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STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 24	04/06/22
BUSINESS UNIT	BUYER
25769029	JOY FISCHER (AS)

CONTRACT NUMBER
84038 O4

VENDOR NUMBER: 2051503

VENDOR ADDRESS:

CBIZ OPTUMAS LLC
7400 E MCDONALD DR STE 101
SCOTTSDALE AZ 85250-6099

THE CONTRACT PERIOD IS:

JANUARY 01, 2019 THROUGH DECEMBER 31, 2023

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

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

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

Original/Bid Document 5868 Z1

Contract to supply Medicaid Managed Care Actuarial and Consulting Services to the State of Nebraska for the contract period January 1, 2019 to December 31, 2023. The contract may be renewed for three (3) additional two (2) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Steve Schramm
Phone: 480-588-2493
E-Mail: steve.schramm@optumas.com

(10/23/18 ml)

Amendment One as attached. (06/11/19 ml)

Amendment Two as attached. (07/19/19 ml)

Amendment Three as attached. (08/21/2019 mh)

Amendment Four as attached. (4/6/22 sc)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR ONE	70,000.0000	EA	1.0000	70,000.00
2	SOW 1 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR ONE	60,000.0000	EA	2.0000	120,000.00

DocuSigned by: Kevin Bagley 4/15/2022
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DHHS Division Director

DocuSigned by: Joy Fischer 4/15/2022
8D62163E69CA4C2...
BUYER

DS PK 4/15/2022

DocuSigned by: Amara Block 4/25/2022
4CFF2711162A4A2...
MATERIEL ADMINISTRATOR

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
3	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR ONE	60,000.0000	EA	1.0000	60,000.00
4	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR ONE	90,000.0000	EA	1.0000	90,000.00
5	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR ONE	45,000.0000	EA	1.0000	45,000.00
6	SOW 2 - CAPITATION RATE REBASING INITIAL CONTRACT PERIOD YEARS ONE THROUGH FIVE	150,000.0000	EA	1.0000	150,000.00
7	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	35,000.0000	35,000.00
8	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	30,000.0000	30,000.00
9	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	50,000.0000	50,000.00
10	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	12,500.0000	12,500.00
11	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	10,000.0000	10,000.00
12	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	10,000.0000	10,000.00
13	CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR ONE	2.0000	EA	20,000.0000	40,000.00
14	DENTAL CAPITALIZATION RATE	1.0000	EA	10,000.0000	10,000.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	FINALIZATION INITIAL CONTRACT PERIOD - YEAR ONE				
15	SOW 7 - DENTAL REBASING INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	30,000.0000	30,000.00
16	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
17	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
18	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
19	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
20	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
21	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
22	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR TWO	70,000.0000	EA	1.0000	70,000.00
23	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR TWO	60,000.0000	EA	1.0000	60,000.00
24	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR TWO	60,000.0000	EA	1.0000	60,000.00
25	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR TWO	90,000.0000	EA	1.0000	90,000.00
26	SOW 1 - CAPITATION RATE FINALIZATION	45,000.0000	EA	1.0000	45,000.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD - YEAR TWO				
27	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	35,000.0000	35,000.00
28	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	30,000.0000	30,000.00
29	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	50,000.0000	50,000.00
30	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	12,500.0000	12,500.00
31	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00
32	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00
33	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR TWO	2.0000	EA	20,000.0000	40,000.00
34	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00
35	SOW 7 - DENTAL REBASING INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	30,000.0000	30,000.00
36	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
37	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
38	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
39	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00

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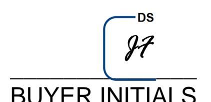
Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
40	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
41	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
42	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR THREE	70,700.0000	EA	1.0000	70,700.00
43	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR THREE	60,600.0000	EA	1.0000	60,600.00
44	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR THREE	60,600.0000	EA	1.0000	60,600.00
45	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR THREE	90,900.0000	EA	1.0000	90,900.00
46	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR THREE	45,450.0000	EA	1.0000	45,450.00
47	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	35,350.0000	35,350.00
48	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	30,300.0000	30,300.00
49	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	50,500.0000	50,500.00
50	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	12,625.0000	12,625.00
51	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION	1.0000	EA	10,100.0000	10,100.00



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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD - YEAR THREE				
52	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00
53	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR THREE	2.0000	EA	20,200.0000	40,400.00
54	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00
55	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
56	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
57	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
58	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
59	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
60	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
61	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR FOUR	70,700.0000	EA	1.0000	70,700.00
62	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FOUR	60,600.0000	EA	1.0000	60,600.00
63	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS	60,600.0000	EA	1.0000	60,600.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD - YEAR FOUR				
64	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR FOUR	90,900.0000	EA	1.0000	90,900.00
65	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FOUR	45,450.0000	EA	1.0000	45,450.00
66	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	35,350.0000	35,350.00
67	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	30,300.0000	30,300.00
68	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	50,500.0000	50,500.00
69	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	12,625.0000	12,625.00
70	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
71	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
72	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FOUR	2.0000	EA	20,200.0000	40,400.00
73	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
74	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
75	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR FOUR	10.0000	HR	205.0000	2,050.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
76	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR FOUR	10.0000	HR	205.0000	2,050.00
77	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR FOUR	15.0000	HR	205.0000	3,075.00
78	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR FOUR	25.0000	HR	205.0000	5,125.00
79	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR FOUR	25.0000	HR	205.0000	5,125.00
80	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR FIVE	70,700.0000	EA	1.0000	70,700.00
81	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FIVE	60,600.0000	EA	1.0000	60,600.00
82	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FIVE	60,600.0000	EA	1.0000	60,600.00
83	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR FIVE	90,900.0000	EA	1.0000	90,900.00
84	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FIVE	45,450.0000	EA	1.0000	45,450.00
85	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	35,350.0000	35,350.00
86	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	30,300.0000	30,300.00
87	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	50,500.0000	50,500.00
88	SOW 6 - DENTAL RATE SETTING	1.0000	EA	12,625.0000	12,625.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD - YEAR FIVE				
89	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
90	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
91	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FIVE	2.0000	EA	20,200.0000	40,400.00
92	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
93	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
94	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
95	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
96	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
97	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
98	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
99	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	71,407.0000	EA	1.0000	71,407.00
100	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION	60,600.0000	EA	1.0000	60,600.00

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	FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE				
101	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	61,206.0000	EA	1.0000	61,206.00
102	SOW 1 - CAPITATION RATE UPDATES FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	122,412.0000	EA	1.0000	122,412.00
103	SOW 1 - CAPITATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	45,905.0000	EA	1.0000	45,905.00
104	CAPITATION RATE REBASING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	153,015.0000	153,015.00
105	SOW 3 - 1915(B) WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	35,704.0000	35,704.00
106	SOW 4 - PACE FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,603.0000	30,603.00
107	SOW 5 - 1115 WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	51,005.0000	51,005.00
108	SOW 6 - DENTAL RATE SETTING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	12,751.0000	12,751.00
109	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
110	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
111	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,402.0000	40,804.00
112	DENTAL CAPITALIZATION RATE FINALIZATION	1.0000	EA	10,201.0000	10,201.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE				
113	DENTAL REBASING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,603.0000	30,603.00
114	LEAD STRATEGIST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
115	PRINCIPAL/PROJECT MANAGER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
116	LEAD ACTUARY FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
117	ACTUARIAL CONSULTANT FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
118	ACTUARIAL ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
119	INFORMATICS ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
120	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	71,407.0000	EA	1.0000	71,407.00
121	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	60,600.0000	EA	1.0000	60,600.00
122	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	61,206.0000	EA	1.0000	61,206.00
123	SOW 1 - CAPITATION RATE UPDATES FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	122,412.0000	EA	1.0000	122,412.00
124	SOW 1 - CAPITATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	45,905.0000	EA	1.0000	45,905.00

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BUSINESS UNIT	BUYER
25769029	JOY FISCHER (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
125	SOW 3 - 1915(B) WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	35,704.0000	35,704.00
126	SOW 4 - PACE FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	30,603.0000	30,603.00
127	SOW 5 - 1115 WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	51,005.0000	51,005.00
128	SOW 6 - DENTAL RATE SETTING FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	12,751.0000	12,751.00
129	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00
130	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00
131	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	20,402.0000	40,804.00
132	DENTAL CAPITALIZATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00
133	LEAD STRATEGIST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
134	PRINCIPAL/PROJECT MANAGER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
135	LEAD ACTUARY FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
136	ACTUARIAL CONSULTANT FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
137	ACTUARIAL ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
138	INFORMATICS ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
139	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	72,121.0000	EA	1.0000	72,121.00
140	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	60,600.0000	EA	1.0000	60,600.00
141	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	61,818.0000	EA	1.0000	61,818.00
142	SOW 1 - CAPITATION RATE UPDATES SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	123,636.0000	EA	1.0000	123,636.00
143	SOW 1 - CAPITATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	46,364.0000	EA	1.0000	46,364.00
144	CAPITATION RATE REBASING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	154,545.0000	154,545.00
145	SOW 3 - 1915(B) WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	36,061.0000	36,061.00
146	SOW 4 - PACE SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,909.0000	30,909.00
147	SOW 5 - 1115 WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	51,515.0000	51,515.00
148	SOW 6 - DENTAL RATE SETTING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	12,879.0000	12,879.00
149	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
150	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00
151	CAPITATION RATE UPDATES SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,606.0000	41,212.00
152	DENTAL CAPITALIZATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00
153	DENTAL REBASING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,909.0000	30,909.00
154	LEAD STRATEGIST SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
155	PRINCIPAL/PROJECT MANAGER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
156	LEAD ACTUARY SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
157	ACTUARIAL CONSULTANT SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
158	ACTUARIAL ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
159	INFORMATICS ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
160	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	72,121.0000	EA	1.0000	72,121.00
161	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	60,600.0000	EA	1.0000	60,600.00
162	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR	61,818.0000	EA	1.0000	61,818.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO				
163	SOW 1 - CAPITATION RATE UPDATES SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	123,636.0000	EA	1.0000	123,636.00
164	SOW 1 - CAPITATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	46,364.0000	EA	1.0000	46,364.00
165	SOW 3 - 1915(B) WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	36,061.0000	36,061.00
166	SOW 4 - PACE SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	30,909.0000	30,909.00
167	SOW 5 - 1115 WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	51,515.0000	51,515.00
168	SOW 6 - DENTAL RATE SETTING SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	12,879.0000	12,879.00
169	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
170	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
171	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	20,606.0000	41,212.00
172	DENTAL CAPITALIZATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
173	LEAD STRATEGIST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
174	PRINCIPAL/PROJECT MANAGER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00

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JOY FISCHER (AS)

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
175	LEAD ACTUARY SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
176	ACTUARIAL CONSULTANT SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
177	ACTUARIAL ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
178	INFORMATICS ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
179	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	72,842.0000	EA	1.0000	72,842.00
180	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	60,600.0000	EA	1.0000	60,600.00
181	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	62,436.0000	EA	1.0000	62,436.00
182	SOW 1 - CAPITATION RATE UPDATES THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	124,872.0000	EA	1.0000	124,872.00
183	SOW 1 - CAPITATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	46,827.0000	EA	1.0000	46,827.00
184	CAPITATION RATE REBASING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	156,091.0000	156,091.00
185	SOW 3 - 1915(B) WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	36,421.0000	36,421.00
186	SOW 4 - PACE THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	31,218.0000	31,218.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
187	SOW 5 - 1115 WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	52,030.0000	52,030.00
188	SOW 6 - DENTAL RATE SETTING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	13,008.0000	13,008.00
189	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,406.0000	10,406.00
190	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	40,406.0000	40,406.00
191	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,812.0000	41,624.00
192	DENTAL CAPITALIZATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,406.0000	10,406.00
193	DENTAL REBASING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	31,218.0000	31,218.00
194	LEAD STRATEGIST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
195	PRINCIPAL/PROJECT MANAGER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
196	LEAD ACTUARY THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
197	ACTUARIAL CONSULTANT THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
198	ACTUARIAL ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
199	INFORMATICS ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
200	SOW 1 - ANNUAL CAPITATION	72,842.0000	EA	1.0000	72,842.00

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25769029	JOY FISCHER (AS)

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO				
201	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	60,600.0000	EA	1.0000	60,600.00
202	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	62,436.0000	EA	1.0000	62,436.00
203	SOW 1 - CAPITATION RATE UPDATES THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	124,872.0000	EA	1.0000	124,872.00
204	SOW 1 - CAPITATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	46,827.0000	EA	1.0000	46,827.00
205	SOW 3 - 1915(B) WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	36,421.0000	36,421.00
206	SOW 4 - PACE THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	31,218.0000	31,218.00
207	SOW 5 - 1115 WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	52,030.0000	52,030.00
208	SOW 6 - DENTAL RATE SETTING THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	13,008.0000	13,008.00
209	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
210	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
211	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS	2.0000	EA	20,812.0000	41,624.00

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	THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO				
212	DENTAL CAPITALIZATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
213	LEAD STRATEGIST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
214	PRINCIPAL/PROJECT MANAGER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
215	LEAD ACTUARY THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
216	ACTUARIAL CONSULTANT THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
217	ACTUARIAL ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
218	INFORMATICS ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
219	SOW 8 - APR DRG ANALYSIS PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
220	SOW 8 - APR DRG ANALYSIS LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
221	SOW 8 - APR DRG ANALYSIS ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
222	SOW 8 - APR DRG ANALYSIS ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
223	SOW 8 -	10.0000	HR	205.0000	2,050.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	APR DRG ANALYSIS INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES				
224	SOW 8 - EAPG ANALYSIS PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
225	SOW 8 - EAPG ANALYSIS LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	15.0000	HR	205.0000	3,075.00
226	SOW 8 - EAPG ANALYSIS ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	30.0000	HR	205.0000	6,150.00
227	SOW 8 - EAPG ANALYSIS ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	75.0000	HR	205.0000	15,375.00
228	SOW 8 - EAPG ANALYSIS INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	75.0000	HR	205.0000	15,375.00
229	SOW 8 - KEY PERFORMANCE INDICATORS LEAD STRATEGIST FOR HERITAGE HEALTH ANALYSES	25.0000	HR	205.0000	5,125.00
230	SOW 8 - KEY PERFORMANCE INDICATORS PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	25.0000	HR	205.0000	5,125.00
231	SOW 8 - KEY PERFORMANCE INDICATORS LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	50.0000	HR	205.0000	10,250.00
232	SOW 8 -	50.0000	HR	205.0000	10,250.00

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	KEY PERFORMANCE INDICATORS ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES				
233	SOW 8 - KEY PERFORMANCE INDICATORS ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	25.0000	HR	205.0000	5,125.00
234	SOW 8 - KEY PERFORMANCE INDICATORS INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	25.0000	HR	205.0000	5,125.00
235	SOW 8 - FQHC APM REBASING LEAD STRATEGIST FOR HERITAGE HEALTH ANALYSES	2.0000	HR	205.0000	410.00
236	SOW 8 - FQHC APM REBASING PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	3.0000	HR	205.0000	615.00
237	SOW 8 - FQHC APM REBASING LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
238	SOW 8 - FQHC APM REBASING ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
239	SOW 8 - FQHC APM REBASING ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
240	SOW 8 - FQHC APM REBASING INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
241	SOW 8 -	2.0000	HR	205.0000	410.00

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	FQHC DENTAL RATE SETTING LEAD STRATEGIST FOR HERITAGE HEALTH ANALYSES				
242	SOW 8 - FQHC DENTAL RATE SETTING PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	3.0000	HR	205.0000	615.00
243	SOW 8 - FQHC DENTAL RATE SETTING LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
244	SOW 8 - FQHC DENTAL RATE SETTING ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
245	SOW 8 - FQHC DENTAL RATE SETTING ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
246	SOW 8 - FQHC DENTAL RATE SETTING INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	15.0000	HR	205.0000	3,075.00
247	SOW 8 - RHC UNDER 50 BEDS RATE SETTING LEAD STRATEGIST FOR HERITAGE HEALTH ANALYSES	2.0000	HR	205.0000	410.00
248	SOW 8 - RHC UNDER 50 BEDS RATE SETTING PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	3.0000	HR	205.0000	615.00
249	SOW 8 - RHC UNDER 50 BEDS RATE SETTING LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	15.0000	HR	205.0000	3,075.00
250	SOW 8 -	15.0000	HR	205.0000	3,075.00

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STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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BUSINESS UNIT	BUYER
25769029	JOY FISCHER (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	RHC UNDER 50 BEDS RATE SETTING ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES				
251	SOW 8 - RHC UNDER 50 BEDS RATE SETTING ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	20.0000	HR	205.0000	4,100.00
252	SOW 8 - RHC UNDER 50 BEDS RATE SETTING INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	20.0000	HR	205.0000	4,100.00
253	SOW 8 - CHIROPRACTIC RATES ANALYSIS LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
254	SOW 8 - CHIROPRACTIC RATES ANALYSIS ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
255	SOW 8 - CHIROPRACTIC RATES ANALYSIS ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
256	SOW 8 - CHIROPRACTIC RATES ANALYSIS INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
257	SOW 8- RATE REFORM INITIATIVE LEAD STRATEGIST	160.0000	HR	205.0000	32,800.00
258	SOW 8- RATE REFORM INITIATIVE PRINCIPAL/PROJECT MANAGER	270.0000	HR	205.0000	55,350.00
259	SOW 8- RATE REFORM INITIATIVE LEAD ACTUARIAL ANALYST	60.0000	HR	205.0000	12,300.00
260	SOW 8- RATE REFORM INITIATIVE ACTUARIAL CONSULTANT	250.0000	HR	205.0000	51,250.00

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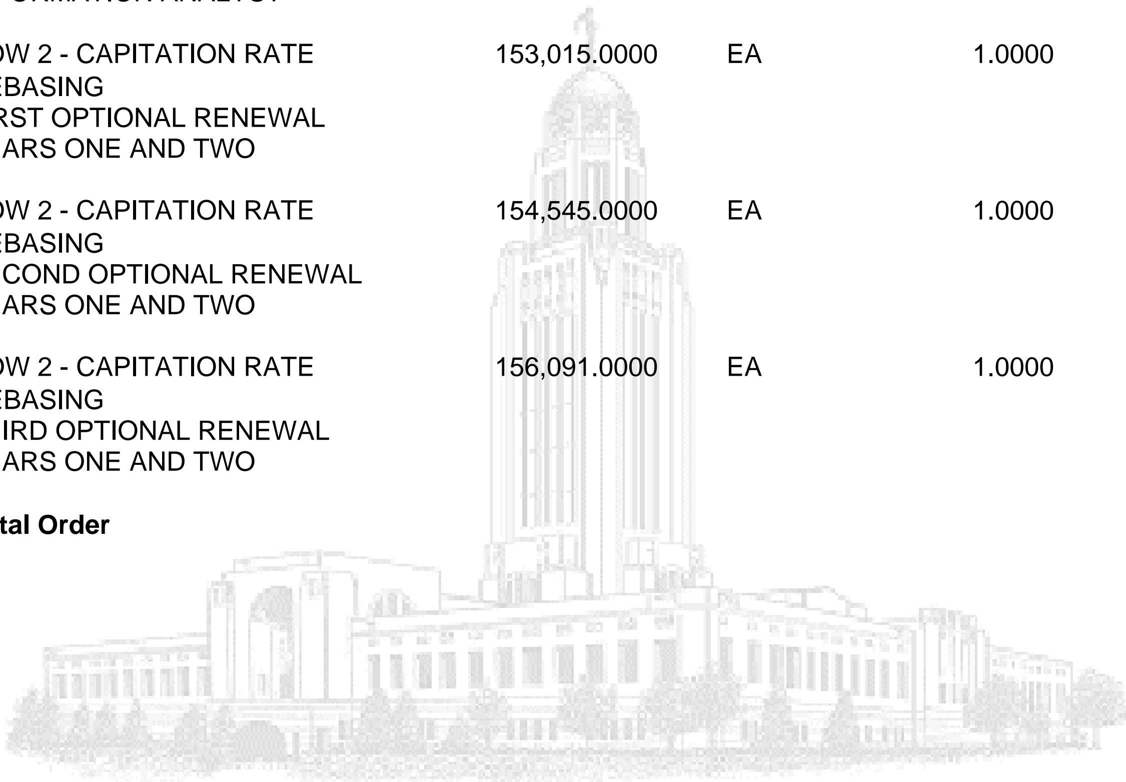
25769029	JOY FISCHER (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
261	SOW 8- RATE REFORM INITIATIVE ACTUARIAL ANALYST	275.0000	HR	205.0000	56,375.00
262	SOW 8- RATE REFORM INITIATIVE INFORMATION ANALYST	885.0000	HR	205.0000	181,425.00
263	SOW 2 - CAPITATION RATE REBASING FIRST OPTIONAL RENEWAL YEARS ONE AND TWO	153,015.0000	EA	1.0000	153,015.00
264	SOW 2 - CAPITATION RATE REBASING SECOND OPTIONAL RENEWAL YEARS ONE AND TWO	154,545.0000	EA	1.0000	154,545.00
265	SOW 2 - CAPITATION RATE REBASING THIRD OPTIONAL RENEWAL YEARS ONE AND TWO	156,091.0000	EA	1.0000	156,091.00
	Total Order				**7,956,072.00**



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AMENDMENT FOUR
Contract 84038 O4
Medicaid Managed Care Actuarial and Consulting Services
for the State of Nebraska
Between
The State of Nebraska and Schramm Health Partners LLC dba Optumas

This Amendment (the "Amendment") is made by the State of Nebraska and Schramm Health Partners LLC (the "Contractor") parties to Contract 84038 O4 (the "Contract") and upon mutual agreement and other valuable consideration, the parties agree to and hereby amend the contract Amendment upon execution as follows:

1. Contractor name has changed from Schramm Health Partners LLC dba Optumas to CBIZ Optumas LLC.

2. Line 6 is hereby superseded and replaced with:

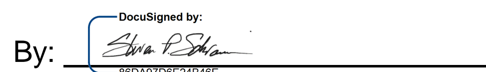
Line	Description	Quantity	Unit of Measure	Unit Price
6	SOW 2 – CAPITATION RATE REBASING INITIAL CONTRACT PERIOD YEARS ONE THROUGH FIVE	150,000.0000	EA	1.0000

3. The following contract lines will be added to the contract per the original cost proposal:

Line	Description	Quantity	Unit of Measure	Unit Price
263	SOW 2 – CAPITATION RATE REBASING FIRST OPTIONAL RENEWAL YEARS ONE AND TWO	153,015.0000	EA	1.0000
264	SOW 2 – CAPITATION RATE REBASING SECOND OPTIONAL RENEWAL YEARS ONE AND TWO	154,545.0000	EA	1.0000
265	SOW 2 – CAPITATION RATE REBASING THIRD OPTIONAL RENEWAL YEARS ONE AND TWO	156,091.0000	EA	1.0000

This Amendment and any attachments hereto will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this Amendment and the Contract or any earlier amendment, the terms of this Amendment will prevail.

