportunity assessment for targeted population segments to identify clinical intervention opportunities that can be incorporated into various types of payment models. This assessment will include analysis of past performance and comparison to industry benchmarks as well as analysis of current value base payment programs in effect, as well as an evaluation of payer and provider readiness to assume risk across people, processes, and technologies. We will also research value based care programs and payment methods utilized and found to be successful in comparable states.

Deloitte was rated by KLAS as the number one firm for ACO advisory services, strategy, assessment, and preparing organization for the transition to value based care

Having worked with private and public entities, we will leverage our experience and the findings of the opportunity assessment to evaluate payment options that align with the State's VBP goals in reducing cost and improving the quality of care. This includes evaluating payment options, populations, services, program parameters, fund distribution, and risk- and case-mix adjustments.

While research of other states and commercial payers and providers will provide insight into successful models, there are certain aspects of the program that might need to be tailored to suit the market landscape of the State. Some of these aspects to be tailored include:

- **Payment Model.** The payment model for value based care programs varies across different circumstances and should be tailored for the State. For instance, retrospective models for implementing bundled payment arrangements have fewer regulatory and administrative burdens at implementation, but require substantial effort to complete the retrospective review. Conversely, when used for complex conditions, the prospective models create significant financial burden for providers since they control payment distribution to individual stakeholders and care providers. Tradeoffs such as these should be carefully vetted in order to guarantee success of the State's VBP initiatives.
- **Program Parameters.** Value based care program parameters should reflect state-specific experience, goals, and population covered. Our ability to provide data analytics on actual Nebraska encounter data, MCO financial data, and other data and ability to leverage existing platforms (e.g., Medicaid Performance Analytics) for potential program parameters will help the DHHS customize them to align with the VBP initiatives.
- **Covered Population and services.** Nebraska has made an effort in building population-based payment models focused on total and high-risk populations. Deloitte has the experience to complement the States' efforts in developing the supporting analytics platform and data warehouse infrastructure. The population included in the managed care and service based payments program as well as the program goals and desired outcomes will help determine what services should be covered. The Medicaid population demographics vary across states. An assessment of the population to be included and the services utilized by those individuals should be conducted to help identify the appropriate services to be covered.

From this research, we can identify potential alternative payment methods and guiding principles for the State to consider. The figure below highlights some of the major payment models in the health care market today.

Payment Model	Provider Organization Payment	Maturity	Potential Financial Risk
Fee-for-Service (FFS)	• Each covered medical service or procedure is paid a set fee after it has occurred	• Started in its current form with the launch of Medicare in 1965 • Prospective payments (per-admission payments to hospitals) began in the early 1980s	• Low risk • Risk is in volume
Shared Savings	• Paid under FFS until year-end reconciliation • Shared savings bonuses are paid if expenditures do not exceed cost-containment goals	• Not yet widely adopted • A growing number of these contracts have started since the passage of the Affordable Care Act (ACA) in 2010, which established a permanent, voluntary	• Medium risk • Risk is only from collecting for savings, no fines from losses • Risk is in not managing costs and missing savings opportunities

Payment Model	Provider Organization Payment	Maturity	Potential Financial Risk
	• Bonuses given if quality goals are achieved • No financial risk if cost or quality goals are not met	program and many Medicare pilots • Some commercial and Medicaid purchasers have sponsored these	• Risk with severity of patients' illness
Bundles	• Episode-based payment • Payment for services across multiple providers and care settings for a treatment or condition during a defined time period	• Started in the mid-1980s by two commercial payers (Prudential, United Healthcare) for solid organ transplants • Further traction with CMS heart bypass demonstration in the 1990s and bundles for end-stage renal disease • The ACA included Medicaid demonstrations (2012) and Medicare pilots (2013) for bundles • CMS continues to offer bundled payment programs for Medicare enrollees • Now being piloted for chronic conditions	• Medium-high risk • Risk from collecting for savings and being fined for losses • Risk is in volume • Risk is in not managing costs and missing savings opportunities • Risk with severity of patients' illness
Shared Risk	• Paid under FFS until year-end reconciliation • Savings bonuses if cost containment and quality goals (upside) are achieved • At risk for a portion of spending that exceeds a cost containment target (downside)	• Not yet widely adopted • Medicare Shared Savings Program proposed rule in 2012 suggests that ACOs will be expected over time to take on shared risk, in addition to shared savings • In 2008, Aetna launched a pilot with its Medicare Advantage program and NovaHealth, an independent physician group in Maine, that shared risk and resulted in quality and efficiency improvements	• High risk • Risk from collecting for savings and being fined for losses • Risk is in not managing costs and missing savings opportunities/being penalized • Risk with severity of patients' illness

Figure 3-25. Examples of Payment Models in the Health Care Market.

Define High-level Designs

Once the payment reform options are identified we can conduct a feasibility assessment to identify the impact within the State programs to better understand the intricacies of each payment method. This assessment relies upon our experience with other states and lessons learned from pursuing and examining similar initiatives. As part of this process, we leverage existing data sources to analyze the cost, utilization, access, and quality impact of selected payment models.

During this step, we gather the available data, evaluate the selected potential alternative payment options, and provide options for the State's consideration as well as participating MCOs, PPSs, IPAs, and other payer and provider groups. We will perform high-level

sensitivity and scenario analysis around key parameters (such as minimum group size, catastrophic claim threshold, and risk corridor size) for each payment option. We will summarize the advantages, disadvantages, and feasibility for each of the payment options as well as the linkages with the State's other initiatives currently in place.

Throughout this process we will work side-by-side to align the payment model with the State's VBP initiatives. We will work closely with the State to provide viable payment models for payer and provider's consideration. Our focus is to help the State continue migrating service based payment structures to value based reimbursement models.

We anticipate the deliverable for this sub-task will be a PowerPoint presentation which will outline our findings and recommendations on the various VBP models to present to DHHS leadership. This information will support DHHS in the development of their VBP roadmap, which will be used to guide the Department on the methodology and timeline of the future VBP initiatives. The work supporting the below related VBP sub-tasks will be based upon the guidance outlined in the VBP roadmap.

3.V.E.1.b – As part of this transformation, the Department anticipates major policy changes over the next several years with the implementation of federal and state health care payment care reform. The contractor will be required to establish and staff a VBP team to analyze federal and state policies and provide technical support and analysis in the transformation of the Department's Medicaid reimbursement system. The contractor will assist in quantifying the impact of proposed policy and legislative changes on existing capitation premiums; those changes that can affect the total number of eligible consumers, the underlying risk of the capitated population, or the Medicaid benefits package, which may increase or decrease the average capitation premium

RFP Reference: Section V.E.1.b, Page 26

After the value based payment model(s) are defined in the VBP roadmap, we can evaluate the cost impact and potential savings opportunities as the DHHS continues to transition more services into managed care. These analyses can be performed to understand the impact on the capitation rates and can be incorporated into the rate setting process.

Our existing rate setting team will form the basis of our VBP team. Deloitte also has over 300 Value Based Care professionals that focus on different aspects of value based payment models including design, implementation, and impact analysis of regulatory and policy changes. We will be able to draw from this pool of professionals to support our existing rate development team. Deloitte also has a large team of consultants who make up the Washington Rewards Policy Center of Excellence as well as the Deloitte Center for Health Solutions. Between these two groups, the Deloitte team is positioned to continuously

monitor legislation and industry change and provide ongoing support to the State around its Value Based Payment initiatives.

Our VBP team will be able to quantify the impact of policy and regulatory changes on eligible enrollment, benefit packages, and capitation premiums. In addition, we can leverage Deloitte's Proactive Policy Analysis Framework and Legislative Review process to enable our analyses and decisions. These processes can be employed by the VBP team specifically to measure the impact of potential VBP policy changes and would support in the effort to increase value based payments as part of the State's Medicaid reimbursement system.

Our Approach

Consistent with the approach we follow when incorporating program adjustments into the capitation rates, we plan to follow a similar approach when analyzing whether VBP initiatives have an impact on the capitation rates. We will monitor, incorporate and update the rate setting process such that the rates are compliant and consistent with new programmatic or legislative changes on an ongoing basis. We will make adjustments, as required, request appropriate data, and make potential methodology changes. More information on our approach for incorporating programmatic adjustments to the capitation rates can be found in our responses to **Section 3.V.D.3** and **Section 3.V.E**. Following the process below, we will work with the DHHS and the VBP workgroup to quantify the impact of such changes and incorporate into the capitation rate setting process, as appropriate. We anticipate these analyses to occur annually, in coordination with the rate setting efforts, as DHHS makes decisions to align with the VBP roadmap.

Proactive Policy Analysis

Analysis in support of developing health policy requires an in-depth understanding of the current legislative environment coupled with the use of a comprehensive array of qualitative and quantitative analytic methods including statistical analysis, case studies, surveys, model development, and cost-benefit analysis. In order to better serve the DHHS in quantifying the impact of redesign initiatives, policy analysis should address the following areas:

- Assess the goals of efficiency and effectiveness
- Account for the role and influence of stakeholders and the structural factors affecting the issue at hand
- Use the most complete and accurate data available
- Clearly written in a readable, concise, focused style
- Operationally ready to meet the DHHS's goals and objectives

To perform meaningful policy analysis for our clients, we employ Deloitte's Proactive Policy Analysis framework. Our Proactive Policy Analysis framework is laid out in the following graphic.

Figure 3-26. Deloitte's Proactive Policy Analysis Framework.

This framework addresses complex problems by employing a rational model approach that first defines the problem, establishes goals and develops appropriate evaluation criteria, identifies potential alternatives, evaluates those alternatives, and reports on the advantages and disadvantages of the policy being considered. In the process, we look at the economic, social, and environmental factors influencing the issue to gain a more complete appreciation of the potential impacts the policy decision may have on the State budget, along with other stakeholders and interested parties.

Legislative Review Process

State and Federal legislation can significantly impact existing and planned programs. The Deloitte team can meet with the DHHS to develop a process to review pending state and federal legislation that could impact the DHHS as a result of the VBP initiatives. The figure below displays our approach to legislative reviews.

Figure 3-27. Legislative Review Process.

- **Monitor Legislative and regulatory Activity.** Identify the trends/topics that are most likely to impact programs and assign the resources to stay abreast of new developments
- **Identify Bills for Analysis.** "What bills will have significant impact on our programs"
- **Conduct Analysis.** "What have we learned, what is the data telling us, what will be the impact of the legislation including cost considerations"
- **Determine Action to Take.** "What are the biggest priorities, what are the strategies to be used to support or oppose the changes – what is the roadmap to address the needs"

Quantifying the Impact

Our process to determine analyze and quantify the impacts of program changes follows these steps:

- **Data Gathering.** Our policy and healthcare specialists will closely monitor the policy and legislative changes and efficiently gather the proper information analysis
- **Impact Analysis.** We will develop a financial model to assess how shifting from the current model to future models and initiatives could affect the capitation rates. Our financial model will have the ability to analyze different levers available for value creation such as eligibility, the underlying risk of the population, or the Medicaid benefits package and can aid to prioritize how aggressively each lever could be pursued.
- **Solution Development.** The Deloitte team will work with the DHHS to provide and incorporate innovative ideas to address the required changes due to policy or legislated changes to assist in the realization of the VBP initiatives throughout the payment transformation

Figure 3-28. Process to Analyze and Quantify Program Changes.

- **Documentation.** The Deloitte team will produce various summaries and reports to communicate analysis results to the DHHS and key program stakeholders
- **Implementation.** We will work with the DHHS to implement innovative solutions to the methodology and the program that address the changes while minimizing the fiscal impact and keeping the program well-positioned for future changes

Leveraging our actuaries, clinicians, financial specialists and data analytics specialists, the Deloitte team has the resources to identify, analyze, and assess the VBP impact to the Medicaid program. We understand that the healthcare programs in Nebraska are continuously evolving. The success of Nebraska's Medicaid Multi-Payer Medical Home Pilot Program is just one example of how reimbursement has evolved in recent years. As reimbursement trends continue towards paying for value and services continue to integrate, our deep experience in the policy and regulation space will provide tremendous value to the success of the State's VBP initiatives.

3.V.E.1.c – The VBP team will also be tasked in assisting the Department with the development and continued maintenance of bundled payments and total cost of care benchmarks

RFP Reference: Section V.E.1.c, Page 27

Deloitte's value based care professionals have expansive knowledge of bundled payment arrangements. Once bundled payments are established in coordination with the VBP roadmap, the VBP team would be tasked to maintain current bundled payments by calculating cost of care benchmarks so that adequate and fair compensation can be determined for services rendered under specific episodes of care.

Deloitte has the subject matter experience and resources to efficiently calculate and analyze cost of care benchmarks using analytic suite of tools outlined in our response to **Task 3.V.E.1.f** and can also leverage DMA. We would incorporate national and state data sets, health plan and provider specific cost, utilization, and other data to generate cost of episode benchmarks. We would then work collaboratively with the DHHS and payer and provider stakeholders so that the proposed updates to bundled payments are viable for the services rendered and aligned with the State's initiatives and VBP goals.

As states approach implementing additional bundled payments, key characteristics in the payment development include:

A phased rollout. Launching bundled payments in waves allows for payer and provider feedback, episode definition adjustments and enhancements to episode identification and administration. As administration infrastructure becomes scalable, additional episodes can be launched at a more rapid pace.

Identifying a select number of bundled payment options for initial rollout, and then phasing in additional waves. When considering bundled payment options, the State should consider the pace at which claims-based strategies to define episodes for payment become available, the efficacy and credibility of risk adjustment methodologies, and overcoming relatively small sample sizes of lower volume episodes or lower volume providers. Common examples of bundled payments that have been implemented by states in initial rollouts include perinatal care, ambulatory upper respiratory infections (URIs), ADHD, CHF, and hip and knee replacements.

We believe the development of bundled payments should have foundation built upon a clear and agreed upon definition of care. This forms the foundation of how services will be bundled and reimbursed. In addition, other considerations include:

- Incorporating incentives to promote efficiency and provider collaboration.
- Developing quality metrics to shift reimbursement to rewarding value over volume. A few example metrics that could be applied to certain episodes include follow-up visit rates, percent of patients on appropriate medication, inpatient admission rates, and screening rates for specific conditions or biometrics.
- Reporting considerations both by the department and the MCOs and/or providers to be able effectively monitor performance, determine scores against quality metrics, understand costs by service and examine overall results by episode.

Deloitte incorporates the above considerations and leverages our experiences and tools in the support of bundled payment development. As described below, we will also follow our Bundled Payment Framework that we use as our high-level approach in supporting bundled payment initiatives:

Figure 3-29. Bundled Payment Framework.

Deloitte can work with the DHHS to establish the bundled payment program and related alternative payment models by identifying and prioritizing opportunities, planning the design and implementation, and finally launching bundled payment pilots. Each of the above components contains additional steps can be broken down as follows:

Identify and Prioritize Opportunity.

- Review specific goals and guiding principles for expanding bundled payment programs within the DHHS' VBP initiatives
- Identify and gather the necessary data sources (with the appropriate grouping codes incorporated) to perform the calculation
- Understand the conditions for bundled payment (e.g., volume, improvement opportunity, ease of clinical impact, etc.)

Design and Implementation Planning

- Review DHHS' bundle definitions
- Establish target bundle prices based on historical claims experience and cost benchmarks
- Confirm the implementation timing against the VBP roadmap

Launch Bundled Payment Pilots

- Review test claims provided by DHHS to determine the bundled payment logic is applied appropriately
- Review internal and external communication materials

Deloitte's VBP team is uniquely suited for maintaining and developing the DHHS's bundled payment programs as payment reform continues to incentivize providers and payers to assume greater risk and be held accountable for the quality of care delivered. Our team will collaborate with the DHHS to align the new bundled payments with the VBP initiatives.

We anticipate there will be a one-time roll-out of a select number of initial bundled payments as defined in the VBP roadmap. We will work with DHHS to scope the appropriate number of bundled payments and revisit the overall scope of this effort based on the final VBP design considerations.

3.V.E.1.d – Provide technical assistance in evaluating management agreements, contracts between related parties, and cost sharing and cost allocation methods as they impact Managed Care plans

RFP Reference: Section V.E.1.d, Page 27

Creating value and improving health outcomes will require a focus on near-term cost efficiencies as well as a commitment from different stakeholders to use standard protocols and tools. We have experience providing technical assistance to entities across the provider, health plan, and public sector spectrums. Our team will use the following steps in assisting the DHHS in evaluating management agreements, contracts between related parties, and cost sharing and cost allocation methods.

Consistency with VBP Plan Design

As agreements, contracts, and other cost sharing provisions are developed as a result of the VBP initiatives, we can support DHHS in the review of the materials. Our assessment can review that the documents align with the underlying VBP principles, in areas such as the following examples (as applicable based on the final VBP Roadmap):

- **Cost Reduction.** Does the contract language include provisions that align with expected total cost of care reductions?
- **Clinical Efficiency.** Do provider agreements incorporate appropriate language for targeted clinical efficiency measures and thresholds?
- **Risk Sharing in Contracts.** Do the cost sharing provisions appropriately reflect the new risk sharing arrangements?

Document Review Findings

As we conduct our review of the selected contractual documents and agreements, we will note areas of inconsistency with the underlying VBP logic and propose modifications and opportunity areas for DHHS to consider.

Facilitate Review Meeting

Upon completion of our documentation review, we can facilitate a meeting with DHHS to review our recommended modifications and opportunities for DHHS to consider. As the final language is determined during this meeting, our team can assess the potential impact on rate setting processes, as appropriate, following a similar approach as outlined in **Task 3.V.E.1.b** above.

3.V.E.1.e – Assist in refinement of existing financial monitoring tools, on-site monitoring, and plan engagement techniques which include, but is not limited to plan encounter validation reports plan encounter data comparison reports.

RFP Reference: Section V.E.1.e, Page 27

We have a broad understanding of financial and reporting issues and in the health care space. Using our extensive accounting and actuarial experience within the health care industry in conjunction with the DHHS's guidance provides the support of your ongoing monitoring process, measure contracted managed care plan financial performance, quality of care performance, and management effectiveness, in addition to providing advice and recommendations on compliance issues, possible sanctions, and technical assistance as requested.

Refinement of Existing Financial Monitoring Tools

We can review the State's existing financial monitoring tools. Our team is experience with monitoring tools and have leveraged them in rate setting projects across other states. For example, our Risk Based Capital Model and our Incurred But Not Paid (IBNP) model, which use regression and cross-sectional analyses to develop plausible relationships among base data, are used to augment a State's current approach to crosschecking and testing data from various sources (such as MCO data, encounter data, and financial data) and different state agencies.

To start the monitoring process, the Deloitte team can meet with the State to discuss the current process in place for financial monitoring. We review the current processes and discuss suggested modifications to the process with the State. The Deloitte team will review the monitoring measures in place. We will review the historical experience of the program and identify additional issues that need to be monitored going forward.

On-site Monitoring

The monitoring of the MCO's financial performance plays a major role in developing the base data used to set actuarially sound capitation rates. Additionally, such financial information is used by the DHHS to monitor an MCO's efficiency at delivering care, compliance with clinical leading practices, and management performance. Our team's financial consultants are highly trained in developing financial monitoring methodologies and performing financial reviews.

Deloitte brings subject matter advisors with on-site monitoring experience:

- We supported CMS in conducting on-site reviews of the financial performance of multiple CO-OPs
- On-site review activities included confirming backlog, gathering claims policies and pricing procedures, claims review, and identifying potential changes to controls from CMS

We can support DHHS in reviewing their onsite monitoring procedures. As part of this review, we can consider the processes in place for activities such as information gathering, claims review, and analysis of MCO financial data against encounter data. The findings from our review of the onsite monitoring process the onsite reviews will be shared in a report to DHHS to support future modifications and resolution plans.

Plan Engagement Techniques

In order to assist the State in its continuing efforts to improve the review of MCO data received, we coordinate our financial monitoring and review efforts with the other tasks requested. A coordinated approach is needed to meet the State's goals.

Deloitte can review the current plan engagement techniques to identify areas of opportunity. We can compare these techniques against best practices found in other states and offer additional recommendations. We understand that components of the plan engagement process may include: compliance with Generally Accepted Accounting Principles, or Statutory basis of accounting, management techniques of appropriate personnel who are principally responsible for financial and accounting matters, and current analytical procedures.

3.V.E.1.f – Develop dashboard reporting with benchmark comparisons by category of service for the Managed Care programs

RFP Reference: Section V.E.1.f, Page 27

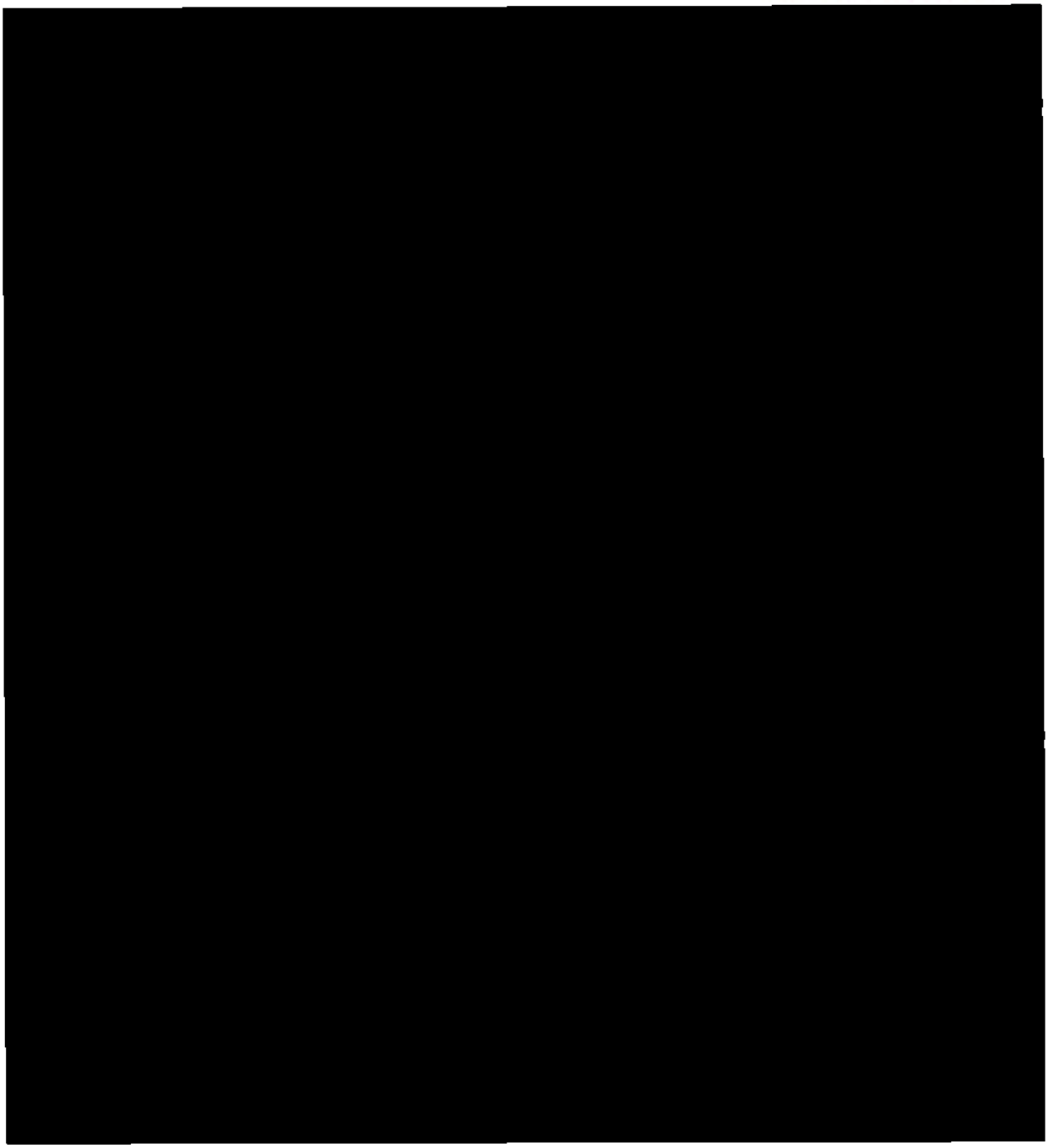
We are a recognized, leading provider of data management and analytics consulting services, focused on assisting clients with business transformations through data management and analytics. Deloitte Analytics brings a wide array of backgrounds in advanced analytics, statistical modeling, operational efficiency, geographic information system (GIS), core business intelligence (BI), data discovery, data science, and more to meet our clients most complex analytic needs. We also have access to leading-edge internal databases that can be used in benchmarking comparisons as needed by the DHHS.