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

State of Nebraska	Contractor: CBIZ Optumas LLC
By:	By: 
Name: Amara Block	Name: Steve Schramm
Title: Interim Materiel Administrator	Title: Managing Director
Date: 4/25/2022	Date: 4/12/2022

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BUSINESS UNIT	BUYER
25769029	NANCY STORANT (AS)

CONTRACT NUMBER
84038 O4

VENDOR NUMBER: 2051503

VENDOR ADDRESS:

SCHRAMM HEALTH PARTNERS LLC
DBA OPTUMAS
7400 E MCDONALD DR STE 101
SCOTTSDALE AZ 85250-0699

THE CONTRACT PERIOD IS:

JANUARY 01, 2019 THROUGH DECEMBER 31, 2023

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

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

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

Contract to supply Medicaid Managed Care Actuarial and Consulting Services to the State of Nebraska for the contract period January 1, 2019 to December 31, 2023. The contract may be renewed for Three (3) additional Two (2) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Steve Schramm
Phone: 480-588-2493
E-Mail: steve.schramm@optumas.com

(10/23/18 ml)

Amendment One as attached. (06/11/19 ml)

Amendment Two as attached. (07/19/19 ml)

Amendment Three as attached. (08/21/2019 mh)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR ONE	70,000.0000	EA	1.0000	70,000.00
2	SOW 1 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR ONE	60,000.0000	EA	2.0000	120,000.00
3	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS	60,000.0000	EA	1.0000	60,000.00

DHHS Division Director

8/23/19

BUYER

8/23/19

MATERIEL ADMINISTRATOR

R43500|NISH0003|NISH0003 20150901

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VENDOR NUMBER: 2051503

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD - YEAR ONE				
4	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR ONE	90,000.0000	EA	1.0000	90,000.00
5	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR ONE	45,000.0000	EA	1.0000	45,000.00
6	SOW 2 - CAPITATION RATE REBASING INITIAL CONTRACT PERIOD - YEAR ONE	150,000.0000	EA	1.0000	150,000.00
12	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	10,000.0000	10,000.00
13	CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR ONE	2.0000	EA	20,000.0000	40,000.00
19	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
22	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR TWO	70,000.0000	EA	1.0000	70,000.00
23	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR TWO	60,000.0000	EA	1.0000	60,000.00
24	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR TWO	60,000.0000	EA	1.0000	60,000.00
25	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR TWO	90,000.0000	EA	1.0000	90,000.00
26	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR TWO	45,000.0000	EA	1.0000	45,000.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
27	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	35,000.0000	35,000.00
28	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	30,000.0000	30,000.00
29	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	50,000.0000	50,000.00
30	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	12,500.0000	12,500.00
31	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00
32	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00
33	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR TWO	2.0000	EA	20,000.0000	40,000.00
34	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00
35	SOW 7 - DENTAL REBASING INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	30,000.0000	30,000.00
36	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
37	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
38	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
39	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
40	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
41	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
42	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR THREE	70,700.0000	EA	1.0000	70,700.00
43	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR THREE	60,600.0000	EA	1.0000	60,600.00
44	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR THREE	60,600.0000	EA	1.0000	60,600.00
45	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR THREE	90,900.0000	EA	1.0000	90,900.00
46	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR THREE	45,450.0000	EA	1.0000	45,450.00
47	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	35,350.0000	35,350.00
48	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	30,300.0000	30,300.00
49	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	50,500.0000	50,500.00
50	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	12,625.0000	12,625.00
51	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00
52	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
53	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR THREE	2.0000	EA	20,200.0000	40,400.00
54	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00
55	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
56	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
57	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
58	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
59	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
60	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
61	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR FOUR	70,700.0000	EA	1.0000	70,700.00
62	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FOUR	60,600.0000	EA	1.0000	60,600.00
63	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FOUR	60,600.0000	EA	1.0000	60,600.00
64	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR FOUR	90,900.0000	EA	1.0000	90,900.00
65	SOW 1 - CAPITATION RATE	45,450.0000	EA	1.0000	45,450.00

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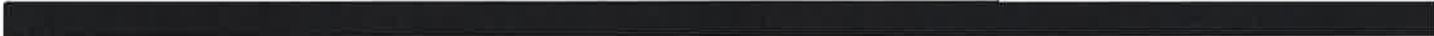

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	FINALIZATION INITIAL CONTRACT PERIOD - YEAR FOUR				
66	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	35,350.0000	35,350.00
67	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	30,300.0000	30,300.00
68	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	50,500.0000	50,500.00
69	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	12,625.0000	12,625.00
70	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
71	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
72	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FOUR	2.0000	EA	20,200.0000	40,400.00
73	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
74	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
75	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
76	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
77	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
78	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
79	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
80	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR FIVE	70,700.0000	EA	1.0000	70,700.00
81	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FIVE	60,600.0000	EA	1.0000	60,600.00
82	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FIVE	60,600.0000	EA	1.0000	60,600.00
83	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR FIVE	90,900.0000	EA	1.0000	90,900.00
84	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FIVE	45,450.0000	EA	1.0000	45,450.00
85	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	35,350.0000	35,350.00
86	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	30,300.0000	30,300.00
87	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	50,500.0000	50,500.00
88	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	12,625.0000	12,625.00
89	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
90	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
91	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FIVE	2.0000	EA	20,200.0000	40,400.00
92	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
93	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
94	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
95	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
96	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
97	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
98	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
99	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	71,407.0000	EA	1.0000	71,407.00
100	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	60,600.0000	EA	1.0000	60,600.00
101	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	61,206.0000	EA	1.0000	61,206.00
102	SOW 1 - CAPITATION RATE UPDATES FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	122,412.0000	EA	1.0000	122,412.00
103	SOW 1 - CAPITATION RATE FINALIZATION	45,905.0000	EA	1.0000	45,905.00

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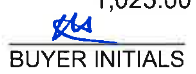
25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE				
104	CAPITATION RATE REBASING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	153,015.0000	153,015.00
105	SOW 3 - 1915(B) WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	35,704.0000	35,704.00
106	SOW 4 - PACE FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,603.0000	30,603.00
107	SOW 5 - 1115 WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	51,005.0000	51,005.00
108	SOW 6 - DENTAL RATE SETTING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	12,751.0000	12,751.00
109	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
110	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
111	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,402.0000	40,804.00
112	DENTAL CAPITALIZATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
113	DENTAL REBASING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,603.0000	30,603.00
114	LEAD STRATEGIST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
115	PRINCIPAL/PROJECT MANAGER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
116	LEAD ACTUARY FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
117	ACTUARIAL CONSULTANT	5.0000	HR	205.0000	1,025.00



BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
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Telephone: (402) 471-6500
Fax: (402) 471-2089

ORDER DATE
08/21/2019

BUSINESS UNIT
25769029

BUYER
NANCY STORANT (AS)

CONTRACT NUMBER
84038 O4

VENDOR NUMBER: 2051503

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE				
118	ACTUARIAL ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
119	INFORMATICS ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
120	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	71,407.0000	EA	1.0000	71,407.00
121	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	60,600.0000	EA	1.0000	60,600.00
122	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	61,206.0000	EA	1.0000	61,206.00
123	SOW 1 - CAPITATION RATE UPDATES FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	122,412.0000	EA	1.0000	122,412.00
124	SOW 1 - CAPITATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	45,905.0000	EA	1.0000	45,905.00
125	SOW 3 - 1915(B) WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	35,704.0000	35,704.00
126	SOW 4 - PACE FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	30,603.0000	30,603.00
127	SOW 5 - 1115 WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	51,005.0000	51,005.00
128	SOW 6 - DENTAL RATE SETTING FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	12,751.0000	12,751.00
129	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
130	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00
131	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	20,402.0000	40,804.00
132	DENTAL CAPITALIZATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00
133	LEAD STRATEGIST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
134	PRINCIPAL/PROJECT MANAGER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
135	LEAD ACTUARY FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
136	ACTUARIAL CONSULTANT FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
137	ACTUARIAL ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
138	INFORMATICS ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
139	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	72,121.0000	EA	1.0000	72,121.00
140	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	60,600.0000	EA	1.0000	60,600.00
141	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	61,818.0000	EA	1.0000	61,818.00
142	SOW 1 - CAPITATION RATE	123,636.0000	EA	1.0000	123,636.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	UPDATES SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE				
143	SOW 1 - CAPITATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	46,364.0000	EA	1.0000	46,364.00
144	CAPITATION RATE REBASING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	154,545.0000	154,545.00
145	SOW 3 - 1915(B) WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	36,061.0000	36,061.00
146	SOW 4 - PACE SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,909.0000	30,909.00
147	SOW 5 - 1115 WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	51,515.0000	51,515.00
148	SOW 6 - DENTAL RATE SETTING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	12,879.0000	12,879.00
149	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00
150	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00
151	CAPITATION RATE UPDATES SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,606.0000	41,212.00
152	DENTAL CAPITALIZATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00
153	DENTAL REBASING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,909.0000	30,909.00
154	LEAD STRATEGIST SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
155	PRINCIPAL/PROJECT MANAGER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00

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NANCY STORANT (AS)

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
156	LEAD ACTUARY SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
157	ACTUARIAL CONSULTANT SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
158	ACTUARIAL ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
159	INFORMATICS ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
160	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	72,121.0000	EA	1.0000	72,121.00
161	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	60,600.0000	EA	1.0000	60,600.00
162	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	61,818.0000	EA	1.0000	61,818.00
163	SOW 1 - CAPITATION RATE UPDATES SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	123,636.0000	EA	1.0000	123,636.00
164	SOW 1 - CAPITATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	46,364.0000	EA	1.0000	46,364.00
165	SOW 3 - 1915(B) WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	36,061.0000	36,061.00
166	SOW 4 - PACE SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	30,909.0000	30,909.00
167	SOW 5 - 1115 WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	51,515.0000	51,515.00
168	SOW 6 - DENTAL RATE SETTING SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	12,879.0000	12,879.00

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25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
169	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
170	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
171	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	20,606.0000	41,212.00
172	DENTAL CAPITALIZATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
173	LEAD STRATEGIST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
174	PRINCIPAL/PROJECT MANAGER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
175	LEAD ACTUARY SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
176	ACTUARIAL CONSULTANT SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
177	ACTUARIAL ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
178	INFORMATICS ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
179	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	72,842.0000	EA	1.0000	72,842.00
180	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	60,600.0000	EA	1.0000	60,600.00
181	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR	62,436.0000	EA	1.0000	62,436.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE				
182	SOW 1 - CAPITATION RATE UPDATES THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	124,872.0000	EA	1.0000	124,872.00
183	SOW 1 - CAPITATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	46,827.0000	EA	1.0000	46,827.00
184	CAPITATION RATE REBASING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	156,091.0000	156,091.00
185	SOW 3 - 1915(B) WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	36,421.0000	36,421.00
186	SOW 4 - PACE THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	31,218.0000	31,218.00
187	SOW 5 - 1115 WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	52,030.0000	52,030.00
188	SOW 6 - DENTAL RATE SETTING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	13,008.0000	13,008.00
189	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,406.0000	10,406.00
190	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	40,406.0000	40,406.00
191	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,812.0000	41,624.00
192	DENTAL CAPITALIZATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,406.0000	10,406.00
193	DENTAL REBASING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	31,218.0000	31,218.00
194	LEAD STRATEGIST	5.0000	HR	205.0000	1,025.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE				
195	PRINCIPAL/PROJECT MANAGER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
196	LEAD ACTUARY THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
197	ACTUARIAL CONSULTANT THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
198	ACTUARIAL ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
199	INFORMATICS ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
200	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	72,842.0000	EA	1.0000	72,842.00
201	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	60,600.0000	EA	1.0000	60,600.00
202	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	62,436.0000	EA	1.0000	62,436.00
203	SOW 1 - CAPITATION RATE UPDATES THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	124,872.0000	EA	1.0000	124,872.00
204	SOW 1 - CAPITATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	46,827.0000	EA	1.0000	46,827.00
205	SOW 3 - 1915(B) WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	36,421.0000	36,421.00
206	SOW 4 - PACE THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	31,218.0000	31,218.00
207	SOW 5 - 1115 WAIVER	1.0000	EA	52,030.0000	52,030.00

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	THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO				
208	SOW 6 - DENTAL RATE SETTING THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	13,008.0000	13,008.00
209	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
210	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
211	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	20,812.0000	41,624.00
212	DENTAL CAPITALIZATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
213	LEAD STRATEGIST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
214	PRINCIPAL/PROJECT MANAGER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
215	LEAD ACTUARY THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
216	ACTUARIAL CONSULTANT THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
217	ACTUARIAL ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
218	INFORMATICS ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
219	SOW 8 - APR DRG ANALYSIS PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
220	SOW 8 - APR DRG ANALYSIS	5.0000	HR	205.0000	1,025.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES				
221	SOW 8 - APR DRG ANALYSIS ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
222	SOW 8 - APR DRG ANALYSIS ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
223	SOW 8 - APR DRG ANALYSIS INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
224	SOW 8 - EAPG ANALYSIS PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
225	SOW 8 - EAPG ANALYSIS LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	15.0000	HR	205.0000	3,075.00
226	SOW 8 - EAPG ANALYSIS ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	30.0000	HR	205.0000	6,150.00
227	SOW 8 - EAPG ANALYSIS ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	75.0000	HR	205.0000	15,375.00
228	SOW 8 - EAPG ANALYSIS INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	75.0000	HR	205.0000	15,375.00
229	SOW 8 - KEY PERFORMANCE INDICATORS LEAD STRATEGIST FOR HERITAGE HEALTH ANALYSES	25.0000	HR	205.0000	5,125.00

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230	SOW 8 - KEY PERFORMANCE INDICATORS PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	25.0000	HR	205.0000	5,125.00
231	SOW 8 - KEY PERFORMANCE INDICATORS LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	50.0000	HR	205.0000	10,250.00
232	SOW 8 - KEY PERFORMANCE INDICATORS ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	50.0000	HR	205.0000	10,250.00
233	SOW 8 - KEY PERFORMANCE INDICATORS ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	25.0000	HR	205.0000	5,125.00
234	SOW 8 - KEY PERFORMANCE INDICATORS INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	25.0000	HR	205.0000	5,125.00
235	SOW 8 - FQHC APM REBASING LEAD STRATEGIST FOR HERITAGE HEALTH ANALYSES	2.0000	HR	205.0000	410.00
236	SOW 8 - FQHC APM REBASING PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	3.0000	HR	205.0000	615.00
237	SOW 8 - FQHC APM REBASING LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
238	SOW 8 - FQHC APM REBASING ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
239	SOW 8 -	10.0000	HR	205.0000	2,050.00

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25769029	NANCY STORANT (AS)

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84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	FQHC APM REBASING ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES				
240	SOW 8 - FQHC APM REBASING INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
241	SOW 8 - FQHC DENTAL RATE SETTING LEAD STRATEGIST FOR HERITAGE HEALTH ANALYSES	2.0000	HR	205.0000	410.00
242	SOW 8 - FQHC DENTAL RATE SETTING PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	3.0000	HR	205.0000	615.00
243	SOW 8 - FQHC DENTAL RATE SETTING LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
244	SOW 8 - FQHC DENTAL RATE SETTING ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
245	SOW 8 - FQHC DENTAL RATE SETTING ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
246	SOW 8 - FQHC DENTAL RATE SETTING INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	15.0000	HR	205.0000	3,075.00
247	SOW 8 - RHC UNDER 50 BEDS RATE SETTING LEAD STRATEGIST FOR HERITAGE HEALTH ANALYSES	2.0000	HR	205.0000	410.00
248	SOW 8 - RHC UNDER 50 BEDS RATE SETTING PRINCIPAL/PROJECT MANAGER FOR	3.0000	HR	205.0000	615.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	HERITAGE HEALTH ANALYSES				
249	SOW 8 - RHC UNDER 50 BEDS RATE SETTING LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	15.0000	HR	205.0000	3,075.00
250	SOW 8 - RHC UNDER 50 BEDS RATE SETTING ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	15.0000	HR	205.0000	3,075.00
251	SOW 8 - RHC UNDER 50 BEDS RATE SETTING ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	20.0000	HR	205.0000	4,100.00
252	SOW 8 - RHC UNDER 50 BEDS RATE SETTING INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	20.0000	HR	205.0000	4,100.00
253	SOW 8 - CHIROPRACTIC RATES ANALYSIS LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
254	SOW 8 - CHIROPRACTIC RATES ANALYSIS ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
256	SOW 8 - CHIROPRACTIC RATES ANALYSIS INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
257	SOW 8- RATE REFORM INITIATIVE LEAD STRATEGIST	160.0000	HR	205.0000	32,800.00
258	SOW 8- RATE REFORM INITIATIVE PRINCIPAL/PROJECT MANAGER	270.0000	HR	205.0000	55,350.00
259	SOW 8- RATE REFORM INITIATIVE LEAD ACTUARIAL ANALYST	60.0000	HR	205.0000	12,300.00
260	SOW 8- RATE REFORM INITIATIVE	250.0000	HR	205.0000	51,250.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	ACTUARIAL CONSULTANT				
261	SOW 8- RATE REFORM INITIATIVE ACTUARIAL ANALYST	275.0000	HR	205.0000	56,375.00
262	SOW 8- RATE REFORM INITIATIVE INFORMATION ANALYST	885.0000	HR	205.0000	181,425.00
	Total Order				**7,295,446.00**

BUYER INITIALS

AMENDMENT THREE
84038 O4
Medicaid Managed Care Actuarial and Consulting Services for the State of Nebraska
Between
The State of Nebraska and Schramm Health Partners LLC DBA Optumas

This Amendment (the "Amendment") is made by the State of Nebraska and Schramm Health Partners LLC DBA Optumas, parties to Contract 84038 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract upon Execution by both parties as follows:

Add the following lines for the SOW 8 for the Division of Developmental Disabilities Rate Reform Initiative:

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
257	SOW 8 – Rate Reform Initiative Lead Strategist	160	HR	$205.00	$32,800.00
258	SOW 8 – Rate Reform Initiative Principal/Project Manager	270	HR	$205.00	$55,350.00
259	SOW 8 – Rate Reform Initiative Lead Actuary	60	HR	$205.00	$12,300.00
260	SOW 8 – Rate Reform Initiative Actuarial Consultant	250	HR	$205.00	$51,250.00
261	SOW 8 – Rate Reform Initiative Actuarial Analyst	275	HR	$205.00	$56,375.00
262	SOW 8 – Rate Reform Initiative Information Analyst	885	HR	$205.00	$181,425.00

This amendment and any attachments hereto will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

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

State of Nebraska

By:

Name: Douglas D Carlson

Title: Materiel Administrator

Date: 8/23/19

Contractor: Schramm Health Partners LLC DBA Optumas

By:

Name: Steven P. Schramm

Title: Managing Director

Date: 8/15/19

Department of Health and Human Services

By:

Name: Matthew A. Van Patton

Title: Director

Date: 23 Aug 2019

Scope of Work for Nebraska DDD Payment Reform
Nebraska Department of Health and Human Services

The **Optumas** Scope of Work (SOW) for the Nebraska Division of Developmental Disabilities (NE DDD) Rate Reform Initiative through June 30, 2019 is detailed below. **Optumas** will work closely with NE DDD in designing, developing, and implementing payment reform regarding how the State pays for services provided to DD individuals.

The tasks associated with the Rate Reform Initiative are discussed in detail in the following section, and a summary of estimated expenses for each task is found at the end of this document. We look forward to building on our successful existing relationship with NE DDD and are available to answer any questions about the proposed analyses and funding levels.

Scope of Services and Deliverables

Discussions with the NE DDD team have identified key areas in which **Optumas** can support the Rate Reform Initiative. Each area is described below:

Tasks:

A. Model Version #1:
Optumas will develop a draft model of enhanced risk identification for individuals receiving services from NE DDD based on their assessment data and other statewide data sources. The completion of the draft model task will include a memo outlining variable categories included in the model.

B. Advisory Group Meeting(s):
Throughout model development, **Optumas** will conduct meeting with Advisory Groups of parents, advocates, and individuals; providers; and clinicians. Advisory Group meetings are scheduled to be conducted twice yearly. Advisory Group meetings will be followed by program staff briefing content and statewide webinars.

C. Strategic Communications and Planning:
Optumas will assist DDD with communications related to the rate study and the enhanced risk identification model development. Communications supplemental to the Advisory Group groups will include the provision of content for program staff updates and statewide webinars.

D. Clinical Hypothetical Study:
Optumas will conduct a Clinical Hypothetical Study, which is an expert review of de-identified assessments for individuals, and classification of them in terms of expected needs. Results of the study will be presented to the State.

E. Governor's Office and Legislative Briefings:
Optumas will assist DDD with briefings for the Governor’s Office and Legislature at the direction of DDD.

Schramm Health Partners, L.L.C.
7400 East McDonald Dr., Suite 101
Scottsdale AZ 85250
480.588.2499 main
480.315.1795 fax

F. Assessment/Placement Planning & Impact on Model Data/Structure:
   As DDD plans the completion of assessments of the individuals they serve, **Optumas** will give input on the implications for model structure and timing. As necessary, **Optumas** will request assessments for specific populations to aid in model development.

G. ICAP/Other Assessment Data Analyses/Reporting & Quality Assurance:
   Interim Inventory for Client and Agency Planning (ICAP) support will be provided, including recommendation for improving processes and quality. A Quality Management System (QMS) review will also be completed, including recommendations on opportunities for quality improvement.

H. Rate Study Updates and Modifications due to Program Changes:
   Optumas will update the rate study as necessary for program changes made by DDD.

I. Operational Assistance - **Optumas** and Alvarez & Marsal (A&M):
   Optumas and A&M will provide ongoing assistance at the discretion and direction of DDD.

Fees and Expenses

Our estimated professional fees for the scope of work described above are listed in the table below. The fees are described by ranges per job title, following DAS guidelines. The estimated hours are converted to estimated dollars using the contracted flat rate of $205 per hour.

Estimated Hours and Total Cost by Task																
Lead Strategist		Principal/ Project Manager		Lead Actuary		Actuarial Consultant		Actuarial Analyst		Informatics Analyst		Total Est. Hours		Sub-contract Allocation	Est. Total Dollars	
100	160	190	270	40	60	160	250	125	275	125	275	740	1290	$125,000	**$276,700**	**$389,450**

The fee estimates described above are all-inclusive, meaning that any additional out-of-pocket or travel expenses incurred in performing the services outlined in this scoping document will not be billed to NE DDD.

We look forward to continuing our relationship with NE DDD. If you have any questions about this scoping document, please do not hesitate to contact us.

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CONTRACT NUMBER
84038 O4

VENDOR NUMBER: 2051503

VENDOR ADDRESS:

SCHRAMM HEALTH PARTNERS LLC
DBA OPTUMAS
7400 E MCDONALD DR STE 101
SCOTTSDALE AZ 85250-0699

THE CONTRACT PERIOD IS:

JANUARY 01, 2019 THROUGH DECEMBER 31, 2023

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

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

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

Original/Bid Document 5868 Z1

Contract to supply Medicaid Managed Care Actuarial and Consulting Services to the State of Nebraska for the contract period January 1, 2019 to December 31, 2023. The contract may be renewed for Three (3) additional Two (2) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Steve Schramm
Phone: 480-588-2493
E-Mail: steve.schramm@optumas.com

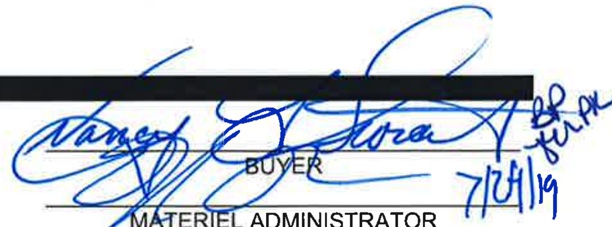
(10/23/18 ml)

Amendment One as attached. (06/11/19 ml)

Amendment Two as attached. (07/19/19 ml)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR ONE	70,000.0000	EA	1.0000	70,000.00
2	SOW 1 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR ONE	60,000.0000	EA	1.0000	60,000.00
3	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR ONE	60,000.0000	EA	1.0000	60,000.00

DHHS DIVISION DIRECTOR



BUYER

MATERIEL ADMINISTRATOR

R43500|NISH0003|NISH0003 20150901

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
4	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR ONE	90,000.0000	EA	1.0000	90,000.00
5	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR ONE	45,000.0000	EA	1.0000	45,000.00
6	SOW 2 - CAPITATION RATE REBASING INITIAL CONTRACT PERIOD - YEAR ONE	150,000.0000	EA	1.0000	150,000.00
7	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	35,000.0000	35,000.00
8	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	30,000.0000	30,000.00
9	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	50,000.0000	50,000.00
10	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	12,500.0000	12,500.00
11	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	10,000.0000	10,000.00
12	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	10,000.0000	10,000.00
13	CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR ONE	2.0000	EA	20,000.0000	40,000.00
14	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	10,000.0000	10,000.00
15	SOW 7 - DENTAL REBASING INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	30,000.0000	30,000.00
16	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
17	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
18	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
19	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
20	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
21	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
22	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR TWO	70,000.0000	EA	1.0000	70,000.00
23	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR TWO	60,000.0000	EA	1.0000	60,000.00
24	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR TWO	60,000.0000	EA	1.0000	60,000.00
25	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR TWO	90,000.0000	EA	1.0000	90,000.00
26	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR TWO	45,000.0000	EA	1.0000	45,000.00
27	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	35,000.0000	35,000.00
28	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	30,000.0000	30,000.00
29	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	50,000.0000	50,000.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
30	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	12,500.0000	12,500.00
31	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00
32	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00
33	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR TWO	2.0000	EA	20,000.0000	40,000.00
34	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00
35	SOW 7 - DENTAL REBASING INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	30,000.0000	30,000.00
36	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
37	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
38	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
39	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
40	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
41	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
42	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR THREE	70,700.0000	EA	1.0000	70,700.00
43	SOW 1 -RATE DATA ANALYSIS	60,600.0000	EA	1.0000	60,600.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR THREE				
44	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR THREE	60,600.0000	EA	1.0000	60,600.00
45	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR THREE	90,900.0000	EA	1.0000	90,900.00
46	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR THREE	45,450.0000	EA	1.0000	45,450.00
47	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	35,350.0000	35,350.00
48	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	30,300.0000	30,300.00
49	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	50,500.0000	50,500.00
50	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	12,625.0000	12,625.00
51	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00
52	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00
53	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR THREE	2.0000	EA	20,200.0000	40,400.00
54	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00
55	LEAD STRATEGIST	5.0000	HR	205.0000	1,025.00