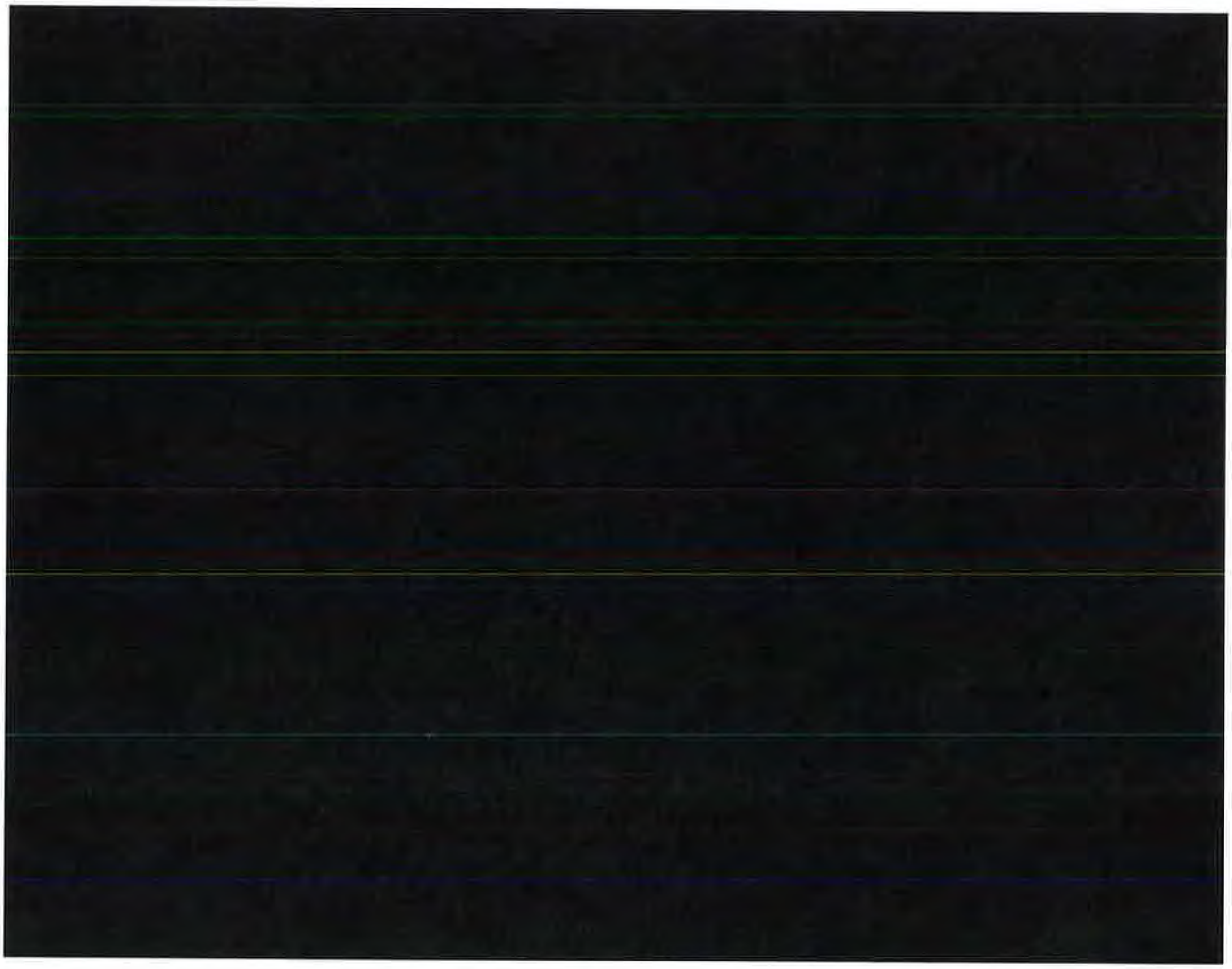
"Deloitte's multi-service approach to its state and local clients is advantageous as clients continue to seek holistic transformation. Blending its IT capability, such as analytics, with other capabilities such as process improvement and human capital strategy, the firm offers an effective roadmap for clients to streamline every aspect of their organizations and improve operations."

Source: Kennedy Consulting Research & Advisory; United States State and Local Government Consulting; Kennedy Consulting Research & Advisory © 2014 Kennedy Information, LLC. Reproduced under license.

This work has been on display most recently at DHHS with Deloitte's work on transforming the program's data management tools and services through the DMA initiative. We will look to continue building on the work done on this project and leverage the dashboards and visualizations within DMA to support this sub-task. As necessary, we can work with DHHS to determine if additional dashboards are necessary and can work with the DMA team to incorporate pre-built, existing connectors into HealthInteractive for reporting and querying against DMA.

These tools can be leveraged to monitor the quality of care, measure consumer outcomes, analyze encounter data, dig into pharmacy cost drivers, and confirm compliance with Federal and state requirements. Examples of other dashboards we have developed for other managed care programs are summarized in the figures that follow. They include supporting a state's 1115 waiver and also monitoring Medicaid prescription drug expenditure and utilization metrics.





3.V.E.1.g – Analyze the accuracy of MCO premiums based on overall MCO financial performance, retrospectively

RFP Reference: Section V.E.1.g, Page 27

By analyzing the accuracy of MCO premiums, it can help to aid in financial evaluation and monitoring efforts of contracted MCOs, stratify costs at the category of service level to provide insights into cost drivers and identify the driver of the variance between the actual and targeted MCO profit margin. In addition, the information can be incorporated into the development of next round of rates. Deloitte's health actuaries have extensive knowledge reviewing and modeling claims data and perform MCO data validation.

Collect Data

To start analyzing the accuracy of MCO premiums, the Deloitte team gathers the premiums by category of services and claims by category of service data from the experienced year.

Compare Actual Experience to Contracted Rates

We validate financial data using applicable encounter data, along with other financial data, including cost reports, where available. Further, we compare results across MCO and category of service to understand inconsistencies. As a final report, we create a side by side comparison of the actual experience to the contracted rates that can easily be viewed and identify the differentials.

Identify Variances

If issues arise that need to be addressed, Deloitte will collaborate with the DHHS to determine the best approach to addressing these issues. As necessary, adjustments can be incorporated into the rate setting process to reflect the analysis of the financial performance of the MCOs.

3.V.E.1.h – Provide on-site plan audit reviews as necessary including but not limited to financial, clinical and operational assessment

RFP Reference: Section V.E.1.h, Page 27

Often when monitoring managed care plan experience, issues arise that need to be addressed. The Deloitte team will collaborate with the DHHS to determine the best approach to addressing these issues. We anticipate that annual reviews may be performed to maintain consistency, as well as onsite reviews at the plans to gather information as needed by the DHHS to provide further crosschecking and validation of the submitted data.

With Deloitte, we provide seasoned accountants, auditors, tax professionals, and CPAs from one of the largest audit firms in the world. As such, we can leverage the high-quality specialists with experience in MCO reviews. Focus areas of the reviews may include items such as the following:

- **Premium Revenue.** Analytic procedures of selected transactions and evaluation of cash to revenue reconciliations.
- **Claims Paid.** Review of selected transactions, evaluation of various reconciliations between claims lag triangles, or large claims and claims inventory
- **Medical Loss Ratio Rebates Liability.** Evaluation of management's analysis, recalculation and reconciliation of MLR inputs
- **Reimbursed Agency Contracts.** Review of contracts to corroborate agency relationship, reconciliation of receivables to unreimbursed claims and IBNR estimates and review of contract reconciliations.

If onsite plan reviews are needed, Deloitte health actuaries can be onsite with the DHHS, providing subject matter analysts in each of the focus areas defined above. During this time, Deloitte team will meet with the DHHS leadership and key staff to determine capabilities, and review systems and other items not able to be determined through a data request. Upon completion of the onsite visit, Deloitte will provide the DHHS with a written report which documents the findings, concerns, and issues associated with the focus areas. The report may contain follow up items which the DHHS may wish to dive deeper and further analyze. We anticipate the onsite reviews may occur up to one time for the five-year contract period.

3.V.E.1.i – Track and analyze financial impacts of populations transitioning from service based payments programs to Managed Care

RFP Reference: Section V.E.1.i, Page 27

We understand from the Question & Answer responses provided for this RFP that the DHHS does not anticipate any upcoming populations to transition from service-based payments to managed care. As necessary in the rate setting and monitoring efforts for this project, we may leverage FFS data to analyze how the performance of the program has changed over time. This information may also be used to supplement the encounter data if it is not deemed fully credible.

As DHHS' needs change and if additional populations are eventually transitioned into managed care, we have the appropriate experience to support DHHS in analyzing the financial impact of the transition. Our team includes practitioners with technical assistance and consulting experience in both FFS and managed care in the majority of states across the country. We will leverage this understanding to fully identify the impact of emerging national practices and other changes on the Nebraska system, and to develop tailored action plans for Nebraska based on its own data.

Our process considers rate considerations such as potential managed care savings, including more competitive unit cost and utilization management, administrative expenditure impacts upon transitioning from FFS to a managed care model, and the impact on expenditures due to access and overall quality of care provided under a managed care model. Further, the adjustments and other data analyses performed during the course of our annual capitation rate setting process can be leveraged as we analyze managed care service expansions.

3.V.E.1.j – Develop annual financial comparison report based on cost report data and financial performance report data comparing all MCOs with each other and with a contractor developed average of all MCOs. The contractor should at a minimum analyze financial and medical management efficiency; MCO medical loss ratio; profitability and financial solvency; net worth per member. Ultimately this analysis will be used to assist the Department with the implementation of a profit cap requirement

RFP Reference: Section V.E.1.j, Page 27

Our accounting and actuarial experience within the health care industry, in conjunction with the State's guidance, provides the DHHS with the knowledge to support ongoing monitoring process, measure contracted health plan financial and quality of care performance, and management effectiveness.

We will work with the State on building out a financial report that will support the proposed implementation of a profit cap requirement. Metrics will be calculated by MCO with the intention of comparing these metrics to other MCOs, industry benchmarks, and aggregate program averages. In developing these reports, we will look at these areas specifically:

- Establish financial solvency measures based on the DHHS criteria
- Analyze minimum loss ratios, aggregate net worth, and contingent reserves
- Assess the reasonableness of income statement (i.e., revenue and expense) and balance sheet items for the various aid categories for which each plan provides care
- Review and assess utilization per 1,000 enrollees by geographic region and aid category
- Review administrative expenditures to determine what portions of costs to include in the profit calculation
- Coordinate with the rate development procedures to ensure the underlying assumptions comply with the managed care regulations and actuarial standards of practice

We anticipate the results of our assessment will be included in a one-time report to aid in DHHS' development of a profit cap requirement. As this requirement is implemented, we will incorporate adjustments into our rate setting process, as deemed appropriate.

3.V.F: SOW 3 – 1915(b) Waiver

RFP Reference: Section V.F, Page 27

Understanding of the Project Requirements

The Deloitte team has assisted over 20 states in the development of some of the most transformative 1915 and 1115 waivers in the country. We understand the waiver processes required to provide valuable assistance to the DHHS during waiver development, renewals, and submission.

We help you strategically and tactically navigate the waiver submission process with CMS. The Deloitte team brings experience working with states to develop and implement federal waivers and renewals, including 1915(b), 1915(c), and 1115 waivers.

Deloitte members have served on the Federal review panel tasked with the review, evaluation and recommendations to CMS regarding awards for "Money Follows the Person", Systems Changes, and Medicaid Infrastructure Grants.

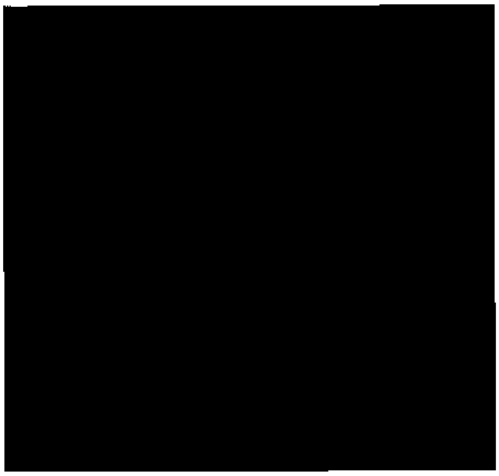
Our experiences include supporting states with end-to-end development of the financial cost-effectiveness and strategy for the waiver submission, including operational aspects such as quality management. We have developed reporting mechanisms and models to continue communication of service delivery details to both state and CMS leadership. These reports provide additional information on the implementation and costs.

Finally, our team is familiar with the CMS 1915 waiver preprint and has the financial and actuarial knowledge to support the assumptions and methods used to project costs and caseload estimates. We use the reporting capabilities of our models to effectively display and communicate the potential costs and savings under the program and will work with the DHHS to analyze current program designs and potentially new program designs to incorporate into the waiver submission. Having worked extensively with CMS on previous engagements, we are familiar with CMS protocols and standards and will provide the required technical support to the DHHS during the waiver submission process.

Proposed Development Approach

We understand that at the core of any 1915(b) waiver is the ability to demonstrate cost-effectiveness using the Waiver Preprint standards established by CMS. The Deloitte team is familiar with the cost-effectiveness section of the 1915(b) waiver application and corresponding Waiver Preprint Appendix Microsoft Excel templates. Our team of actuaries and specialists works collaboratively with the DHHS to understand the critical characteristics of the program and innovative program changes and integrate this knowledge into our modeling process.

The Deloitte team uses our Waiver Cost-effectiveness Model and 1915 Waiver Template to develop the prospective year enrollment and costs under the waiver. The model incorporates the base period experience for the program (typically two retrospective years), actuarial sound adjustments for policy, program, benefit and network changes, administrative costs, population changes, and medical cost trends. Our dynamic models allow us to efficiently quantify and summarize the waiver cost projections and savings to allow DHHS to understand the financial impact and cost-effectiveness of selected program changes. Our modeling considerations include:

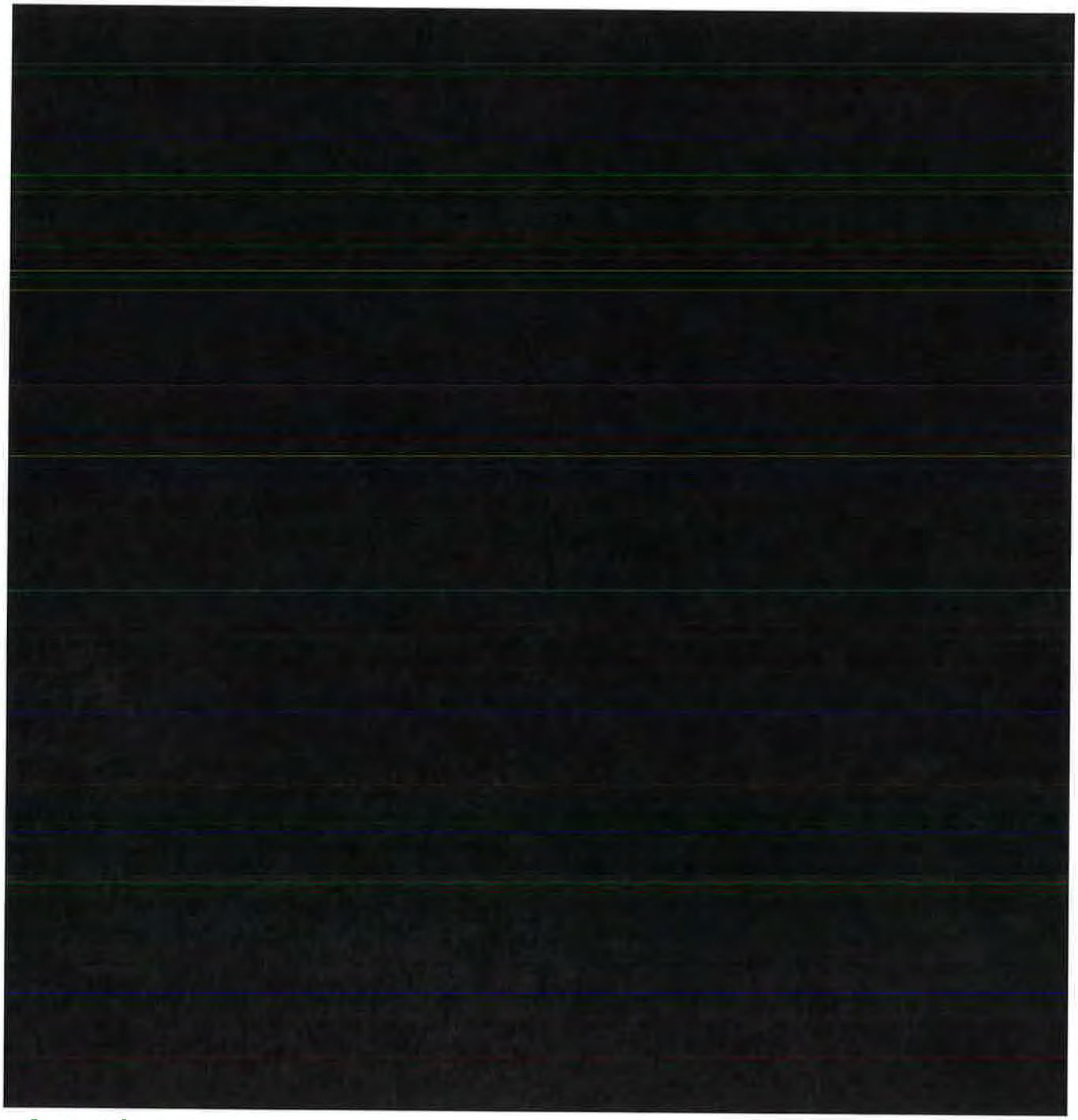


- Evaluation of aggregate PMPM expenditures and impact on cost effectiveness
- Applied trend assumptions (including the ability to use historical trend assumptions vs. other trend sources)
- Results of monitoring efforts from historical waivers to understand actual waiver costs vs. original projections

In addition to the cost-effectiveness requirements outlined in the waiver instructions, the Deloitte team has the program and policy specialists available to assist DHHS in the responses to the narrative components of the Waiver Preprint. The team leverages the models used in the development of the cost-effectiveness calculations to support responses in these sections.

In alternate years when the 1915(b) renewal is not due, our team can support DHHS in the ongoing maintenance and monitoring requirements. This may include quarterly and annual tracking of program expenses in comparison to original cost effectiveness projections.

The following figure summarizes our proposed waiver support process and considerations:

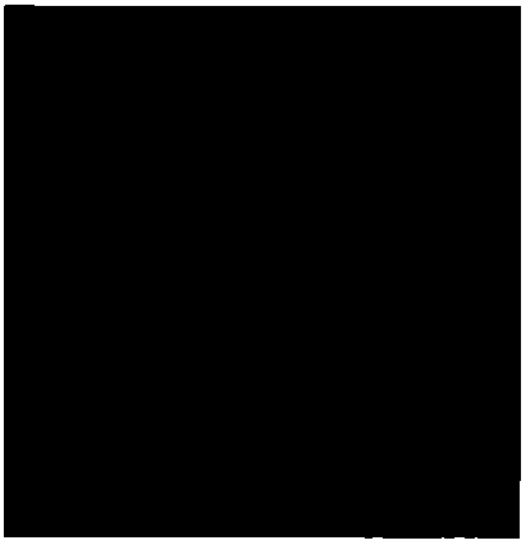


Cost and Budget-Neutrality Projections

Our team will use our Waiver Cost-Effectiveness Projection model, as used in other states, to develop the prospective year enrollment and costs under the waiver. The model incorporates the base period experience for the program, actuarially sound adjustments for policy, program, benefit and network changes, administrative costs, population changes, and medical cost trends. Our dynamic models allow us to efficiently quantify and summarize

the waiver cost projections and savings to allow DHHS to understand the financial impact and cost-effectiveness of selected program changes or amendments. Our modeling uses the most recent two years of experience, when reasonable, to represent the retrospective years in the waiver application. Demonstrating cost-effectiveness is reliant on the ability to populate our waiver projection models with the appropriate data. We leverage the encounter data and MCO cost report data, and supplement as needed with normative data to develop an actuarially credible base data set. We work collaboratively with DHHS to determine the appropriate populations and claims experience to use in the submission.

Waiver Submission Support



We are experienced in the waiver process, including providing appropriate documentation outlining the waiver methodology and assumptions, as well the negotiation process with CMS. We understand the waiver submission is an iterative process and may require various forms of technical support and documentation to incorporate changes. Our team will provide clear documentation and technical support to allow DHHS to satisfactorily address CMS questions and concerns, and to negotiate with CMS on important waiver aspects including savings assumptions and trend selection.

Our waiver support includes:

- Use of budget neutrality and cost-effectiveness templates that present organized, clear and concise state information to facilitate DHHS and CMS review
- Documentation for DHHS use in communications with CMS
- Developing internal prioritization of requested waiver elements with DHHS to facilitate an effective negotiation strategy with CMS
- Identification and analysis of next steps and negotiation strategy based on new information presented by CMS

As indicated above, throughout the process Deloitte provides documentation of the alternatives considered, as well as analysis in support of these alternatives. A consultative approach is used to identify the items that DHHS requires, and we share our experiences in other states in order to inform the State's decision. Deloitte also provides supporting documentation in accordance with the Actuarial Standards of Practice and in compliance with CMS requirements.

Documentation of cost and access will be modified as necessary to answer questions from CMS. Through prior experience we have found that careful documentation of both the process and the decisions made within the waiver process is important when working with CMS. Thus, we use a documentation log to facilitate communications with CMS.