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	INITIAL CONTRACT PERIOD - YEAR THREE				
56	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
57	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
58	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
59	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
60	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
61	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR FOUR	70,700.0000	EA	1.0000	70,700.00
62	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FOUR	60,600.0000	EA	1.0000	60,600.00
63	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FOUR	60,600.0000	EA	1.0000	60,600.00
64	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR FOUR	90,900.0000	EA	1.0000	90,900.00
65	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FOUR	45,450.0000	EA	1.0000	45,450.00
66	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	35,350.0000	35,350.00
67	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	30,300.0000	30,300.00
68	SOW 5 - 1115 WAIVER	1.0000	EA	50,500.0000	50,500.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD - YEAR FOUR				
69	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	12,625.0000	12,625.00
70	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
71	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
72	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FOUR	2.0000	EA	20,200.0000	40,400.00
73	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
74	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
75	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
76	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
77	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
78	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
79	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
80	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR FIVE	70,700.0000	EA	1.0000	70,700.00
81	SOW 1 -RATE DATA ANALYSIS AND	60,600.0000	EA	1.0000	60,600.00

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25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

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84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	MANIPULATION INITIAL CONTRACT PERIOD - YEAR FIVE				
82	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FIVE	60,600.0000	EA	1.0000	60,600.00
83	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR FIVE	90,900.0000	EA	1.0000	90,900.00
84	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FIVE	45,450.0000	EA	1.0000	45,450.00
85	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	35,350.0000	35,350.00
86	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	30,300.0000	30,300.00
87	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	50,500.0000	50,500.00
88	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	12,625.0000	12,625.00
89	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
90	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
91	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FIVE	2.0000	EA	20,200.0000	40,400.00
92	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
93	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
94	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
95	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
96	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
97	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
98	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
99	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	71,407.0000	EA	1.0000	71,407.00
100	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	60,600.0000	EA	1.0000	60,600.00
101	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	61,206.0000	EA	1.0000	61,206.00
102	SOW 1 - CAPITATION RATE UPDATES FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	122,412.0000	EA	1.0000	122,412.00
103	SOW 1 - CAPITATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	45,905.0000	EA	1.0000	45,905.00
104	CAPITATION RATE REBASING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	153,015.0000	153,015.00
105	SOW 3 - 1915(B) WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	35,704.0000	35,704.00
106	SOW 4 - PACE FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,603.0000	30,603.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
107	SOW 5 - 1115 WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	51,005.0000	51,005.00
108	SOW 6 - DENTAL RATE SETTING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	12,751.0000	12,751.00
109	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
110	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
111	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,402.0000	40,804.00
112	DENTAL CAPITALIZATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
113	DENTAL REBASING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,603.0000	30,603.00
114	LEAD STRATEGIST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
115	PRINCIPAL/PROJECT MANAGER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
116	LEAD ACTUARY FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
117	ACTUARIAL CONSULTANT FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
118	ACTUARIAL ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
119	INFORMATICS ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
120	SOW 1 - ANNUAL CAPITATION RATE SETTING	71,407.0000	EA	1.0000	71,407.00

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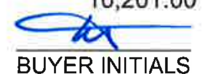
Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO				
121	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	60,600.0000	EA	1.0000	60,600.00
122	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	61,206.0000	EA	1.0000	61,206.00
123	SOW 1 - CAPITATION RATE UPDATES FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	122,412.0000	EA	1.0000	122,412.00
124	SOW 1 - CAPITATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	45,905.0000	EA	1.0000	45,905.00
125	SOW 3 - 1915(B) WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	35,704.0000	35,704.00
126	SOW 4 - PACE FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	30,603.0000	30,603.00
127	SOW 5 - 1115 WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	51,005.0000	51,005.00
128	SOW 6 - DENTAL RATE SETTING FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	12,751.0000	12,751.00
129	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00
130	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00
131	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	20,402.0000	40,804.00
132	DENTAL CAPITALIZATION RATE	1.0000	EA	10,201.0000	10,201.00



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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO				
133	LEAD STRATEGIST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
134	PRINCIPAL/PROJECT MANAGER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
135	LEAD ACTUARY FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
136	ACTUARIAL CONSULTANT FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
137	ACTUARIAL ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
138	INFORMATICS ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
139	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	72,121.0000	EA	1.0000	72,121.00
140	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	60,600.0000	EA	1.0000	60,600.00
141	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	61,818.0000	EA	1.0000	61,818.00
142	SOW 1 - CAPITATION RATE UPDATES SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	123,636.0000	EA	1.0000	123,636.00
143	SOW 1 - CAPITATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	46,364.0000	EA	1.0000	46,364.00
144	CAPITATION RATE REBASING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	154,545.0000	154,545.00

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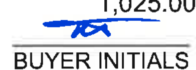
Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
145	SOW 3 - 1915(B) WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	36,061.0000	36,061.00
146	SOW 4 - PACE SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,909.0000	30,909.00
147	SOW 5 - 1115 WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	51,515.0000	51,515.00
148	SOW 6 - DENTAL RATE SETTING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	12,879.0000	12,879.00
149	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00
150	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00
151	CAPITATION RATE UPDATES SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,606.0000	41,212.00
152	DENTAL CAPITALIZATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00
153	DENTAL REBASING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,909.0000	30,909.00
154	LEAD STRATEGIST SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
155	PRINCIPAL/PROJECT MANAGER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
156	LEAD ACTUARY SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
157	ACTUARIAL CONSULTANT SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
158	ACTUARIAL ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
159	INFORMATICS ANALYST	5.0000	HR	205.0000	1,025.00



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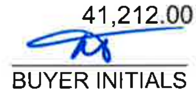
Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE				
160	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	72,121.0000	EA	1.0000	72,121.00
161	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	60,600.0000	EA	1.0000	60,600.00
162	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	61,818.0000	EA	1.0000	61,818.00
163	SOW 1 - CAPITATION RATE UPDATES SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	123,636.0000	EA	1.0000	123,636.00
164	SOW 1 - CAPITATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	46,364.0000	EA	1.0000	46,364.00
165	SOW 3 - 1915(B) WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	36,061.0000	36,061.00
166	SOW 4 - PACE SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	30,909.0000	30,909.00
167	SOW 5 - 1115 WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	51,515.0000	51,515.00
168	SOW 6 - DENTAL RATE SETTING SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	12,879.0000	12,879.00
169	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
170	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
171	CAPITATION RATE UPDATES	2.0000	EA	20,606.0000	41,212.00



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	RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO				
172	DENTAL CAPITALIZATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
173	LEAD STRATEGIST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
174	PRINCIPAL/PROJECT MANAGER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
175	LEAD ACTUARY SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
176	ACTUARIAL CONSULTANT SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
177	ACTUARIAL ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
178	INFORMATICS ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
179	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	72,842.0000	EA	1.0000	72,842.00
180	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	60,600.0000	EA	1.0000	60,600.00
181	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	62,436.0000	EA	1.0000	62,436.00
182	SOW 1 - CAPITATION RATE UPDATES THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	124,872.0000	EA	1.0000	124,872.00
183	SOW 1 - CAPITATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	46,827.0000	EA	1.0000	46,827.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
184	CAPITATION RATE REBASING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	156,091.0000	156,091.00
185	SOW 3 - 1915(B) WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	36,421.0000	36,421.00
186	SOW 4 - PACE THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	31,218.0000	31,218.00
187	SOW 5 - 1115 WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	52,030.0000	52,030.00
188	SOW 6 - DENTAL RATE SETTING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	13,008.0000	13,008.00
189	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,406.0000	10,406.00
190	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	40,406.0000	40,406.00
191	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,812.0000	41,624.00
192	DENTAL CAPITALIZATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,406.0000	10,406.00
193	DENTAL REBASING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	31,218.0000	31,218.00
194	LEAD STRATEGIST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
195	PRINCIPAL/PROJECT MANAGER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
196	LEAD ACTUARY THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
197	ACTUARIAL CONSULTANT THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00

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198	ACTUARIAL ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
199	INFORMATICS ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
200	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	72,842.0000	EA	1.0000	72,842.00
201	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	60,600.0000	EA	1.0000	60,600.00
202	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	62,436.0000	EA	1.0000	62,436.00
203	SOW 1 - CAPITATION RATE UPDATES THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	124,872.0000	EA	1.0000	124,872.00
204	SOW 1 - CAPITATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	46,827.0000	EA	1.0000	46,827.00
205	SOW 3 - 1915(B) WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	36,421.0000	36,421.00
206	SOW 4 - PACE THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	31,218.0000	31,218.00
207	SOW 5 - 1115 WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	52,030.0000	52,030.00
208	SOW 6 - DENTAL RATE SETTING THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	13,008.0000	13,008.00
209	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00

BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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Lincoln, Nebraska 68508

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Fax: (402) 471-2089

ORDER DATE
07/19/19

BUSINESS UNIT
25769029

BUYER
NANCY STORANT (AS)

CONTRACT NUMBER
84038 O4

VENDOR NUMBER: 2051503

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
210	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
211	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	20,812.0000	41,624.00
212	DENTAL CAPITALIZATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
213	LEAD STRATEGIST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
214	PRINCIPAL/PROJECT MANAGER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
215	LEAD ACTUARY THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
216	ACTUARIAL CONSULTANT THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
217	ACTUARIAL ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
218	INFORMATICS ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
219	SOW 8 - APR DRG ANALYSIS PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
220	SOW 8 - APR DRG ANALYSIS LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
221	SOW 8 - APR DRG ANALYSIS ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
222	SOW 8 - APR DRG ANALYSIS	10.0000	HR	205.0000	2,050.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES				
223	SOW 8 - APR DRG ANALYSIS INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
224	SOW 8 - EAPG ANALYSIS PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
225	SOW 8 - EAPG ANALYSIS LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	15.0000	HR	205.0000	3,075.00
226	SOW 8 - EAPG ANALYSIS ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	30.0000	HR	205.0000	6,150.00
227	SOW 8 - EAPG ANALYSIS ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	75.0000	HR	205.0000	15,375.00
228	SOW 8 - EAPG ANALYSIS INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	75.0000	HR	205.0000	15,375.00
229	SOW 8 - KEY PERFORMANCE INDICATORS LEAD STRATEGIST FOR HERITAGE HEALTH ANALYSES	25.0000	HR	205.0000	5,125.00
230	SOW 8 - KEY PERFORMANCE INDICATORS PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	25.0000	HR	205.0000	5,125.00
231	SOW 8 - KEY PERFORMANCE INDICATORS LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	50.0000	HR	205.0000	10,250.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
232	SOW 8 - KEY PERFORMANCE INDICATORS ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	50.0000	HR	205.0000	10,250.00
233	SOW 8 - KEY PERFORMANCE INDICATORS ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	25.0000	HR	205.0000	5,125.00
234	SOW 8 - KEY PERFORMANCE INDICATORS INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	25.0000	HR	205.0000	5,125.00
235	SOW 8 - FQHC APM REBASING LEAD STRATEGIST FOR HERITAGE HEALTH ANALYSES	2.0000	HR	205.0000	410.00
236	SOW 8 - FQHC APM REBASING PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	3.0000	HR	205.0000	615.00
237	SOW 8 - FQHC APM REBASING LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
238	SOW 8 - FQHC APM REBASING ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
239	SOW 8 - FQHC APM REBASING ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
240	SOW 8 - FQHC APM REBASING INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
241	SOW 8 -	2.0000	HR	205.0000	410.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	FQHC DENTAL RATE SETTING LEAD STRATEGIST FOR HERITAGE HEALTH ANALYSES				
242	SOW 8 - FQHC DENTAL RATE SETTING PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	3.0000	HR	205.0000	615.00
243	SOW 8 - FQHC DENTAL RATE SETTING LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
244	SOW 8 - FQHC DENTAL RATE SETTING ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
245	SOW 8 - FQHC DENTAL RATE SETTING ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
246	SOW 8 - FQHC DENTAL RATE SETTING INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	15.0000	HR	205.0000	3,075.00
247	SOW 8 - RHC UNDER 50 BEDS RATE SETTING LEAD STRATEGIST FOR HERITAGE HEALTH ANALYSES	2.0000	HR	205.0000	410.00
248	SOW 8 - RHC UNDER 50 BEDS RATE SETTING PRINCIPAL/PROJECT MANAGER FOR HERITAGE HEALTH ANALYSES	3.0000	HR	205.0000	615.00
249	SOW 8 - RHC UNDER 50 BEDS RATE SETTING LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	15.0000	HR	205.0000	3,075.00
250	SOW 8 - RHC UNDER 50 BEDS RATE SETTING ACTUARIAL CONSULTANT FOR	15.0000	HR	205.0000	3,075.00

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STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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VENDOR NUMBER: 2051503

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	HERITAGE HEALTH ANALYSES				
251	SOW 8 - RHC UNDER 50 BEDS RATE SETTING ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	20.0000	HR	205.0000	4,100.00
252	SOW 8 - RHC UNDER 50 BEDS RATE SETTING INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	20.0000	HR	205.0000	4,100.00
253	SOW 8 - CHIROPRACTIC RATES ANALYSIS LEAD ACTUARY FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
254	SOW 8 - CHIROPRACTIC RATES ANALYSIS ACTUARIAL CONSULTANT FOR HERITAGE HEALTH ANALYSES	5.0000	HR	205.0000	1,025.00
255	SOW 8 - CHIROPRACTIC RATES ANALYSIS ACTUARIAL ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
256	SOW 8 - CHIROPRACTIC RATES ANALYSIS INFORMATION ANALYST FOR HERITAGE HEALTH ANALYSES	10.0000	HR	205.0000	2,050.00
	Total Order				**7,030,621.00**

BUYER INITIALS

AMENDMENT TWO
84038 O4
Medicaid Managed Care Actuarial and Consulting Services for the State of Nebraska
Between
The State of Nebraska and Schramm Health Partners LLC DBA Optumas

This Amendment (the "Amendment") is made by the State of Nebraska and Schramm Health Partners LLC DBA Optumas, parties to Contract 84038 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract upon Execution by both parties as follows:

Add the following lines for the SOW for Additional Heritage Health Analyses:

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
219	SOW 8 – APR DRG Analysis Principal/Project Manager for Heritage Health Analyses	5	HR	$205.00	$1,025.00
220	SOW 8 – APR DRG Analysis Lead Actuary for Heritage Health Analyses	5	HR	$205.00	$1,025.00
221	SOW 8 – APR DRG Analysis Actuarial Consultant for Heritage Health Analyses	10	HR	$205.00	$2,050.00
222	SOW 8 – APR DRG Analysis Actuarial Analyst for Heritage Health Analyses	10	HR	$205.00	$2,050.00
223	SOW 8 – APR DRG Analysis Information Analyst for Heritage Health Analyses	10	HR	$205.00	$2,050.00
224	SOW 8 – EAPG Analysis Principal/Project Manager for Heritage Health Analyses	5	HR	$205.00	$1,025.00
225	SOW 8 – EAPG Analysis Lead Actuary for Heritage Health Analyses	15	HR	$205.00	$3,075.00
226	SOW 8 – EAPG Analysis Actuarial Consultant for Heritage Health Analyses	30	HR	$205.00	$6,150.00
227	SOW 8 – EAPG Analysis Actuarial Analyst for Heritage Health Analyses	75	HR	$205.00	$15,375.00
228	SOW 8 – EAPG Analysis Information Analyst for Heritage Health Analyses	75	HR	$205.00	$15,375.00
229	SOW 8 – Key Performance Indicators Lead Strategist for Heritage Health Analyses	25	HR	$205.00	$5,125.00

230	SOW 8 – Key Performance Indicators Principal/Project Manager for Heritage Health Analyses	25	HR	$205.00	$5,125.00
231	SOW 8 – Key Performance Indicators Lead Actuary for Heritage Health Analyses	50	HR	$205.00	$10,250.00
232	SOW 8 – Key Performance Indicators Actuarial Consultant for Heritage Health Analyses	50	HR	$205.00	$10,250.00
233	SOW 8 – Key Performance Indicators Actuarial Analyst for Heritage Health Analyses	25	HR	$205.00	$5,125.00
234	SOW 8 – Key Performance Indicators Information Analyst for Heritage Health Analyses	25	HR	$205.00	$5,125.00
235	SOW 8 - FQHC APM Rebasing Lead Strategist for Heritage Health Analyses	2	HR	$205.00	$410.00
236	SOW 8 - FQHC APM Rebasing Principal/Project Manager for Heritage Health Analyses	3	HR	$205.00	$615.00
237	SOW 8 - FQHC APM Rebasing Lead Actuary for Heritage Health Analyses	5	HR	$205.00	$1,025.00
238	SOW 8 - FQHC APM Rebasing Actuarial Consultant for Heritage Health Analyses	10	HR	$205.00	$2,050.00
239	SOW 8 - FQHC APM Rebasing Actuarial Analyst for Heritage Health Analyses	10	HR	$205.00	$2,050.00
240	SOW 8 - FQHC APM Rebasing Information Analyst for Heritage Health Analyses	10	HR	$205.00	$2,050.00
241	SOW 8 – FQHC Dental Rate Setting Lead Strategist for Heritage Health Analyses	2	HR	$205.00	$410.00
242	SOW 8 – FQHC Dental Rate Setting Principal/Project Manager for Heritage Health Analyses	3	HR	$205.00	$615.00
243	SOW 8 – FQHC Dental Rate Setting Lead Actuary for Heritage Health Analyses	10	HR	$205.00	$2,050.00
244	SOW 8 – FQHC Dental Rate Setting Actuarial Consultant for Heritage Health Analyses	10	HR	$205.00	$2,050.00
245	SOW 8 – FQHC Dental Rate Setting Actuarial Analyst for Heritage Health Analyses	10	HR	$205.00	$2,050.00

246	SOW 8 – FQHC Dental Rate Setting Information Analyst for Heritage Health Analyses	15	HR	$205.00	$3,075.00
247	SOW 8 - RHC Under 50 Beds Rate Setting Lead Strategist for Heritage Health Analyses	2	HR	$205.00	$410.00
248	SOW 8 - RHC Under 50 Beds Rate Setting Principal/Project Manager for Heritage Health Analyses	3	HR	$205.00	$615.00
249	SOW 8 - RHC Under 50 Beds Rate Setting Lead Actuary for Heritage Health Analyses	15	HR	$205.00	$3,075.00
250	SOW 8 - RHC Under 50 Beds Rate Setting Actuarial Consultant for Heritage Health Analyses	15	HR	$205.00	$3,075.00
251	SOW 8 - RHC Under 50 Beds Rate Setting Actuarial Analyst for Heritage Health Analyses	20	HR	$205.00	$4,100.00
252	SOW 8 - RHC Under 50 Beds Rate Setting Information Analyst for Heritage Health Analyses	20	HR	$205.00	$4,100.00
253	SOW 8 – Chiropractic Rates Analysis Lead Actuary for Heritage Health Analyses	5	HR	$205.00	$1,025.00
254	SOW 8 – Chiropractic Rates Analysis Actuarial Consultant for Heritage Health Analyses	5	HR	$205.00	$1,025.00
255	SOW 8 – Chiropractic Rates Analysis Actuarial Analyst for Heritage Health Analyses	10	HR	$205.00	$2,050.00
256	SOW 8 – Chiropractic Rates Analysis Information Analyst for Heritage Health Analyses	10	HR	$205.00	$2,050.00

This amendment and any attachments hereto will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

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

State of Nebraska

By: ______

Name: Douglas D Carlson

Title: Materiel Administrator

Date: 7/29/19

Contractor: Schramm Health Partners LLC DBA Optumas

By: ______

Name: STEVEN P. SCHRAMM

Title: MANAGING DIRECTOR

Date: 7/11/19

Department of Health and Human Services

By: ______

Name: Matthew A. Van Patton

Title: Director

Date: 22 July 2019

Scope of Work for Additional Heritage Health Analyses
Nebraska Department of Health and Human Services

New analyses have become necessary based on the continued evolution and development of Nebraska's Heritage Health program. The current contract between **Optumas** and DHHS does not consider or include funding for these analyses, so it is necessary to add funding to the contract to support the expanding Heritage Health rate development process under Special Projects per Scope of Work (SOW) 8. The new analyses are discussed in detail in the following section, and a summary of estimated hours and expense for each project is found at the end of this document. We look forward to building on our successful existing relationship with DHHS and are available to answer any questions about the proposed analyses and funding levels.

Scope of Services, Deliverables, and Timeline

Discussions with the DHHS team have identified new projects that will be added to **Optumas'** current scope of services to provide actuarial support for the Heritage Health program. Each project is described below, with hour and price estimates provided in the summary table in the Fees and Expenses section. The timeline for each project is Calendar Year 2019. Before beginning any work on any of the projects set forth below, DHHS must provide **Optumas** written authorization to begin work. Written authorization shall come from the Contract Manager or an individual designated by the Contract Manager. DHHS, through the Contract Manager or an individual designated by the Contract Manager, may also instruct **Optumas** to stop working on any project, to cease working on any project, or to prioritize any project, in its sole discretion, as otherwise consistent with the terms of the contract. Said instruction must also be in writing.

<u>APR DRG Analysis</u>

DHHS is moving to version 36 of the All Patients Refined Diagnosis Related Groups (APR DRG). To transition to a new version of the APR DRG it is necessary to model historical payments under the current grouper version as well as the prospective grouper version. This allows for payment changes to be applied correctly to each Category of Aid (COA) covered by Heritage Health, ensuring a match between expected claims payments and capitation rate funding at a population level.

In order to complete this analysis, **Optumas** will access the 3M APR DRG grouper software and run the most recent available Heritage Health data through the software. This will provide us with the new grouper category and associated DRG weight that will apply to each inpatient hospital claim. We will then price this data under the State's proposed facility base rates to

Schramm Health Partners, L.L.C.
7400 East McDonald Dr., Suite 101
Scottsdale AZ 85250
480.588.2499 main
480.315.1795 fax

determine the estimated change in reimbursement that is caused by the move to APR DRG version 36.

EAPG Analysis

Reimbursement for Outpatient Hospital services is moving from a cost to charge ratio basis to the Enhanced Ambulatory Patient Group (EAPG). This is a substantial shift in payment methodology and has the potential to shift payments across services, providers, and capitated rate cohorts. **Optumas** will analyze this change and incorporate it into the Heritage Health program using a similar approach to the APR DRG Analysis: the grouper will be run on the Heritage health data, prospective payments will be modeled, and changes from historical payments will serve as the basis for rating adjustments. In addition to the initial run of the EAPG grouper, it is anticipated that multiple working discussions will be necessary with Navigant, who is the current firm handling the development of the EAPG weights and base rates, to ensure proper interpretation and implementation of the results for Heritage Health Rate Setting purposes.

Key Performance Indicators

DHHS approached **Optumas** with the desire to develop analytic tools that could be used as one of the Key Performance Indicators (KPIs) analyzed during the review and evaluation of Heritage Health MCO contracts. **Optumas** has conducted internal review and development of a proposed KPI that has been presented to DHHS. Further work will be required if DHHS pursues the proposed KPI or desires new options for consideration. The current cost proposal is based on evaluating and executing the proposed use of PROMETHEUS Analytics as a KPI as well as further brainstorming and discussions DHHS would like to engage in with **Optumas** to support other KPI opportunities.

The concept behind **Optumas'** current KPI proposal is to share PROMETHEUS output with the MCOs at a very detailed level, allowing them to see the specific providers, procedures, diagnoses, and episodes that drive their inefficiency. After reviewing this data, the MCOs will be required to submit a written care management plan to the State describing what processes/systems/procedures they will develop to address the inefficiencies. At this point the design of this idea becomes very flexible. Depending on the state's desired level of oversight, the MCOs could have the freedom to pick any episode they deem most appropriate for their population, or they can be steered to specific episodes of interest. Additionally, the MCOs could be required to submit only a theoretical report stating what they will do, or they could also be required to submit an estimate of potential savings (which **Optumas** could then incorporate as

a reduction to future capitation rates if desired by the State). There are many other potential nuances that can be decided as this KPI is finalized, such as potentially sharing savings with plans who set up exemplary care management programs, but the core idea is to address known concerns with the lack of consistent management across MCOs by forcing the development of targeted intervention programs. It also creates a pass/fail metric that can be evaluated in a timely manner to assist in the contract renewal process.

FQHC APM Rebasing and Dental Rate Setting

Effective January 2016, DHHS implemented an updated reimbursement policy for its Medical Federally Qualified Health Center (FQHC) encounters to begin reimbursing via an Alternative Payment Methodology (APM) approach. DHHS is considering developing a re-based Medical FQHC APM rate for each of its FQHCs. Additionally, Dental services provided at an FQHC are currently reimbursed on a fee-for-service (FFS) basis; DHHS is also considering developing a specific Dental FQHC APM encounter rate. DHHS has requested **Optumas** prepare a cost estimate for the re-base of the Medical FQHC APM rate as well as the development of a Dental FQHC APM rate.