Technical Considerations

Given that the legacy physical health, behavioral health, and pharmacy service components were integrated for the first time in January of 2017, we should consider the data quality and credibility of the experience encounter data once the renewal is due in June of 2019. In addition, consideration should be given for the credibility of the dental experience that phased in as of October of 2017. As the data is reviewed for reasonableness, discussions will be held with DHHS to determine if additional historic information should be blended into the experience period.

It will be important to isolate the physical health, behavioral health, and pharmacy components separately by the applicable MEGs for comparison to prior years to identify changes in cost trends due to the integration. It may also prove useful to analyze the program experience separately for the three MCOs to provide insights to the state with respect to relative performance in the MCOs, as well as analyzing changes in population health and longer-term expectations in population health outcomes as it relates to the benefits of the integrated waiver and ultimately the cost savings realized with the waiver.

Detailed Project Work Plan

We will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval.

A high-level project timeline is included in Appendix 3, based on a June 2019 effective date for the next 1915(b) waiver renewal submission.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we may provide for the 1915(b) waiver renewals and amendments. We understand these dates may change as program changes are implemented. We will work closely with DHHS in the beginning stages of the engagement to develop the detailed work plan and deliverable due dates.

Deliverable	Our Understanding of the 1915(b) Waiver Renewal Deliverables	Anticipated Due Date
Data Request	Prepare a data request that outlines the necessary data	August 2019
Data, Questions, and Key Decisions Log	Document data received as well as pertinent questions and responses between Deloitte and MLTC	November 2019
Cost Effectiveness Model and Exhibits	Preparation of the Waiver Appendix D Preprint form or an alternative set of cost-effectiveness demonstration exhibits as necessary.	November 2019
Cost Model Documentation	Prepare associated documentation detailing the development of the model from data collection, adjustments, and model population	December 2019
Narrative Support for Submission	Prepare narratives related to the cost-effectiveness analyses as part of the submission to CMS	December 2019

Figure 3-35. Potential 1915(b) Waiver Renewal Deliverables.

3.V.G: SOW 4 – Program of All Inclusive Care for the Elderly (PACE) Rate Setting

RFP Reference: Section V.G, Page 27

Understanding of the Project Requirements

The Program for All-Inclusive Care for the Elderly (PACE) is a federally-managed care model that began in Nebraska in 2013. This optional program includes long term care, acute care, and physician services for certain frail and community-dwelling elderly or disabled individuals at least 55 years of age, most of whom are dually eligible for Medicare and Medicaid benefits. An individual must also be certified as eligible for nursing home care by the State and be able support themselves without full-time nursing home level care at the time of enrollment. Enrolled members must use providers from within PACE organizations. There is currently one PACE plan approved to operate in Nebraska and as of December 2017, 152 members were enrolled. The PACE service area is currently limited to select zip codes in Douglas and Sarpy counties and portions of Cass, Dodge, Saunders, and Washington counties.

SECTION HIGHLIGHTS

Members of the Deloitte team have supported PACE programs across the country with setting both UPL and capitation rates. As such, the Deloitte team can provide:

- A comprehensive process that will reflect the specific needs of Nebraska's PACE program
- Useful insights on drivers affecting Nebraska's PACE UPL and capitation rates
- Proactive consideration of unique challenges and factors inherent in PACE rate setting as the State plans to transition LTSS benefits into managed care

Reimbursement for organizations participating in the PACE program must follow guidelines developed by CMS within the PACE Medicaid Capitation Rate Setting Guide released in December 2015. Per this guidance, capitation rates are established separately for dual eligible versus non-dual eligible enrollees and must comply with the federal regulations for the PACE program, which are presented in the graphic below:

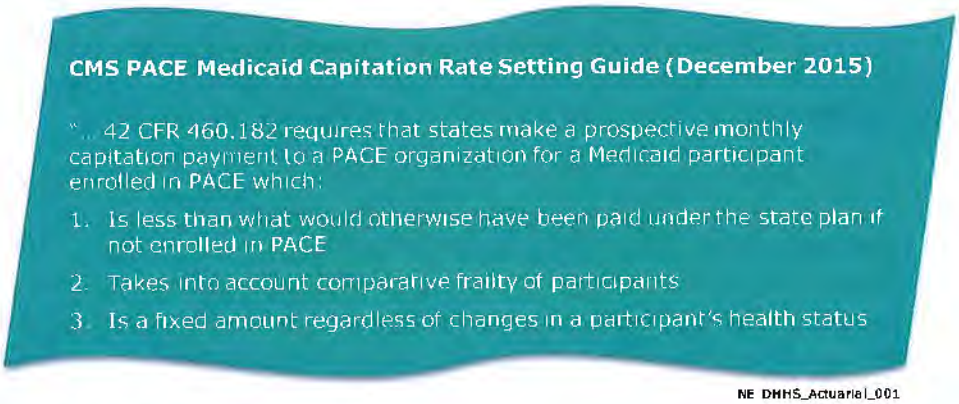
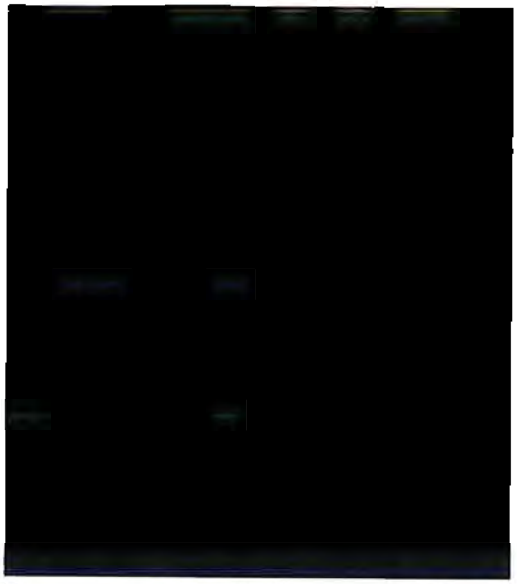


Figure 3-36. PACE Rate Setting Guidance.

The amounts that would have been paid under the State Plan if not enrolled in PACE, also referred to as the "Amount that Would Otherwise have been Paid" or "AWOP", was previously referred to as the "Upper Payment Limit" or "UPL". Consistent with the language in the RFP, the abbreviation UPL will be used in the remainder of this section. Any capitation rates paid to PACE organizations are required to be less than the UPL.

The Deloitte team is well-qualified to assist DHHS in the development and documentation of the PACE UPL amounts and resulting PACE capitation rates.

Proposed Development Approach



As capitation rates paid to PACE organizations are required to be less than the UPL, the development of the UPL is an essential consideration of the capitation rate development. The Deloitte team has developed a detailed process based on many years of experience working with PACE programs. Additionally, members on our team have had experience working for CMS to review over 25 different state PACE rate package submissions and providing technical assistance and guidance both to states and CMS on PACE rate setting issues. Our proposed UPL rate-setting process is outlined below.

Base Data Collection and Validation. Accurate, complete, and timely historical data is foundational to setting accurate capitation rates. This data can take many forms and generally depends on whether the PACE-eligible population is receiving services through the state's FFS program, Medicaid managed care program or some combination. The intent of the UPL is to estimate expense levels for PACE-eligible populations that would otherwise have been paid in the absence of the PACE program. Because PACE is an optional program, this is best achieved by reviewing recent experience for PACE-eligible individuals who did not choose to enroll in PACE. Guidance from CMS requires the reference data supporting the UPL to be "recent and free from material omission". As such, the UPL calculations rely on assumptions for expense the State would incur for these PACE-eligible individuals during the same time period for which the PACE capitation rates will be paid.

As of January 1, 2017, nearly all Nebraska Medicaid members are enrolled in the Heritage Health managed care program. Heritage Health provides enrollees a single plan that provides all of their physical health, behavioral health, and pharmacy benefits and services in an integrated health care program. Certain services applicable to the PACE-eligible population, particularly long-term supports and services ("LTSS") including home and community-based waiver services, State Plan personal assistance services, and long-term residential services provided through facilities like nursing homes, are not included in the managed care benefit package and are administered on a Fee-for-Service ("FFS") basis.

The PACE program offers a comprehensive benefit package, including both LTSS and additional acute care services. Therefore, the UPL is expected to be primarily informed by the FFS data of eligible members but also supplemented by managed care encounter and financial data submitted by the plans participating in the Heritage Health program. Deloitte has experience developing PACE UPL rates based on a combination of FFS and managed care data for states that have transitioned PACE-eligible populations to managed care. We believe that multiple years of data from various sources should be considered to confirm that base data is comprehensive and reasonable, to analyze recent trends for projection purposes, and so that the effects of programmatic changes are captured. Multiple years of historical data is particularly important for capitation rate cells that have small membership where the historical data may be less credible.

The experience utilized for rate development will be organized by the categories of service (COS) consistent with the PACE benefit package and the reporting structure of reference information included in the development of the UPL. The data will also be customized based on circumstances specific to Nebraska's PACE program, such as distinctions for members in long-term nursing home stays and those receiving care in the community. Our team of actuaries and health plan financial reviewers has the experience and knowledge needed to review the quality and completeness of the data. The data will be reviewed and assessed per Actuarial Standard of Practice 23 (Data Quality) in order to deem the data sufficient to support rate-setting.

Base Data and Programmatic Changes. Adjustments to the base data are typically needed to normalize the data for known issues such as program changes that affect paid benefits differently between the base period and projection period, unusual past experience due to fluctuations in services or changes in delivery systems, or the impact of changes in eligibility or demographics. Such program changes can be widespread affecting nearly all eligibility categories due to changes in provider reimbursement levels or the inclusion or exclusion of certain medical services, or they can be narrowly focused and affect only a single category of service or geographic area. For example, adjustments in costs may be needed to account for future changes in Medicare cost share for certain services in order to adjust costs to better match the Medicaid payment responsibility for Dual-eligible members. To determine estimates of future costs for the projection period in scope for rate-setting, we would adjust the base data to reflect those program changes put in place during the historical experience period and those occurring after the start of the base period. The Deloitte team's broad experience with many different PACE programs, as well as other Medicaid managed care programs similar to PACE brings the requisite program knowledge to carefully assess the cost and/or utilization impact of such programmatic changes.

Trend. Health care inflation, or trend, stems from the annual changes in both the cost and the number of services provided in the Medicaid program. Our actuaries have the experiences needed to understand the nature and source of trend on both utilization and unit cost in order to estimate the effect on the program during the projection year. Our actuaries will use their judgment based on a complete and thorough understanding of the applicable program, combined with knowledge of the health care delivery system, and

experience with similar programs in other states to arrive at a credible estimate of trend. Deloitte will primarily leverage multiple years of FFS and managed care data, analyzing cost per member, unit costs, and service utilization. Depending on credibility, the data will be organized by major category of service and region for trend development. Data will be normalized for any applicable program changes or population shifts during the experience period. For credibility and reasonability, Deloitte will also consider publicly available information on trends and other industry factors. The trend development is typically separate from incorporating the impact of prospective program changes and is typically developed by broad category of service and region.

Non-Benefit Expenses. The UPL rate should incorporate expenses that would otherwise be incurred by PACE-eligible members. Deloitte has experience in developing non-benefit expense provisions for other state Medicaid programs for both services that are provided FFS and services that are provided through managed care.

As LTSS services for eligible members are administered FFS, this will entail developing a reasonable assumption for the administrative and care management expense incurred by the State for the administration of benefits for these individuals.

For acute care services received through the Heritage Health managed care program, a provision for administrative loading, care management, quality incentives, risk margin, and other taxes and surcharges will be considered in the UPL development. We will coordinate the general methodology of non-benefit expense development for these individuals with the development of non-benefit expenses for the Heritage Health capitation rate development as described in **Section 3.V.D – SOW 1**. Deloitte will additionally adjust the non-benefit expense amounts included in the Heritage Health capitation rates for the UPL development to reflect the acuity of the PACE-eligible population, if necessary.

Finalize UPL Rates. Following the methodology described above, the Deloitte team will finalize and recommend UPL rates by cohort (Dual-eligible and Non-Dual eligible) and geographic rating area. We will review aspects of our rate development with DHHS. The sources of the base data used, data adjustments that are applied and why, the impact of programmatic changes, trend calculations, and other adjustments will be thoroughly discussed and documented in written reports to provide understanding and consensus in approach.

Determine Capitation Payment Rates. Per CMS requirements, the capitation payment rates paid to each PACE organization need to be less than the UPL rates. Per the Nebraska Medicaid State Plan Amendment[5], the State has flexibility in setting in the capitation payment rates as long as the negotiated rates are less than the UPL rates. Capitation rate development can range from simply taking a dollar amount or percentage deduction from the UPL rates to taking a more complex cost-based approach and separately developing capitation rates using PACE organization financial reporting or encounter data. Capitation

[5] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NE/NE-14-017.pdf

payment rates can also take into consideration additional factors such as efficiencies achieved through managed care. The Deloitte team has experience in a variety of payment rate calculation techniques used in other states and will work with the State to determine the most appropriate capitation payment rate development approach. Given the smaller size of the PACE program in Nebraska, data quality of information reported by the PACE organization(s) should be a consideration in determination of an appropriate rate development approach. Should a cost-based approach be explored, Deloitte will leverage a similar development approach to that described above in this section and in response to **Section 3.V.D - SOW 1**, accounting for factors such as differences in data sources.

Develop Documentation. The Deloitte team will provide both a high-level review of the capitation rate development process and develop a detailed document outlining the capitation rate-setting process including assumptions, adjustments and calculations. In addition, the Deloitte team will provide relevant documentation and actuarial certifications of the UPL amounts as requested by DHHS.

Our rate documentation typically includes:

- An overview of the rate calculation process used
- A description of the methodology used to develop and analyze the base data
- A description and explanation of the adjustments made to the data
- A description of the trend calculation methodology and data
- A description of the other actuarial assumptions made and supporting reasoning
- A table of year-over-year changes to the rates or rate ranges

Other ad-hoc documentation or descriptive data reports are available upon request for DHHS's understanding of the critical elements of the rate development process.

Technical Considerations

Based on our extensive experience in rate-setting for PACE and similar programs in other states, we understand there are unique challenges and factors that should be considered in the development of the UPL rates and corresponding capitation payment rates.

Data Quality. Rate-setting is highly dependent on accurate, complete, and timely data. For the UPL development, the quality of data submitted by health plans in the Heritage Health program, and the FFS data reflecting LTSS costs, will be an important consideration given challenges the plans may encounter in consistently reporting in the initial years of the program's existence. For the capitation payment rates, data credibility of the historical PACE experience data will be a key consideration given the amount of membership currently enrolled in PACE in Nebraska.

Population Identification. One of the unique challenges for the PACE UPL determination is identification of the comparable population of individuals eligible but not enrolled in PACE. In the situations where State eligibility systems do not identify the subset of FFS members

otherwise eligible for PACE, Deloitte will work with the State to develop a methodology to isolate this population and its resulting expense from the underlying managed care experience and FFS claims data based on age, Medicare eligibility status, and the persistent use of long-term services and supports. Deloitte has experience in developing algorithms to isolate this population from broad data sets in other states.

Incorporation of Managed Care Experience. CMS requires that the base data used to develop the UPL be no more than three years old. With nearly all Nebraska Medicaid members receiving physical and behavioral health, and pharmacy benefits and services through managed care as of January 1, 2017, the UPL is expected to be informed not only by FFS data but also increasing levels of encounter and financial data. This will become pertinent as the State considers moving long-term services and supports currently paid through FFS into a managed care program. There are challenges with appropriately incorporating the managed care data to the traditionally FFS-based development of the UPL, but Deloitte has experience developing PACE UPL rates based on a combination of FFS and managed care data for states that have transitioned more populations to managed care.

Risk Adjustment. While there is currently only one PACE plan active in Nebraska, should there be an expansion of PACE plans within the state, the State may want to consider how risk adjustment can be included in rate development to reflect the regional and plan specific risk affecting each plan. Our actuaries have experience with a variety of risk adjustment mechanisms, including for programs that provide LTSS benefits such as PACE. Deloitte will review the current methodology in place for other programs with DHHS and discuss our experience with other managed care risk adjustment methodologies to determine the best path forward to recognizing the cost and geographic differences by plan.

Value-Based Payments. We understand the importance of cost containment strategies and can work with the State to develop a value-based payment (VBP) strategy for the PACE program. VBP frameworks for the PACE program will take into consideration that the impact of cost of care containment strategies such as VBP are typically focused on reductions in acute care costs. Therefore, incentive alignment is required in order to achieve the successful implementation of VBP protocols that seek to reward providers for improving outcomes. Our team brings deep VBP experience with both health plans, providers and Public Sector agencies in establishing fair and transparent shared savings targets, establishing bundled payment mechanisms in high impact areas, and other total cost of care models across the risk spectrum.

Service Area Expansion. Currently, there is one approved PACE plan in Nebraska with a service area limited to Douglas and Sarpy counties and portions of Cass, Dodge, Saunders, and Washington counties. Should there be a service area expansion by the current PACE plan or introduction of additional PACE plans into other counties within the state, the State will need to consider how to manage the service area expansion in developing capitation payment rates. Deloitte will work with the State to develop expansion rates for new service counties based on the rate development for current counties and incorporate additional factors needed. For example, geographic relativity factors may be warranted to account for expected cost differences in the expanded service area relative to the current service area.

Acuity Adjustments. There may be underlying acuity differences between PACE enrollees and the population included in the base data used the UPL development. The State and Deloitte may need to consider acuity adjustments to account for characteristics of the population enrolled in the PACE program or to reflect risk selection of individuals who elect to enroll in PACE. While not commonly developed for PACE programs but if deemed appropriate, acuity adjustments can be developed based on a variety of methods including LTSS risk adjustment models, relativities in observed historical data, or other methods.

Detailed Project Work Plan

We will work closely with DHHS staff in the beginning stages of the engagement to develop a detailed work plan and deliverable due dates. The proposed work plan will include a timeline, resources, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and other key dates will be contingent on DHHS's approval.

The Deloitte team has experience in the PACE rate-setting process with many clients and are proficient at applying the skills needed to successfully produce UPL rates and the corresponding payment rates. We also bring a deep understanding of the long-term care and health care environments. We understand state and federal policies and have resources at our disposal to deepen our understanding of the unique circumstance of the DHHS.

A high-level project timeline is included in Appendix 3.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we may provide for this program. Example due dates for each deliverable are included in the work plan in Appendix 3. We will work closely with DHHS in the beginning stages of the engagement to develop the detailed work plan and deliverable due dates.

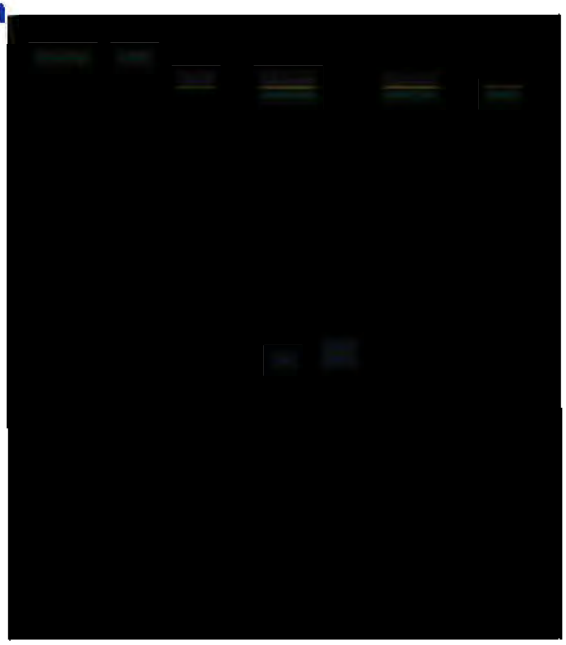
Deliverable	Our Understanding of Program of All-Inclusive Care for the Elderly (PACE) Rate Setting
UPL Rates and Methodology Letter	Using our proposed development approach, we will calculate UPL rates that comply with the CMS requirements. A methodology letter documenting the development of the rates for submission to CMS for approval will also be provided.
Capitation Payment Rates and Methodology Report	Using a development approach agreed on by the DHHS and Deloitte, we will assist DHHS in the calculation of capitation payment rates that comply with Federal and State requirements. A methodology letter documenting the development of the rates will also be provided.

Figure 3-37. Potential PACE Rate Setting Deliverables.

3.V.H: SOW 5 – 1115 Waiver Development and Submission

RFP Reference: Section V.H, Page 27

Understanding of the Project Requiremen



The Deloitte team has assisted over 20 states in the development of some of the most transformative 1915 and 1115 waivers in the country. We understand the waiver processes required to provide valuable assistance to DHHS during waiver development, renewals, and submission. We help strategically and tactically navigate the waiver submission process with CMS. The Deloitte team brings experience working with states to develop and implement federal waivers and renewals, including 1115 waivers.

We understand DHHS is considering an 1115 waiver demonstration to implement opioid use disorder and substance use disorder services Deloitte recognizes the crucial role these service areas play in future years and draws from highly skilled and experienced specialists in clinical practice, policy and analytics to support this task.

Our team brings an understanding of the opioid epidemic including its systemic impact including the pressures upon the health and behavioral health care system, communities as well as individuals and families. The impact across all walks of life challenges states to consider how programs may coordinate efforts and provide cost-effective solutions. Such solutions may be effected by an increased need for accessible treatment across age groups, the effectiveness of the Internet System for Tracking Over-Prescribing (I-STOP) Prescription Monitoring Program, and communicating and supporting the March 2016 CDC guidelines for prescribing opioids for chronic pain.

Currently, we are working with organizations across the country to provide the clinical experience to recognize efficiencies and improve program management and delivery. Our clinical professionals have years of experience providing behavioral health services across populations (including children, adults, elderly) and across a wide breadth of diagnoses, (including autism, serious and persistent mental illness, and substance abuse). The Deloitte team brings experience providing and advising on clinical practice guidelines and clinical operations, leading and promising practices, and care coordination. Deloitte also brings national perspectives based on experiences working with states across the country on Medicaid health programs.

The Deloitte team is innovating solutions to address the opioid epidemic. Leaders in our healthcare policy sector recently published a report on "Strategies for Stemming the Opioid Crisis: How Data Analytics Can Help Health Plans and Pharmacy Benefits Managers Chart Their Course". The report explores leveraging data and emerging technologies, streamlining data collection and sharing and aligning to federal and other state policies as effective measures to address the growing epidemic.