Optumas will work with DHHS to receive recent Medicare cost reports for each of the FQHCs. When **Optumas** worked with DHHS to develop the 2016 FQHC APM rates, Medicare cost reports for 2012 through 2014 were made available by the FQHCs. If DHHS chooses to re-base the 2020 APM rates, **Optumas** requests that Medicare cost reports for 2016 through 2018 be provided as the base data for rate development.

It is **Optumas'** understanding that the Medicare cost reports for each FQHC will provide adequate detail to itemize the costs appropriate to be included within the Medical APM rate, so that FQHC allowable costs can be itemized. Additionally, it is anticipated that dental-related costs will be itemized, so that costs appropriate to be included within the Dental APM rate can be identified.

Optumas will work with DHHS to ensure that we are interpreting the Medicare Cost Reports correctly, and that allowable costs and associated visit counts can be identified. As part of this work, **Optumas** can take part in calls with FQHCs, to the extent that any follow-up questions surrounding FQHC Cost Reports warrant such a call. Once **Optumas** and DHHS are confident that the appropriate base costs are being captured, **Optumas** will conduct analyses to develop the Medical and Dental FQHC APM rates per DHHS request.

The estimated hours in this document have been itemized to show the Medical FQHC APM Rebasing and Dental FQHC APM Rate Development separately.

RHC Under 50 Beds Rate Setting

Current Nebraska State regulations state that the Rural Health Clinic (RHC) under 50 bed provider payments should be "the lower of cost or charges as established by Medicare." DHHS would like to pursue an APM rate for RHCs with fewer than 50 beds moving forward. Similar to the FQHC APM rates, **Optumas** will work with DHHS to receive recent Medicare cost reports for each of the applicable RHCs. **Optumas** requests that Medicare cost reports for 2016 through 2018 be provided as the base data for rate development. It is **Optumas'** understanding that the Medicare cost reports for each RHC will provide adequate detail to itemize the costs appropriate to be included within the APM rate, so that RHC allowable costs can be itemized. **Optumas** will work with DHHS to ensure that we are interpreting the Medicare Cost Reports correctly, and that allowable costs and associated visit counts can be identified. As part of this work, **Optumas** can take part in calls with RHCs, to the extent that any follow-up questions surrounding RHC Cost Reports warrant such a call.

Once **Optumas** and DHHS are confident that the appropriate base costs are being captured, **Optumas** will conduct analysis to develop the RHC under 50 bed APM rates per DHHS request.

Chiropractic Rates Analysis

DHHS has made the policy decision to remove the 12-visit limit for adults on medically necessary Chiropractic claims effective January 1, 2020. Additionally, there will be covered codes which will be newly reimbursable for provision by a Chiropractor. DHHS has requested **Optumas** review the impact of this policy change to develop an estimated impact to the Heritage Health capitation rates.

In order to develop an estimated impact for this policy change, **Optumas** will review the historical detailed claims data for chiropractic services to identify members who have approached or reached the current 12-visit limit. This will then serve as a basis for which utilization assumptions can be developed to estimate a reasonable level of expected utilization increase as a result of this policy. Additionally, assumptions will be developed related to the potential for additional utilization resulting from the procedure codes which will now be eligible for reimbursement by a Chiropractor. The result of this review will determine the level of adjustment that is warranted within the Heritage Health capitation rates.

Fees and Expenses

Our estimated professional fees for the scope of work described above are listed in the table below. The estimated hours are converted to estimated dollars using the contracted flat rate of $205 per hour for each job title.

Estimated Hours and Total Cost by Project - Scope of Work 8 Projects								
Project	Lead Strategist	Principal/ Project Manager	Lead Actuary	Actuarial Consultant	Actuarial Analyst	Informatics Analyst	Total Est. Hours	Est. Dollars
APR DRG Analysis	-	5	5	10	10	10	40	$8,200
EAPG Analysis	-	5	15	30	75	75	200	$41,000
Key Performance Indicators	25	25	50	50	25	25	200	$41,000
FQHC APM Rebasing	2	3	5	10	10	10	40	$8,200
FQHC Dental Rate Setting	2	3	10	10	10	15	50	$10,250
RHC Under 50 Beds Rate Setting	2	3	15	15	20	20	75	$15,375
Chiropractic Rates Analysis	-	-	5	5	10	10	30	$6,150

The fee estimates described above are all-inclusive, meaning that any additional out-of-pocket or travel expenses incurred in performing the services outlined in this scoping document will not be billed to DHHS.

We look forward to continuing our relationship with DHHS. If you have any questions about this scoping document, please do not hesitate to contact us.

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 18	06/11/19
BUSINESS UNIT	BUYER
25769029	NANCY STORANT (AS)

CONTRACT NUMBER
84038 O4

VENDOR NUMBER: 2051503

VENDOR ADDRESS:

SCHRAMM HEALTH PARTNERS LLC
DBA OPTUMAS
7400 E MCDONALD DR STE 101
SCOTTSDALE AZ 85250-0699

THE CONTRACT PERIOD IS:

JANUARY 01, 2019 THROUGH DECEMBER 31, 2023

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

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

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

Original/Bid Document 5868 Z1

Contract to supply Medicaid Managed Care Actuarial and Consulting Services to the State of Nebraska for the contract period January 1, 2019 to December 31, 2023. The contract may be renewed for Three (3) additional Two (2) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Steve Schramm
Phone: 480-588-2493
E-Mail: steve.schramm@optumas.com

(10/23/18 ml)

Amendment One as attached. (06/11/19 ml)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR ONE	70,000.0000	EA	1.0000	70,000.00
2	SOW 1 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR ONE	60,000.0000	EA	1.0000	60,000.00
3	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR ONE	60,000.0000	EA	1.0000	60,000.00
4	SOW 1 - CAPITATION RATE UPDATES	90,000.0000	EA	1.0000	90,000.00

DHHS DIVISION DIRECTOR

6/13/19 BUYER

MATERIEL ADMINISTRATOR 6/14/19

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
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25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD - YEAR ONE				
5	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR ONE	45,000.0000	EA	1.0000	45,000.00
6	SOW 2 - CAPITATION RATE REBASING INITIAL CONTRACT PERIOD - YEAR ONE	150,000.0000	EA	1.0000	150,000.00
8	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	30,000.0000	30,000.00
9	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	50,000.0000	50,000.00
12	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	10,000.0000	10,000.00
13	CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR ONE	2.0000	EA	20,000.0000	40,000.00
16	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
17	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
18	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
19	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
20	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
21	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
22	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR TWO	70,000.0000	EA	1.0000	70,000.00

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25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
23	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR TWO	60,000.0000	EA	1.0000	60,000.00
24	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR TWO	60,000.0000	EA	1.0000	60,000.00
25	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR TWO	90,000.0000	EA	1.0000	90,000.00
26	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR TWO	45,000.0000	EA	1.0000	45,000.00
27	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	35,000.0000	35,000.00
28	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	30,000.0000	30,000.00
29	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	50,000.0000	50,000.00
30	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	12,500.0000	12,500.00
31	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00
32	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00
33	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR TWO	2.0000	EA	20,000.0000	40,000.00
34	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00

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VENDOR NUMBER: 2051503

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
35	SOW 7 - DENTAL REBASING INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	30,000.0000	30,000.00
36	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
37	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
38	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
39	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
40	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
41	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
42	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR THREE	70,700.0000	EA	1.0000	70,700.00
43	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR THREE	60,600.0000	EA	1.0000	60,600.00
44	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR THREE	60,600.0000	EA	1.0000	60,600.00
45	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR THREE	90,900.0000	EA	1.0000	90,900.00
46	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR THREE	45,450.0000	EA	1.0000	45,450.00
47	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	35,350.0000	35,350.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
48	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	30,300.0000	30,300.00
49	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	50,500.0000	50,500.00
50	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	12,625.0000	12,625.00
51	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00
52	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00
53	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR THREE	2.0000	EA	20,200.0000	40,400.00
54	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00
55	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
56	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
57	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
58	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
59	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
60	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
61	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION	70,700.0000	EA	1.0000	70,700.00

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VENDOR NUMBER: 2051503

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD - YEAR FOUR				
62	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FOUR	60,600.0000	EA	1.0000	60,600.00
63	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FOUR	60,600.0000	EA	1.0000	60,600.00
64	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR FOUR	90,900.0000	EA	1.0000	90,900.00
65	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FOUR	45,450.0000	EA	1.0000	45,450.00
66	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	35,350.0000	35,350.00
67	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	30,300.0000	30,300.00
68	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	50,500.0000	50,500.00
69	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	12,625.0000	12,625.00
70	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
71	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
72	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FOUR	2.0000	EA	20,200.0000	40,400.00
73	DENTAL CAPITALIZATION RATE FINALIZATION	1.0000	EA	10,100.0000	10,100.00

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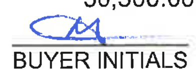
Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD - YEAR FOUR				
74	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
75	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
76	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
77	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
78	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
79	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
80	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR FIVE	70,700.0000	EA	1.0000	70,700.00
81	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FIVE	60,600.0000	EA	1.0000	60,600.00
82	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FIVE	60,600.0000	EA	1.0000	60,600.00
83	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR FIVE	90,900.0000	EA	1.0000	90,900.00
84	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FIVE	45,450.0000	EA	1.0000	45,450.00
85	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	35,350.0000	35,350.00
86	SOW 4 - PACE	1.0000	EA	30,300.0000	30,300.00



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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD - YEAR FIVE				
87	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	50,500.0000	50,500.00
88	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	12,625.0000	12,625.00
89	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
90	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
91	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FIVE	2.0000	EA	20,200.0000	40,400.00
92	DENTAL CAPITALIZATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
93	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
94	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
95	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
96	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
97	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
98	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
99	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	71,407.0000	EA	1.0000	71,407.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
100	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	60,600.0000	EA	1.0000	60,600.00
101	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	61,206.0000	EA	1.0000	61,206.00
102	SOW 1 - CAPITATION RATE UPDATES FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	122,412.0000	EA	1.0000	122,412.00
103	SOW 1 - CAPITATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	45,905.0000	EA	1.0000	45,905.00
104	CAPITATION RATE REBASING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	153,015.0000	153,015.00
105	SOW 3 - 1915(B) WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	35,704.0000	35,704.00
106	SOW 4 - PACE FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,603.0000	30,603.00
107	SOW 5 - 1115 WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	51,005.0000	51,005.00
108	SOW 6 - DENTAL RATE SETTING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	12,751.0000	12,751.00
109	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
110	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
111	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,402.0000	40,804.00

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NANCY STORANT (AS)

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
112	DENTAL CAPITALIZATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
113	DENTAL REBASING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,603.0000	30,603.00
114	LEAD STRATEGIST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
115	PRINCIPAL/PROJECT MANAGER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
116	LEAD ACTUARY FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
117	ACTUARIAL CONSULTANT FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
118	ACTUARIAL ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
119	INFORMATICS ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
120	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	71,407.0000	EA	1.0000	71,407.00
121	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	60,600.0000	EA	1.0000	60,600.00
122	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	61,206.0000	EA	1.0000	61,206.00
123	SOW 1 - CAPITATION RATE UPDATES FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	122,412.0000	EA	1.0000	122,412.00
124	SOW 1 - CAPITATION RATE FINALIZATION	45,905.0000	EA	1.0000	45,905.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO				
125	SOW 3 - 1915(B) WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	35,704.0000	35,704.00
126	SOW 4 - PACE FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	30,603.0000	30,603.00
127	SOW 5 - 1115 WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	51,005.0000	51,005.00
128	SOW 6 - DENTAL RATE SETTING FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	12,751.0000	12,751.00
129	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00
130	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00
131	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	20,402.0000	40,804.00
132	DENTAL CAPITALIZATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00
133	LEAD STRATEGIST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
134	PRINCIPAL/PROJECT MANAGER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
135	LEAD ACTUARY FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
136	ACTUARIAL CONSULTANT FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
137	ACTUARIAL ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
138	INFORMATICS ANALYST	5.0000	HR	205.0000	1,025.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO				
139	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	72,121.0000	EA	1.0000	72,121.00
140	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	60,600.0000	EA	1.0000	60,600.00
141	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	61,818.0000	EA	1.0000	61,818.00
142	SOW 1 - CAPITATION RATE UPDATES SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	123,636.0000	EA	1.0000	123,636.00
143	SOW 1 - CAPITATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	46,364.0000	EA	1.0000	46,364.00
144	CAPITATION RATE REBASING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	154,545.0000	154,545.00
145	SOW 3 - 1915(B) WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	36,061.0000	36,061.00
146	SOW 4 - PACE SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,909.0000	30,909.00
147	SOW 5 - 1115 WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	51,515.0000	51,515.00
148	SOW 6 - DENTAL RATE SETTING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	12,879.0000	12,879.00
149	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00
150	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR	1.0000	EA	10,303.0000	10,303.00

BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

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Fax: (402) 471-2089

PAGE	ORDER DATE
13 of 18	06/11/19
BUSINESS UNIT	BUYER
25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE				
151	CAPITATION RATE UPDATES SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,606.0000	41,212.00
152	DENTAL CAPITALIZATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00
153	DENTAL REBASING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,909.0000	30,909.00
154	LEAD STRATEGIST SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
155	PRINCIPAL/PROJECT MANAGER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
156	LEAD ACTUARY SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
157	ACTUARIAL CONSULTANT SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
158	ACTUARIAL ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
159	INFORMATICS ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
160	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	72,121.0000	EA	1.0000	72,121.00
161	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	60,600.0000	EA	1.0000	60,600.00
162	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	61,818.0000	EA	1.0000	61,818.00
163	SOW 1 - CAPITATION RATE UPDATES	123,636.0000	EA	1.0000	123,636.00

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PAGE	ORDER DATE
14 of 18	06/11/19
BUSINESS UNIT	BUYER
25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO				
164	SOW 1 - CAPITATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	46,364.0000	EA	1.0000	46,364.00
165	SOW 3 - 1915(B) WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	36,061.0000	36,061.00
166	SOW 4 - PACE SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	30,909.0000	30,909.00
167	SOW 5 - 1115 WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	51,515.0000	51,515.00
168	SOW 6 - DENTAL RATE SETTING SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	12,879.0000	12,879.00
169	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
170	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
171	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	20,606.0000	41,212.00
172	DENTAL CAPITALIZATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
173	LEAD STRATEGIST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
174	PRINCIPAL/PROJECT MANAGER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
175	LEAD ACTUARY SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
176	ACTUARIAL CONSULTANT SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00

BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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ORDER DATE
06/11/19

BUSINESS UNIT
25769029

BUYER
NANCY STORANT (AS)

CONTRACT NUMBER
84038 O4

VENDOR NUMBER: 2051503

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
177	ACTUARIAL ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
178	INFORMATICS ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
179	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	72,842.0000	EA	1.0000	72,842.00
180	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	60,600.0000	EA	1.0000	60,600.00
181	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	62,436.0000	EA	1.0000	62,436.00
182	SOW 1 - CAPITATION RATE UPDATES THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	124,872.0000	EA	1.0000	124,872.00
183	SOW 1 - CAPITATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	46,827.0000	EA	1.0000	46,827.00
184	CAPITATION RATE REBASING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	156,091.0000	156,091.00
185	SOW 3 - 1915(B) WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	36,421.0000	36,421.00
186	SOW 4 - PACE THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	31,218.0000	31,218.00
187	SOW 5 - 1115 WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	52,030.0000	52,030.00
188	SOW 6 - DENTAL RATE SETTING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	13,008.0000	13,008.00
189	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION	1.0000	EA	10,406.0000	10,406.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE				
190	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	40,406.0000	40,406.00
191	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,812.0000	41,624.00
192	DENTAL CAPITALIZATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,406.0000	10,406.00
193	DENTAL REBASING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	31,218.0000	31,218.00
194	LEAD STRATEGIST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
195	PRINCIPAL/PROJECT MANAGER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
196	LEAD ACTUARY THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
197	ACTUARIAL CONSULTANT THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
198	ACTUARIAL ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
199	INFORMATICS ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
200	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	72,842.0000	EA	1.0000	72,842.00
201	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	60,600.0000	EA	1.0000	60,600.00
202	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR	62,436.0000	EA	1.0000	62,436.00

BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
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PAGE	ORDER DATE
	06/11/19
BUSINESS UNIT	BUYER
25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO				
203	SOW 1 - CAPITATION RATE UPDATES THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	124,872.0000	EA	1.0000	124,872.00
204	SOW 1 - CAPITATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	46,827.0000	EA	1.0000	46,827.00
205	SOW 3 - 1915(B) WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	36,421.0000	36,421.00
206	SOW 4 - PACE THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	31,218.0000	31,218.00
207	SOW 5 - 1115 WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	52,030.0000	52,030.00
208	SOW 6 - DENTAL RATE SETTING THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	13,008.0000	13,008.00
209	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
210	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
211	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	20,812.0000	41,624.00
212	DENTAL CAPITALIZATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
213	LEAD STRATEGIST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
214	PRINCIPAL/PROJECT MANAGER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
215	LEAD ACTUARY	5.0000	HR	205.0000	1,025.00

BUYER INITIALS

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25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO				
216	ACTUARIAL CONSULTANT THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
217	ACTUARIAL ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
218	INFORMATICS ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
	Total Order				**6,802,946.00**

BUYER INITIALS

R43500|NISH0003|NISH0003 20150901

AMENDMENT One
84038 O4
Medicaid Managed Care Actuarial and Consulting Services for the State of Nebraska
Between
The State of Nebraska and Schramm Health Partners LLC DBA Optumas

This Amendment (the "Amendment") is made by the State of Nebraska and Schramm Health Partners LLC DBA Optumas, parties to Contract 84038 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract upon Execution by both parties as follows:

Deleted Lines 1 through 6 and replace with the following:

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination Initial Contract Period – Year One	70,000	$	$1.00	$70,000.00
2	SOW 1 – Rate Data Analysis and Manipulation Initial Contract Period – Year One	60,000	$	$1.00	$60,000.00
3	SOW 1 – Interim Reporting and Other Deliverables for Rate Setting Functions Initial Contract Period – Year One	60,000	$	$1.00	$60,000.00
4	SOW 1 – Capitation Rate Updates Initial Contract Period – Year One	90,000	$	$1.00	$90,000.00
5	SOW – 1 Capitation Rate Finalization Initial Contract Period – Year One	45,000	$	$1.00	$45,000.00
6	SOW 2 – Capitation Rate Rebasing Initial Contract Period – Year One	150,000	$	$1.00	$150,000

Delete Lines 22 through 26 and replace with the following:

22	SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination Initial Contract Period – Year Two	70,000	$	$1.00	$70,000.00
23	SOW 1 – Rate Data Analysis and Manipulation Initial Contract Period – Year Two	60,000	$	$1.00	$60,000.00
24	SOW 1 – Interim Reporting and Other Deliverables for Rate Setting Functions Initial Contract Period – Year One	60,000	$	$1.00	$60,000.00
25	SOW 1 – Capitation Rate Updates Initial Contract Period – Year One	90,000	$	$1.00	$90,000.00

26	SOW – 1 Capitation Rate Finalization Initial Contract Period – Year One	45,000	$	$1.00	$45,000.00

Delete lines 42 through 46 and replace with the following:

42	SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination Initial Contract Period – Year Three	70,700	$	$1.00	$70,700.00
43	SOW 1 – Rate Data Analysis and Manipulation Initial Contract Period – Year Three	60,600	$	$1.00	$60,600.00
44	SOW 1 – Interim Reporting and Other Deliverables for Rate Setting Functions Initial Contract Period – Year Three	60,600	$	$1.00	$60,600.00
45	SOW 1 – Capitation Rate Updates Initial Contract Period – Year Three	90,900	$	$1.00	$90,900.00
46	SOW – 1 Capitation Rate Finalization Initial Contract Period – Year Three	45,450	$	$1.00	$45,450.00

Delete Lines 61 through 65 and replace with the following:

61	SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination Initial Contract Period – Year Four	70,700	$	$1.00	$70,700.00
62	SOW 1 – Rate Data Analysis and Manipulation Initial Contract Period – Year Four	60,600	$	$1.00	$60,600.00
63	SOW 1 – Interim Reporting and Other Deliverables for Rate Setting Functions Initial Contract Period – Year Four	60,600	$	$1.00	$60,600.00
64	SOW 1 – Capitation Rate Updates Initial Contract Period – Year Four	90,900	$	$1.00	$90,900.00
65	SOW – 1 Capitation Rate Finalization Initial Contract Period – Year Four	45,450	$	$1.00	$45,450.00

Delete lines 80 through 84 and replace with the following:

80	SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination Initial Contract Period – Year Five	70,700	$	$1.00	$70,700.00
81	SOW 1 – Rate Data Analysis and Manipulation Initial Contract Period – Year Five	60,600	$	$1.00	$60,600.00

82	SOW 1 – Interim Reporting and Other Deliverables for Rate Setting Functions Initial Contract Period – Year Five	60,600	$	$1.00	$60,600.00
83	SOW 1 – Capitation Rate Updates Initial Contract Period – Year Five	90,900	$	$1.00	$90,900.00
84	SOW – 1 Capitation Rate Finalization Initial Contract Period – Year Five	45,450	$	$1.00	$45,450.00

Delete lines 99 through 103 and replace with the following:

99	SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination First Optional Renewal Period – Year One	71,407	$	$1.00	$71,407.00
100	SOW 1 – Rate Data Analysis and Manipulation First Optional Renewal Period – Year One	60,600	$	$1.00	$60,600.00
101	SOW 1 – Interim Reporting and Other Deliverables for Rate Setting Functions First Optional Renewal Period – Year One	61,206	$	$1.00	$61,206.00
102	SOW 1 – Capitation Rate Updates First Optional Renewal Period – Year One	122,412	$	$1.00	$122,412.00
103	SOW – 1 Capitation Rate Finalization First Optional Renewal Period – Year One	45,905	$	$1.00	$45,905.00

Delete Lines 120 through 124 and replace with the following:

120	SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination First Optional Renewal Period – Year Two	71,407	$	$1.00	$71,407.00
121	SOW 1 – Rate Data Analysis and Manipulation First Optional Renewal Period – Year Two	60,600	$	$1.00	$60,600.00
122	SOW 1 – Interim Reporting and Other Deliverables for Rate Setting Functions First Optional Renewal Period – Year Two	61,206	$	$1.00	$61,206.00
123	SOW 1 – Capitation Rate Updates First Optional Renewal Period – Year Two	122,412	$	$1.00	$122,412.00
124	SOW – 1 Capitation Rate Finalization First Optional Renewal Period – Year Two	45,905	$	$1.00	$45,905.00

Delete Lines 139 through 143 and replace with the following:

139	SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination Second Optional Renewal Period – Year One	72, 121	$	$1.00	$72,121.00

140	SOW 1 – Rate Data Analysis and Manipulation Second Optional Renewal Period – Year One	60,600	$	$1.00	$60,600.00
141	SOW 1 – Interim Reporting and Other Deliverables for Rate Setting Functions Second Optional Renewal Period – Year One	61,818	$	$1.00	$61,818.00
142	SOW 1 – Capitation Rate Updates Second Optional Renewal Period – Year One	123,636	$	$1.00	$123,636.00
143	SOW – 1 Capitation Rate Finalization Second Optional Renewal Period – Year One	46,364	$	$1.00	$46,364.00

Delete Lines 160 through 164

160	SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination Second Optional Renewal Period – Year Two	72, 121	$	$1.00	$72,121.00
161	SOW 1 – Rate Data Analysis and Manipulation Second Optional Renewal Period – Year Two	60,600	$	$1.00	$60,600.00
162	SOW 1 – Interim Reporting and Other Deliverables for Rate Setting Functions Second Optional Renewal Period – Year Two	61,818	$	$1.00	$61,818.00
163	SOW 1 – Capitation Rate Updates Second Optional Renewal Period – Year Two	123,636	$	$1.00	$123,636.00
164	SOW – 1 Capitation Rate Finalization Second Optional Renewal Period – Year Two	46,364	$	$1.00	$46,364.00

Delete Lines 179 through 183 and replace with:

179	SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination Third Optional Renewal Period – Year One	72, 842	$	$1.00	$72,842.00
180	SOW 1 – Rate Data Analysis and Manipulation Third Optional Renewal Period – Year One	60,600	$	$1.00	$60,600.00
181	SOW 1 – Interim Reporting and Other Deliverables for Rate Setting Functions Third Optional Renewal Period – Year One	62,436	$	$1.00	$62,436.00
182	SOW 1 – Capitation Rate Updates Third Optional Renewal Period – Year One	124,872	$	$1.00	$124,872.00
183	SOW – 1 Capitation Rate Finalization Third Optional Renewal Period – Year One	46,827	$	$1.00	$46,827.00

Delete Lines 200 through 204 and replace with the following:

200	SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination Third Optional Renewal Period – Year Two	72, 842	$	$1.00	$72,842.00
201	SOW 1 – Rate Data Analysis and Manipulation Third Optional Renewal Period – Year Two	60,600	$	$1.00	$60,600.00
202	SOW 1 – Interim Reporting and Other Deliverables for Rate Setting Functions Third Optional Renewal Period – Year Two	62,436	$	$1.00	$62,436.00
203	SOW 1 – Capitation Rate Updates Third Optional Renewal Period – Year Two	124,872	$	$1.00	$124,872.00
204	SOW – 1 Capitation Rate Finalization Third Optional Renewal Period – Year Two	46,827	$	$1.00	$46,827.00

This amendment and any attachments hereto will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

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

State of Nebraska

By: ______________________

Name: Douglas D Carlson

Title: Materiel Administrator

Date: 6/14/19

Contractor: Schramm Health Partners LLC DBA Optumas

By: ______________________

Name: STEVEN P. SCHRAMM

Title: MANAGING DIRECTOR

Date: WEDNESDAY JUNE 5, 2019

Department of Health and Human Services

By: ______________________

Name: Matthew A. Van Patton, DHA

Title: Director of Medicaid

Date: 12 Jun 2019

STATE OF NEBRASKA SERVICE CONTRACT AWARD

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
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PAGE	ORDER DATE
1 of 17	10/23/18
BUSINESS UNIT	BUYER
25769029	NANCY STORANT (AS)

CONTRACT NUMBER
84038 O4

VENDOR NUMBER: 2051503

VENDOR ADDRESS:

SCHRAMM HEALTH PARTNERS LLC
DBA OPTUMAS
7400 E MCDONALD DR STE 101
SCOTTSDALE AZ 85250-0699

AN AWARD HAS BEEN MADE TO THE VENDOR/CONTRACTOR NAMED ABOVE FOR THE SERVICES AS LISTED BELOW FOR THE PERIOD:

JANUARY 01, 2019 THROUGH DECEMBER 31, 2023

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

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

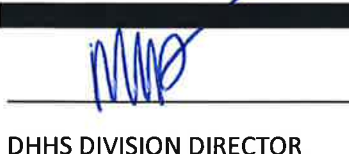
Original/Bid Document 5868 Z1

Contract to supply Medicaid Managed Care Actuarial and Consulting Services to the State of Nebraska for the contract period January 1, 2019 to December 31, 2023. The contract may be renewed for Three (3) additional Two (2) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Steve Schramm
Phone: 480-588-2493
E-Mail: steve.schramm@optumas.com

(10/23/18 ml)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	70,000.0000	70,000.00
2	SOW 1 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	60,000.0000	60,000.00
3	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	60,000.0000	60,000.00
4	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR ONE	2.0000	EA	45,000.0000	90,000.00
5	SOW 1 - CAPITATION RATE FINALIZATION	1.0000	EA	45,000.0000	45,000.00



DHHS DIVISION DIRECTOR

BUYER

MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AWARD

State Purchasing Bureau
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BUSINESS UNIT 25769029	BUYER NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD - YEAR ONE				
6	SOW 2 - CAPITATION RATE REBASING INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	150,000.0000	150,000.00
7	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	35,000.0000	35,000.00
8	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	30,000.0000	30,000.00
9	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	50,000.0000	50,000.00
10	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	12,500.0000	12,500.00
11	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	10,000.0000	10,000.00
12	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	10,000.0000	10,000.00
13	CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR ONE	2.0000	EA	20,000.0000	40,000.00
14	DENTAL CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	10,000.0000	10,000.00
15	SOW 7 - DENTAL REBASING INITIAL CONTRACT PERIOD - YEAR ONE	1.0000	EA	30,000.0000	30,000.00
16	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
17	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
18	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
19	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00

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25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
20	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
21	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
22	SOW 1 - ANNUAL CAPITATION RATE SETTING CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	70,000.0000	70,000.00
23	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	60,000.0000	60,000.00
24	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	60,000.0000	60,000.00
25	SOW 1 - CAPITATION RATE UPDATES INITIAL CONTRACT PERIOD - YEAR TWO	2.0000	EA	45,000.0000	90,000.00
26	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	45,000.0000	45,000.00
27	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	35,000.0000	35,000.00
28	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	30,000.0000	30,000.00
29	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	50,000.0000	50,000.00
30	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	12,500.0000	12,500.00
31	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00
32	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
33	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR TWO	2.0000	EA	20,000.0000	40,000.00
34	DENTAL CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	10,000.0000	10,000.00
35	SOW 7 - DENTAL REBASING INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	30,000.0000	30,000.00
36	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
37	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
38	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
39	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
40	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
41	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
42	SOW 1 - ANNUAL CAPITATION RATE SETTING INITIAL CONTRACT PERIOD - YEAR TWO	1.0000	EA	70,700.0000	70,700.00
43	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	60,600.0000	60,600.00
44	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	60,600.0000	60,600.00
45	SOW 1 - CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR THREE	2.0000	EA	45,450.0000	90,900.00

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VENDOR NUMBER: 2051503

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
46	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	45,450.0000	45,450.00
47	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	35,350.0000	35,350.00
48	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	30,300.0000	30,300.00
49	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	50,500.0000	50,500.00
50	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	12,625.0000	12,625.00
51	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00
52	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00
53	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR THREE	2.0000	EA	20,200.0000	40,400.00
54	DENTAL CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	10,100.0000	10,100.00
55	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
56	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
57	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
58	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
59	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR THREE	5.0000	HR	205.0000	1,025.00
60	INFORMATICS ANALYST	5.0000	HR	205.0000	1,025.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD - YEAR THREE				
61	SOW 1 - ANNUAL CAPITATION RATE SETTING INITIAL CONTRACT PERIOD - YEAR THREE	1.0000	EA	70,700.0000	70,700.00
62	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	60,600.0000	60,600.00
63	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	60,600.0000	60,600.00
64	SOW 1 - CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FOUR	2.0000	EA	45,450.0000	90,900.00
65	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	45,450.0000	45,450.00
66	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	35,350.0000	35,350.00
67	SOW 4 - PACE INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	30,300.0000	30,300.00
68	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	50,500.0000	50,500.00
69	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	12,625.0000	12,625.00
70	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
71	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
72	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FOUR	2.0000	EA	20,200.0000	40,400.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
73	DENTAL CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	10,100.0000	10,100.00
74	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
75	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
76	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
77	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
78	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
79	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR FOUR	5.0000	HR	205.0000	1,025.00
80	SOW 1 - ANNUAL CAPITATION RATE SETTING INITIAL CONTRACT PERIOD - YEAR FOUR	1.0000	EA	70,700.0000	70,700.00
81	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	60,600.0000	60,600.00
82	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	60,600.0000	60,600.00
83	SOW 1 - CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FIVE	2.0000	EA	45,450.0000	90,900.00
84	SOW 1 - CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	45,450.0000	45,450.00
85	SOW 3 - 1915(B) WAIVER INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	35,350.0000	35,350.00
86	SOW 4 - PACE	1.0000	EA	30,300.0000	30,300.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD - YEAR FIVE				
87	SOW 5 - 1115 WAIVER INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	50,500.0000	50,500.00
88	SOW 6 - DENTAL RATE SETTING INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	12,625.0000	12,625.00
89	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
90	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
91	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS INITIAL CONTRACT PERIOD - YEAR FIVE	2.0000	EA	20,200.0000	40,400.00
92	DENTAL CAPITATION RATE FINALIZATION INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	10,100.0000	10,100.00
93	LEAD STRATEGIST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
94	PRINCIPAL/PROJECT MANAGER INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
95	LEAD ACTUARY INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
96	ACTUARIAL CONSULTANT INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
97	ACTUARIAL ANALYST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
98	INFORMATICS ANALYST INITIAL CONTRACT PERIOD - YEAR FIVE	5.0000	HR	205.0000	1,025.00
99	SOW 1 - ANNUAL CAPITATION RATE SETTING INITIAL CONTRACT PERIOD - YEAR FIVE	1.0000	EA	71,407.0000	71,407.00
100	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION	1.0000	EA	60,600.0000	60,600.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE				
101	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	61,206.0000	61,206.00
102	SOW 1 - CAPITATION RATE UPDATES RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	61,206.0000	122,412.00
103	SOW 1 - CAPITATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	45,905.0000	45,905.00
104	CAPITATION RATE REBASING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	153,015.0000	153,015.00
105	SOW 3 - 1915(B) WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	35,704.0000	35,704.00
106	SOW 4 - PACE FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,603.0000	30,603.00
107	SOW 5 - 1115 WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	51,005.0000	51,005.00
108	SOW 6 - DENTAL RATE SETTING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	12,751.0000	12,751.00
109	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
110	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
111	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,402.0000	40,804.00
112	DENTAL CAPITATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,201.0000	10,201.00
113	DENTAL REBASING	1.0000	EA	30,603.0000	30,603.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE				
114	LEAD STRATEGIST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
115	PRINCIPAL/PROJECT MANAGER FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
116	LEAD ACTUARY FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
117	ACTUARIAL CONSULTANT FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
118	ACTUARIAL ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
119	INFORMATICS ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
120	SOW 1 - ANNUAL CAPITATION RATE SETTING FIRST OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	71,407.0000	71,407.00
121	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	60,600.0000	60,600.00
122	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	61,206.0000	61,206.00
123	SOW 1 - CAPITATION RATE UPDATES RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	61,206.0000	122,412.00
124	SOW 1 - CAPITATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	45,905.0000	45,905.00
125	SOW 3 - 1915(B) WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	35,704.0000	35,704.00
126	SOW 4 - PACE FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	30,603.0000	30,603.00

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
127	SOW 5 - 1115 WAIVER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	51,005.0000	51,005.00
128	SOW 6 - DENTAL RATE SETTING FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	12,751.0000	12,751.00
129	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00
130	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00
131	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	20,402.0000	40,804.00
132	DENTAL CAPITATION RATE FINALIZATION FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,201.0000	10,201.00
133	LEAD STRATEGIST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
134	PRINCIPAL/PROJECT MANAGER FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
135	LEAD ACTUARY FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
136	ACTUARIAL CONSULTANT FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
137	ACTUARIAL ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
138	INFORMATICS ANALYST FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
139	SOW 1 - ANNUAL CAPITATION RATE SETTING FIRST OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	72,121.0000	72,121.00
140	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	60,600.0000	60,600.00

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BUSINESS UNIT	BUYER
25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
141	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	61,818.0000	61,818.00
142	SOW 1 - CAPITATION RATE UPDATES RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	61,818.0000	123,636.00
143	SOW 1 - CAPITATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	46,364.0000	46,364.00
144	CAPITATION RATE REBASING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	154,545.0000	154,545.00
145	SOW 3 - 1915(B) WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	36,061.0000	36,061.00
146	SOW 4 - PACE SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,909.0000	30,909.00
147	SOW 5 - 1115 WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	51,515.0000	51,515.00
148	SOW 6 - DENTAL RATE SETTING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	12,879.0000	12,879.00
149	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00
150	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00
151	CAPITATION RATE UPDATES SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,606.0000	41,212.00
152	DENTAL CAPITATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,303.0000	10,303.00
153	DENTAL REBASING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	30,909.0000	30,909.00
154	LEAD STRATEGIST	5.0000	HR	205.0000	1,025.00

BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AWARD

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

ORDER DATE	BUSINESS UNIT	BUYER
10/23/18	25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE				
155	PRINCIPAL/PROJECT MANAGER SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
156	LEAD ACTUARY SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
157	ACTUARIAL CONSULTANT SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
158	ACTUARIAL ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
159	INFORMATICS ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
160	SOW 1 - ANNUAL CAPITATION RATE SETTING SECOND OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	72,121.0000	72,121.00
161	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	60,600.0000	60,600.00
162	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	61,818.0000	61,818.00
163	SOW 1 - CAPITATION RATE UPDATES RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	61,818.0000	123,636.00
164	SOW 1 - CAPITATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	46,364.0000	46,364.00
165	SOW 3 - 1915(B) WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	36,061.0000	36,061.00
166	SOW 4 - PACE SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	30,909.0000	30,909.00
167	SOW 5 - 1115 WAIVER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	51,515.0000	51,515.00
168	SOW 6 - DENTAL RATE SETTING	1.0000	EA	12,879.0000	12,879.00

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PAGE	ORDER DATE
14 of 17	10/23/18
BUSINESS UNIT	BUYER
25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO				
169	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
170	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
171	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	20,606.0000	41,212.00
172	DENTAL CAPITATION RATE FINALIZATION SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,303.0000	10,303.00
173	LEAD STRATEGIST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
174	PRINCIPAL/PROJECT MANAGER SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
175	LEAD ACTUARY SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
176	ACTUARIAL CONSULTANT SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
177	ACTUARIAL ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
178	INFORMATICS ANALYST SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
179	SOW 1 - ANNUAL CAPITATION RATE SETTING SECOND OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	72,842.0000	72,842.00
180	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	60,600.0000	60,600.00
181	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	62,436.0000	62,436.00

BUYER INITIALS

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PAGE	ORDER DATE
	10/23/18
BUSINESS UNIT	BUYER
25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
182	SOW 1 - CAPITATION RATE UPDATES RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	62,436.0000	124,872.00
183	SOW 1 - CAPITATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	46,827.0000	46,827.00
184	CAPITATION RATE REBASING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	156,091.0000	156,091.00
185	SOW 3 - 1915(B) WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	36,421.0000	36,421.00
186	SOW 4 - PACE THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	31,218.0000	31,218.00
187	SOW 5 - 1115 WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	52,030.0000	52,030.00
188	SOW 6 - DENTAL RATE SETTING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	13,008.0000	13,008.00
189	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,406.0000	10,406.00
190	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	40,406.0000	40,406.00
191	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	2.0000	EA	20,812.0000	41,624.00
192	DENTAL CAPITATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	10,406.0000	10,406.00
193	DENTAL REBASING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	31,218.0000	31,218.00
194	LEAD STRATEGIST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
195	PRINCIPAL/PROJECT MANAGER	5.0000	HR	205.0000	1,025.00

BUYER INITIALS

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25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE				
196	LEAD ACTUARY THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
197	ACTUARIAL CONSULTANT THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
198	ACTUARIAL ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
199	INFORMATICS ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	5.0000	HR	205.0000	1,025.00
200	SOW 1 - ANNUAL CAPITATION RATE SETTING THIRD OPTIONAL RENEWAL PERIOD - YEAR ONE	1.0000	EA	72,842.0000	72,842.00
201	SOW 1 -RATE DATA ANALYSIS AND MANIPULATION CAPITATION RATE METHODOLOGY DEVELOPMENT DETERMINATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	60,600.0000	60,600.00
202	SOW 1 - INTERIM REPORTING AND OTHER DELIVERABLES FOR THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	62,436.0000	62,436.00
203	SOW 1 - CAPITATION RATE UPDATES RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	62,436.0000	124,872.00
204	SOW 1 - CAPITATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	46,827.0000	46,827.00
205	SOW 3 - 1915(B) WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	36,421.0000	36,421.00
206	SOW 4 - PACE THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	31,218.0000	31,218.00
207	SOW 5 - 1115 WAIVER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	52,030.0000	52,030.00
208	SOW 6 - DENTAL RATE SETTING THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	13,008.0000	13,008.00

BUYER INITIALS

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25769029	NANCY STORANT (AS)

VENDOR NUMBER: 2051503

CONTRACT NUMBER
84038 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
209	SOW 6 - RATE DATA ANALYSIS AND MANIPULATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
210	SOW 6 - INTERIM REPORTING AND OTHER DELIVERABLES FOR THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
211	CAPITATION RATE UPDATES RATE SETTING FUNCTIONS THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	2.0000	EA	20,812.0000	41,624.00
212	DENTAL CAPITATION RATE FINALIZATION THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	1.0000	EA	10,406.0000	10,406.00
213	LEAD STRATEGIST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
214	PRINCIPAL/PROJECT MANAGER THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
215	LEAD ACTUARY THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
216	ACTUARIAL CONSULTANT THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
217	ACTUARIAL ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
218	INFORMATICS ANALYST THIRD OPTIONAL RENEWAL PERIOD - YEAR TWO	5.0000	HR	205.0000	1,025.00
	Total Order				**6,900,446.00**

BUYER INITIALS

For public information purposes only; not part of contract.

Request for Proposal Number 5868 Z1
Contract Number 84038 O4
Proposal Opening: July 13, 2018

In accordance with Nebraska Revised Statutes §84.712.05(3), the following material(s) has not been included due to it being marked proprietary.

Optumas

1. **None**

Response to the
Nebraska State Purchasing Bureau

Solicitation Number RFP 5868 Z1
Medicaid Managed Care Actuarial and Consulting Services

Technical Proposal

Original

Submitted by:
Optumas
7400 E. McDonald Drive Suite 101
Scottsdale, AZ 85250

Response to the
Nebraska State Purchasing Bureau

Solicitation Number RFP 5868 Z1
Medicaid Managed Care Actuarial and Consulting Services

Technical Proposal

Original

Submitted by:
Optumas
7400 E. McDonald Drive Suite 101
Scottsdale, AZ 85250

Transmittal Letter

Transmittal Letter

July 10, 2018

Ms. Nancy Storant and Ms. Teresa Fleming
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

Subject: Request for Proposal (RFP #5868 Z1) — Medicaid Managed Care Actuarial and Consulting Services for Nebraska Medicaid

Dear Ms. Storant and Ms. Fleming:

The team at Schramm Health Partners, L.L.C., doing business as **Optumas**, is excited to provide this response to the State of Nebraska, Department of Administrative Services (DAS) to provide actuarial and consulting services to the Nebraska Medicaid department. With our analytic capabilities, rate setting experience, and experience as your current actuarial consultant, advisor, and partner, we will provide the superior services the Department requires to successfully complete the projects outlined in this Request for Proposal (RFP), with consideration for the three addendums posted as part of the RFP: "Addendum 1 – Revised Schedule of Events", "Addendum 2 – Questions and Answers", and "Addendum 3 – Revised Schedule of Events". In this Transmittal Letter, we provide a brief introduction to our proposal and close by noting the contact person authorized to bind the firm.

Optumas has been the Department's actuary of record since 2013, and in that time, we have been able to successfully partner with the Department staff to exceed the goals and objectives for the various rate development cycles. Over the last five years; we have built trust by working side-by-side with the Department throughout all aspects of the actuarial rate development process. We understand our role as the Department's actuary and advisor; this collaborative process will continue and only become stronger as we transition seamlessly from the past contract to this new contract.

Over the years, the team at **Optumas** has established a proven approach to rate development in Nebraska that focuses on accuracy and reasonableness by working collaboratively with the Department. We take our work within the Nebraska Medicaid program very seriously because we realize the size of the capitation contracts (i.e., the amount of money being paid out to the MCOs) and the impact our work has on the Department, the contracted MCOs, and most importantly, the enrolled Medicaid members. In addition, we take our actuarial credentials seriously, so we take the time to understand Nebraska's programs, covered benefits, and contracting requirements. We will carry that same thoroughness and proven process to the future rate development work and consulting if we are chosen as the successful respondent to this RFP.

We have structured our response to highlight our commitment to maintaining our relationship with the Department; first and foremost by proposing to use the same team and rate development methodology for this contract term that is currently working for the Department. Having worked with the Department, **Optumas** understands the unique challenges that Nebraska Medicaid presents and is personally committed to ensuring that the rates for the Department's programs are explained and defended to interested stakeholders. We have an established track record of providing superior

actuarial/analytic results in Nebraska, and this response will demonstrate that we are the best actuarial consulting firm for your team. **Optumas** is excited for this opportunity to build on our existing successful relationship with the Department.

We recognize that a few components of this RFP are outside the services we have traditionally provided for the Department. We proposed to subcontract with Myers and Stauffer, LC to complete the audit, plan management, on-site monitoring, and managed care evaluations contained under the Policy and Financial Management Consulting Services. Myers and Stauffer, LC (**MSLC**) is an industry-leader in these services and has partnered with **Optumas** in the past to provide similar services to state Medicaid agencies. We are excited to add their expertise to our own in the interest of providing the Department with the best services possible.

Figure I.i below provides a brief overview of the main sections contained in this proposal and crosswalks each section to the RFP requirements.

Figure I.i – RFP Requirement Crosswalk

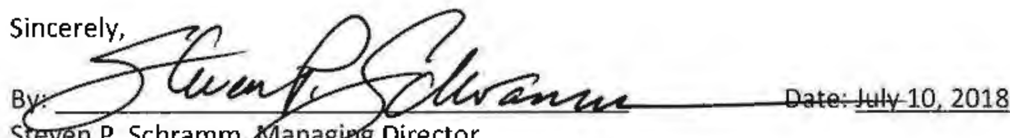
Proposal Section	RFP Reference	Overview
Section II. Terms and Conditions	II. Terms and Conditions, Page 7-14	**Optumas** acknowledges the terms and conditions contained within this RFP. Steve Schramm, the person authorized to bind the firm, has initialed subsections A-T, accepting all terms and conditions listed without changes.
Section III. Contractor Duties	III. Contractor Duties, Page 15-21	**Optumas** understands the duties outlined within this RFP. Steve Schramm has initialed subsections A-O, acknowledging all contractor duties listed.
Section IV. Payment	IV. Payment, Page 22-23	**Optumas** accepts the payment conditions contained within this RFP. Steve Schramm has initialed subsections A-H, agreeing to all payment circumstances listed.
Section V. Project Description and Scope of Work	V. Project Description and Scope of Work, Page 24-29	**Section V.A. Project Overview** – This RFP requirement is addressed beginning on page 19 of this response. **Optumas** highlights our team's knowledge and expertise with actuarially sound rate range development for enrollees in Medicaid Programs. **Section V.B. Project Environment** – This RFP requirement is addressed beginning on page 23 of this response. **Optumas** briefly summarizes our experience, positive outcomes, and knowledge gained over the last five years with the Department's core programs: MCO, PIHP, PACE, and MLTSS. **Section V.C. Scope of Work** – This RFP requirement is addressed beginning on page 27 of this response. **Optumas** describes how we exceed the qualifications necessary to carry out a project of this magnitude within this section. We have included a figure for each SOW (Section V.D. SOW 1 – Capitation Rate Setting through Section V.K. SOW 8 – Special Projects), summarizing our responses to the specifications

Proposal Section	RFP Reference	Overview
		contained in sections a-j under "C. Scope of Work (SOW)" on page 25 of the RFP.
Section VI. Proposal Instructions	VI. Proposal Instructions, Page 30-33	**Section VI.A.1. Request for Proposal Form** – This form required by the RFP can be found on page 57 of this response. **Optumas** provides a signed "RFP for Contractual Services" form, guaranteeing compliance with the provisions stated in this RFP, agreeing to the Terms and Conditions stated in this RFP, and certifying that we maintain a drug free work place environment. **Section VI.A.2. Corporate Overview** – This RFP requirement is addressed beginning on page 59 of this response. **Optumas** provides an in-depth overview of our corporate experience, financial stability, and proposed personnel approach. We have included a response to subsections a-k contained under "2. Corporate Overview" on pages 30-33 in the RFP. **Optumas** presents an experienced, qualified team with direct experience calculating actuarial rate ranges for Nebraska's Medicaid managed care programs. **Section VI.A.3. Technical Approach** – This RFP requirement is addressed beginning on page 85 of this response. **Optumas** describes in detail our technical approach to each SOW included in this RFP. We have provided a description of our understanding of the project requirements, proposed development approach, technical considerations, detailed project work plan, and deliverables/due dates for each SOW contained in this RFP.

We are available to answer any questions, conduct an interview, and provide any further information necessary to demonstrate that we are the best choice to assist the Department. We look forward to discussing our proposal with the Department in more detail.

I am authorized to bind the firm to all statements, including services and prices, contained in the proposal and any RFP addenda. My contact information is noted below.

Sincerely,



By: ______________________ Date: July 10, 2018

Steven P. Schramm, Managing Director
Schramm Health Partners, LLC dba **Optumas**
7400 East McDonald Drive, Suite #101
Scottsdale, AZ 85250
480.588.2493 (Direct) 602.625.6155 (Cell) 480.315.1795 (Fax)
Email: Steve.Schramm@Optumas.com
Website: www.Optumas.com

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:	**Optumas**
Bidder Address:	7400 E. McDonald Drive Suite 101 Scottsdale, AZ 85250
Contact Person & Title:	Steve Schramm, Managing Director
E-mail Address:	Steve.schramm@optumas.com
Telephone Number (Office):	480-588-2493
Telephone Number (Cellular):	602-625-6155
Fax Number:	480-315-1795

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:	**Optumas**
Bidder Address:	7400 E. McDonald Drive Suite 101 Scottsdale, AZ 85250
Contact Person & Title:	Steve Schramm, Managing Director
E-mail Address:	Steve.schramm@optumas.com
Telephone Number (Office):	480-588-2493
Telephone Number (Cellular):	602-625-6155
Fax Number:	480-315-1795

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Section II:
Terms and Conditions

Section II. Terms and Conditions

Within this section of our RFP response we accept the terms and conditions outlined under "II. Terms and Conditions" on pages 7-14 of the RFP.