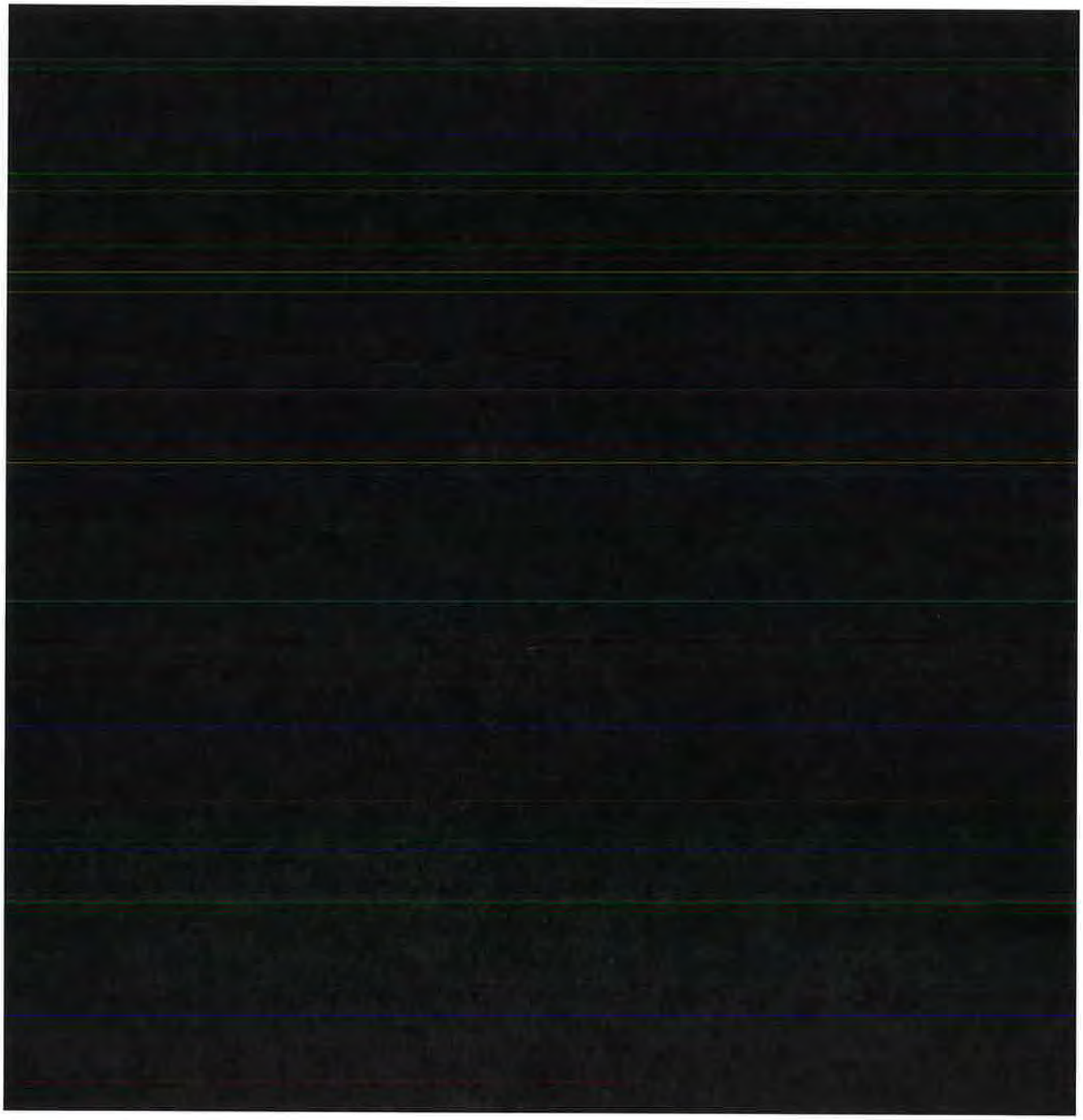
We recognize the importance of cost neutrality when considering policy issues, either federal or state. The Deloitte team has successful experience with various states and CMS on evaluating policy issues based on cost neutrality:

- Assisting with the budget neutrality calculations for an initial 1115 waiver submission for mandatory managed care
- Participating in strategy and policy discussions, performing budget neutrality/cost-effectiveness calculations
- Participating in CMS negotiations and responding to questions regarding the budget neutrality and cost-effectiveness calculations
- Conducting procurement processes for a State's managed care program, including developing and presenting databooks and rate setting methodology at bidder's conferences and technical assistance meetings for prospective health plans as part of larger 1115 waiver program submission

Proposed Development Approach

Our experiences include supporting states with end-to-end development of the financial plan and strategy for the waiver application. We have developed reporting mechanisms to continue communication of service delivery details to both state and CMS leadership. These reports provide additional information on the implementation and costs.

The following figure summarizes our proposed waiver development process and considerations:



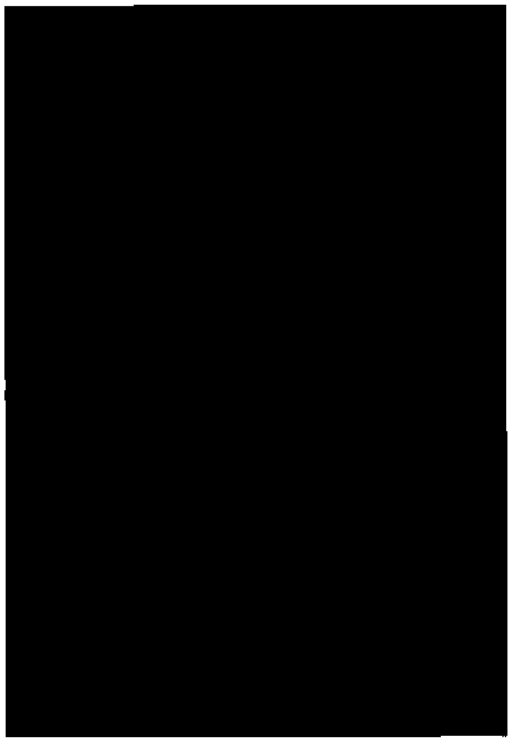
Waiver Design

We will assist DHHS in the design considerations of the 1115 waiver, leveraging our waiver and policy experience from other states. Our assessment on waiver design addresses topics such as what services should be included in the waiver request, what provisions need to be waived, how access and quality issues may be affected, how provider supply may be affected, and what cost and savings have been experienced in other states with similar

waivers. With our team's waiver experience, we also have a significant level of insight into what issues CMS might have with a given waiver proposal and what information may be required to assuage those issues. Furthermore, our team's experience with other states allows us to more easily identify other innovative, cost-effective waiver programs that have been implemented in other states.

In addition to our familiarity with the technical process of developing an 1115 waiver, the Deloitte team couples deep behavioral health and rate setting experience with our knowledge of the Nebraska healthcare landscape to assist the State of Nebraska in continuing to drive their innovative behavioral health and substance abuse programs forward. Our team delivers through our services, tools, and experience as we work with the State of Nebraska to research and develop a successful program addressing Substance Abuse Disorder and Opioid Abuse Disorder.

Cost and Savings Projections



The breadth of experiences of our team allows us to work collaboratively to identify and quantify the impact of innovative program changes and new services. We leverage our *Waiver Cost-effectiveness* projection model to efficiently develop projected costs and caseload estimates for the waiver submission. This model develops the required waiver cost projections needed to show that the waiver costs are reasonable and consistent. For new waivers, we project the cost-effectiveness of the waiver by comparing the projected "with waiver" costs to the "without waiver costs". This analysis may use the research conducted as described above to determine what other states have experienced and assess how that experience might translate to Nebraska.

The model incorporates the base period experience for the program (typically five retrospective years), actuarial sound adjustments for policy, program, benefit and network changes, administrative costs, population changes, and medical cost trends. Our dynamic models allow us to efficiently quantify and summarize the waiver cost projections and savings to allow DHHS to understand the **financial impact and cost-effectiveness** of selected program changes. Our modeling considerations include:

- Evaluation of aggregate (global budget) versus PMPM budget neutrality limits (i.e., whether state bears risk for caseload changes)
- Development of baseline costs that include expenditures that could have been provided absent a waiver (to maximize without waiver budget limit)

- Applied trend assumptions (including the ability to use historical trend assumptions vs. other trend sources)
- Results of monitoring efforts from historical waivers to understand actual waiver costs vs. original projections

In addition to the budget neutrality calculations, the Deloitte team will support DHHS in developing the supporting budget neutrality documentation to be submitted to CMS and aid in technical assistance calls. We anticipate that this documentation will include support for the underlying data utilized, key assumptions used in the development of the without and with waiver projections, and other data considerations.

Conforming to CMS Standards

We understand that at the core of any 1115 waiver is the ability to demonstrate budget neutrality according to CMS standards. Our team is familiar with the CMS guidelines and the waiver submission process. Our team of actuaries and specialists' collaboration with DHHS allows a better understanding of the critical characteristics of the program and innovative program changes and provides the ability to integrate this knowledge into our modeling process.

We incorporate the appropriate actuarial adjustments to the data when developing the cost-effective prospective waiver costs. Most importantly, we properly document our approach, data, and assumptions consistent with the applicable Actuarial Standards of Practice to assist in the waiver negotiations with CMS.

Waiver Submission Assistance

We use the reporting capabilities of our models to effectively display and communicate the potential costs and savings under the program and will work with DHHS to analyze and select the program designs to incorporate into the waiver submission. Having worked extensively with CMS on previous engagements, we are familiar with CMS protocols and standards and will provide the required technical support to DHHS during the waiver submission process to ensure the waiver application includes the necessary components and meets the standards set forth in 42 CFR 431.412.

Technical Considerations

Many of the technical considerations of the 1115 waiver development will be dependent upon the final program design. As noted in the figure on the right, CMS has identified several priority areas states should consider when developing programs to combat opioid and substance use disorders.

Additionally, the credibility of the underlying data will be an important factor in the development of the cost projections. The underlying populations with these disorders may not be fully credible or may not be easily identifiable in the encounter data.

The data credibility will need to be analyzed as the waiver design is further refined. The credibility may impact the design strategy, such as the Medicaid Eligibility Groupings, as well as the data sources available to incorporate program and trend adjustments when developing with the without waiver and with waiver cost and caseload projections.

During the waiver design phase, we will coordinate with DHHS on the design elements and communicate additional technical considerations as they are identified throughout the process.

CMS has made addressing the opioid epidemic a top priority and is providing help and resources to clinicians, beneficiaries, and families to combat misuse and promote programs that support treatment and recovery support services. The CMS effort includes four priority areas:

- Implement more effective person-centered and population-based strategies to reduce the risk of opioid use disorders, overdoses, inappropriate prescribing, and drug diversion
- Expand naloxone use, distribution, and access, when clinically appropriate
- Expand screening, diagnosis, and treatment of opioid use disorders, with an emphasis on increasing access to medication-assisted treatment
- Increase the use of evidence-based practices for acute and chronic pain management

Detailed Project Work Plan

The timeline and activities will vary by depending on the waiver design. We will work closely with DHHS staff in the beginning stages of the engagement to determine the requested scope of services and develop a detailed work plan. The proposed work plan will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and other key dates will be contingent on DHHS's approval.

An illustrative example of a high-level project timeline we may develop in support of the 1115 waiver development activities is included in Appendix 5.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we could provide for the 1115 waiver development task. We will work closely with DHHS in the beginning stages of the engagement to determine the final scope of services, develop the detailed work plan, and deliverable due dates.

Deliverable	Our Understanding of the 1115 Waiver Development Deliverables
Data Request	Prepare a data request that outlines the necessary data
Data, Questions, and Key Decisions Log	Document data received as well as pertinent questions and responses between Deloitte and DHHS
Budget Neutrality Model and Exhibits	Preparation of the Budget Neutrality calculation exhibits, or an alternative set of cost-effectiveness demonstration exhibits as necessary.
Cost Model Documentation	Prepare associated documentation detailing the development of the model from data collection, adjustments, and model population
Narrative Support for Submission	Prepare narratives related to the cost-effectiveness analyses as part of the submission to CMS

Figure 3-39. Potential 1115 Waiver Development Deliverables.

3.V.I: SOW 6 – Dental Capitation Rate Setting

RFP Reference: Section V.I, Pages 27-28

Understanding of Project Requirements

SECTION HIGHLIGHTS

The Deloitte team's approach to capitation rate development includes:

- Implementing a comprehensive and actuarially sound process for developing capitation rates
- Our team's focus on unique process components that may be necessary for the Dental program
- A proven methodology that is stepwise and includes the DHHS in each component
- Delivering a documentation structure that clearly lays out the rate setting process to the DHHS and applicable parties

The Deloitte team is well qualified to assist the DHHS in the development of its actuarially sound rates and rate ranges, and to analyze risk mitigation techniques. We bring in-depth knowledge of the rate setting process and hands-on experience with large Medicaid programs. Our rate setting methodology follows the documentation protocols laid out by the Academy of Actuaries, CMS certification requirements, and the DHHS specifications.

Our documentation includes assumptions, adjustments, and calculations made to arrive at the rates and provides a narrative description of each factor. We are prepared to provide required technical support to the DHHS, the Dental Benefit Program Manager, and other interested stakeholders. Our support encompasses rate development, data analysis, participation in rate meetings, providing technical support for rate negotiations, and technical discussions around emerging rate issues such as trend development, programmatic changes, service utilization, and efficiency. As the vast majority of Nebraska's Medicaid population is now receiving care through managed care, it is increasingly important that we collaborate across interested stakeholders in Nebraska throughout the rate setting process.

Our advanced analytic techniques provide the targeted analytics that enable the DHHS to make informed decisions about its program's future. We are at the forefront of assisting our clients with integrating innovative solutions such as value based payments to better align managed care programs to the future of health care administration.

We note that our approach for the Dental capitation rate setting will be very similar with the Heritage Health Plan capitation rate setting process as discussed further in our response to RFP **Section 3.D, SOW 1 – Capitation Rate Setting**. Within our response to this task, we have outlined where differences may occur in the approach between the Heritage Health Plan and the Dental plan.

Proposed Development Approach

Consistent with our approach for SOW 1, the Deloitte team develops actuarially sound rates and rate ranges following the applicable actuarial standards of practice, CMS' rate setting managed care rate development guide, and the requirements of CFR 438. We calculate rates for all managed care cohorts and any applicable geographic regions. We will thoroughly review with the DHHS rate calculations and rate methodologies to provide a complete understanding of the base data used, the adjustments made, and assumptions applied. Premium efficiency and/or dental management adjustments are discussed in detail with the DHHS prior to application.

We discuss risk mitigation approaches and reinsurance arrangements with the DHHS as part of our processes to employ risk management assistance. We thoroughly document the base encounter and financial data, assumptions and adjustments in a detailed financial summary that breaks down cost and utilization information by geographic region.

We certify that the resulting rates are actuarially sound under CFR 438, the Federal regulation covering capitation rates, and provide analytic support during negotiations with CMS, as needed. Our team's experience supporting other state programs, including CMS. provides the DHHS and its stakeholders with the confidence in our processes, models, methodologies, and, ultimately, the rates.

A detailed description of our rate setting process is found in **Section 3.V.I.a** below.

The following table summarizes our high-level understanding of the subtasks. Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Subtask	The Deloitte team's Understanding of the Subtasks
3.V.I.a	Utilize capitation rate methodology to develop capitation rates for the dental program
3.V.I.b	Develop rates based on the defining characteristics of each managed care cohort
3.V.I.c	Assist in the risk adjustment methodology (where applicable)
3.V.I.d	Calculate actuarially sound capitation rate range bounds

Figure 3-40. Task 3.V.I Subtasks.

Technical Considerations

While our team is responsible for updating the actuarial capitation rates and rate ranges for each period, similar to SOW 1, there are key items we collaborate with DHHS to collect in the rate setting process including:

Base Data for Rate Setting

The State of Nebraska's Dental Managed Care program is a newly implemented program in late 2017. Therefore, since credible emerging managed care experience may not be yet available for the entire benefit package covered by the state, we may leverage additional

data sources such as historical FFS data to utilize a credible data source in the rate setting process. As the newer services have emerging managed care experience that can be deemed credible, we can rebase the rates to utilize these new sources.

Rate Setting Considerations

To develop the capitation rates and rate ranges, we work with DHHS to collect detailed background information used in the consideration of the rate setting approach for the program. Examples of this include model contracts, historical certifications and actuarial memorandums, risk sharing arrangements, MLR requirements, Stop-Loss documentation, historical payment rates, historical correspondence with CMS and rate presentations. Deloitte works with DHHS to collect the detailed documents for the state to provide an easy transition in developing the capitation rates in the upcoming rating year.

Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Detailed Project Work Plan

Consistent with our rate setting steps for SOW 1, we will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval.

A high-level project timeline is included in Appendix 1. We will work closely with the DHHS in the beginning stages of the engagement to develop detailed work plans for the dental managed care program.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we may provide for this program. We will work closely with DHHS in the beginning stages of the engagement to develop the detailed work plan and deliverable due dates.

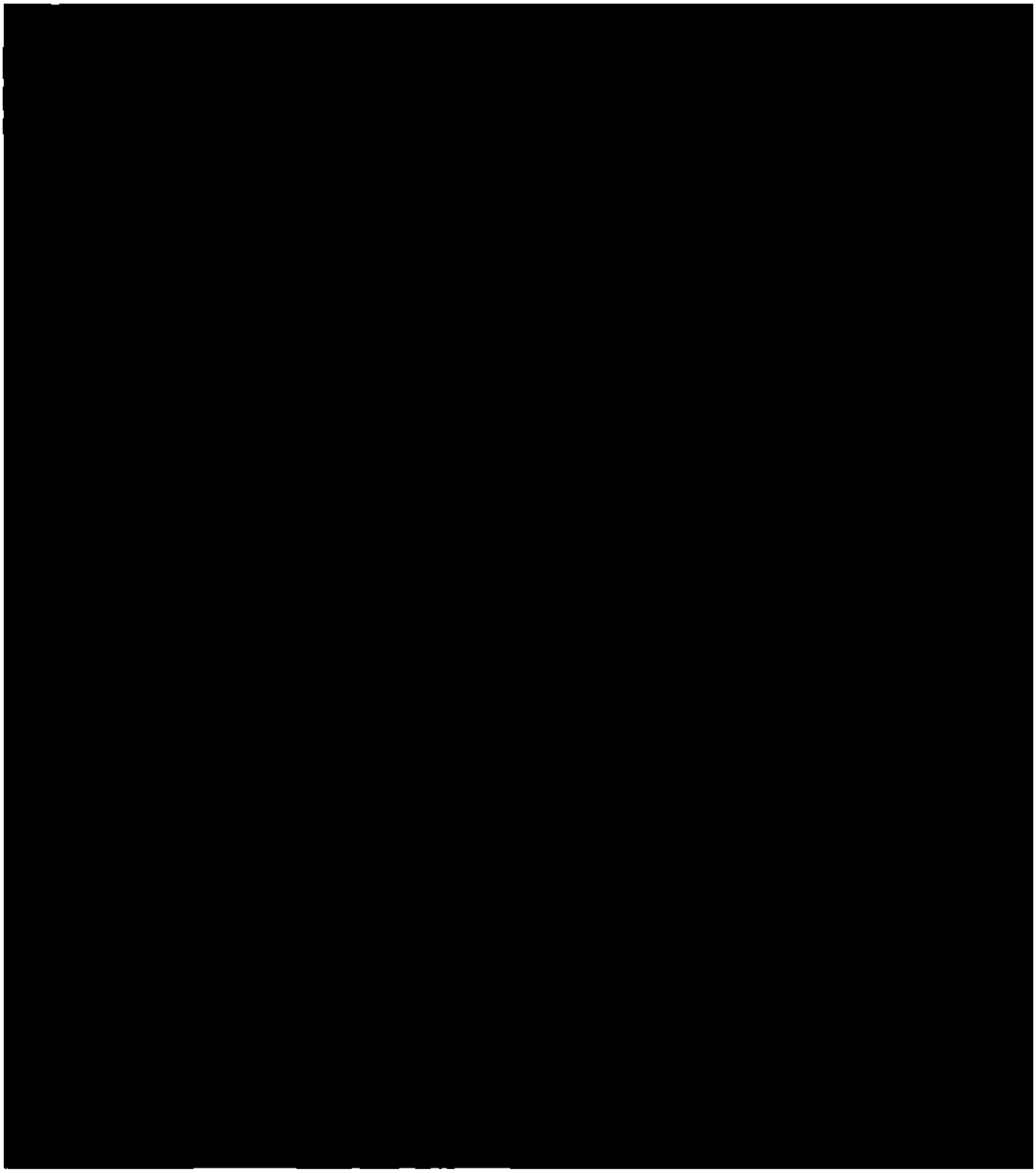
Deliverable	Our Understanding of Dental Capitation Rate Setting Deliverables
Actuarially Sound Capitation Rate(s) and Rate Ranges	Using our Capitation Model, we calculate actuarially sound capitation rates that comply with CFR 438.6(c), the AAA standards of practice, and the CMS rate development guide.
Actuarial memorandum, Actuarial certification and CMS rate guide index	Actuarial memorandum with detailed descriptions of how the rates were developed from base data, program changes, trend, administrative loads, etc. An actuarial certification certifying the rates as actuarially sound. A detailed index for each item requested as documentation by CMS in the managed care rate development guide to expedite CMS' review of the capitation rate development.
Program Change Rate Impact	Leverage encounter data analytics to assess the effect on current program rates to understand the impact of program changes

Figure 3-41. Potential Deliverables for Dental Capitation Rate Setting.

3.V.I.a – Capitation Rate Methodology Development and Determination

RFP Reference: Section V.I. a, Page 28

Developing actuarially sound capitation rates and rate ranges that meet the certification requirements of CFR 438, CMS' rate setting managed care rate development guide, the American Academy of Actuaries' (AAA) standards of practice and the DHHS's responsibilities requires a rigorous and tested process. The Deloitte team has developed a detailed process based on many years of experience working with state managed care programs which we will customize based on the DHHS's program requirements. Our proposed rate setting process is outlined in the following figure.



Consistent with SOW 1, to develop actuarially sound rates, the Deloitte team will collect data across various rating periods and geographies for the Dental program. These data sources will include FFS data, encounter data, DBM financial data, policy and programmatic changes, managed care trends, managed care assumptions, market trends, other state

information and other applicable sources. DBM administrative costs will also be collected. Once this information is compiled, we will work with the DHHS to determine the best way to develop the rate ranges and calculate actuarially sound rates or rate ranges. Discussed below are some of the key steps in rate setting that we will review with the DHHS during the rate setting process.

Review Methodology, Assumptions, and Calculations

Base Data Collection and Validation. We will follow a similar data collection and validation process as outlined in SOW 1. However, an important difference for the Dental program is the maturity of the program and credibility of the base data. As the program matures and the Dental Benefit Manager gains experience, fee-for-service data can largely be replaced by encounter data.

To validate that the encounter data submitted is complete, we propose that supplemental data in the form of DBM financial data be gathered. By performing a detailed financial review of this data and comparing it to the reported encounter data, we can identify potential issues with the encounter data and bring those to the attention of the DBM for process improvement and revision.

Data Adjustments. Adjustments to the base data generally take four forms: normalizing the data for known issues (such as prior program changes, unusual past experience due to fluctuations in services or changes in delivery systems, the impact of unexpected changes in eligibility or demographics); trending the data for anticipated changes in cost and utilization; other assumptions covering planned or proposed changes in medical management, efficiency, eligibility or demographics, and DBM administration; and risk adjusting the data to reflect geographic and DBM specific variations in costs. We address the key adjustment issues in more detail below:

Programmatic Changes. The data underlying actuarially sound rates must take into account those programmatic changes brought on by implemented changes in the policy or operation of the Dental program. These program changes can be widespread affecting nearly all eligibility categories due to changes in provider reimbursement levels or the inclusion or exclusion of certain dental services, or they can be narrowly focused and affect only a single geographic area. To underpin the actuarially sound rate calculations, we adjust the base data to reflect those program changes put in place during the historical experience period.

Trend. Health care inflation, or trend, stems from the annual changes in both the cost and the number of services provided. While trend is often represented by a complex logarithmic projection of past experience, this approach only serves to explain historical experience. Our actuaries use their judgment based on a complete and thorough understanding of the applicable program, combined with knowledge of the health care delivery system, to arrive at a credible projection of trend. Trend estimates can be reviewed at the procedural level for dental services. Additional considerations may include the impact of new dental treatments and procedures.

Other Assumptions. Other adjustments to the base data include assumptions for upcoming program changes due to expected improvements in service substitutions or administrative cost allowances. With the exception of planned changes in a plan's allowed administrative costs, these types of adjustments are usually projections based on the actuaries' knowledge and understanding of the program and health care delivery system.

Risk Adjustment. We do not anticipate a risk adjustment methodology to be applied given there is only one statewide Dental Benefit Manager. In the future, if DHHS elects to expand coverage to more than one DBM, we can discuss options to incorporate risk adjustment into the rate development process.

Developing Actuarially Sound Rate Ranges. Our actuaries comply with federal regulations (CFR 438) which require an actuary developing rates for a managed care program to do so following actuarially sound principles. CMS had outlined what it considers to be the approved process in its Capitation Rate Development Guide. The American Academy of Actuaries (AAA) developed a practice note addressing the issue of actuarial soundness. The purpose of the practice note was to provide nonbinding guidance to an actuary when certifying rates or rate ranges for capitation of managed care programs. Effective July 1, 2018, actuaries may still develop actuarial rate ranges, but will need to certify to specific point estimates within that range.

Finalize Capitation Cohort Rates and Rate Ranges. Following the rate development methodology we describe in detail above, we finalize and recommend rate ranges by managed care cohort and geographic rating area. We take into account the unique characteristics of each region and may develop separate adjustments for programmatic changes, trend, dental management practices, or other assumptions. DHHS can then determine final payment rates by cohort based on the recommended ranges.

Review Rate Setting Process with the DHHS. We will review aspects of our rate development with the DHHS. The sources of the base data used, what data adjustments should be applied and why, the impact of programmatic changes, how trend was calculated and applied, DBM administration allowances, and the level of efficiency adjustments applied are discussed to provide understanding and consensus in approach.

Attest to Actuarial Soundness. We certify the rates we develop as meeting the federal requirements for actuarial soundness as specified under CFR 438. Our rate certification is documented in a certification letter that can be sent to CMS as well as a CMS response guide to the CMS managed care rate setting guide. This letter provides details on the data, adjustments, assumptions, and methodology used to arrive at the actuarially sound rate ranges. Further, we are available for related discussion with CMS on our certification.

Develop Financial Summary. An important component in enhancing the participating DBM's understanding and acceptance of the calculated capitation rates is the provision of a financial summary. We publish a summary that outlines the cost and utilization statistics from the historical data used to form the base data for rate setting. It provides data and narrative explanation of the adjustments, trend, and assumptions used.

3.V.I.b – Develop Dental Benefit Manager (DMB) cohorts and capitation rates, using a variety of parameters, including but not limited to, recipients' age, gender, category of eligibility, level of care, and geographic location

RFP Reference: Section V.I. b, Page 28

We understand that dental costs vary by parameters such as but not limited to age, gender, eligibility group, level of care and geographic region. The base data sets used to develop capitation rate ranges should be divided into cohorts that represent consolidated groupings which inherently represent differing levels of risk or geographic cost variation. Developing cohorts involves the following steps:

1. Start with a base period eligibility and dental expense data
2. Develop the cohort by working with DHHS to determine the necessary logic for managed care cohorts to be credible but reflect appropriate levels of cost variation
3. Review methodology with DHHS
4. Reviewing and evaluate data adjustments as required

Our approach in defining the rate cohorts for the Dental program will be conducted in a manner consistent as under SOW 1. Additionally, we will assist the state to develop and refine the logic to define these cohorts as described in **Task 3.V.J.c.**

3.V.I.c – Develop a risk adjustment methodology

RFP Reference: Section V.I.c, Page 28

We do not anticipate a risk adjustment methodology to be applied given there is only one statewide Dental Benefits Manager. In the future, if DHHS elects to expand coverage to more than one DBM, we can discuss options to incorporate risk adjustment into the rate development process.

3.V.I.d – Develop a range of rates that are actuarially sound

RFP Reference: Section V.I.d, Page 25

The Deloitte team will use the rate development process discussed in the beginning of this section to determine actuarially sound rate ranges based on the appropriate range of assumptions and adjustments. The low and high bounds of the rate range are intended to represent the levels at which appropriately managed care would be able to meet the levels of access and care as specified under the program. In developing these low and high bounds rates by rate cell, the Deloitte team makes multiple actuarial assumptions. As these assumptions are estimates of various impacts of the given component, our team applies a

range to the assumptions and uses multiple sources such as program-specific experience, industry research, Deloitte actuarial tools and models to apply ranges for these assumptions that are actuarially sound. Typical adjustments that have a range include program changes, trends, efficiency, administrative costs, taxes and risk margin.

Our team will provide documentation on how the ranges were developed. We will specify which assumptions had low/target/high estimates applied to the base rates to develop the ranges. Additionally, we will document the low/target/high values of these assumptions and provide the source material as well as a description of the data utilized.

In the most recent version of the managed care rate development guide from CMS applicable for Rating Periods beginning from July 1, 2017 to June 30, 2018, CMS requires that each individual capitation rate be certified as actuarially sound. Deloitte will work with DHHS to follow this guideline and will certify that each final rate is within the actuarial sound rate range developed.

3.V.I.1: Rate Data Analysis and Manipulation

RFP Reference: Section V.I.1, Page 28

Understanding of the Project Requirements

Through our experience, we recognize the development of rates is not simply a calculation exercise; rather it is an ongoing process involving data analysis and reporting, actuarial rate calculations, development of assumptions, evaluations of the DBM and their reported data, proper documentation and communication, technical assistance with providers, and strategy support with the State as we work to deliver innovative ideas and efficiencies into the Medicaid program.

We understand the importance of data quality and its impact on the ability to develop actuarial sound rates. Therefore, we believe that the State needs a partner who truly understands how Medicaid health care data is collected, validated and manipulated, using analytics to develop actuarially sound rates. To accomplish this, the ability to look at, understand, and manipulate data in more sophisticated ways is needed.

Proposed Development Approach

Consistent with the support for SOW 1, Deloitte will work under the guidance of Actuarial Standards of Practice #23 on Data Quality and section 438.6(c) of the Code of Federal Regulations (CMS Medicaid Rate Development Guide) when carrying out data analysis tasks.

As depicted in the following figure, our approach to rate data analysis and manipulation at a high level involves the following steps, as further described in our response to **Section 3.V.D.1.**

Figure 3-43. High Level Steps for Data Analysis and Manipulation.

The following table summarizes our high-level understanding of the subtasks. Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Deloitte's Understanding of the Subtasks	
3.V.I.1.a	Appropriate base period membership and claims information can be sourced from Enrollment rosters, FFS databases, DBM encounter data and DBM financial data. Cross validation can occur amongst these sources. We can validate and verify data relied upon for completeness, comprehensiveness, reliability and accuracy.
3.V.I.1.b	The Deloitte team will analyze new regulatory requirements or program changes and develop factors to adjust capitation rates to reflect changes.
3.V.I.1.c	Our team can analyze base period data to develop utilization and cost profile patterns by managed care cohorts and service categories to provide valuable insights into the data which can help to determine trend drivers, completeness of data and material defects in the source data.
3.V.I.1.d	The Deloitte team will be prudent to understand and analyze specific and necessary claim and non-claim adjustments to the base period data of the DBM and discuss these items with state Medicaid personnel.
3.V.I.1.e	We can measure and reflect changes in the Medicaid environment that have an impact on program characteristics and, consequently, rates. Our team has access to national databases and benchmark metrics to compare State Medicaid performance.

Figure 3-44. 3.V.I.1 Subtasks.

Technical Considerations

Data Quality

Not all reported data is free from error and any errors can impact the results of any actuarial analysis. When using any data, we operate under the guidance of Actuarial Standards of Practice #23 on Data Quality to facilitate quality results.

Before using any data, we carry out reasonableness and consistency checks by reviewing each data element, identifying questionable data values and reviewing current data for consistency with data used in prior analyses. In order to confirm completeness of data we shall evaluate utilization and volume metrics to benchmark statistics. In cases where material defects are identified, we will carry out practical steps to improve the quality of data.

Lack of Credible Data

As Dental services were recently moved to managed care in 2017, the available experience data may not be fully credible or contain low quality data. We understand the challenges involved with new populations and services and possess the expertise to develop actuarially sound capitation rates for these new populations and services.

For new populations and services without appropriate or credible historical data, we will utilize other data sources for rate development. We will work with the State to determine which sources of data to use, based on which source is determined to have the highest degree of reliability specific to the program and rate development requirements.

Sparse Data Available for Programmatic Changes

Often new benefits under managed care will have very little, if any, actual experience on which to base the programmatic change adjustment. Programmatic changes may also

include little background information necessary to development and adjustment for the capitation rates. We have experience incorporating these new services into the managed care capitation rates and understand the nuances involved with these new services. We will work with the State to determine the most appropriate and reliable data sources to utilize in the cost estimates of these new services.

Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Detailed Project Work Plan

We will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval.

A high-level project timeline is included in Appendix 1. We will work closely with the DHHS in the beginning stages of the engagement to develop detailed work plans for each managed care program.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we may provide for Rate Data Analysis and Manipulation. We will work closely with DHHS in the beginning stages of the engagement to develop the detailed work plan and deliverable due dates.

Deloitte's Understanding of the Deliverables	
Base Data Summaries	Summaries of the base data PMPMs utilized in the actuarially sound capitation rates will be produced. These summaries will include category of service level information and be specific to each rate cell. These summaries may also include applicable adjustments made to the base data. Base data utilized will comply with Actuarial Standard of Practice #23 on Data Quality and 42 CFR 438.5(c).
Programmatic Change Adjustment Summaries	Summaries of the impact of the programmatic change adjustments utilized in the actuarially sound capitation rates will be produced. These summaries will include the impact on capitation rates at the level of detail applied in capitation rate development specific to each rate cell on either a PMPM or percentage basis. Programmatic change adjustment development will be consistent with 42 CFR 438.5(f) and applicable actuarial guidance.
Trend Summaries	Summaries of the trends utilized in the actuarially sound capitation rates will be produced. These summaries will include selected trends specific to each rate cell at the level applied in capitation rate development. Trend development will be consistent with 42 CFR 438.5(d) and applicable actuarial guidance.
Actuarial Memorandum	An actuarial memorandum will be produced documenting actuarial assumptions made, as well as the data, materials, and methodologies used in the development of each component of the capitation rates.

Figure 3-45. Potential 3.V.I.1 Deliverables.

3.V.I.1.a – Analyze the financial statement data of managed care entity with focus on relevant issues affecting capitation rate development

RFP Reference: Section V.I.1.a, Page 28

The Deloitte team can provide a holistic review of reports to identify opportunities to condense data points and sources necessary to meet reporting requirements, in addition to identifying opportunities for process automation. Standardization of data collection tools may also be important.

In a manner consistent with SOW 1, we will carefully analyze the following Medicaid program data sources and other relevant sources:

DBM Financial Statements

Deloitte will assist the State to review DBM financial information by using the benefit manager's reported financial data. Financial data provides a detailed view of cost and utilization experienced by the DBM and is submitted to the State on a periodic basis. Financial data includes information such as revenue, claims, and administrative expenses, DBM spending in different care settings, amount of capitation rate spent on administrative expenses compared to services, the types, level and cost of various services provided to members, and the number of members receiving different types of services or no services.

Deloitte will review submitted information for accuracy and completeness by analyzing the DBM's membership and revenue data against those collected by the State's other tracking systems. We will also review the data by analyzing membership information, claims expenses, and administrative costs by different cohorts in order to understand the DBM's financial performance.

The following table shows some components of financial data and the approach for reviewing each component:

Deloitte's Approach for Reviewing Financial Data	
Membership	Review for accuracy and completeness by comparing to state enrollment data
Premium	Verify the premium information reflects underlying capitation payments reported in the State's tracking system
Claim Costs	Compare per capita rates by cohort to benchmarks and historical levels to determine if large variances
Utilization	Review utilization rates and trend compared to benchmarks
Admin	Consider plan efficiency when reviewing admin expense, particularly focusing on medical management staffing and costs compared to benchmarks

Figure 3-46. Financial Data Review Components.

Enrollment Data

Medicaid Managed Care Enrollment Report shows the number of Medicaid recipients currently enrolled and the number of Medicaid recipients eligible to enroll in Nebraska's Medicaid managed care program.

The data is presented for each MCO by county and Medicaid Aid Category. These reports are generated from primary and secondary roster reports. These reports provide enrollment counts as of the 1st of the month thereby allowing the report to be posted the same month of enrollment. We can review these numbers against other data sources such as DMA.

FFS Data

Due to the recent implementation of Dental managed care, we may need to rely on historical FFS data. FFS data will be summarized and analyzed for new services without fully credible encounter data to understand key trends.

Encounter Data

Deloitte will collaborate with the State in gathering, analyzing and exploring ways to further use encounter data in rate setting. Deloitte will conduct validation and completeness checks on encounter data to confirm that it was properly loaded and is reliable for rate setting purposes. Completeness check will be evaluated using metrics such as:

- Proportion of members using services
- Utilization rate per thousand members
- Encounters per member

Where appropriate, Deloitte will estimate incurred-but-not-reported (IBNR) encounters in order to complete validated encounter data. Encounter data will then be summarized by cohort and procedures to provide insight into utilization and cost profile patterns. The data discovery and data cleansing efforts under the DMA initiative will accelerate the encounter data review efforts for the rate setting project.

Other Data Sources

Deloitte will consider other data sources with relevant information for actuarially sound rate development. Examples include, but are not limited to: National Medicaid databases, data from research and consulting firms, intercompany experience studies, etc.

3.V.I.1.b – Analyze any programmatic changes that will be effective in the state fiscal year and utilize the data to calculate adjustment factors to be applied to the existing capitation rate ranges, as applicable

RFP Reference: Section V.I.1.b, Page 28

We work diligently to monitor, incorporate and update the rate setting process such that the rates are compliant and consistent with new programmatic or legislative changes on an ongoing basis. We make adjustments as required, request appropriate data and make potential methodology changes. As depicted in the figure to the right, and consistent with our approach for SOW 1, we work with the State to quantify the impact of such changes and develop innovative solutions while balancing the financial stability of the managed care organizations. To address changes, our adjustments can be made by county or zone, and by phases to dampen the impact of significant policy changes on the organizations and their members.

Figure 3-47. Process to Analyze and Quantify Program Changes.

Further information on our approach to implementing programmatic changes is included in our response to **Section 3.V.D.1.b.**

3.V.I.1.c – Analyze dental service utilization and cost profile patterns by category of service for all DBM rating cohorts

RFP Reference: Section V.I.1.c, Page 28

Deloitte believes that studying cost trends is very useful not only to aid in development of actuarially sound rate, but also for opportunity identification. Deloitte team has strong skills that will analyze dental data to identify abnormalities and to determine reasons and implications of inconsistencies. These analyses will be used to evaluate and certify reasonableness and credibility of FFS data, DBM encounter data or financial data.

We typically calculate benchmarking statistics from the data and analyze the results in relation to previous years' data, and/or external benchmarks. Such metrics include but are not limited to trends in cost, utilization, & intensity per enrolled member. Consistent with our approach for SOW 1, analysis will be done by specialty, procedure, and condition.

These analyses will help to identify differences between and within dental benefits, variations in specialties and diagnosis categories, and changes in products and markets. Outcomes of these analyses will enable accurate assessment of trends specific to the cohort and the State to use fact-based information to manage their health care costs.

Utilization metrics measure incidences of using healthcare goods and services and count of units of healthcare goods and services being used. Analyzing changes in these metrics over time will reveal important information in the operations of a dental program.

3.V.I.1.d – Provide technical assistance in the evaluation of individual DBMs, including areas such as IBNR claims adjustments, administrative overhead, care management overhead, and appropriateness of dental costs incurred

RFP Reference: Section V.I.1.d, Page 28

Deloitte understands the importance of complete and accurate DBM financial data. Deloitte will review the financial reporting information to determine if calculations and amounts appear reasonable. We further perform analytical procedures and potentially review a sample of supporting documents to determine if information stated appears reasonable and whether further evaluation of DBM financial reporting is needed.

Deloitte will provide technical assistance to help the State to examine and evaluate reasonableness of the DBM's medical and non-medical components of its costs in their financial statements. We will assist the State to analyze IBNR, admin, and medical costs.

We anticipate the approach for providing technical assistance in evaluation of the DBM in areas such as IBNR, administrative overhead, and the appropriateness of the costs incurred will be conducted in a manner consistent with SOW 1. Additional information on our approach is included in our response to **Section 3.V.D.1.d.**

3.V.I.1.e – Analyze inflation, economic, and health related trends

RFP Reference: Section V.I.1.e, Page 28

Deloitte understands that external sources of trend should be well understood, measured and reflected when determining DBM future costs. Deloitte has specialists that will analyze and support the State as opportunities or challenges surface due to market trends. Deloitte is fully capable of monitoring trends in the healthcare landscape nationally and within Nebraska.

We constantly scan the market for trends in economic factors such as changes in household income, general inflation, physician supply, demographics, and federal and state regulations. Some useful sources of trend information that we review include Medicare trends, National Health expenditure (NHE) of GDP, Medical Consumer Price Index (M-CPI) and trend surveys.

Deloitte develops benchmark statistics from these external data sources. These provide valuable metrics against which programs in Nebraska can be compared to. In addition, Deloitte has the ability to access national databases to help review Nebraska results against national averages. Deloitte is best placed to analyze both historical and emerging forces of Medicaid trend. Following are some examples:

- **Demographic Changes.** Increase in elderly or disabled persons
- **Geographic Trends.** Population movement into higher or lower cost regions
- **New Technologies.** These affect care delivery systems leading to reduced cost across the healthcare system
- **Provider Practice Patterns.** Changes in the structure of the DBM's provider contracts have an impact on costs
- **Legislative Changes.** Introduction of new taxes or mandated benefits lead to increased medical costs
- **Benefit or Product Changes and their Impact.** Changes made to existing benefits package may lead to shifts or increases in costs

Deloitte will analyze multiple years of data related to these factors and their impact on dental costs. Adjustments needed to reflect observed trends will be assessed and incorporated into capitation rate development process when developing prospective trend assumptions.

3.V.I.2: Interim Reporting and Other Deliverables for Rate Setting Functions

RFP Reference: Section V.I.2, Page 28

Understanding of the Project Requirements

The Deloitte team will collaborate with the State to clearly present our results, recommendations, and consultative guidance during each rate cycle of the capitation rate development. A clear communication process is important to the success of this engagement. Our team is prepared to support the State through consultations and meetings for the requested deliverables and follow actuarially sound practices when communicating and documenting our findings.

Proposed Development Approach

We anticipate our approach for developing interim reporting and other rate setting deliverables for the Dental program will be conducted in a manner consistent with SOW 1. The primary steps and considerations are summarized below and further described in our response to **Section 3.V.D.2.**

- Produce documents and facilitate meetings
- Improve accuracy of the existing and new capitation rate development methodologies
- Collaborate to determine communication plan and work plan
- Develop dynamic rating methodologies and train staff

The following table summarizes our high-level understanding of the subtasks. Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Deloitte's Understanding of the Subtasks	
3.V.I.2.a	Participate in periodic meetings with Department staff to discuss the parameters, priorities, methodology, timelines, and ongoing results of capitation rate development in each rate cycle
3.V.I.2.b	Provide documents and data, as directed by Department staff, to discuss at these meetings
3.V.I.2.c	Provide project management staff and project/timeline updates for all tasks associated with the capitation rate setting process
3.V.I.2.d	Work collaboratively with Department staff to improve the accuracy and efficiency of the existing data sources and new data sources used for capitation rate development
3.V.I.2.e	Work collaboratively with Department staff and other Department vendors to improve the accuracy and efficiency of capitation rate development methodologies
3.V.I.2.f	Provide the Department with exhibits, reports, and calculations in the format(s) specified by the Department, including all formulae, databases, data sets, analyses, and documents relevant to the capitation rate setting process

Deloitte's Understanding of the Subtasks	
3.V.I.2.g	Develop work plans for rates to be determined including milestones for completion
3.V.I.2.h	Meet work plan milestones and timelines as agreed upon with the Department
3.V.I.2.i	Provide staff training in methodologies used to develop rates
3.V.I.2.j	Develop or assist in development of rate methodology for any new program(s) that may be implemented during the contract period

Figure 3-48. 3.V.I.2 Subtasks.

Technical Considerations

Deloitte understands the importance of meeting project milestones and delivering results in a timely manner. We will work with the State to comply with the agreed upon workplans and overcome challenges that arise to deliver high quality results.

Data Delays

Delays in receiving high quality data could present challenges to meeting the agreed upon timing. Data delays could be caused by many factors including late data submissions, longer than expected data cleansing, or data access issues. When data delays occur, Deloitte with work closely with the State to revise any impacted timelines and workplans and work to keep the overall progress on track with the project timeframe. We anticipate data delays can be mitigated by utilizing data from DMA.

Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Detailed Project Work Plan

We will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval.

A high-level project timeline is included in Appendix 1. We will work closely with the DHHS in the beginning stages of the engagement to develop detailed work plans for each managed care program.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we may provide for Interim Reporting and Other Deliverables for Rate Setting Functions. We will work closely with DHHS in the beginning stages of the engagement to develop the detailed work plan and deliverable due dates.

Deloitte's Understanding of the Deliverables	
Status Reports	Regular status reports, at the appropriate cadence, will be provided to DHHS. These status reports may include timelines, lists of priorities, progress updates, exhibits detailing results of actuarial analyses including in the capitation rate development, and descriptions of methodologies used in rate development to discuss with the Department.
Workplans	At the outset of rate setting tasks, we will provide a workplan with anticipated tasks and expected project milestones for discussion with the Department. Progress on these workplans will be communicated through the status reports.
Actuarial Rate Package	In connection with the actuarial memorandum, the team will provide a package of exhibits to be provided to the Department that detail base data, adjustments, trend, non-medical expenses, and final capitation rate estimates. These will be provided in a format agreed upon by Deloitte and the State and include formulae, databases, data sets, analyses, and documents relevant to the capitation rate setting process.

Figure 3-49. Potential 3.V.I.2 Deliverables.