A. General

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

B. Notification

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

C. Governing Law (Statutory)

Optumas will 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:
[initials]			

E. Change Orders

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

F. Notice of Potential Contractor Breach

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[signature]			

G. Breach

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[signature]			

H. Non-Waiver of Breach

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[signature]			

I. Severability

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[signature]			

J. Indemnification

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[signature]			

K. Attorney's Fees

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

L. Assignment, Sale, or Merger

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

M. Contracting with Other Nebraska Political Subdivisions

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

N. Force Majeure

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

O. Confidentiality

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

P. Office of Public Counsel (Statutory)

Optumas will comply with the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8240 et seq.

Q. Long-Term Care Ombudsman (Statutory)

Optumas will comply with the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

R. Business Associate Agreement (BAA)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

S. Early Termination

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

T. Contract Closeout

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

Section III:
Contractor Duties

Section III. Contractor Duties

Within this section of our RFP response we acknowledge the contractor duties listed under "III. Contractor Duties" on pages 15-21 of the RFP.

A. Independent Contractor/Obligations

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

B. Employee Work Eligibility Status

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

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

Optumas will comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. **Optumas** will also ensure all subcontractors comply.

D. Cooperation with Other Contractors

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

E. Permits, Regulations, and Laws

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

F. Ownership of Information and Data/Deliverables

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

G. Insurance Requirements

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

H. Antitrust

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

I. Conflict of Interest

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

J. State Property

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

K. Site Rules and Regulations

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

L. Advertising

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

M. Nebraska Technology Access Standards (Statutory)

Optumas has reviewed the Nebraska Technology Access Standards and can ensure the Department that all products and services provided under the contract will comply with the applicable standards.

N. Disaster Recovery/Back Up Plan

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

O. Drug Policy

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

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Section IV:
Payment

Section IV. Payment

Within this section of our RFP response we accept the payment conditions contained in "IV. Payment" on pages 22-23 of the RFP.

A. Prohibition Against Advance Payment (Statutory)

Optumas recognizes that payments shall not be made until contractual deliverable(s) are received and accepted by the State.

B. Taxes (Statutory)

Optumas recognizes that the State is not required to pay taxes and assumes no such liability as a result of the RFP solicitation.

C. Invoices

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

D. Inspection and Approval

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

E. Payment

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

F. Late Payment (Statutory)

Optumas understands that the Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act.

G. Subject to Funding/Funding Out Clause for Loss of Appropriations

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[signature]			

H. Right to Audit

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[signature]			

Section V:
Project Description/SOW

Section V. Project Description and Scope of Work

Within this section of our RFP response we address the qualifications contained in "V. Project Description and Scope of Work" on pages 24-29 of the RFP.

Optumas has identified each subsection of Section V separately using dividers in this response. This was done to assist with the evaluation process and to comply with the RFP instructions on page 30 that state "Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals". For consistency throughout the document, the SOW subsections have also been identified using dividers when they are addressed within Section VI.

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A. Project Overview

A. Project Overview

Within this section of our RFP response we provide narrative surrounding "V.A. Project Overview" on page 24 of the RFP.

Optumas has been the consulting actuarial firm to the Department since April 2013 and has more than 80 years of collective staff experience providing actuarial and consulting services to State Medicaid programs across the nation. Our expertise is in the calculation of actuarially sound, risk-adjusted capitation rates for Medicaid Managed Care programs (physical health, behavioral health, and long-term service and supports (LTSS)) as well as other supporting analyses and consulting services for Medicaid programs. **Optumas** prides itself as a company on ensuring that every rate development project we work on be a transparent, collaborative approach to rate setting, emphasizing the importance that all rate development and other analytic methodologies we develop are actuarially sound, acceptable to the Centers for Medicare and Medicaid Services (CMS) and readily replicated. Our analytic capabilities, rate setting experience across the nation, and in particular, our Nebraska specific work experience as the current actuarial consultant for Nebraska Medicaid capitation rate development enable us to provide the expert services the Department requires to successfully complete each Scope of Work (SOW) outlined in this RFP.

During our time working with the Department, our collaboration has led to many positive outcomes. A major example of this is the work we have done guiding the Department through the development, implementation, and ongoing operationalization of the Heritage Health managed care program. The Department's goal of re-procuring managed care contracts and integrating physical health and behavioral health services (as well as bringing new populations, services, and eligibility periods) under managed care has been successfully realized. **Optumas** played a major role in pre-procurement meetings, allowing potential vendors to understand the Heritage Health program design and risk-based payment arrangements. This led to a large pool of interested vendors and gave the Department numerous choices when selecting the managed care plans that would help implement their vision for Nebraska Medicaid. After program implementation, **Optumas** has continually monitored the program to evaluate components like the ideal risk adjustment methodology, encounter data submission quality, and plan reimbursement patterns. We have used the insights gained from this analytic approach to ensure risk adjustment parameters constantly align with Heritage Health enrollment and data patterns, encounter data is properly utilized, and drivers of plan profitability are understood. This detailed involvement makes us more knowledgeable about Nebraska Medicaid than any other possible vendor and makes **Optumas** the ideal choice to continue working with the Department on future Medicaid program design changes.

We take our work with all Medicaid programs seriously because we realize the substantial impact our work has on the Department, contracted MCOs, and most importantly, the enrolled Medicaid beneficiaries. Our actuarial credentials are an essential part of our operations, so we ensure we spend the time necessary to fully understand each of our client's Medicaid programs, covered benefits, and contracting requirements. By working with members of the **Optumas** team for the last five years, the Department knows that we follow a very structured approach when developing capitation rates and all supplemental projects and analyses. The **Optumas** team conducts detailed analyses throughout the rate development process with multiple reasonableness checks, benchmarking the impact of Nebraska policy and program changes to our experiences in similar Medicaid marketplaces, while maintaining frequent touchpoints with the Department and participating MCOs along the way to ensure payment matches

risk at the end of the rate setting process. We currently carry that same thoroughness and proven process to all our work regarding the SOWs we are currently completing for the Department and will continue to do so if retained as the consulting actuaries to the Department.

Optumas' actuarial team has worked all over the country on innovative Medicaid managed care initiatives during their careers. The actuarial team at **Optumas** has overseen the development of, certified to, or reviewed the actuarially sound risk adjusted capitation rates for members served by Medicaid programs in the states shown within Figure V.A.i during their career at **Optumas** (or in previous positions).

Figure V.A.i Actuarially Sound Medicaid Managed Care Rate Setting Experience

Actuarially Sound Medicaid Managed Care Rate Setting Experience			
Alabama	**Iowa**	Missouri	**North Dakota**
Arkansas	**Kansas**	Montana	Ohio
California	Kentucky	NGA**	**Oregon**
Colorado	Louisiana	**Nebraska**	Pennsylvania
Connecticut	**Maryland**	New Hampshire	Rhode Island
Delaware	Massachusetts	New Mexico	Tennessee
Hawaii	Maine	New York	Texas

States in **bold are current clients where **Optumas** is the certifying Actuary*
***On behalf of the National Governor's Association; State to remain confidential*

Figure V.A.ii below provides an overview of our nationwide experience as an actuarial consulting firm providing services consistent with each SOW outlined in Section V.D through Section V.K. of the Request for Proposal (RFP).

Figure V.A.ii Optumas' State Experience

	Optumas State Experience																
Scope of Work	AL	AR	CA	CO	CT	IA	KS	MA	MD	ME	ND	NE	NH	NY	OH	OR	VT
Capitation Rate Setting	X	X	X	X		X	X		X		X	**X**				X	
Capitation Rate Rebasing	X	X	X	X		X	X		X		X	**X**				X	
1915(b) Waiver	X	X			X		X	X				**X**	X	X		X	
PACE Rate Setting				X		X	X				X	**X**				X	
1115 Waiver Development and Submission	X	X	X		X		X	X		X		**X**		X	X	X	X
Dental Capitation Rate Setting		X	X	X		X	X		X		X	**X**			X	X	
Dental Capitation Rate Rebasing		X	X	X		X	X		X		X	**X**			X	X	
Special Projects	X	X	X	X	X	X	X	X	X	X	X	**X**	X	X	X	X	X

Optumas will continue to use the knowledge and skills attained through our experience in other markets for similar SOWs to provide the Department with actuarial, analytical, and consulting services that consistently exceed their expectations throughout the contract period.

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B. Project Environment

B. Project Environment

Within this section of our RFP response we summarize our experience with the Department's programs listed in "V.B. Project Environment" on page 24 of the RFP.

Throughout **Optumas'** experience providing actuarial and consulting services for Medicaid programs nationwide, our team has gained invaluable insight and knowledge surrounding various delivery systems used to provide managed care to Medicaid beneficiaries. Our current work as the consulting actuaries to the Department gives us a unique advantage because we are intimately familiar with the specific historical and new programs Nebraska Medicaid Managed Care has implemented. We possess the data (including knowledge of the claims data and Nebraska-specific coding nuances), the historical context, and working relationships with the Department's staff that allows us to instantly work on any project desired by the Department. In addition to the uniquely transparent and creative methodologies we bring to serve the Department, we also require no start-up time or learning curve, which is something that no other firm can claim. We possess a deep familiarity with all the delivery systems employed by the Department and have shown the number of states where we have worked on each system in Figure V.B.i below:

Figure V.B.i Delivery System Experience

Delivery System	Number of States
MCO	11
PIHP	11
PACE	5
MLTSS	4

A brief description of **Optumas'** experience with each of Nebraska's delivery systems is described below.

1. Managed Care Organization (MCO)

Optumas has significant experience setting fully-capitated Medicaid capitation rates for MCOs operating under risk-comprehensive contracts, where the MCOs are at risk for services outlined in the Basics Benefits package as set forth in the contract terms. In particular, **Optumas** has worked in numerous states setting capitation rates or reviewing capitation rates on behalf of MCOs. Most recently, we have provided MCO-specific or regional capitation rate development for managed care programs in Alabama, Colorado, Iowa, Kansas, Maryland, Nebraska, North Dakota, and Oregon. Figure V.B.ii below illustrates the Medicaid capitation amount certified annually as the state's actuary of record in the most recent year of rate development.

Figure V.B.ii Annual Medicaid Capitation Certified

Client	Annual Medicaid Capitation Certified
Alabama	$60 Million
Colorado	$1.3 Billion
Iowa	$4.2 Billion
Kansas	$3.2 Billion

Client	Annual Medicaid Capitation Certified
Maryland	$5.8 Billion
Nebraska	$1.3 Billion
North Dakota	$300 Million
Oregon	$5.2 Billion
Total	**$21.2 Billion**

Our skills have been honed through years of actuarial consulting experience with multiple programs, clients, and stakeholders. We have a successful track record of assisting our various public and private clients with capitation rate development, savings projections, trend development, public policy adjustment, and all requisite underlying actuarial analyses. For example, in Nebraska specifically, we have demonstrated our exemplary consulting skills by guiding the Department through the successful procurement of Heritage Health managed care contracts and receiving CMS approval on all capitation rate submissions, which have included nuanced trend development and intricate public policy adjustments. Additionally, our consultants have worked across the country certifying, developing, reviewing, and critiquing, and managing the development of actuarially sound capitation rates and rate projection methodologies in over two dozen state Medicaid managed care programs in the last 20 years and are extremely familiar with MCO operations within a Medicaid managed care program.

The **Optumas** team has direct experience calculating actuarially sound full-risk capitation rates within the Nebraska Medicaid program. The Department is familiar with our work setting the Nebraska Physical Health Program region-specific capitation rates for the multiple contract periods between July 2014 through December 2016. Additionally, we have performed the rate development for the recently implemented integrated behavioral health and physical health program, Heritage Health, beginning in January 2017. Over the last five years, we have ensured that the capitation rates within Nebraska Medicaid are actuarially sound and appropriate for Nebraska Medicaid. Our work helped guarantee that the transition between the historical stand-alone program and current integrated Nebraska managed care programs ran smoothly so the approximately 230,000 Medicaid members were able to continue receiving benefits within the managed care delivery system without interruption.

***Optumas'** work for Nebraska Medicaid helped facilitate a smooth transition from to the stand-alone physical health and behavioral health programs to an integrated managed care program.*

2. Prepaid Inpatient Health Plan (PIHP)

Optumas has experience setting capitation payments for Nebraska's Prepaid Inpatient Health Plan (PIHP) operating under the stand alone Behavioral Health Program from July 2014 – December 2016. Magellan, the PIHP operating within Nebraska, was responsible for arranging and providing behavioral health inpatient hospital services, as well as other professional behavioral health services, to most Nebraska Medicaid beneficiaries. As the consulting actuaries to the Department, **Optumas** ensured that the methodology used to develop all rates for the Behavioral Health program complied with the CMS guidance for the development of actuarially sound rates.

Similar to the Physical Health MCO rate setting processes discussed above, **Optumas** worked in conjunction with the Department to identify the necessary rate development components for the PIHP rates, accounting for the covered services and populations as described in the contract. Over the last five years, the methodology for the PIHP rate development evolved over time, as areas for efficiencies and the need for supporting analytics were identified.

One unique aspect of the Nebraska Behavioral Health program rate development process was the frequent development of three-month and six-month rates through the July 2014 – December 2016 time period. **Optumas** and the Department worked in partnership identifying specific time periods where additional uncertainty surrounding the implementation of new program changes and policies within Nebraska caused both partners to come to an agreement: to better match payment to risk, the rates should be set with shorter contract periods. This joint decision allowed emerging experience for the PIHP to be continuously monitored and incorporated in the next cycle of the rate development and better inform the final capitation rates. This frequent rate development demonstrates **Optumas'** flexibility and dedication to ensuring that the Department operates a sustainable Medicaid program with actuarily sound capitation rates.

3. Program for All-inclusive Care for the Elderly

Optumas has experience developing the Medicaid PACE UPLs and capitation rates for PACE Organizations (POs) providing comprehensive coordinated long-term services and supports to Medicaid and Medicare enrollees. Most recently, **Optumas** has developed, or is currently developing, PACE rates within Nebraska as well as Colorado, Iowa, Kansas, North Dakota, and Oregon. Additionally, **Optumas** has worked as the actuarial consultant for CalPACE, a group of 15 POs operating throughout various regions of California, since 2011. The **Optumas** team has unique insight into all aspects of a PACE program since we are involved in developing the payment rates for Medicaid programs and through the consulting services we have provided POs in California. As the consulting actuary to the California POs, **Optumas** was responsible for performing various analyses to help the POs understand rate impacts and the impact of policy changes, assisting POs with financial reporting, and participating in encounter data reporting workgroups with the California Medicaid department and the individual POs.

Optumas has set PACE rates four times for Nebraska over the last five years. **Optumas** has applied the experiences gained from PACE rate setting in other states as well as consulting experience from our work representing individual POs to understand the points and arguments made on both sides of the stakeholders involved in PACE rate development. This unique combination allows **Optumas** to anticipate areas of concern or interest that the Department and POs may have within our own rate development and preemptively address questions that may arise within our communication and interactions with all PACE program stakeholders.

4. Long-Term Care Managed Care

Optumas has experience providing consulting and rate setting services on fully-capitated Medicaid capitation rates for Long-Term Care Managed Care programs within the states of Kansas, Iowa, Nebraska, and Ohio. **Optumas** won Nebraska's 2013 RFP to provide the Department with actuarial consulting services for the proposed Managed Long-Term Services and Supports (MLTSS) program that will provide long-term services and supports in the home/community setting or Nursing Facility to Medicaid enrollees.

As noted on page 24 of the RFP, a portion of the MLTSS Medicaid recipients will be dually eligible for Medicare and Medicaid. Although, Nebraska is not currently proposing a state demonstration to CMS to integrate care for dual eligible members at this time, **Optumas'** experience reviewing the Ohio MyCare program capitation rates for the past four years will be very valuable to the Department should the state choose to explore that path. The experience **Optumas** has gained both from MLTSS rate development in Kansas and Iowa, as well as numerous years of rate review will be beneficial and position the Department for a successful managed care program transition in long-term care. Our experience includes MLTSS program design, so we can assist in both the policy and actuarial work. The assistance and guidance **Optumas** provided during the Heritage Health RFP process is a perfect example of what the Department can expect from our team with the development of an MLTSS program within Nebraska.

Optumas recognizes that the expectations and populations for long-term care management outlined within the RFP are subject to change prior to implementation. The size of our firm, our familiarity with the Nebraska Medicaid program, as well as experience setting rates for other MLTSS programs and involvement in procurement processes provides us with the ability to quickly react to any changes that the Department may make prior to implementation. To the extent additional populations or programs are added before the end of the contract term, **Optumas** will be able to easily provide the Department with the actuarial services, consulting, and analytical support necessary to model the impact of any such programmatic changes and ultimately ensure a smooth program implementation.

C. Scope of Work

C. Scope of Work (SOW)

Within sections V.D. through V.K of our proposal we provide a brief response to sections a-j contained in "V.C. Scope of Work (SOW)" on page 25 of the RFP for each SOW.

The following figures are provided in response to RFP Section V.C. All subsections a-j are addressed for each scope of work project per the RFP Q&A responses. The RFP instructions state that completeness of response and ease of review are both priorities in evaluation. The sections below are included to ensure a complete response was offered, however if a more concise review is desired, an evaluator can proceed to Section VI for a comprehensive response to each Scope of Work proposed under this RFP. The more detailed responses can be found beginning on page 87 of this response document.

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D. SOW1-Capitation Rate Setting

D. SOW 1 – Capitation Rate Setting

Please see Figure V.D.i below for the **Optumas**/Myers and Stauffer LC (**MSLC**) team's compliance with the required components of the RFP for SOW 1 - Capitation Rate Setting.

Figure V.D.i SOW 1 – Capitation Rate Setting Required Sections

Scope of Work Required Sections for SOW 1 – Capitation Rate Setting	
a. Process, staffing, and timeframe	**Process – Optumas** will follow all applicable regulations in place for capitation rate setting, including 42 CFR 438.4 and 438.5, Actuarial Standards of Practice 5, 23, 41, 45, and 49 as well as the applicable annual CMS rate setting guidance. Further details on the rate development process are provided in SOW 1 through SOW 1.3 beginning on page 87. **Staffing – Optumas** will use the current Nebraska core team proposed within the "Proposed Personnel/Management Approach" subsection, beginning on page 77 within this response, with additional resources available as needed. Over the last five years, **Optumas** has formed a dedicated Nebraska team who has gained an intrinsic knowledge of the Department's capitation rate setting methodology. All members of the proposed staff are already up to speed on all aspects of the Nebraska Medicaid program, allowing an effortless transition into the new contract, and completely eliminating any learning curve from your actuarial team or additional training burden on the Nebraska Medicaid state staff. **Timeframe** – Our proposed timeframe is consistent with the RFP requirement of rate submissions five months prior to the effective date. Please see SOW 1 through SOW 1.3 beginning on page 87 and Appendix II(A) for further details on a detailed project work plan as well as deliverables and due dates.
b. Methodology for performing service	**a. Capitation Rate Methodology** – The key trait that differentiates **Optumas'** methodology from our competitor is our transparency. All credentialed actuaries can perform the necessary calculations and analyses; where **Optumas** separates ourselves from the competition is by sharing all our deliverables and methodologies with the Department and contracted MCOs. This leads to a healthy Medicaid managed care environment where MCOs view the state as a partner rather than an adversary. A more detailed description of our current rate methodology is provided in SOW 1 in the subsection beginning on page 87. **b. Cohort Development – Optumas'** primary focus in cohort development is risk mitigation. Like-cost populations are grouped together and populations with significantly different costs are split apart. Consideration must simultaneously be given to operational constraints in place as well as the need to ensure MCOs do not experience gains or losses simply because they have a disproportionate membership mix compared to the base data used for rate setting. A more detailed description of managed care cohort development can be found in SOW 1 in the subsection beginning on page 91. **c. Risk Adjustment Methodology** – Risk adjustment methodology is largely tied to data constraints in place. If reliable data is available (as it is in Nebraska),

Scope of Work Required Sections for SOW 1 – Capitation Rate Setting	
	Optumas prefers to use CDPS+Rx as the risk adjustment tool. If limitations exist either CDPS or Medicaid Rx can serve as valid substitutes. Another key is to ensure appropriate application of risk adjustment. Certain populations (e.g. Duals) and services (e.g. LTSS) are not appropriately addressed via traditional risk adjustment. Custom tools must be used if these populations and services are to be risk adjusted. Please see SOW 1, the subsection beginning on page 92 for a more detailed description of the risk adjustment methodology **Optumas** employed in the Heritage Health program. **d. Develop a range of rates that are actuarially sound** – Even though CMS no longer approves rate ranges, CMS does allow rate ranges in the process as long as the final rates are certified to; thus, **Optumas** still develops actuarially sound rate ranges for the Department and our other clients. Rate ranges acknowledge the uncertainty in future experience and provide the Department with flexibility in rate payment and **Optumas** certifies to the final rates paid. Please see SOW 1, the subsection beginning on page 96 for a more detailed description of the development of actuarially sound rate ranges.
c. Prior experience	The **Optumas** team has developed actuarially sound rates in over 28 states, either as **Optumas** or for former employers. Additional details can be found in the Corporate Overview on page 59.
d. Successes achieved	**Optumas** is currently the actuary of record in eight states and has received CMS approval on certified rates worth over $21 billion in annual capitation across those eight states. Additional details can be found in the Corporate Overview subsection beginning on page 62.
e. Challenges present	**Optumas** has navigated challenges pertaining to missing/incomplete data (addressed by supplementing with well-thought out financial statements or reference quality data), a high degree of public/political scrutiny (addressed with meticulous detail, transparency, and stakeholder meetings), new programs without applicable base data (addressed by incorporating survey data or data from other states/similar programs with appropriate adjustments), and implementation of new risk adjustment tools (addressed with statistical analyses and risk adjustment model/weight review). Additionally, **Optumas** has overcome challenges around data sharing arrangements by providing multiple sharing options such as secure FTP sites, secure email, and hard drive transfers and balancing vendor relationships through routine touchpoints and clear communication of roles with the Department. **Optumas** overcomes challenges associated with CMS and MCO approval of capitation rates by implementing a transparent, collaborative process. We proactively address previous questions in subsequent reports, openly share our work product, and address stakeholder concerns when possible to achieve program buy-in and approval from all interested parties. Please see subsection C of SOW 1 through SOW 1.3 for further details on the challenges and technical considerations involved in the rate development process. These subsections can be found beginning on page 96.
f. Number of years performing the service	**Optumas** has been performing these services since the firm's inception in 2006. Our staff has more than 80 years of collective experience with capitation rate setting.

Scope of Work Required Sections for SOW 1 – Capitation Rate Setting	
g. Any requirements to be provided by the Department	Building upon our current successful system, **Optumas** will continue to look to the Department to assist with data collection as needed from the MCOs. **Optumas** has an existing data extract protocol with the Department's data vendor, so additional FFS data needs should be minimal.
h. Estimated timeline	Capitation rate development typically requires three months. Having been the Department's contracted actuary for the past five years, **Optumas** has gained a thorough understanding of Nebraska's capitation rate development process, the claims transmission process with the Department's data vendor, the coding nuances of Nebraska, and the strengths and weaknesses of the Nebraska data, allowing us to complete the capitation rate setting in an expedited timeframe. **Optumas** has included a detailed project plan within Appendix II(A).
i. All costs proposed must be all-inclusive	Confirmed, proposed costs are all-inclusive.
j. All analysis, findings, and/or recommendations must be in line with current statutory	Confirmed, all work will comply with current statutory and actuarial requirements.

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E. SOW 2-Capitation Rate Rebasing

E. SOW 2 – Capitation Rate Rebasing

Please see Figure V.E.i below for the **Optumas/MSLC** team's compliance with the required components of the RFP for SOW 2 – Capitation Rate Rebasing.