3.V.I.2.a – Participate in periodic meetings with Department staff to discuss the parameters, priorities, methodology, timelines, and ongoing results of capitation rate development in each rate cycle

RFP Reference: Section V.I.2.a, Page 28

Deloitte is fully committed to working closely with the State to confirm projects are successfully completed. As mentioned above, Deloitte will be available for regular, scheduled, onsite meetings. Deloitte will have ad hoc meetings as required and when requested, onsite or via phone. We will be available during business hours to respond to questions from Department staff, and Deloitte will designate a primary point of contact to address issues on a daily basis.

A clear meeting cadence will be finalized prior to the start of the engagement. Regular status meetings will be scheduled to review the status report and discuss project risks. In addition, conference calls, video conferences via Skype, and other meetings will be planned accordingly to the project timeline and on an as needed basis to discuss approach, review results, and address questions throughout the engagement.

A clear documentation trail will also be necessary. Each meeting will have an agenda created so that attendees can prepare in advance. Meeting minutes will be distributed in a standard template to document the discussion.

3.V.I.2.b – Provide documents and data, as directed by Department staff, to discuss at these meetings

RFP Reference: Section V.I.2.b, Page 28

The Deloitte team will produce documents and data requested by Department staff to aid discussion at meetings. Materials will be distributed an appropriate amount of time in advance of the meeting to maximize the time during the meeting to review results and answer questions.

3.V.I.2.c – Provide project management staff and project/timeline updates for all tasks associated with the capitation rate setting process

RFP Reference: Section V.I.2.c, Page 28

We will designate a project manager to be responsible for operation of the contract duties and will be responsible for consultation and assistance with the State's personnel. The project manager will serve as the daily point of contact should issues arise and need to be addressed.

In addition to the project manager, we will have dedicated staff members responsible for the coordination of various project management duties. This will include development of meeting templates which include agendas, meeting minutes, and status reports. Agendas will be developed and distributed in advance of meetings. Meeting minutes will be captured and distributed to meeting attendees. A weekly status report will be distributed on a regular basis to discuss key activities, project timelines, and risks.

Open communication with the Department is important to keep the engagement on track. Deloitte will hold weekly meetings with Department staff in order to provide updates on the engagement status. We will work closely with Department staff in the beginning stages of the engagement to determine the frequency of these meetings and develop a status report template that aligns with the detailed project plan and timeline to monitor progress throughout the engagement.

3.V.I.2.d – Work collaboratively with Department staff to improve the accuracy and efficiency of the existing data sources and new data sources used for capitation rate development

RFP Reference: Section V.I.2.d, Page 28

Throughout our data analysis we will be reviewing the data for accuracy and actively seek out opportunities to improve the data. The ability to validate, store, and report essential data on a consistent basis is a major factor in the success of capitation rate development. We anticipate that by using DMA as a primary data source for rate setting, many of the data collection and data validation efforts can be accelerated.

Elimination of data errors starts with a well-conceived and executed data collection plan. Such a plan lays out in detail what data is to be formatted and reported. To address potential issues, we will work with the Department staff to review the state's current data collection practices, and potentially recommend changes to strengthen data accuracy. Some recommendations might include creating a data collection plan, providing training sessions for the DBM, and devising a data dictionary to codify terms and field definitions to support consistent data formatting. Deloitte will employ data validation by performing statistical analyses on the data to identify concerns caused by technical or reporting issues.

In any engagement, it is crucial to have quality data; which may involve appropriately assessing and adjusting existing data sources to eliminate potential biases and data anomalies. Upon project initiation, Deloitte will verify the accuracy and reliability of the available data based on reporting provided from the Department and standard checks for completeness. Additionally, we will perform high level validations of the data based on other available data sources whenever required.

Deloitte will follow the Actuarial Standards of Practice #23 on Data Quality. We will follow the guidance on a) selecting the data that underlie the actuarial work product; b) relying on data supplied by others; c) reviewing data; d) using data; and e) making appropriate disclosures with regard to data quality. Generally, data that are completely accurate, appropriate, and comprehensive are frequently not available. Deloitte will use their professional judgement to assess the data quality and take action to improve issues identified. If data limitations are identified, we will disclose the limitations and implications on our analyses.

3.V.I.2.e – Work collaboratively with Department staff and other Department vendors to improve the accuracy and efficiency of capitation rate development methodologies

RFP Reference: Section V.I.2.e, Page 26

Deloitte has internal quality controls in place to confirm the accuracy and quality of the work delivered and supporting documents to be delivered to the Department. Use of tools allows Deloitte to provide the Department with reports and documents that were produced using tested and validated processes and analyses on a timely basis. This will help Deloitte confirm that all such reports are accurate, correct, and complete to give the Department the analysis it needs for program management. Deloitte will work closely with DHHS staff and any other Department vendors to confirm that the most efficient and accurate capitation rate development methodologies are being utilized.

Additionally, as a majority of our proposed team are credentialed actuaries and Members of the American Academy of Actuaries, we meet the Qualification Standards of the American Academy of Actuaries. Our actuarial methods, considerations, and analyses conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board.

Any report or memorandum created by Deloitte for public distribution will be submitted to the Department for review and approval prior to release. The reports will be developed in a manner consistent with the requirements of this contract.

3.V.I.2.f – Provide the Department with exhibits, reports, and calculations in the format(s) specified by the Department, including all formulae, databases, data sets, analyses, and documents relevant to the capitation rate setting process

RFP Reference: Section V.I.2.f, Page 28

Consistent with our approach for SOW 1, the Deloitte team will make available project documents related to the services listed in this RFP, in the format requested by Department staff. Our team provides both a high-level review of the rate development process and develops a detailed document outlining the rate setting process including assumptions, adjustments and calculations as part of the capitation rate certification letter for submission to CMS. Other ad hoc documentation or descriptive data reports are available upon request, to provide the State with an understanding of the critical elements of the rate development process.

Documentation of Our Rate Development

Our rate documentation includes:

- A description of the rate calculation process used
- A description of the methodology used to develop and validate the base data
- A description and explanation of the adjustments made to the data
- A description of the trend calculation methodology and data
- A description of the assumptions used and supporting reasoning
- A table of year-over-year changes to the rates or rate ranges

Provide Management Summary Materials

At the end of the rate setting process, we present our results to the State, and outline year over year rate changes. Additionally, in this presentation, the Deloitte team addresses anomalies in the year over year rate analysis, and provides documentation explaining why these anomalies exist and where there may be areas for process optimization. During the first year of the contract, existing reporting and data books are reviewed and evaluated against the State's goals. We work collaboratively with the State to develop a reporting plan that maintains consistency while enhancing the information available to support the State and its strategic decision-making process.

Systematic Documentation

The Deloitte team produces a wide variety of rate certification letters, financial review summaries, and other reports to communicate the results from analytics completed using our suite of methods, accelerators, and tools.

3.V.I.2.g – Develop work plans for rates to be determined including milestones for completion

RFP Reference: Section V.I.2.g, Page 28

We will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval.

A high-level project timeline is included in Appendix 1. We will work closely with the State in the beginning stages of the engagement to develop detailed work plans for each managed care program.

3.V.I.2.h – Meet work plan milestones and timelines as agreed upon with the Department

RFP Reference: Section V.I.2.h, Page 28

Milestone dates will be provided in the work plans, and will be contingent on the Department's approval. The Deloitte project manager will track the progress of each deliverable via a deliverable dashboard which logs each milestone due date, as well as the delivered date, review dates, and approval dates. Refer to our responses to **Part 2, Section 2.i – Summary of Bidder's Proposed Management Approach**, for more information on our project management and quality control approach.

3.V.I.2.i – Provide staff training in methodologies used to develop rates

RFP Reference: Section V.I.2.i, Page 28

Consistent with our approach for SOW 1, our team will work with the State to provide a training session to Department staff. This session will assist the Department staff to gain understanding of the methodologies used to develop rates.

The methodologies of developing the rates will be documented in detail and pulled into a manual to share with the State. To kick off the training process, the Deloitte team will host a general meeting and give an overview presentation of the rate development. This overview presentation is to help the Department staff set the stage and get the ground information. We would then conduct an in person meeting to walk through the rate development process step by step.

Our project manager will also available to address questions that the Department staff may have throughout the process.

3.V.I.2.j – Develop or assist in development of rate methodology for any new program(s) that may be implemented during the contract period

RFP Reference: Section V.I.2.j, Page 28

Consistent with our approach for SOW 1, we will work closely with the State to understand the project objectives, timeline, and work plan. The Deloitte team has been assembled to support the dynamic environment of Healthcare. We are able to develop, or assist in the development of the rate methodology for new programs. Deloitte brings the on-demand knowledge in fiscal strategy, Medicaid rate setting, and healthcare to serve the Department in creating, analyzing, and/or responding to emergent trends and new initiatives in the Department.

In addition, Deloitte can also provide the Department with access to our national innovative research and analysis teams such as the Deloitte Center for Health Solutions. Deloitte Center for Health Solutions researches and develops solutions to our nation's health care and public-health related challenges. The Center has conducted extensive research and published numerous articles in the areas of health care reform, consumerism, health insurance exchanges, electronic health records, as well as Accountable Care Organizations, and medical homes. Our team will be able to leverage this research to develop innovative models and accelerate research for the Department.

It is critical for these methodologies to be innovative and cost-effective in order for the new program to be properly positioned for the future of health care. Our approach to assist in development of rate methodology for new programs follows the steps in the figure below, which is discussed further in our response to **Section 3.V.D.2.j.**

Figure 3-50. Approach for Rate Methodology Development for New Programs.

3.V.I.3: Capitation Rate Finalization

RFP Reference: Section V.I.3, Page 28

Our response in this section provides a general overview of the final actuarial memorandum and supporting documentation provided to DHHS. Each task associated with finalizing the capitation rates, including the types of documentation created and how regulations are followed is specifically addressed. We anticipate this process to be consistent with the rate finalization approach utilized for SOW 1.

Understanding of the Project Requirements

Through our experiences in setting Medicaid managed care rates across a wide array of clients with various goals and needs, we recognize that clear and detailed documentation of the rate setting process is critical to the success of our relationship with DHHS. Our credentialed and experienced actuaries follow the documentation protocols laid out by the Academy of Actuaries, CMS certification requirements, and DHHS specifications. The actuarial memorandum, data book and other supporting documentation we produce will include assumptions, adjustments, and calculations made to arrive at the rates and will provide a narrative description of each factor.

We will provide required technical support to DHHS, the DBM, and other interested stakeholders. Our support encompasses maintaining data, participation in rate meetings, providing technical support for rate negotiations with CMS, and technical discussions around emerging rate issues such as trend development, programmatic changes, service utilization, and medical and administrative efficiency.

Proposed Development Approach

Consistent with SOW 1, our rate setting process follows the documentation protocols laid out by the Academy of Actuaries, the actuarial standards of practice, the CMS Rate Development Guide, the Balanced Budget Act of 1997 (BBA), and DHHS specifications. Our approach is further described in our response to **Section 3.V.D.3.**

The following table summarizes our high-level understanding of the subtasks. Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Subtask	The Deloitte team's Understanding of the Subtasks
3.V.I.3.a	Document our rate development process and provide a memorandum disclosing the data, assumptions, and methodology used in developing rates
3.V.I.3.b	Attest that the rate setting process is compliant with all rate setting requirements described in the BBA
3.V.I.3.c	Certify that the rates are actuarially sound and provide the documentation to support this certification

Subtask	The Deloitte team's Understanding of the Subtasks
3.V.I.3.d	Provide documentation supporting that the rates were developed in accordance with CMS guidance
3.V.I.3.e	Prepare presentation materials to support discussions with DHHS rate setting meetings
3.V.I.3.f	Attend DHHS meetings with CMS and support DHHS as needed
3.V.I.3.g	Provide final rates and rate exhibits to DHHS by requested deadline, 150 days or 5 months before effective date

Figure 3-51. 3.V.I.3 Subtasks.

Technical Considerations

As the Deloitte team documents our rate development process and provides final rate exhibits, memorandum, and certifications, the following are potential technical aspects to consider.

CMS Rule Compliance. The CMS rule finalized in 2016 requires new documentation to be developed and delivered to CMS, as well as additional considerations in the rate development. The required documentation will need to be developed with DHHS as the requirements become effective. We will work collaboratively with DHHS to develop the required documentation and ensure the documentation and rate development meets the new standards.

Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Detailed Project Work Plan

We will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval.

A high-level project timeline is included in Appendix 1. We will work closely with the DHHS in the beginning stages of the engagement to develop detailed work plans for each managed care program.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we may provide for the programs in scope. We will work closely with DHHS in the beginning stages of the engagement to develop the detailed work plan and deliverable due dates.

Deliverable	Our Understanding of the Deliverables
Actuarially Sound Capitation Rates & Actuarial Memorandum	Using our rate setting model, we calculate actuarially sound capitation rates that take into account program specific considerations and comply with CFR 438.4, the AAA standards of practice, and the CMS rate setting checklist. As part of this, an actuarial memorandum will be produced documenting actuarial assumptions made, as well as the data, materials, and methodologies used in the development of the rates.

Deliverable	Our Understanding of the Deliverables
Certification Letter for Submission to CMS	We will produce a certification letter to CMS. This letter will provide details on the data, adjustments, assumptions, and methodology used to arrive at the actuarially sound rates. This certification letter will meet all requirements are stated in the CMS Rate Development Guide.
Presentation Material	We will provide supporting documentation and presentation material as requested by DHHS for DHHS rate setting discussions and meetings.

Figure 3-52. Potential 3.V.I.3 Deliverables.

3.V.I.3.a – Produce an actuarial memorandum that provides a detailed description of the methodology for developing the capitation rates along with all actuarial assumptions made and all other data, and materials used in the development of rates

RFP Reference: Section V.I.3.a, Page 28

The Deloitte team will provide a memorandum detailing our rate calculation process, the data and adjustments applied, the assumptions made, and a summary of year over year changes.

As discussed in **Section 3.V.I** above, our rate setting documentation provides the justification supporting each of our assumptions and adjustments. Our rate setting methodology adjusts for the following external factors:

- Programmatic changes brought on by implemented changes in the policy and operation of the DHHS programs
- Trend and unit cost inflation, based on assumptions developed from historical data by our credentialed actuaries and adjusted based on their knowledge of the Nebraska Medicaid program and the health care delivery system in general
- Other changes in population risk status, managed care programs, covered population, and other external factors

Our memorandum will be prepared under the supervision of Deloitte actuaries who are members of the AAA and have extensive experience certifying capitation rates for a multitude of states and a wide variety of Medicaid programs.

3.V.I.3.b – Certify that the rates comply with all requirements for managed care rate setting as described in the Balanced Budget Act (BBA) of 1997 including attestations of actuarial soundness and certification of plan rates in accordance to the BBA

RFP Reference: Section V.I.3.b, Page 28

In the memorandum discussed above, we will attest and certify that the methodology and assumptions used in our rate development comply with the requirements of the BBA as well as the Code of Federal Regulations section 438.4 and the CMS Rate Development Guide. We are experienced with these regulations and documents. We also follow generally accepted actuarial principles and practices by referring to the actuarial Code of Professional Conduct and the relevant Actuarial Standards of Practice (ASOP), such as ASOP #23 regarding data quality and ASOP #49 regarding Medicaid Managed Care Capitation Rate Development and Certification.

3.V.I.3.c – Provide actuarial certification as to the soundness of the rates along with all associated exhibits supporting the development of capitation rates

RFP Reference: Section V.I.3.c, Page 28

Our actuaries comply with federal regulations (CFR 438.4) updated in 2016 which require an actuary developing rates for a Medicaid managed care program to do so following actuarially sound principles. CMS had outlined what it considers to be the approved process in its Rate Development Guide. When certifying our final rates, we will reference the practice note[6] from The American Academy of Actuaries (AAA) addressing the issue of actuarial soundness in Medicaid as well as the study[7] released by AAA discussing the definition of actuarial soundness. Our team's actuaries are members of the AAA and are very familiar with the applicable requirements and actuarial practices. We will validate the base data as described above, apply the required adjustments, trend, and assumptions developed in cooperation with the DHHS, to arrive at actuarially sound rates.

[6] Medicaid Rate Certification Work Group of the American Academy of Actuaries "Health Practice Council Practice Note, Actuarial Certification of Rates for Medicaid Managed Care Programs", August, 2005

[7] The Actuarial Soundness Task Force, American Academy of Actuaries, "A Public Policy Special Report, Actuarial Soundness", May, 2012

3.V.I.3.d – Provide necessary certification to meet the requirements of the CMS rate setting consultation guide

RFP Reference: Section V.I.3.d, Page 26

The Deloitte actuarial team will certify the rates we develop as meeting the federal requirements for actuarial soundness as specified under 438.4. Our rate certification is documented in a certification letter that can be sent to CMS. This letter provides details on the data, adjustments, assumptions, and methodology used to arrive at the actuarially sound rates. Further, we will be available for related discussion with CMS on our certification.

Per the CMS Rate Development Guide, we will validate and document that payment rates are:

- Certified to be actuarially sound as described above
- Developed using generally accepted actuarial principles and practices
- Based only upon services covered under the State Plan (or costs directly related to providing these services, for example DBM administration)
- Reflective of adjustments for external factors
- Provided under the contract to Medicaid-eligible individuals only

3.V.I.3.e – Prepare all presentation material, attend and participate in DBM meetings as requested to promote approved recommendations

RFP Reference: Section V.I.3.e Page 28

We intend to support you throughout the rate development and rate negotiation process in a manner that meets your needs. As discussed in the introduction, we will create all exhibits, memoranda, and other supporting documentation for DHHS rate setting discussions and meetings. Further, we are prepared to incorporate an onsite team, as necessary, to work efficiently with DHHS.

This team will attend, participate, and provide support at DHHS rate setting meetings. Deloitte has key experiences supporting rate development discussions across a wide array of clients, including conversations with managed care organizations, Medicaid directors, and CMS.

3.V.I.3.f – Attend, participate, and provide support in the Department's rate setting discussions and meetings with CMS

RFP Reference: Section V.D.3.f, Page 28

The Deloitte team brings experience in working with State Medicaid agencies, MCOs, and CMS in particular with discussions related to the rate setting process, calculated rates, and changes to the Medicaid reimbursement structure. In fact, our team members have worked with CMS to develop CMS rate setting checklists. Additionally, team members have previously worked for CMS and are familiar with the rate negotiation process from CMS' point of view. This work has allowed us to gain insight into CMS' processes and practices.

We also have key experience working to support states in discussions with CMS, both with regard to managed care rate development and accountable care organization rates.

Based on our experiences working on rate setting with states including Kentucky, Maine, Minnesota, Texas, and New York, we have developed a deep understanding of State Medicaid programs and how we can best support them in discussions with CMS. These experiences position Deloitte's team to have significant impact while participating in DHHS meetings with CMS.

As discussed in the response to **Task 3.V.I.3.c** above, we are prepared to assist DHHS transition to the new reporting requirements described in the 2016 final CMS ruling as they are implemented. We will identify new opportunities for DHHS through the allowance of value based payments under capitation, and will provide support in discussions with CMS regarding these new opportunities.

3.V.I.3.g – Submit final rates and final rate exhibits 150 days or 5 months prior to their effective date

RFP Reference: Section V.I.3.g, Page 28

The timely development and finalization of rates is essential to operating an efficient managed care program. We will work closely with DHHS in the beginning stages of the engagement to develop detailed work plans for each managed care program so that final rates and supporting rate exhibits can be shared with DHHS in a timely manner before their effective date.

3.V.J: SOW 7 – Dental Capitation Rate Rebasing

RFP Reference: Section V.J, Page 29

Understanding of the Project Requirements

The Deloitte team is well qualified to support DHHS in rebasing the rates on a yearly basis for new emerging experience observed in the Medicaid program. Our team has extensive experience in accounting for new emerging data and how that data impacts different adjustments used in the initial rates and the trend applied to bring the base data forward to the rating period. Our team will work with the State to utilize new data as it is available in order to re-estimate the managed care rates applicable for the upcoming rating period.

As the Department wishes to utilize new base data sources and new rate setting methodologies, the Deloitte team will assist the DHHS in analyzing different types of rate methodologies and models that can be utilized in the development of its actuarially sound rates and rate ranges. Through our team members, we bring in-depth knowledge of different methodologies used in the rate setting process and hands-on experience with utilizing a variety of different data sources used to set the rates. Additionally, our team has extensive knowledge of the CMS Regulations on rate setting laid out in CFR 438 and the managed care rate development published each year from CMS.

SECTION HIGHLIGHTS

The Deloitte team's approach to rebasing the capitation rate development includes:

- Analyzing emerging experience and making necessary adjustments to account for changes in recent experience
- Considering alternative methodologies for developing capitation rates
- Confirming alternative methodologies and rebased data proposed will be acceptable based on CMS guidelines
- Delivering a documentation structure that clearly lays out the impact of rebasing to DHHS and applicable parties

We are prepared to provide required technical support to the DHHS, the Dental Benefit Manager, and other interested stakeholders throughout the capitation rate rebasing process. Our support encompasses rate development, data analysis, participation in rate meetings, providing technical support for rate negotiations, technical discussions around emerging trends, analysis of alternative rate cells, training for department staff and preparing presentation materials on the impact of capitation rate rebasing.

We note that our approach for the Dental rebasing will be very similar to the Heritage Health Plan capitation rate rebasing process as discussed further in our response to RFP **Section 3.E, SOW 2 – Capitation Rate Rebasing**. Within our response to this task, we have outlined where differences may occur in the approach between the Heritage Health Plan and the Dental plan.

Proposed Development Approach

Consistent with our approach for SOW 2, the Deloitte team develops actuarially sound rates and rate ranges following the applicable actuarial standards of practice, CMS' rate setting managed care rate development guide, and the requirements of CFR 438. As more recent data is collected our team can consider modifications to the rates developed through rebasing the data for more emerging experience. As emerging experience becomes available and additional data sources such as encounter data continue to improve, Deloitte will work with DHHS to rebase the rates towards these new data sources.

Additionally, we will work with DHHS to implement new rate setting methodologies utilizing different base data sources, different data sources for program changes and different assumptions that may be applied to trend to reflect more recent data available. A detailed description of our rate setting process is found in **Section 3.I.C.1.a.** The remainder of this section describes how rebasing would reflect that process.

The following table summarizes our high-level understanding of the subtasks. Please refer to our responses to each specific subtask in the sub-sections below for additional information on our proposed approach, technical considerations, and experience in supporting each subtask.

Subtask	The Deloitte team's Understanding of the Subtasks
3.V.J.a	Consider different rate setting methodologies and models to utilize in the rate development process
3.V.J.b	Analyze emerging data for considerations in rebasing the rates
3.V.J.c	Consider changes in potential cohorts for the managed care program
3.V.J.d	Confirm any revisions to the rate development methodology follow CMS guidelines
3.V.J.e	Provide documentation and training for department staff for new rate setting methodologies
3.V.J.f	Provide actuarial certification to the soundness of any rebased rates
3.V.J.g	Develop presentation materials for any rebased rates

Figure 3-53. 3.V.J Sub-tasks.