Figure V.E.i SOW 2 – Capitation Rate Rebasing Required Sections

Scope of Work Required Sections for SOW 2 – Capitation Rate Rebasing	
a. Process, staffing, and timeframe	**Process – Optumas** will follow all applicable regulations in place for capitation rate setting, including 42 CFR 438.4 and 438.5, and Actuarial Standards of Practice 5, 23, 41, 45, and 49 as well as annual CMS rate setting guidance. Please see SOW 2 and SOW 2.1 beginning on page 143 for further details on the capitation rate rebasing process. **Staffing – Optumas** will use the current Nebraska core team proposed within the "Proposed Personnel/Management Approach" subsection, beginning on page 77 within this response, with additional resources available as needed. The proposed **Optumas** team members have extensive experience with capitation rate rebasing for the Nebraska Medicaid program. This experience, coupled with our strong relationship with Department staff, will allow efficient completion of future capitation rate rebasing under this proposed contract. SOW 2.1 surrounding policy and financial management consulting services will be the primary focus of **Optumas'** subcontractor on this project, **MSLC. MSLC** is a leading accounting and plan management firm and can bring a wide array of services related to plan evaluation and program monitoring to the Department. This task will be staffed by the proposed **MSLC** team with resumes included in Appendix I(A). The **MSLC** team will work seamlessly with **Optumas**, meaning the Department will be able to contact them through the proposed Principal, providing a streamlined communication process. **Timeframe** – Our proposed timeframe for rate rebasing is consistent with the RFP requirement of rate submissions five months prior to the effective date. Please see SOW 2 and SOW 2.1, specifically the subsections beginning on page 155, and Appendix II(A) for further details on a detailed project work plan as well as deliverables and due dates related to capitation rate rebasing.
b. Methodology for performing service	**a. Analyze different rate methodologies – Optumas'** experience spans 28 states and includes Medicaid, Medicare, Commercial, County-level, and Provider-level rate setting. We have exposure to numerous rate methodologies that we can use to benefit the Department, as evidenced by our work operationalizing the Heritage Health capitation rate methodology. For a more detailed description of the process we use when analyzing different rate methodologies please see the subsection beginning on page 143 within SOW 2. **b. Analyze paid claims** – Under our current contract with the Department, **Optumas** has validated paid claims data from MMIS extracts and from extracts received directly from contracted MCOs. This process has been in place for the past six years and has allowed us to obtain data from 1/1/2006 to the present day. Due to our detailed process, **Optumas** has found multiple inconsistencies in

Scope of Work Required Sections for SOW 2 – Capitation Rate Rebasing	
	the Nebraska data that were later corrected with updated data. Please see the subsection beginning on page 146 within SOW 2 for more details surrounding paid claims analyses. **c. Analyze rate cell alternatives – Optumas** has proposed rate cells alternatives for the Department on numerous occasions. We developed the rate structure for the 599 CHIP population, constructed the current geographic rating regions, and suggested further rate cell alternatives that ultimately were not incorporated (e.g. disease and episode-based cohorts). Please see the subsection beginning on page 149 within SOW 2 for further details surrounding the methodology of analyzing rate cell alternatives. **d. Assess rate methodology compliance** – All rate development certification reports produced by **Optumas** certify that capitation rates are compliant with all relevant regulations, including 42 CFR 438.4 and 438.5 and the Balanced Budget Act of 1997. For additional information on **Optumas'** process of assessing rate methodology compliance please see the subsection beginning on page 151 within SOW 2. **e. Provide documentation and training for Department staff** – Since we currently enjoy a very collaborative relationship with the Department, we always walk the Department through our analyses, covering the approach, results, trickle-down impacts, and considerations. For more in-depth training, **Optumas** has held on-site training sessions for clients in the recent past to educate them on tasks that we perform on their behalf. Specific training sessions we have held on behalf of the Department include topics such as pass-through payments, Waiver submission and approval processes, Medicaid Expansion cost mechanisms, and PROMETHEUS Analytics output. Please see the subsection beginning on page 152 within SOW 2 for a more detailed description of how **Optumas** intends to provide documentation and training for Department staff. **f. Provide actuarial certification** – Actuarial certifications are provided to the Department and CMS for all rating periods and rate updates. Certifications include detailed explanations of the rate development methodology, exhibits walking through the rate development process, a table showing how every aspect of the CMS rate setting consultation guide is addressed by our document, and certification statements attesting that the rates are compliant with applicable federal regulations. Please see the subsection beginning on page 153 within SOW 2 for further details surrounding the actuarial certification **Optumas** provides within rate rebasing projects. **g. Present to and work with MCOs – Optumas** presents rate results to the Department's MCOs on a regular basis. We have worked with the Department team to coordinate messaging and build a relationship with the MCOs that allows them to be involved in the process as partners dedicated to improving Nebraska Medicaid. Please see the subsection beginning on page 153 within SOW 2 for

Scope of Work Required Sections for SOW 2 – Capitation Rate Rebasing	
	further details surrounding the methodology and process **Optumas** follows when leading presentations and attending MCO meetings.
c. Prior experience	The **Optumas** team has performed all the above tasks in the course of developing actuarially sound rates in over 28 states. **MSLC** has completed tasks associated with policy and financial management consulting services in dozens of states across the nation. Collectively, **Optumas** and **MSLC** have experience working in every state in the nation. Additional details can be found in the Corporate Overview on page 59.
d. Successes achieved	**Optumas** has used the methodologies described in this section to receive CMS approval and MCO buy-in on certified rates worth over $21 billion in annual capitation across 8 different states. **MSLC** has developed Value Based Payment programs and fulfilled other tasks associated with this scope of work in Georgia, Iowa, Louisiana, Maryland, Mississippi, New Mexico, Nevada, Nebraska, New Jersey, Pennsylvania, Texas, Virginia, and Washington. Additional details can be found in the Corporate Overview subsection beginning on page 62.
e. Challenges present	Rate Rebasing presents many of the same challenges as sections of SOW 1, including data quality (addressed by rigorous data validation and supplemental data as necessary), programmatic change review (addressed by detailed analyses and frequent communication with the Department), and MCO feedback (addressed by incorporating valid concerns and providing data to refute other concerns). Policy and Financial Management services presents many of the same challenges as sections of SOW 1. Additional challenges include subcapitation design options (addressed using the wealth of experience we possess testing programs across the nation), MCO communication gaps (addressed via flexible scheduling and development of clear and thorough work plans), and substantial federal policy changes (addressed with a team of policy subject matter experts monitoring and interpreting changes).
f. Number of years performing the service	**Optumas** has been performing these services since the firm's inception in 2006. Our staff has more than 80 years of collective experience rebasing capitation rates. **MSLC** has been performing these services for over 35 years. The proposed team has over 100 years of experience.
g. Any requirements to be provided by the Department	**MSLC** will have data needs for the financial analyses to support the rate rebasing. Since **Optumas** already has a data receipt protocol established with the Department, it is anticipated that many of the **MSLC** rate rebasing data needs can be satisfied with no effort from the Department. Remaining **Optumas** or **MSLC** rate rebasing data needs will be discussed with the Department as they arise.
h. Estimated timeline	Capitation rate development typically requires three months; however, **Optumas** is confident that we can perform the capitation rate rebasing quicker than any other firm using lessons learned over the last five years and our in-depth knowledge of Nebraska Medicaid as the Department's actuary for the last five years. The tasks proposed in this section will be completed towards the end of the three-month span. **Optumas** has included a detailed project plan within Appendix II(A).

Scope of Work Required Sections for SOW 2 – Capitation Rate Rebasing	
	Timelines for the proposed policy and financial management consulting tasks can vary widely based on the details surrounding the project. It is possible to provide some estimates now (e.g. technical assistance evaluating MCO agreements is expected to take approximately three months), but other tasks will require more details from the Department before a timeline can be reasonably provided.
i. All costs proposed must be all-inclusive	Confirmed, proposed costs are all-inclusive.
j. All analysis, findings, and/or recommendations must be in line with current statutory	Confirmed, all work will comply with current statutory and actuarial requirements.

F. SOW 3-1915(b) Waiver

F. SOW 3 – 1915(b) Waiver

Please see Figure V.F.i below for the **Optumas/MSLC** team's compliance with the required components of the RFP for SOW 3 – 1915(b) Waiver.

Figure V.F.i SOW 3 – 1915(b) Required Sections

Scope of Work Required Sections for SOW 3 – 1915(b) Waiver	
a. Process, staffing, and timeframe	**Process** – **Optumas** follows all applicable regulations in place for 1915(b) Waiver submissions and spends time understanding services and populations covered by the waiver and aggregating the data necessary to perform cost effectiveness tests. Please see the subsection beginning on page 181 within SOW 3 for further details on the 1915(b) Waiver submission process. **Staffing** – **Optumas** will use the current Nebraska core team proposed within the "Proposed Personnel/Management Approach" subsection, beginning on page 77 within this response, with additional resources available as needed. As discussed later in the SOW 3 Technical Approach on page 181, **Optumas** spent a considerable amount of time learning the detailed nuances of Nebraska's 1915(b) Waiver. To the extent we are awarded this contract, **Optumas** will be able to use our knowledge of Nebraska's 1915(b) Waiver to complete renewals and amendments in an expedited timeframe. **Timeframe** – Work will be completed in timeframes as specified by the Department, including compliance with the RFP requirement of exhibit submission four months prior to effective date. Please see SOW 3, Subsections D and E on page 184 and Appendix II(B) for further details on a detailed project work plan as well as deliverables and due dates with regards to the 1915(b) Waiver submission.
b. Methodology for performing service	**Optumas** conducts our 1915(b) Waiver work by developing a detailed understanding of the waiver's covered services and populations. Waiver design can be very complex, so it is necessary to have calls with the Department to make sure all relevant information is captured. Our vast 1915(b) Waiver experience has familiarized **Optumas** with what questions to ask that will lead to the most cohesive waiver submission possible. Our dedicated team members go above and beyond to familiarize themselves with all nuances surrounding the design and submission of 1915(b) Waivers. We are unique in that we construct our models for the Department's benefit, making them easy to understand to ensure that our process not only satisfies their waiver design, but that it exceeds their expectations and allows the Department to use the models directly themselves if need be. Please see the subsection beginning on page 181 within SOW 3 for further details on the proposed methodology for the Department's 1915(b) Waiver submission.
c. Prior experience	**Optumas** has submitted the Department's 1915(b) Waiver for the last five years. Each one of our submissions have successfully resulted in CMS approval, allowing the Department to successfully enroll members into their innovative managed care programs. Additionally, **Optumas** has performed 1915(b) analyses in seven other states and has received CMS approval on each submission.

Scope of Work Required Sections for SOW 3 – 1915(b) Waiver	
d. Successes achieved	**Optumas** has submitted and received approval from CMS in seven states. In a few of these programs, CMS had follow-up questions that were easily answered through **Optumas'** transparent modeling, detailed analytics, clear communication, and stellar reputation with CMS. In addition to fast approval processes, **Optumas** overhauled the data reporting and collection used in the Department's 1915(b) wavier to drastically reduce the time necessary to complete waiver cost effectiveness forms.
e. Challenges present	**Optumas** has confronted and overcome challenges associated with Waiver service definitions (addressed by detailed calls with the Department and creation of many service coverage exhibits), availability of data (addressed by using reference data and adjusting it to be appropriate to the market being studied), and CMS policy constraints (addressed with technical assistance calls and delivery of very detailed documentation to CMS).
f. Number of years performing the service	**Optumas** has been performing these services since the firm's inception in 2006. Our staff has more than 80 years of collective experience with the methodological principles required by 1915(b) Waiver work.
g. Any requirements to be provided by the Department	**Optumas** will look to the Department to assist with data collection as needed from the MCOs. **Optumas** has an existing data extract protocol with the Department's data vendor, so additional FFS data needs should be minimal. Having worked diligently with the Department on creating consistent, quarterly data extracts, the Department will save a significant amount of time and internal state resources by choosing **Optumas** as their contracted vendor.
h. Estimated timeline	**Optumas** has implemented efficiencies in the Department's 1915(b) wavier form submission, and now estimates that waiver cost effectiveness could be completed in approximately three weeks, a significantly shorter timeframe than any other firm can offer. Please note, waiver submissions are typically contingent upon knowing the final developed capitation rates, so this is considered three weeks after the finalization of capitation rates. **Optumas** has included a detailed project plan within Appendix II(C).
i. All costs proposed must be all-inclusive	Confirmed, proposed costs are all-inclusive.
j. All analysis, findings, and/or recommendations must be in line with current statutory	Confirmed, all work will comply with current statutory and actuarial requirements.

G. SOW 4-PACE Rate Setting

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

Please see Figure V.G.i below for the **Optumas/MSLC** team's compliance with the required components of the RFP for SOW 4 – Program of All-Inclusive Care for the Elderly (PACE) Rate Setting.

Figure V.G.i SOW 4 – PACE Rate Setting Required Sections

Scope of Work Required Sections for SOW 4 – PACE Rate Setting	
a. Process, staffing, and timeframe	**Process – Optumas** utilizes FFS data to develop the cost for a population determined to be comparable to the individuals who enroll in PACE. Please see the subsection beginning on page 186 within SOW 4 for further details on the PACE UPL development and rate setting process. **Staffing – Optumas** will use the current Nebraska core team proposed within the "Proposed Personnel/Management Approach" subsection, beginning on page 77 within this response, with additional resources available as needed. **Optumas'** proposed staff have developed a strong relationship and with Department over the last five years. Our collaborative working relationship will continue and only become stronger as we transition seamlessly from the past contract to this new contract. **Timeframe** – Work will be completed in timeframes as specified by the Department. Typically, the Department has utilized flexibility in the PACE contract to develop rates on an as-needed basis. **Optumas** can continue operating under this approach or transition to a more structured rate development timeline if desired by the Department. Please see SOW 4, Subsections D and E beginning on page 190 and Appendix II(C) for further details on a detailed project work plan as well as deliverables and due dates with regards PACE rate setting.
b. Methodology for performing service	**Optumas** proposes to use a methodology consistent with what we have implemented for the Department while developing PACE rates during the past five years. This consists of conducting a durational analysis to identify Nursing Home residents and Waiver Service recipients in the FFS base data. **Optumas** then uses the medical expenditures for these members to develop an Upper Payment Limit. Any public policy changes, such as Nursing Facility reimbursement changes, are applied to the historical experience. Please see the subsection beginning on page 186 within SOW 4 for further details on the proposed methodology for PACE rate setting.
c. Prior experience	**Optumas** has developed PACE rates for the Department for the previous five years. We have also developed PACE rates in 4 other states across the nation during the same time.
d. Successes achieved	**Optumas** has had PACE rates approved by CMS in Nebraska, Colorado, North Dakota, and Alabama in the past year and has received approval for more than two dozen PACE rate certification in the last four years.
e. Challenges present	**Optumas** has confronted challenges associated with using FFS data to set PACE rates (addressed by meticulous review of population differences), PACE rate setting without comparable FFS data (addressed by setting rates using Amounts that Would Otherwise been Paid (AWOP) for comparable managed care populations), LTSS reimbursement (address by repricing services at recent fee

Scope of Work Required Sections for SOW 4 – PACE Rate Setting	
	schedules), and PACE Organization rate concerns (addressed by collecting financial data to help demonstrate rate sufficiency).
f. Number of years performing the service	**Optumas** has been performing these services since the firm's inception in 2006. Our staff has more than 80 years of collective experience performing analyses related to PACE rate development.
g. Any requirements to be provided by the Department	**Optumas** will look to the Department to assist with data collection as needed from the PACE Organization(s). **Optumas** has an existing data extract protocol with the Department's data vendor, so additional FFS data needs should be minimal.
h. Estimated timeline	PACE rates can be developed in three to six weeks depending on the methodology selected by the Department. Having built the detailed, Nebraska-specific PACE UPL model that has been used for the last five years, **Optumas** can successfully develop the PACE UPLs in an expedited timeframe. Rate setting activities can begin at the Department's discretion based on PACE Organization contract requirements. **Optumas** has included a detailed project plan within Appendix II(D).
i. All costs proposed must be all-inclusive	Confirmed, proposed costs are all-inclusive.
j. All analysis, findings, and/or recommendations must be in line with current statutory	Confirmed, all work will comply with current statutory and actuarial requirements.

H. SOW 5-1115 Waiver
Development/Submission

H. SOW 5 – 1115 Waiver Development and Submission

Please see Figure V.H.i below for the **Optumas/MSLC** team's compliance with the required components of the RFP for SOW 5 – 1115 Waiver Development and Submission.

Figure V.H.i SOW 5 – 1115 Waiver Development and Submission Required Sections

Scope of Work Required Sections for SOW 5 – 1115 Waiver Development and Submission	
a. Process, staffing, and timeframe	**Process** – All 1115 Waivers are unique and substantially different from each other. The primary process link that connects all of **Optumas'** 1115 projects is a deep background understanding of the waiver's intent combined with clear deliverables allowing our client to see that intent has been properly reflected in all subsequent analyses. Please see the subsection beginning on page 193 within SOW 5 for further details on the 1115 Waiver development and submission process. We have helped states with every step of their 1115 Waiver development process; from Concept Paper to Program Design, Public Comment, Budget Neutrality, Waiver Submission, Reporting Protocols, CMS Negotiations, and Special Terms and Conditions (STC) Design and Implementation. **Staffing** – **Optumas** will use the current Nebraska core team proposed within the "Proposed Personnel/Management Approach" subsection, beginning on page 77 within this response, with additional resources available as needed. **Optumas'** proposed team has worked directly with the Department for the last five years and has gained a deep understanding of Nebraska's Medicaid program. Having this level of insight into the Nebraska Medicaid program allows **Optumas** to support the Department in a quick, efficient, and seamless manner – we effectively become extensions of the Department staff. The **Optumas** team members have worked on more than two dozen successful 1115 Waivers, including most recently in Alabama, Arkansas, Kansas, and Vermont (combined All-Payer Model Agreement). **Timeframe** – Work will be completed in timeframes as specified by the Department. Please see the subsection beginning on page 196 within SOW 5 and Appendix II(D) for further details on a detailed project work plan as well as deliverables and due dates with regards to 1115 Waivers.
b. Methodology for performing service	Specific to the Department's 1115 Waiver, **Optumas** will identify applicable Substance Use Disorder services provided at an Institute for Mental Disease (IMD). **Optumas** then takes the IMD admission spans and combs back through all historic Nebraska Medicaid data to find non-IMD services provided during the IMD admission window. Next, we calculate the total member months during which members were admitted to IMDs. The cost of all services occurring during the IMD admission window is divided by the IMD member. For further details on the 1115 Waiver development and submission process **Optumas** intends to follow please see the subsection beginning on page 193 within SOW 5.
c. Prior experience	**Optumas** has completed 1115 Waivers in seven states over the past 10 years and more than two dozen overall for **Optumas** or former employers.
d. Successes achieved	**Optumas** has received CMS approval for 1115 Waivers in seven states. Many of these 1115 Waiver are used to authorize our clients' managed care programs, so

Scope of Work Required Sections for SOW 5 – 1115 Waiver Development and Submission	
	the entire care delivery system is contingent upon waiver approval and sustained budget neutrality.
e. Challenges present	**Optumas** has resolved challenges related to waiver design (addressed via detailed client calls and production of graphics/exhibits illustrating waiver impact concepts) and data availability (addressed using survey and/or reference data).
f. Number of years performing the service	**Optumas** has been performing these services since the firm's inception in 2006. Our staff has more than 80 years of collective experience with the methodological principles required by 1115 Waiver work.
g. Any requirements to be provided by the Department	**Optumas** will look to the Department to assist with data collection as needed from the MCOs. **Optumas** has an existing data extract protocol with the Department's data vendor, so additional FFS data needs should be minimal.
h. Estimated timeline	Complex 1115 Waivers frequently take more than a year to complete; SUD IMD Waivers can be completed much more quickly, in as little as two to three months. For an ideal project plan, **Optumas** would like to receive background information on the waiver design prior to the public comment period, that way we can begin working on budget neutrality templates while the waiver receives public comments (budget neutrality work is typically exempt from public comment requirements). Any changes required by public comments can be efficiently incorporated, and the time used waiting for public comment can be put to use by allowing progress to be made on the data work necessary to establish budget neutral thresholds. **Optumas** recently completed the 1115 SUD IMD Waiver projections for the Department. **Optumas** will not need to spend a considerable amount of time discussing background information/waiver design and will be able to quickly turnaround any updated SUD IMD projections needed by the Department. **Optumas** has included a detailed project plan within Appendix II(E).
i. All costs proposed must be all-inclusive	Confirmed, proposed costs are all-inclusive.
j. All analysis, findings, and/or recommendations must be in line with current statutory	Confirmed, all work will comply with current statutory and actuarial requirements, including 42 CFR 431.412.

I. SOW 6-Dental Capitation Rate Setting

I. SOW 6 – Dental Capitation Rate Setting

Please see Figure V.I.i below for the **Optumas/MSLC** team's compliance with the required components of the RFP for SOW 6 – Dental Capitation Rate Setting.

Figure V.I.i SOW 6 – Dental Capitation Rate Setting Required Sections

Scope of Work Required Sections for SOW 6 – Dental Capitation Rate Setting	
a. Process, staffing, and timeframe	**Process – Optumas** will follow all applicable regulations in place for capitation rate setting, including 42 CFR 438.4 and 438.5, and Actuarial Standards of Practice 5, 23, 41, 45, and 49. Further details on the dental rate development process are provided in SOW 6 through SOW 6.3 beginning on page 197. **Staffing – Optumas** will use the current Nebraska core team proposed within the "Proposed Personnel/Management Approach" subsection, beginning on page 77 within this response, with additional resources available as needed. All **Optumas** team members have been trained on best practices for building models used for Dental capitation rate development. All **Optumas** staff can easily navigate the existing Nebraska Dental models, saving both **Optumas** and the Department significant time and effort in not having to rebuild models from scratch. **Timeframe** – Our proposed timeframe is consistent with the RFP requirement of rate submissions five months prior to the effective date. A detailed project work plan as well as deliverables and due dates are provided beginning on page 200 within SOW 6 through SOW 6.3 and Appendix II(F).
b. Methodology for performing service	**a. Capitation Rate Methodology – Optumas'** transparent rate setting methodology differentiates us from our competitors because we share all deliverables and methodologies with both the Department and the contracted Dental Benefit Manager (DBM) in Nebraska. This increased level of transparency cultivates a healthy managed care environment where DBMs view the Department as a partner rather than an adversary and encourages collaboration and sharing of information to continuously improve the Nebraska Dental Benefits Managed Care Program. Please see the subsection beginning on page 197 within SOW 6 for a more detailed description of our current dental rate methodology. **b. Cohort Development** – Risk mitigation achieved by grouping similar-cost populations together and splitting out populations with significantly different costs into separate rating cohorts is **Optumas'** primary focus in cohort development. Rating cohorts are typically defined based on client demographics such as age and gender or eligibility status of the population, but special consideration must also be given to any operational constraints of the program. Please see the subsection beginning on page 199 within SOW 6 for a more detailed description of the process **Optumas** used when developing the current rating cohorts for the Dental Benefits Managed Care Program. **c. Risk Adjustment Methodology** – While risk adjustment is a common component of Medicaid Managed Care Capitation rates, this is generally not the case with dental capitation rates. The current structure of Nebraska's Dental

Scope of Work Required Sections for SOW 6 – Dental Capitation Rate Setting	
	Benefits Managed Care program involves only one contracted DBM and does not include risk adjustment methodologies. Please see the subsection beginning on page 199 within SOW 6 for a more detailed description of the risk adjustment methodology **Optumas** would use should the need for risk adjustment arise within the dental capitation rate setting. **d. Develop a range of rates that are actuarially sound** – Even though CMS no longer approves rate ranges, **Optumas** still develops actuarially sound rate ranges for the Department and our other clients. Rate ranges acknowledge the uncertainty in future experience and provide the Department with flexibility in rate payment. Please see the subsection beginning on page 199 within SOW 6 for a more detailed description of the development of actuarially sound rate ranges.
c. Prior experience	The **Optumas** team has developed actuarially sound capitation rates specifically for dental programs, or programs that include dental as a covered service, in the following seven states: Arkansas, Colorado, Kansas, Nebraska, North Dakota, Iowa, and Oregon.
d. Successes achieved	**Optumas** has developed actuarially sound dental capitation rates within seven states across the nation and has submitted and received approval for dental rates in Nebraska since the Dental Benefits Managed Care Program's inception.
e. Challenges present	The same challenges that were discussed in SOW 1 Capitation Rate Setting often apply to Dental Capitation Rate Setting. This includes challenges pertaining to missing/incomplete data or the development of new programs without applicable base data which is overcome through the use of supplemental data extracts and detailed financial statements. A frequent challenge in dental rate setting for Medicaid programs is balancing reimbursement assumptions with access to care standards as Medicaid FFS dental reimbursement is typically low compared to commercial dental plans so special consideration needs to be made to account for the impact reimbursement changes may have on dental service utilization. Finally, challenges associated with CMS and DBM approval of capitation rates are overcome by **Optumas** by being collaborative and transparent throughout the entire rate setting process. Please see subsection C within SOW 6 through SOW 6.3 beginning on page 200 for further details on the challenges and technical considerations involved in the dental capitation rate development process.
f. Number of years performing the service	The staff at **Optumas** has more than 80 years of collective experience with all types of capitation rate setting and has been performing dental capitation rate development services since the firm's inception in 2006.
g. Any requirements to be provided by the Department	**Optumas** has an existing data extract protocol with the Department's data vendor, so additional FFS data or DBM encounter data needs should be minimal for future rate setting cycles, but **Optumas** will look to the Department to assist with any supplemental data and financial data collection from the DBMs as well as information on policy changes that may impact the Dental Benefits Managed Care Program.
h. Estimated timeline	Capitation rate development typically requires three months. Having been the contracted actuaries since the Dental Managed Care program's inception, **Optumas** has the experience to complete the SOW 6 tasks in an accelerated

Scope of Work Required Sections for SOW 6 – Dental Capitation Rate Setting	
	timeframe, allowing more time for CMS to review the rate development methodology. **Optumas** has included a detailed project plan within Appendix II(F).
i. All costs proposed must be all-inclusive	Confirmed, proposed costs are all-inclusive.
j. All analysis, findings, and/or recommendations must be in line with current statutory	Confirmed, all work will comply with current statutory and actuarial requirements.