Technical Considerations

While our team is responsible for updating the actuarial capitation rate ranges for each period, similar to SOW 2, there are key items we collaborate with DHHS to collect in the rate setting process including:

Base Data items for Rate Setting

The State of Nebraska's Dental Managed Care program is a newly implemented program in late 2017. Therefore, since credible emerging managed care experience may not be yet available for the entire benefit package covered by the state, we may leverage additional data sources such as historical FFS data to utilize a credible data source in the rate setting process. As the newer services have emerging managed care experience that can be deemed credible, we can rebase the rates to utilize these new sources.

Detailed Project Work Plan

We will work closely with Department staff in the beginning stages of the engagement to develop detailed work plans. The proposed work plans will include a timeline, resources, critical path, dependencies, and a schedule of key events and dates. Project deliverables, milestone dates, and key dates will be contingent on the Department's approval.

A high-level project timeline is included in Appendix 1. We will work closely with the DHHS in the beginning stages of the engagement to develop a detailed work plan.

Deliverables and Due Dates

The following figure lists examples of the deliverables we anticipate we may provide for this program. We will work closely with DHHS in the beginning stages of the engagement to develop the detailed work plan and deliverable due dates.

Deliverable	Our Understanding of Dental Capitation Rate Rebasing Deliverables
Encounter Data and Financial Report Comparison	A detailed summary on how the different base data sources such as encounter data and financial reports compare for considerations in changing the methodology utilized to develop the rates
Impact of Rebasing Rates	Detailed summary and presentation materials of how changing the rating methodology would impact historical rates for considerations in modifying rate development methodology going forward.

Figure 3-54. Potential Deliverables for Dental Capitation Rate Rebasing.

3.V.J.a – Analyze different types of rate methodologies and models used by governmental and commercial entities upon request

RFP Reference: Section V.J.a, Page 29

The Deloitte team has extensive experience in considering different rate methodologies and models that can be used in setting managed care rates for the DHHS and will work the Department to update for new models as they are requested. As different stakeholders gain familiarity with the DHHS Medicaid program and have suggestions on how to reflect certain program change adjustments differently or different sources that can be utilized, the Deloitte team has a process in place to collaborate with those departments and take into consideration other stakeholder feedback in the rate setting process.

Additionally, as requested, the Deloitte team will recommend different models for DHHS to consider that our team has implemented in other states or are newer methodologies or models that are being utilized by other states.

3.V.J.b – Analyze paid claims (both fee-for-service and managed care, managed care financial statement data, and managed care encounter data with a specific focus on developing a rate range of high/target/low full risk capitation rates

RFP Reference: Section V.J.b, Page 29

As mentioned in the opening Section of SOW 6, actuarially sound rates are highly dependent on accurate, complete, and timely data. This data can take many forms and generally depends on the maturity of the program and sophistication of the participating health plans. As services in the program mature and the Dental Benefit Manager gains experience, fee-for-service data can largely be replaced by encounter data. However, encounter data raises new issues in that there is no longer a direct one-to-one correlation with a claim and a payment.

Throughout the capitation rate rebasing process, we will evaluate new data sources to consider if they can be utilized when rate setting and what their impact may be on the high, target and low capitation rates. For the encounter data, we propose that supplemental data in the form of Dental Benefit Manager financial data be gathered. By performing a detailed financial review of this data and comparing it to the reported encounter data, we can identify potential issues with the encounter data and bring those to the attention of the Dental Benefit Manager for process improvement and revision.

3.V.J.c – Analyze rate cell alternatives for identification of various groupings for the population (e.g. age, gender, eligibility)

RFP Reference: Section V.J.c, Page 29

As part of the rebasing process, we will analyze if there are different ways to potentially divide the base data sets based on differing levels of risk or geographic cost variation. As part of this rebasing analysis, we will consider the following steps:

1. Start with the same base period eligibility and dental expense data used in the rate setting process
2. Analyze a potential range of cohort variations to determine the necessary logic for managed care cohorts to be credible but reflect appropriate levels of cost variation
3. Review potential cohort changes with DHHS
4. Adjust rate setting process in future for any agreed upon changes in the cohorts in the state

3.V.J.d – Assess compliance of rate methodologies and applications with Federal and State laws, rules, and regulations regarding reimbursement and budget-related issues

RFP Reference: Section V.J.d, Page 29

In rebasing rates, it is important that any changes to the methodology comply with the appropriate federal and state laws, rules and regulations. In the rebasing process, our actuaries comply with federal regulations (CFR 438) which require an actuary developing rates for a Medicaid managed care program to do so following actuarially sound principles. CMS has outlined what it considers to be the approved process in its Capitation Rate Checklist. The American Academy of Actuaries (AAA) developed a practice note addressing the issue of actuarial soundness in Medicaid managed care rate setting. The purpose of the practice note was to provide nonbinding guidance to an actuary when certifying rates or rate ranges for capitation of Medicaid managed care programs. Recently the AAA released a study discussing, in part, the definition of actuarial soundness. Our team's actuaries are members of the AAA and are very familiar with the applicable requirements and actuarial practices. The Deloitte team actuaries have developed actuarially sound rates under the applicable regulations for many years.

For any items that are rebased or changed as part of the rebasing process, we will validate the changes and assumptions developed in cooperation with DHHS, to arrive at rebased actuarially sound rates. We will provide a certification that the rates or rate ranges were developed in compliance with relevant regulations and the guidance set forth.

3.V.J.e – Provide documentation and training for Department staff on new capitation rate-setting methodologies and procedures. Documentation and training shall be easily understood, allowing the Department to implement and manage the execution of new capitation rate-setting methodologies

RFP Reference: Section V.J.e, Page 29

Deloitte team will work with DHHS to provide a training session to Department staff on any new methodologies resulting from the rebasing process. This session will assist the Department staff to gain understanding of the methodologies used to develop rates and efficiently use the programs and software developed for contracted services, as agreed to in the final contract terms.

The methodologies of developing the rates will be documented in detail and pulled into a manual to share with DHHS. To kick off the training process, the Deloitte team will host a general meeting and give an overview presentation of the rate development. This overview presentation is to help the Department staff set the stage and get the ground information. We would then conduct an in-person meeting to walk through the rate development process step by step:

- Describe the base data selected as part of the rebasing process
- Discuss how assumptions are modified based on the rebasing
- Explain the new modeling files in addition to the existing modeling tools DHHS has and the ways we used them to complete the rate development using rebased rates.

Our project manager will also be available to address questions that the Department staff may have throughout the process.

3.V.J.f – Provide an actuarial certification as to the soundness of the rates the contractor develops

RFP Reference: Section V.J.f, Page 29

Our actuaries comply with federal regulations (CFR 438.4) updated in 2016 which require an actuary developing rates for a Medicaid managed care program to do so following actuarially sound principles. CMS had outlined what it considers to be the approved process in its Rate Development Guide. The American Academy of Actuaries (AAA) developed a practice note addressing the issue of actuarial soundness in Medicaid. The purpose of the practice note was to provide nonbinding guidance to an actuary when certifying rates or rate ranges for capitation of Medicaid managed care programs. Our team's actuaries are members of the AAA and are very familiar with the applicable requirements and actuarial practices. We will validate the base data as described above, apply the required adjustments, trend, and assumptions developed in cooperation with the DHHS, to arrive at actuarially sound rates.

Additionally, we recognize there were new elements introduced in the CMS rule approved in 2016. Under the rule, all rate cells must be submitted to CMS, provider-preventable conditions must be identified and reported, rates must be developed in accordance with new network adequacy and MLR guidance, and value based payments under capitation are allowed. We are prepared to partner with DHHS to create and submit the additional required documentations as the requirements become effective and will certify that the rates were developed in accordance with new guidance.

Further, we will partner with DHHS to identify new opportunities presented by the allowance of value based payments. Based on our experiences supporting states in their efforts to save costs and innovate, we understand the challenges present when implementing and designing new programs as well as the potential efficiencies and savings opportunities which they represent.

3.V.J.g – Prepare all presentation material, and attend and participate in DBM meetings as requested to promote approved recommendations

RFP Reference: Section V.J.g, Page 29

We intend to support you throughout the rate development and rate negotiation process in a manner that meets your needs. As discussed in the introduction, we will develop exhibits, memoranda, comprehensive data books and other supporting documentation for DHHS rate setting discussions and meetings.

This team will attend, participate, and provide support at DHHS rate setting meetings. Our team is prepared to support DHHS by travelling on-site periodically as needed and for key meetings to allow for flexibility and efficiency in communications as we partner with DHHS in the rate setting and rate negotiation process.

3.V.K: SOW 8 – Special Projects (Optional)

RFP Reference: Section V.K, Page 29

Understanding Project Requirements

We are prepared to provide any necessary additional technical and actuarial support to the Department in a timely and efficient manner. We understand that our support could encompass financial analysis and actuarial consultation, program modifications, performance evaluation of managed care plans, and Managed Care encounter validation activities.

SECTION HIGHLIGHTS

The Deloitte team will provide ad hoc analyses as requested by the Department

- Apply actuarial judgement for each applicable request
- Deliver a broad-based team of resources capable of scalping to meet the Department's needs
- Deliver our solutions collaboratively alongside the DHHS
- Access our suite of tools, methods, and accelerators to enhance ad hoc analysis process and drive data-driven decisions

Deloitte is one of the world's leading consulting organizations for technology, human capital, and business strategy and operations services. We are well-positioned to offer the State of Nebraska access to a full range of integrated solutions that meet your business and technical needs. The State benefits significantly from this integrated structure; it allows us to quickly bring to bear the required knowledge and skills to handle any potential challenge to deliver a successful project. Our access to the wide range of skills available in our integrated, member firms is what sets us apart from one dimensional integrators and service providers. For additional information on our experience and qualifications, please refer to our response to **Part 2 – Corporate Overview.**

Proposed Development Approach

Below we have outlined examples of the approach we may follow depending on the nature of the ad hoc request. We will work closely with DHHS staff in the beginning stages of each project to outline the request and our anticipated approach, and develop a detailed work plan.

Financial Analysis and Actuarial Consultation

As part of financial analysis and monitoring process, we can provide reports relating to:

- **Medical Loss Ratio.** Our tools help us to evaluate MCO medical loss ratios, key financial indicators, and other important financial measures.
- **Reserve Adequacy.** Our analysis and our actuaries' knowledge provides an assessment of a MCO's reserve position,
- **Comparative Statistics and Industry Benchmarks.** Based on our extensive experience and access to industry benchmark data, we can supply the Department with

comparisons and rankings of the participating MCO plans/facilities in terms of efficiency and cost-effectiveness

- **Observations on Emerging Trends.** Information that may affect the MCO-provided financial information

Managed Care Plans and Program Enhancements

We will work with the Department to identify potential improvements and/or implement enhancements to the managed care plans and programs. Examples of such enhancements include:

- Payment system refinement
- Waiver development
- Policy and Regulation Changes

Payment System Refinement

We do not take a siloed approach to program redesign by focusing only on payment reform; we believe it is critical to look at program design and development, stakeholder meeting facilitation, financial monitoring, policy analysis, waiver support and development, and revenue planning as part of the potential reform options being presented to the Department. Our team understands the intricacies of provider cost-based rates, fee schedule rates, and outcome based rates to present the Department with alternative payment methodologies rooted in the insights gained from years of consulting to many facets of the health care system.

Waiver Development

Waivers are designed to bring strategies and solutions that focus on maximizing the individual's independence within a safe and supportive environment and providing opportunities for the individual to engage in productive and meaningful activities that enhance his or her quality of life and well-being.

Our team's diverse experience allows us to work collaboratively to identify and quantify the impact of innovative program changes. Specifically, we leverage our *Waiver Cost-Effectiveness Model* to efficiently analyze the financial impact of program changes to waiver development components such as claims, claims trend, and administrative expenses. Our team of specialists uses the outcomes from the model to assist the Department with options analysis and recommendations for program design.

Policy and Regulation Changes

Changes to federal and state Medicaid policies and programs can provide substantial opportunities to enhance service delivery models that can have a material impact on the costs of care within the states. Our team closely monitors the legislative environment and when opportunities like these present themselves, our team quantifies the potential impact

of changes that our clients may want to consider. We work collaboratively to develop a solution based on these new opportunities that best addresses the policy requirements and the Managed Care programs.

We have experience in reaching collaborative strategic decisions through our public sector and provider work. We recognize the need to gather feedback from a variety of stakeholders to achieve common understanding of the risks and rewards of options and reach consensus on the optimal solutions. Our ability to communicate effectively and gather information from a variety of sources facilitates the Department's decision-making process.

Our team delivers an extensive toolset that can be leveraged to quantify the cost impact of program changes, and to identify and present the different payment options to the Department. Tools such as our *Customizable Benefit Tools*, which re-adjudicate and re-price claims to analyze the cost impact of program benefit changes, are used to quantify the cost impact and identify the different payment options available.

Managed Care Plans Performance Evaluation

To evaluate the effectiveness of MCO performance, we can conduct an evaluation on performance metrics such as cost and quality. Similar to the financial analyses described above, we can review unit cost and utilization metrics at the MCO level and compare across the program to identify opportunities for improvement. Additionally, an assessment of their underlying administrative expenditures compared to program averages may yield cost savings opportunities.

For quality measures, quality metrics submitted by the MCOs can be analyzed to identify areas of opportunity. Additionally, as noted in our efficiency adjustment approach in rate development, additional modeling can be conducted on the encounter data to identify avoidable or preventable admissions and visits.

The findings of our analysis can be summarized into a report for DHHS that will identify the areas of opportunity, including a summary of our approach, data sources, and assumptions utilized during the course of the evaluation.

Managed Care Encounter Validation

In general, the base data can take many forms and depends on the maturity of the program and sophistication of the participating health plans. Some plans might have challenges submitting complete and accurate encounter data. Actuarially sound rates are highly dependent on accurate, complete, and timely data. To validate the encounter data used to develop capitation rates is complete, we would use supplemental data identified in collaboration with the Department. Our team has the experience and knowledge needed to perform detailed review to determine where a health plan's encounter data reporting is deficient or when a plan's financial data does not support its reported level of service. Through this determination, we can improve the credibility of the financial reports and encounter data used in the rate development process.

To determine if the data received is credible we first check the validity, reasonableness and completeness of the data received with the following summaries and comparisons.

- Summarize the data in aggregate and compare to financial report provided
- Analyze data for completeness and for key data elements such as payment or unit fields
- Analyze frequency of key data elements (# of procedures, visits, etc.)
- Check the relationship between diagnosis and procedure codes
- Check for inappropriate age or gender for procedures
- Check for inappropriate ages with date of birth
- Summarize distributions by rating group and analyze trends to see if consistent
- Work with the Department to understand differences that appear and either receive supplemented data or make assumptions when needed

We have assisted several clients in improving vendor reporting requirements and identifying performance standards that put accountability on the providers. The collection of accurate and detailed data is critical to calculating reasonable capitation rates, identifying areas for program improvement, including opportunities to increase efficiency, and potential cost containment opportunities. Please refer to our response to RFP **Section 3.V.D.2.d** for more information on how encounter data quality procedures are incorporated into our rate development approach.

Implementing New Risk Adjustment Models

As the DHHS is interested in considering new risk adjustment models for historical populations or new populations are considered for risk adjustment, Deloitte can work with the DHHS to investigate multiple different risk adjustment models for different Medicaid populations.

The first step in selecting and implementing a risk adjustment model for a given Medicaid population is a solid understanding of the DHHS's strategic goals, expectations from the risk adjustment model and program within the rate setting process, as well as restrictions such as cost considerations, data availability, and continuity across populations, etc. Having a baseline of information will help the team to understanding the framework in which the model analysis should be conducted and expectations of how the assessment should be completed.

After setting up analysis parameters and goals, the Deloitte team will assess each potential models' ability to meet DHHS goals, identify the model's strengths as well as deficiencies or limitations within the context of identified parameters, what add on modules are available to supplement the risk adjustment model for future consideration. After considering the high-level strengths and weakness or limitations of the full range of risk adjustment models. The Deloitte team will present findings to the DHHS and offer suggestions on which models should be on the short list for the detailed testing phase of the model selection analysis.

Detailed Model Analysis

Prior to conducting the detailed model analysis, we would recommend an analysis of the data that will be utilized for risk adjustment purposes to verify that the data is complete and appropriate for use for risk adjustment. If deficiencies are discovered, adjustments should be made prior to completing the detailed model analysis to remove unintended bias in model performance.

As noted above, a short list of well aligned risk adjustment models will be run and analyzed in detail. This process is more time consuming, so only those models that are strong contenders for being selected should be analyzed to reduce the potential for confusion when reviewing detailed metrics. Below are components of the detailed analysis to be completed on each of the models:

- Run each model with both national benchmark data as well as actual DHHS Medicaid data. Running on both national and actual Nebraska data will help to understand if there are models best suited for Nebraska now, but also allow for considerations of general performance against a broad data set which informs the DHHS of its continued applicability and reliability if the population being covered changes over time.
- Extract risk scores and demographic information for use within statistical and performance analyses
- Conduct statistical analysis of each models' outputs such as R-Squared & Grouped R-Squared, Predictive Ratios, Cumming's Prediction Measure (CPM), or the Loss Ratio Advantage (LRA).
- The statistical analyses will be conducted on various cuts of the data such as by region, decile, or population/cohort

Final Model Selection

While it is ultimately the DHHS's decision on which model to select, it is our goal to be the DHHS's trusted business advisor and partner supporting the DHHS through each step of the process. Therefore, after completing the various detailed analyses; the results will be consolidated, reviewed, and a summary developed for distribution and review with the DHHS. The summary will cover model performance within each analysis, review findings and suggestions on model viability against DHHS goals, and other considerations. Our team will collaborate with the DHHS to select a model that best meets the program goals and requirements.

Model Implementation Prep

Upon selecting a model that will be the backbone for the risk adjustment program, additional analysis will be required to prepare for implementation into the rate setting process. A few of the additional analysis that the Deloitte team would conduct for the DHHS include:

- Test runs to support an analysis of using concurrent vs. prospective weights
- Analyze whether standard weights or custom Nebraska weights should be utilized
- Test the impact of risk adjustment phase-in
- Conduct dry runs using all final decisions from previous analyses and actual plan data to understand what the impact would be on capitation rates and subsequent health plan revenue compared to the without risk adjustment scenario

We suggest holding stakeholder meetings at different phases within the risk adjustment program and model selection process to allow plans to provide input around data availability and timing, and other considerations. Being able to provide stakeholders information on the process that will be utilized to select the model, test the outcome and then present preliminary results will help to foster a collaborative atmosphere with the plans that will be directly impacted by this new process. If the plans do not have experience dealing with risk adjustment, additional technical assistance beyond stakeholder sessions may be required.

Technical Considerations

The technical considerations of the optional ad hoc special projects will vary based on the requested task. During the initial kick-off phase of each special project task, we will work with DHHS to identity technical considerations that may impact scope and timing, develop mitigation plans, and incorporate the strategy and key decisions into the work plan.

Project Plan, Deliverables, and Due Dates

The project plan, deliverables, and timing will vary based on the requested special project task. We will work closely with DHHS at the beginning of each special project to develop a Scope of Work, including a detailed work plan. The Scope of Work will include a timeline, resources, critical path, dependencies, quality review procedures, a schedule of key events and dates, and projected hours. Project deliverables and milestone dates will be contingent on the Department's approval. During the course of the work within the project plan, we will update the Department on our progress, review our process and the underlying methodology, as well as answer any questions the Department may have.

Appendix 1 - SOW 1, 2, 6, and 7 Sample Work Plan

For Rates Effective January 1, 2020

Step #	Task Name / Description	Start	Finish	Primary Owner
Managed Care Rate Development				
0	**Weekly Program Touchpoints**	**Tuesday, September 4, 2018**	**Thursday, January 2, 2020**	**Deloitte**
1	**Engagement Kick-Off**	**Tuesday, September 4, 2018**	**Friday, December 28, 2018**	**Deloitte**
1.1	Determine meeting participants, develop and distribute meeting agenda, facilitate kick-off meeting	Tuesday, September 4, 2018	Friday, September 7, 2018	Deloitte
1.2	Finalize and distribute work plan	Monday, September 10, 2018	Friday, November 16, 2018	Deloitte
1.3	DHHS reviews and provides feedback on Deloitte work plan	Monday, November 19, 2018	Friday, December 14, 2018	DHHS
1.4	Finalize work plan	Monday, December 17, 2018	Friday, December 28, 2018	Deloitte
2	**Data Collection and Validation**	**Monday, November 5, 2018**	**Friday, April 5, 2019**	**Deloitte/DHHS**
2.1	Work with DHHS to identify and gather available data to be used in the rate development process	Monday, November 5, 2018	Friday, December 14, 2018	Deloitte
2.2	Perform data checks for reasonableness including conducting data and methodology discussion with Optumas	Monday, December 17, 2018	Friday, March 1, 2019	Deloitte
2.3	Facilitate data review discussions with DHHS to resolve data variances, missing data elements, or data outliers	Friday, February 1, 2019	Friday, March 22, 2019	Deloitte/DHHS
2.4	Summarize base data after resolving data issues and variances	Monday, March 18, 2019	Friday, March 29, 2019	Deloitte
2.5	Review base data with DHHS and receive final sign-off on Data Collection and Validation	Monday, April 1, 2019	Friday, April 5, 2019	Deloitte/DHHS
3	**Base Data Adjustments**	**Monday, March 18, 2019**	**Friday, April 26, 2019**	**Deloitte**
3.1	Develop base data adjustments and conduct internal review	Monday, March 18, 2019	Friday, April 19, 2019	Deloitte
3.2	Discuss results with DHHS and receive final sign-off on Base Data Adjustments	Monday, April 15, 2019	Friday, April 26, 2019	Deloitte/DHHS
4	**Program changes**	**Monday, January 7, 2019**	**Friday, May 3, 2019**	**Deloitte**
4.1	Develop pricing, benefit, population, and other adjustments	Monday, January 7, 2019	Friday, April 19, 2019	Deloitte
4.2	Deloitte internal review	Monday, April 1, 2019	Friday, April 26, 2019	Deloitte
4.3	Discuss results with DHHS and receive final sign-off on Program Changes	Monday, April 22, 2019	Friday, May 3, 2019	Deloitte/DHHS
5	**MCO and Other Assumptions**	**Monday, January 28, 2019**	**Friday, April 26, 2019**	**Deloitte/DHHS**
5.1	Develop other expected upcoming program change adjustments and conduct internal review	Monday, January 28, 2019	Monday, April 8, 2019	Deloitte
5.2	Discuss results with DHHS and receive final sign-off on MCO and Other Assumptions	Monday, April 1, 2019	Friday, April 26, 2019	Deloitte/DHHS
6	**Trend Analysis**	**Monday, January 14, 2019**	**Friday, May 17, 2019**	**Deloitte/DHHS**
6.1	Analyze trends and determine trend assumptions	Monday, January 14, 2019	Friday, May 3, 2019	Deloitte
6.2	Review trends internally	Monday, April 22, 2019	Friday, May 10, 2019	Deloitte
6.3	Discuss results with DHHS and receive final sign-off on Trend and Risk Adjustment	Monday, May 6, 2019	Friday, May 17, 2019	Deloitte/DHHS
7	**Risk Adjustment**	**Monday, January 7, 2019**	**Friday, May 31, 2019**	**Deloitte/DHHS**
7.1	Develop risk adjustment factors that will be applied to the rates and conduct internal review	Monday, January 7, 2019	Friday, May 17, 2019	Deloitte
7.2	Discuss results with DHHS and receive final sign-off on Trend and Risk Adjustment	Monday, May 13, 2019	Friday, May 31, 2019	Deloitte/DHHS
8	**Non-Medical Expenses**	**Monday, February 4, 2019**	**Wednesday, May 1, 2019**	**Deloitte/DHHS**
8.1	Determine administrative, care management, premium based taxes, underwriting gain, etc	Monday, February 4, 2019	Friday, May 17, 2019	Deloitte
8.2	Deloitte internal review	Monday, May 13, 2019	Friday, May 24, 2019	Deloitte
8.3	Discuss results with DHHS and receive final sign-off on Non-Medical Expenses	Monday, May 20, 2019	Friday, May 31, 2019	Deloitte/DHHS
9	**Develop Draft Rates**	**Monday, May 20, 2019**	**Monday, June 17, 2019**	**Deloitte/DHHS**
9.1	Incorporate rating assumptions	Monday, May 20, 2019	Friday, May 24, 2019	Deloitte
9.2	Develop draft rates and exhibits to summarize results	Monday, May 20, 2019	Friday, May 24, 2019	Deloitte
9.3	Conduct internal and DHHS review sessions and address feedback from DHHS	Thursday, May 23, 2019	Monday, June 17, 2019	Deloitte
9.4	Deliver draft rates to DHHS	Monday, June 17, 2019	Monday, June 17, 2019	Deloitte/DHHS
10	**Develop MCO rate discussion materials**	**Monday, June 3, 2019**	**Friday, June 28, 2019**	**Deloitte/DHHS**
10.1	Develop MCO rate discussion materials	Monday, June 3, 2019	Friday, June 28, 2019	Deloitte
10.2	Conduct internal and DHHS review sessions and address feedback from DHHS	Monday, June 10, 2019	Friday, June 28, 2019	Deloitte
10.3	Review Rate Meeting Materials with DHHS	Monday, June 17, 2019	Friday, June 28, 2019	Deloitte/DHHS
11	**Finalize Rates**	**Monday, June 17, 2019**	**Wednesday, July 31, 2019**	**Deloitte/DHHS**
11.1	DHHS reviews Draft rates	Monday, June 17, 2019	Monday, July 15, 2019	DHHS
11.2	Deloitte reviews State rates	Monday, June 17, 2019	Monday, July 15, 2019	Deloitte
11.3	Facilitate meetings with DHHS to discuss rate differences and changes and implement changes	Monday, July 15, 2019	Wednesday, July 31, 2019	Deloitte/DHHS
11.4	Finalize Rates	Wednesday, July 31, 2019	Wednesday, July 31, 2019	Deloitte
12	**Actuarial Rate Certification**	**Monday, June 17, 2019**	**Wednesday, July 31, 2019**	**Deloitte/DHHS**
12.1	Draft rate certification and exhibits	Monday, June 17, 2019	Monday, July 15, 2019	Deloitte
12.2	Conduct internal and DHHS review sessions and address feedback from DHHS	Monday, July 8, 2019	Wednesday, July 31, 2019	Deloitte
13	**Periodic Support (as needed)**	**Monday, September 9, 2019**		**Deloitte**
13.1	Address MCO questions	Monday, September 9, 2019		Deloitte
13.2	Support rate modifications	Monday, September 9, 2019		Deloitte
13.3	Address CMS questions	Monday, September 9, 2019		Deloitte

Appendix 2 - SOW 3 – 1915(b) Waiver Renewal Sample Work Plan

For Waiver Renewal Effective July 1, 2019

Step #	Task Name / Description	Task Description / Notes	Duration	Duration	Start	Finish	Primary Owner	Comments/Questions
1915(b) Waiver Renewal Submission								
0	**Weekly Program Touchpoints**	Deloitte and DHHS will have weekly meetings to discuss status and questions	Weekly	Weekly	Monday, August 6, 2018	Friday, March 30, 2019	Deloitte	
1	**Engagement Kick-Off**	Facilitate an engagement kick-off meeting with DHHS stakeholders and finalize meeting cadence and timelines	14	14 Days	Monday, August 6, 2018	Monday, August 20, 2018	Deloitte	
1.1	Determine meeting participants		1	1 Day	Monday, August 6, 2018	Monday, August 6, 2018	Deloitte	
1.2	Develop and distribute meeting agenda		2	2 Days	Monday, August 6, 2018	Tuesday, August 7, 2018	Deloitte	
1.3	Facilitate kick-off meeting		1	1 Day	Wednesday, August 8, 2018	Wednesday, August 8, 2018	Deloitte	
1.4	Finalize and distribute work plan	Includes cadence of status meetings, timelines, deliverables, milestones, etc.	5	5 Days	Thursday, August 9, 2018	Monday, August 13, 2018	Deloitte	
1.5	DHHS reviews and provides feedback on Deloitte work plan		5	5 Days	Monday, August 13, 2018	Friday, August 17, 2018	DHHS	
1.6	Finalize work plan		1	1 Day	Monday, August 20, 2018	Monday, August 20, 2018	Deloitte	
2	**Data Collection and Validation**	Coordinate with the DHHS to collect necessary data to support rate setting analysis	42	42 Days	Wednesday, August 15, 2018	Wednesday, September 26, 2018	Deloitte/DHHS	
2.1	Distribute data request after program kick-off meetings	Prepare data request based on feedback on available data from kick-off meeting	2	2 Days	Wednesday, August 15, 2018	Thursday, August 16, 2018	Deloitte	
2.2	Gather and access data	Data will include MCO encounter data, enrollment data, and may include cost reports and FFS claims	15	15 Days	Friday, August 17, 2018	Friday, August 31, 2018	Deloitte/DHHS	
2.3	Perform data checks for reasonableness		11	11 Days	Friday, August 31, 2018	Monday, September 10, 2018	Deloitte	
2.4	Facilitate data review discussions with the DHHS to resolve data variances, missing data elements, or data outliers	As needed - Draft Data, Questions, and Key Decisions Log as part of this process	25	25 Days	Friday, August 31, 2018	Monday, September 24, 2018	Deloitte/DHHS	
2.5	Review base data with DHHS and receive final sign-off on Data Collection and Validation		1	1 Day	Wednesday, September 26, 2018	Wednesday, September 26, 2018	Deloitte/DHHS	
3	**Base Data Adjustments**	Incorporate data adjustments to normalize data for rate effective period	44	44 Days	Wednesday, September 26, 2018	Friday, November 9, 2018	Deloitte	
3.1	Policy and Program Adjustments	Work with DHHS to identify prospective program changes to incorporate in base data for waiver projection period	10	10 Days	Wednesday, September 26, 2018	Friday, October 5, 2018	Deloitte/DHHS	
3.2	Benefit and Network Adjustments	Work with DHHS to identify benefit and network changes to incorporate in base data for waiver projection period	11	11 Days	Friday, October 5, 2018	Monday, October 15, 2018	Deloitte/DHHS	
3.3	Administrative Costs	Analyze changes in administrative costs based on changing MCO reporting requirements, DHHS reporting, etc	8	8 Days	Monday, October 15, 2018	Monday, October 22, 2018	Deloitte	
3.4	Populations Adjustments	Work with DHHS to identify prospective program changes to incorporate in base data for waiver period	8	8 Days	Tuesday, October 23, 2018	Tuesday, October 30, 2018	Deloitte/DHHS	
3.5	Medical Cost Trend	Analyze historic data by applicable MEG and COS to develop costs trends to apply to waiver projection period	10	10 Days	Wednesday, October 31, 2018	Friday, November 9, 2018	Deloitte/DHHS	
4	**Waiver Cost-Effectiveness Model**	Develop Cost Effectiveness Model for Waiver Preprint Template	13	13 Days	Friday, November 9, 2018	Thursday, November 22, 2018	Deloitte	
4.1	Project Waiver Costs	Project the with-waiver and without-waiver costs by applicable MEG/COS for the duration of the waiver	11	11 Days	Friday, November 9, 2018	Monday, November 19, 2018	Deloitte	
4.2	Insert projected costs into Waiver Preprint Template	Fill out CMS Waiver Preprint Template and demonstrate that with-waiver costs are less than or equal to without-waiver costs	3	3 Days	Monday, November 19, 2018	Wednesday, November 21, 2018	Deloitte	
4.3	Review Waiver Template with DHHS	Review and discuss filled out template with DHHS	1	1 Day	Thursday, November 22, 2018	Thursday, November 22, 2018	Deloitte	
5	**Develop Cost-Effectiveness Model Documentation**		17	17 Days	Thursday, November 22, 2018	Sunday, December 9, 2018	Deloitte/DHHS	
5.1	Draft cost-effectiveness model documentation		12	12 Days	Thursday, November 22, 2018	Monday, December 3, 2018	Deloitte	
5.2	Review Documentation with DHHS		2	2 Days	Tuesday, December 4, 2018	Wednesday, December 5, 2018	Deloitte/DHHS	
5.3	Revise or Clarify Documentation	Revise/clarify documentation based on DHHS feedback	5	5 Days	Wednesday, December 5, 2018	Sunday, December 9, 2018	Deloitte	
6	**Develop Narrative Support for Submission**		15	15 Days	Tuesday, December 4, 2018	Wednesday, December 19, 2018	Deloitte/DHHS	
6.1	Draft narrative	Draft narrative to accompany waiver template submission	10	10 Days	Tuesday, December 4, 2018	Thursday, December 13, 2018	Deloitte	
6.2	Review narrative with DHHS		2	2 Days	Thursday, December 13, 2018	Friday, December 14, 2018	Deloitte	
6.3	Revise or Clarify Narrative	Revise/clarify narrative based on DHHS feedback	6	6 Days	Friday, December 14, 2018	Wednesday, December 19, 2018	Deloitte	
7	**Submit Waiver Model, Documentation, and Narrative**		1	1 Day	Friday, December 21, 2018	Friday, December 21, 2018	Deloitte/DHHS	

Appendix 3 - SOW 4 – PACE Rate Setting Sample Work Plan

For Rates Effective July 1, 2019

Step #	Task Name / Description	Start	Finish	Primary Owner
Managed Care Rate Development				
0	**Weekly Program Touchpoints**	**Monday, September 3, 2018**	**Monday, July 1, 2019**	**Deloitte**
1	**Engagement Kick-Off**	**Monday, September 3, 2018**	**Friday, September 14, 2018**	**Deloitte**
1.1	Determine meeting participants, develop and distribute meeting agenda, facilitate kick-off meeting	Monday, September 3, 2018	Wednesday, September 5, 2018	Deloitte
1.2	Finalize and distribute work plan	Wednesday, September 5, 2018	Monday, September 10, 2018	Deloitte
1.3	DHHS reviews and provides feedback on Deloitte work plan	Monday, September 10, 2018	Friday, September 14, 2018	DHHS
1.4	Finalize work plan	Friday, September 14, 2018	Friday, September 14, 2018	Deloitte
2	**Data Collection and Validation - UPL & Capitation Payment Rates**	**Monday, September 3, 2018**	**Monday, December 17, 2018**	**Deloitte/DHHS**
2.1	Work with DHHS to identify and gather available data to be used in the rate development process	Monday, September 3, 2018	Monday, October 15, 2018	Deloitte
2.2	Perform data checks for reasonableness	Monday, September 10, 2018	Friday, November 2, 2018	Deloitte
2.3	Facilitate data review discussions with DHHS to resolve data variances, missing data elements, or data outliers	Monday, September 10, 2018	Friday, November 2, 2018	Deloitte/DHHS
2.4	Summarize base data after resolving data issues and variances	Friday, November 2, 2018	Monday, December 17, 2018	Deloitte
2.5	Review base data with DHHS and receive final sign-off on Data Collection and Validation	Monday, December 17, 2018	Monday, December 17, 2018	Deloitte/DHHS
3	**Base Data Adjustments - UPL & Capitation Payment Rates**	**Monday, November 19, 2018**	**Monday, February 11, 2019**	**Deloitte**
3.1	Develop base data adjustments	Monday, November 19, 2018	Friday, February 1, 2019	Deloitte
3.2	Deloitte internal review	Monday, February 4, 2019	Monday, February 11, 2019	
3.3	Discuss results with DHHS and receive final sign-off on Base Data Adjustments	Monday, February 11, 2019	Monday, February 11, 2019	Deloitte/DHHS
4	**Program changes - UPL & Capitation Payment Rates**	**Monday, November 26, 2018**	**Friday, February 22, 2019**	**Deloitte**
4.1	Develop pricing, benefit, population, and other adjustments	Monday, November 26, 2018	Friday, February 8, 2019	Deloitte
4.2	Deloitte internal review	Monday, February 11, 2019	Friday, February 22, 2019	Deloitte
4.3	Discuss results with DHHS and receive final sign-off on Program Changes	Friday, February 22, 2019	Friday, February 22, 2019	Deloitte/DHHS
5	**Trend Analysis - UPL & Capitation Payment Rates**	**Monday, December 3, 2018**	**Friday, March 1, 2019**	**Deloitte/DHHS**
5.1	Analyze trends and determine trend assumptions	Monday, December 3, 2018	Friday, February 15, 2019	Deloitte
5.2	Review trends internally	Monday, February 18, 2019	Friday, March 1, 2019	Deloitte
5.3	Discuss results with DHHS and receive final sign-off on Trend	Friday, March 1, 2019	Friday, March 1, 2019	Deloitte/DHHS
6	**Non-Benefit Expenses - UPL & Capitation Payment Rates**	**Monday, December 3, 2018**	**Friday, March 8, 2019**	**Deloitte/DHHS**
6.1	Determine administrative, care management, premium based taxes, underwriting gain, etc.	Monday, December 3, 2018	Friday, February 22, 2019	Deloitte
6.2	Deloitte internal review	Monday, February 25, 2019	Friday, March 8, 2019	Deloitte
6.3	Discuss results with DHHS and receive final sign-off on Non-Medical Expenses	Friday, March 8, 2019	Friday, March 8, 2019	Deloitte/DHHS
7	**Develop UPL Rates**	**Monday, March 11, 2019**	**Friday, May 31, 2019**	**Deloitte/DHHS**
7.1	Incorporate rating assumptions	Monday, March 11, 2019	Friday, March 22, 2019	Deloitte
7.2	Develop draft UPL rates and exhibits to summarize results	Monday, March 25, 2019	Friday, April 12, 2019	Deloitte
7.3	Conduct internal and DHHS review sessions and address feedback from DHHS	Monday, April 15, 2019	Friday, May 31, 2019	Deloitte
7.4	Deliver final UPL rates to DHHS	Friday, May 31, 2019	Friday, May 31, 2019	Deloitte/DHHS
8	**Develop Capitation Payment Rates**	**Monday, March 11, 2019**	**Friday, May 31, 2019**	**Deloitte/DHHS**
8.1	Incorporate rating assumptions	Monday, March 11, 2019	Friday, March 22, 2019	Deloitte
8.2	Develop draft rates and exhibits to summarize results	Monday, March 25, 2019	Friday, April 12, 2019	Deloitte
8.3	Conduct internal and DHHS review sessions and address feedback from DHHS	Monday, April 15, 2019	Friday, May 31, 2019	Deloitte
8.4	Deliver final capitation payment rates to DHHS	Friday, May 31, 2019	Friday, May 31, 2019	Deloitte/DHHS
9	**Rate Documentation**	**Monday, March 11, 2019**	**Friday, May 31, 2019**	**Deloitte/DHHS**
9.1	Draft UPL rate certification and exhibits	Monday, March 11, 2019	Monday, April 1, 2019	Deloitte
9.2	Draft capitation payment rate memorandum and exhibits	Monday, March 11, 2019	Monday, April 1, 2019	Deloitte
9.2	Conduct internal and DHHS review sessions and address feedback from DHHS	Monday, March 18, 2019	Friday, May 31, 2019	Deloitte
10	**Periodic Support (as needed)**	**Monday, March 11, 2019**	**Ongoing**	**Deloitte**
10.1	Address MCO questions	Monday, March 11, 2019		Deloitte
10.2	Support rate modifications	Monday, July 1, 2019		Deloitte
10.3	Address CMS questions	Monday, July 1, 2019		Deloitte

Appendix 4 - SOW 5 – 1115 Waiver Development Sample Work Plan

For Waiver Effective July 1, 2019

Step #	Task Name / Description	Task Description / Notes	Duration	Duration	Start	Finish	Primary Owner	Comments/ Questions
1115 Waiver Development and Submission								
0	**Weekly Program Touchpoints**	**Deloitte and DHHS will have weekly meetings to discuss status and questions**	**Weekly**	**Weekly**	**Monday, August 6, 2018**	**Friday, March 30, 2018**	**Deloitte**	
1	**Engagement Kick-Off**	**Facilitate an engagement kick-off meeting with DHHS stakeholders and finalize meeting cadence and timelines**	**14**	**14 Days**	**Monday, August 6, 2018**	**Monday, August 20, 2018**	**Deloitte**	
1.1	Determine meeting participants		1	1 Day	Monday, August 6, 2018	Monday, August 6, 2018	Deloitte	
1.2	Develop and distribute meeting agenda		2	2 Days	Monday, August 6, 2018	Tuesday, August 7, 2018	Deloitte	
1.3	Facilitate kick-off meeting		1	1 Day	Wednesday, August 8, 2018	Wednesday, August 8, 2018	Deloitte	
1.4	Finalize and distribute work plan	Includes cadence of status meetings, timelines, deliverables, milestones, etc.	5	5 Days	Thursday, August 9, 2018	Monday, August 13, 2018	Deloitte	
1.5	DHHS reviews and provides feedback on Deloitte work plan		5	5 Days	Monday, August 13, 2018	Friday, August 17, 2018	DHHS	
1.6	Finalize work plan		1	1 Day	Monday, August 20, 2018	Monday, August 20, 2018	Deloitte	
2	**Data Collection and Validation**	**Coordinate with the DHHS to collect necessary data to support rate setting analysis**	**42**	**42 Days**	**Wednesday, August 15, 2018**	**Wednesday, September 26, 2018**	**Deloitte/DHHS**	
2.1	Distribute data request after program kick-off meetings	Prepare data request based on feedback on available data from kick-off meeting	2	2 Days	Wednesday, August 15, 2018	Thursday, August 16, 2018	Deloitte	
2.2	Gather and access data	Data will include MCO encounter data, enrollment data, and may include cost reports and FFS claims	15	15 Days	Friday, August 17, 2018	Friday, August 31, 2018	Deloitte/DHHS	
2.3	Perform data checks for reasonableness		11	11 Days	Friday, August 31, 2018	Monday, September 10, 2018	Deloitte	
2.4	Facilitate data review discussions with the DHHS to resolve data variances, missing data elements, or data outliers	As needed - Draft Data, Questions, and Key Decisions Log as part of this process	25	25 Days	Friday, August 31, 2018	Monday, September 24, 2018	Deloitte/DHHS	
2.5	Review base data with DHHS and receive final sign-off on Data Collection and Validation		1	1 Day	Wednesday, September 26, 2018	Wednesday, September 26, 2018	Deloitte/DHHS	
3	**Base Data Adjustments**	**Incorporate data adjustments to normalize data for rate effective period**	**44**	**44 Days**	**Wednesday, September 26, 2018**	**Friday, November 9, 2018**	**Deloitte**	
3.1	Policy and Program Adjustments	Work with DHHS to identify prospective program changes to incorporate in base data for waiver projection period	10	10 Days	Wednesday, September 26, 2018	Friday, October 5, 2018	Deloitte/DHHS	
3.2	Benefit and Network Adjustments	Work with DHHS to identify benefit and network changes to incorporate in base data for waiver projection period	11	11 Days	Friday, October 5, 2018	Monday, October 15, 2018	Deloitte/DHHS	
3.3	Administrative Costs	Analyze changes in administrative costs based on changing MCO reporting requirements, DHHS reporting, etc.	8	8 Days	Monday, October 15, 2018	Monday, October 22, 2018	Deloitte	
3.4	Populations Adjustments	Work with DHHS to identify prospective program changes to incorporate in base data for waiver period	8	8 Days	Tuesday, October 23, 2018	Tuesday, October 30, 2018	Deloitte/DHHS	
3.5	Medical Cost Trend	Analyze historic data by applicable MEG and COS to develop costs trends to apply to waiver projection period	10	10 Days	Wednesday, October 31, 2018	Friday, November 9, 2018	Deloitte/DHHS	
4	**Waiver Budget Neutrality Model**	**Develop Budget Neutrality Calculations**	**13**	**13 Days**	**Friday, November 9, 2018**	**Thursday, November 22, 2018**	**Deloitte**	
4.1	Project Waiver Costs	Project the with-waiver and without-waiver costs by applicable MEG/COS for the duration of the waiver	11	11 Days	Friday, November 9, 2018	Monday, November 19, 2018	Deloitte	
4.2	Insert projected costs into Waiver Preprint Template	Fill out CMS Waiver Preprint Template and demonstrate that with-waiver costs are less than or equal to without-waiver costs	3	3 Days	Monday, November 19, 2018	Wednesday, November 21, 2018	Deloitte	
4.3	Review Waiver Template with DHHS	Review and discuss filled out template with DHHS	1	1 Day	Thursday, November 22, 2018	Thursday, November 22, 2018	Deloitte	
5	**Develop Budget Neutrality Model Documentation**		**17**	**17 Days**	**Thursday, November 22, 2018**	**Sunday, December 9, 2018**	**Deloitte/DHHS**	
5.1	Draft budget neutrality model documentation		12	12 Days	Thursday, November 22, 2018	Monday, December 3, 2018	Deloitte	
5.2	Review Documentation with DHHS		2	2 Days	Tuesday, December 4, 2018	Wednesday, December 5, 2018	Deloitte/DHHS	
5.3	Revise or Clarify Documentation	Revise/clarify documentation based on DHHS feedback	5	5 Days	Wednesday, December 5, 2018	Sunday, December 9, 2018	Deloitte	
6	**Develop Narrative Support for Submission**		**15**	**15 Days**	**Tuesday, December 4, 2018**	**Wednesday, December 19, 2018**	**Deloitte/DHHS**	
6.1	Draft narrative	Draft narrative to accompany waiver template submission	10	10 Days	Tuesday, December 4, 2018	Thursday, December 13, 2018	Deloitte	
6.2	Review narrative with DHHS		2	2 Days	Thursday, December 13, 2018	Friday, December 14, 2018	Deloitte	
6.3	Revise or Clarify Narrative	Revise/clarify narrative based on DHHS feedback	6	6 Days	Friday, December 14, 2018	Wednesday, December 19, 2018	Deloitte	
7	**Submit Waiver Model, Documentation, and Narrative**		**1**	**1 Day**	**Friday, December 21, 2018**	**Friday, December 21, 2018**	**Deloitte/DHHS**	