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J. SOW 7-Dental Capitation Rate Rebasing

J. SOW 7 – Dental Capitation Rate Rebasing

Please see Figure V.J.i below for the **Optumas/MSLC** team's compliance with the required components of the RFP for SOW 7 – Dental Capitation Rate Rebasing.

Figure V.J.i SOW 7 – Dental Capitation Rate Rebasing Required Sections

Scope of Work Required Sections for SOW 7 – Dental Capitation Rate Rebasing	
a. Process, staffing, and timeframe	**Process – Optumas** will follow all applicable regulations in place for capitation rate setting, including 42 CFR 438.4 and 438.5, and Actuarial Standards of Practice 5, 23, 41, 45, and 49. Please see the subsection beginning on page 219 within SOW 7 for further details on the dental capitation rate rebasing process. **Staffing – Optumas** will use the current Nebraska core team proposed within the "Proposed Personnel/Management Approach" subsection, beginning on page 77 within this response, with additional resources available as needed. The entire **Optumas** team is available to answer questions related to the dental capitation rate rebasing for the Department. Having worked with the Department since the Dental managed care programs inception, every proposed team member is up to speed on all aspects of the dental capitation rate rebasing methodology. **Timeframe** – Our proposed timeframe for rate rebasing is consistent with the RFP requirement of rate submissions five months prior to the effective date. Please see the subsection beginning on page 226 within SOW 7 and Appendix II(F) for further details on a detailed project work plan as well as deliverables and due dates related to capitation rate rebasing.
b. Methodology for performing service	**a. Analyze different rate methodologies – Optumas** has set Medicaid dental capitation rates for seven different states within the nation and has gained exposure to various rate development methodologies through this work. We can leverage our previous work performed during the operationalization of the current Nebraska Dental Benefits Managed Care capitation rate methodology and combine this with the methodologies of other rate developments to develop a rating methodology that fits the Department's needs. Please see the subsection beginning on page 219 within SOW 7 for a more detailed description of the process we use when analyzing different rate methodologies. **b. Analyze paid claims – Optumas** has analyzed and validated paid claims data from the FFS delivery environment to use within historical rate development as well as the emerging MMIS experience from the current DBM, who began operating October 2017, through our current contract with the Department. Please see the subsection beginning on page 221 within SOW 7 for more details surrounding paid claims analyses within the dental capitation rate rebasing process. **c. Analyze rate cell alternatives** – In the development of the initial DBM capitation rates, **Optumas** worked with the Department to determine the rating cohorts currently used within the DBM program. Please see the subsection beginning on page 223 within SOW 7 for further details surrounding the

Scope of Work Required Sections for SOW 7 – Dental Capitation Rate Rebasing	
	methodology of analyzing rate cell alternatives as well as the initial rating cohort development for Nebraska's DBM program. **d. Assess rate methodology compliance** – **Optumas** produces rate certification reports for each cycle of dental capitation rate development. These reports certify that capitation rates are compliant with all relevant regulations, including 42 CFR 438.4 and 438.5 and the Balanced Budget Act of 1997. Please see the subsection beginning on page 223 within SOW 7 for additional information on **Optumas'** process of assessing rate methodology compliance. **e. Provide documentation and training for Department staff** – **Optumas** prides itself as a firm that is focused on collaboration and transparency. We walk the Department through all analyses and discuss any assumptions or considerations that need to be taken into account within the modeling, providing methodology narratives or documentation as requested. For more in-depth training, **Optumas** has held on-site training sessions for clients to educate them on the work we perform on their behalf. Please see the subsection beginning on page 224 within SOW 7 for a more detailed description of how **Optumas** intends to provide documentation and training for Department staff for new dental capitation rate setting methodologies. **f. Provide actuarial certification** – **Optumas** provides actuarial certifications to the Department and CMS for all contract rating periods and actuarial addendums for mid-contract rate updates. Certifications clearly describe and outline every step of the rate development process and include detailed exhibits for each component or adjustment to the rate starting with the raw base data. Additionally, we include a table showing how every aspect of the CMS rate setting consultation guide is addressed by our document and certification statements attesting that the rates are compliant with applicable federal regulations. Please see the subsection beginning on page 225 within SOW 7 for further details surrounding the actuarial certification **Optumas** provides within dental capitation rate rebasing projects. **g. Present to and work with DBMs** – Throughout the rate development process **Optumas** has several predetermined touch points with the Department and DBMs where we present our progress on individual components of rate development and allow the DBMs to ask questions and provide feedback. We have worked with the Department to build a collaborative relationship with the current DBM that allows them to be involved in the rate setting process as partners dedicated to improving Nebraska Medicaid. Please see the subsection beginning on page 225 within SOW 7 for further details surrounding the methodology and process **Optumas** follows when presenting and attending meetings with the contracted DBM.
c. Prior experience	The **Optumas** team has performed all the above tasks as associated with dental managed care capitation rate development in the course of developing actuarially sound dental capitation rates within seven states.

Scope of Work Required Sections for SOW 7 – Dental Capitation Rate Rebasing	
d. Successes achieved	**Optumas** has received CMS approval for Nebraska dental rates since the inception of the Dental Benefits Managed Care Program and has developed actuarially sound dental capitation rates within a total of seven states across the nation.
e. Challenges present	Rate Rebasing for dental capitation rates presents many of the same challenges as outlined within standard managed care capitation rate setting described in SOW 2 (page 143), including data quality, programmatic change review, and DBM feedback. **Optumas** has overcome each of these challenges respectively through rigorous data validation processes and the use of supplemental data as necessary, detailed analyses and frequent communication with the Department, and incorporating valid concerns or providing substantiation data to refute other concerns.
f. Number of years performing the service	The staff at **Optumas** has more than 80 years of collective experience with various types of managed care program capitation rate setting and has been performing dental capitation rate development services since the firm's inception in 2006.
g. Any requirements to be provided by the Department	No additional requirements outside of those already mentioned within SOW 6 are needed to be provided by the Department.
h. Estimated timeline	Although capitation rate development typically requires at least three months, **Optumas** will rely on our extensive experience with Nebraska's Dental Managed Care program to realize efficiencies in the capitation rate rebasing process. **Optumas** has included a detailed project plan within Appendix II(F).
i. All costs proposed must be all-inclusive	Confirmed, proposed costs are all-inclusive.
j. All analysis, findings, and/or recommendations must be in line with current statutory	Confirmed, all work will comply with current statutory and actuarial requirements.

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K. SOW 8-Special Projects (Optional)

K. SOW 8 – Special Projects (Optional)

Please see Figure V.K.i below for the **Optumas/MSLC** team's compliance with the required components of the RFP for SOW 8 – Special Projects (Optional).

Figure V.K.i SOW 8 – Special Projects (Optional) Required Sections

Scope of Work Required Sections for SOW 8 – Special Projects	
a. Process, staffing, and timeframe	**Process** – The varied nature of Special Projects makes it impossible to provide a direct process proposal. Instead, **Optumas** emphasizes continuing our collaborative, transparent relationship with the Department that encourages them to reach out to us whenever they could use our assistance. **Optumas** uses our weekly touchpoints with the Department to proactively inquire about any future analyses that may need to be considered. Please see the subsection beginning on page 229 within SOW 8 for further details on some of the proposals **Optumas** has included within this response. **Staffing – Optumas** will use the current Nebraska core team proposed within the "Proposed Personnel/Management Approach" subsection, beginning on page 77 within this response, with additional resources available as needed. Having worked directly with the Department over the last five years, the proposed **Optumas** team is better suited than any other firm to provide helpful insight into any special projects that arise throughout the term of the contract. Depending on the Special Project, the subcontracted **MSLC** team may be involved within in the work performed. If applicable, the project will be staffed by the proposed **MSLC** team with resumes included in Appendix I(A). The **MSLC** team will work seamlessly with **Optumas**, meaning the Department will be able to contact them through the proposed Principal, providing a streamlined communication process. **Timeframe** – Work will be completed in timeframes as specified by the Department for each Special Project. Please see the subsection beginning on page 242 within SOW 8 and Appendix II(F) for further details on a sample project work plan as well as deliverables and due dates related to a sample Special Project.
b. Methodology for performing service	**a. RFP assistance – Optumas** played an integral work in the writing of the Heritage Health RFP. Our experience designing managed care programs allows us to bring significant knowledge to bear on behalf of our clients. Please see the subsection beginning on page 230 within SOW 8 for further details surrounding the RFP assistance **Optumas** has provided the Department in the past and the methodology we will continue to follow in the future. **b. Modifications to existing managed care programs** – In order to submit modifications to existing managed care programs, it is first necessary to have a thorough understanding of the strengths and weaknesses of the managed care program in question. No actuarial firm can match the knowledge **Optumas** has gained while serving as the Department actuarial consultant for the past five years. This knowledge makes our insight much more applicable to the Nebraska Medicaid environment and will allow us to suggest more impactful managed care modifications. Please see the subsection beginning on page 231 within SOW 8 for

Scope of Work Required Sections for SOW 8 – Special Projects	
	further details surrounding the methodology for making modifications to existing managed care programs. **c. Annual review of managed care plan performance – Optumas** currently conducts managed care plan performance reviews in the form of PROMETHEUS Analytics and financial statement analyses. By partnering with **MSLC** for this RFP response, we will add a new layer of quality metric and accounting review that will provide the Department with additional insight to the contracted managed care plans. Please see the subsection beginning on page 234 within SOW 8 for specific details surrounding annual review of managed care plan performance. **d. Managed Care encounter validation – Optumas** has conducted encounter data validation since being awarded Nebraska's actuarial consulting RFP five years ago. Our rigorous approach to evaluating encounter data over time, by service, by provider, and in conjunction with other files (e.g. evaluating how well the encounter data connects with eligibility/provider data) indicated that the MMIS encounter extracts prior to 1/1/17 were not appropriate for actuarially sound rate development work. Please see the subsection beginning on page 237 within SOW 8 for more details surrounding the managed care encounter data validation process **Optumas** follows.
c. Prior experience	**Optumas** has performed Special Projects for all our clients, including the Department. Services provided include budget analyses, data quality review, health plan quality metric development, gain augmentation programs, new benefit pricing, rate adequacy studies, medical management evaluation, PBM contracting review, and rating cohort overhauls. **Optumas** proactively suggests ad-hoc analyses that we think may benefit our clients. For example, to the extent a state is considering a policy change, **Optumas** will suggest conducting a fiscal analysis to analyze the potential impact on the Medicaid budget. This type of fiscal analysis allows the Department to be better informed on policy implications and to pursue the policy that best services the Medicaid recipients.
d. Successes achieved	**Optumas'** successes include incorporation of newly-priced benefits in Nebraska and Colorado, publication of hospital report cards in Colorado, production of the Heritage Health RFP, and Medicaid budget studies on behalf of 11 of our clients.
e. Challenges present	Special projects are typically marked by quick turnaround times and constantly changing project requirements. **Optumas** has faced challenges related to quick turnaround times (addressed by structuring our teams so that every team member is fully up to speed and able to being working on ad-hoc requests immediately), uncertain project requirements (addressed by building tools that are flexible and able to incorporate new information efficiently via assumption input sections), and topics outside our core expertise (addressed by developing and employing a network of experts in the fields of information technology, medical management, project planning, Waiver service utilization practices, and any other area the Department may choose to analyze).
f. Number of years performing the service	**Optumas** has been performing services outside of the established scope of work for our clients since the firm's inception in 2006.

Scope of Work Required Sections for SOW 8 – Special Projects	
g. Any requirements to be provided by the Department	**Optumas** will look to the Department to assist with data collection as needed from the MCOs and DBM. **Optumas** has an existing data extract protocol with the Department's data vendor, so additional FFS data needs should be minimal.
h. Estimated timeline	The time necessary to complete Special Projects can vary widely. As demonstrated repeatedly over the last five years, when the Nebraska staff needs assistance immediately, the **Optumas** team responds; **Optumas** can meet quick turnaround times as needed by the Department.
i. All costs proposed must be all-inclusive	Confirmed, proposed costs are all-inclusive.
j. All analysis, findings, and/or recommendations must be in line with current statutory	Confirmed, all work will comply with current statutory and actuarial requirements.

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Section VI: Proposal Instructions

Section VI. Proposal Instructions

Within this section of our RFP response we provide a response to sections "VI.A.1. Request for Proposal Form" through "VI.A.3 Technical Approach" on pages 30-33 of the RFP.

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A.1. Request for Proposal Form

A.1. Request for Proposal Form

Within this section of our RFP response we provide a signed "RFP for Contractual Services" form as required in "VI.A.1. Request for Proposal Form" on page 30 of the RFP.

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.

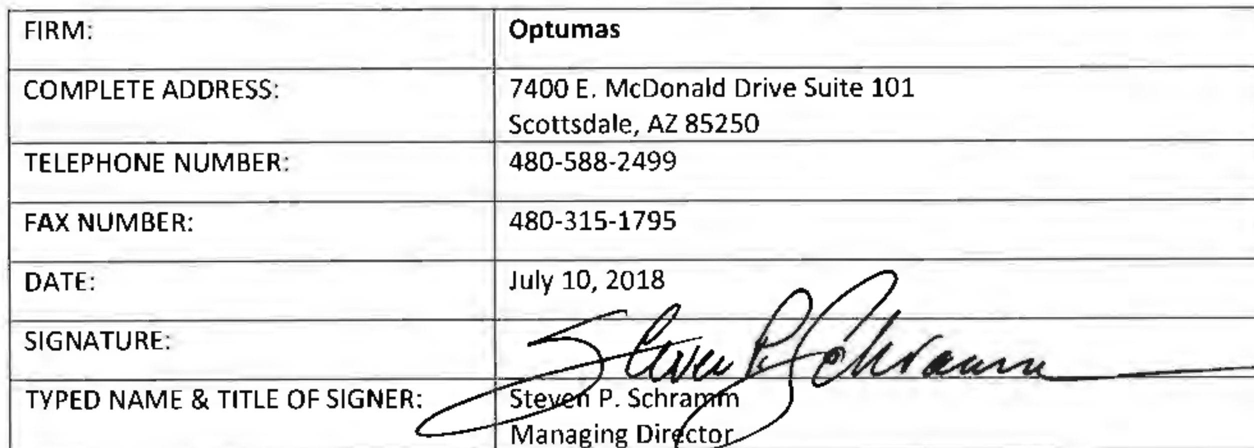
Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ 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:	**Optumas**
COMPLETE ADDRESS:	7400 E. McDonald Drive Suite 101 Scottsdale, AZ 85250
TELEPHONE NUMBER:	480-588-2499
FAX NUMBER:	480-315-1795
DATE:	July 10, 2018
SIGNATURE:	[signature]
TYPED NAME & TITLE OF SIGNER:	Steven P. Schramm Managing Director

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A.2. Corporate Overview

A.2. Corporate Overview

Within this section of our RFP response we provide an in-depth overview of our corporate experience, as required under sections a-k in "VI.A.2. Corporate Overview" on pages 30-33 of the RFP.

a. Bidder Identification and Information

Bidder's Full Company Name: Schramm Health Partners, LLC dba **Optumas**

Address of the Company's Headquarters:
7400 East McDonald Drive, Suite #101
Scottsdale, AZ 85250

Entity Organization: Limited Liability Corporation (LLC)

State in Which Bidder is Incorporated of Otherwise Organized to do Business: Arizona

Year in Which the Bidder First Organized to do Business: 2006

Whether the Name and Form of Organization Has Changed Since First Organized:
The name of the organization has changed since first organized. The organization began as schramm-raleigh Health Strategy, LLC in 2006 and was renamed to Schramm Health Partners, LLC dba **Optumas** in 2010 as part of a corporate restructuring.

b. Financial Statements

Optumas is a privately-held limited liability corporation originally organized under the laws of the State of Arizona in 2006. In lieu of financial statements, we are enclosing a description of the organization and other pertinent information such that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization in Figure VI.A.2.i below. Additionally, a banking reference can be found in Appendix III.

Figure VI.A.2.i – Company Overview

Optumas Company Overview	
Annual Revenue: Approximately $7.0 - $8.0 million **Client Base:** 29 Current Clients in 13 States **U.S.- Based Consultants:** Approximately 30 FTEs (all consultants are based in the U.S.) **U.S. Offices:** Scottsdale, Arizona Denver, Colorado	**Description of Specialization:** **Optumas** specializes in helping publicly-sponsored health and welfare programs reform the way they deliver, pay for, and oversee health care services for their covered populations. As strategists, economists, actuaries, clinicians, and data analysts, we help our clients reform their programs by identifying, quantifying, and managing their population and program risk. What differentiates us from traditional actuarial firms is our ability to present the results of our work clearly in

<table>
<tr><th colspan="2">Optumas Company Overview</th></tr>
<tr><td><u>Banking Reference:</u>
Brian Kallemeyn
Vice President
Senior Business Relationship Manager
Wells Fargo
2123 W. Happy Valley Road
Phoenix, AZ 85085
623.587.3736 (direct)</td><td>public presentations so that the expert as well as the layman understands our analyses.

<u>Doing the analytics correctly</u> is not enough; our clients recognize the importance of <u>presenting the analytics effectively</u>.</td></tr>
<tr><td colspan="2"><u>Expertise:</u>
• Setting actuarially sound capitation rates/ranges
• Designing innovative risk-mitigation strategies, such as risk adjustment
• Manipulating detailed claims, encounter, and eligibility data
• Analyzing financial statement information submitted by managed care plans
• Quantifying programmatic changes on future and existing capitation rates/ranges
• Developing proprietary trend models to project medical expenses, pharmacy spends and administrative costs
• Working collaboratively with clients to improve the capitation rate setting process
• Producing comprehensive actuarial certification letters which exceed CMS requirements
• Rebasing capitation rates using updated data and revised trend projections
• Strategizing on Value Based Payment models and other alternative reimbursement structures
• Demonstrating cost effectiveness through 1915(b) Waiver projections
• Developing actuarially sound capitation rates for the Program of All-Inclusive Care for the Elderly and other Long-Term Care populations
• Creating budget neutrality models for 1115 Waiver
• Consulting with State Medicaid Departments on special, ad-hoc analyses</td></tr>
</table>

Optumas has no known judgments, is not named in any pending or expected litigation, and has no real or potential financial reversals, which might materially affect the viability or stability of the organization. No such conditions are known to exist.

c. Change of Ownership

No change in ownership or control of the company (Schramm Health Partners, LLC dba **Optumas**) is anticipated during the 12 months following the proposal due date of July 13, 2018.

d. Office Location

Optumas has two locations: Arizona and Colorado. The addresses for both locations are outlined in Figure VI.A.2.ii below:

Figure VI.A.2.ii – Office Locations

Location	Address
Arizona	7400 East McDonald Avenue, Suite 101 Scottsdale, AZ 85250 (Corporate Offices)
Colorado	383 Corona St. Suite 202 Denver, CO 80218

e. Relationships with the State

For the last five years, **Optumas** has served as the actuarial consulting firm assisting the Department with their actuarial needs. During this time, **Optumas** has been presented with projects ranging from developing capitation rates for a new integrated care program and developing projections for a 1915(b) Waiver, to more typical projects such as dental managed care rate development. **Optumas** has applied our actuarial expertise and consulting professionalism to each task provided to the Department with outstanding results. Figure VI.A.2.iii contains a list of contract numbers associated with this work:

Figure VI.A.2.iii – Contracts with the Department

Contract #	Service Dates
55789 O4	Initial: 4/1/2013 – 3/31/2016 Renewal: 4/1/2016 – 3/31/2017 Renewal: 4/1/2017 – 3/31/2018
58451 O4	Initial: 12/15/2013 – 8/31/2016 Renewal: 9/1/2016 – 8/31/2017 Renewal: 9/1/2017 – 8/31/2018 Renewal: 9/1/2018 – 8/31/2019

f. Bidder's Employee Relations to State

No Party named in the bidder's proposal response is or was an employee of the State within the past 12 months.

No employee of any agency of the State of Nebraska is employed by the bidder or is a Subcontractor to the bidder, as of the due date for proposal submission of July 13, 2018.

These statements apply to both **Optumas** and **MSLC**.

g. Contract Performance

The bidder has not had a contract terminated for default during the past 10 years, nor has its subcontractor, **MSLC**.

Neither the bidder not its subcontractor has had a contract terminated during the past 10 years for convenience, non-performance, non-allocation of funds, or any other reason.

h. Summary of Bidder's Corporate Experience

Figure VI.A.2.iv shows **Optumas'** Corporate Experience with Nebraska Medicaid

Figure VI.A.2.iv – Optumas Corporate Experience with Nebraska Medicaid

Project	Nebraska Medicaid – **Optumas**
Narrative Description	Overview: As the Department's actuary of record and strategy consultant for the past five years, **Optumas** has developed actuarially sound capitation rates for the previous Physical Health and Behavioral Health managed care programs. **Optumas** also provided program design, strategy, and operational consulting for the development of Nebraska's current integrated care program, Heritage Health. This program represents a revamped Medicaid delivery system that incorporates a broader population and suite of services, potentially to include Long-Term Services and Supports (LTSS). In addition to assisting Nebraska with a complete overhaul of the managed care delivery system, **Optumas** also develops PACE rates and Dental rates for the Department. We have recently assisted the Department with the creation of a stand-alone Dental managed care plan. The methodology underlying the Dental rates is consistent with our general rate setting approach, but the outcomes can be drastically different. A good example of this is the development of rating cohorts. We conduct a cohort analysis consistent with our Heritage Health work, but the results for Dental services indicated a substantially different cohort structure was appropriate. Instead of creating cohorts based on member enrollment indicators (TANF, SSI, Foster Care, etc.), **Optumas** found that enrollee age was the only necessary differentiator of Dental spend. This simplifies the rating cohort structure, allowing for easier operationalization while still providing the necessary enrollment mix mitigation. Separate from our traditional rate setting work, we assist Nebraska with their 1915(b) cost-effectiveness calculations and 1115 budget neutrality analysis. This requires very detailed analytics and a thorough understanding of Nebraska's Medicaid delivery systems to ensure all relevant costs are captured. Additionally, **Optumas** produces spreadsheets and reports that walk CMS through the results of our cost effectiveness tests, helping Nebraska receive federal approval for the desired initiatives. Successes Achieved: • **Optumas'** assistance with the Heritage Health RFP resulted in an effective procurement of managed care contracts and the launch of a new integrated managed care program. • **Optumas** has developed a collaborative relationship with both the Heritage Health MCOs and CMS. Our transparency and successful collaboration has helped the Department receive approval from all stakeholders in an expedited manner.

Project	Nebraska Medicaid – **Optumas**
	• In redesigning the PACE rate methodology, **Optumas** made it significantly more transparent than the previous consultant by focusing on better incorporating touchpoints and input from both the Department and the contracted PACE Organization. We required the PACE Organization to submit more detailed financial information and justify any requests for potential rate increases to help Nebraska better control their PACE managed care program. • **Optumas** has used PROMETHEUS to analyze efficiency between MCOs and quantify savings associated with the new Heritage Health program. **Optumas** plans to use the PROMETHEUS analytics to make a managed care savings adjustment in the rate development process, resulting in lower, more sustainable rates for Nebraska Medicaid.
a) Time Period of Project	2013 – Present
b) Scheduled and Actual Completion Dates	Scheduled: this is a continuously ongoing engagement, with rate setting typically scheduled for January to March for projects on a State Fiscal Year timeline and July to September for projects on a Calendar Year timeline. Actual: All projects under this contract have been completed on time.
c) Contractor Responsibility	**Optumas** serves the Nebraska Department of Health and Human Services (DHHS) with actuarial support for managed care programs, capitation rate development, risk adjustment, managed care efficiency analyses, Developmentally Disabled population and service analyses, 1915(b) and 1115 Waiver cost effectiveness/budget neutrality, PACE UPL development, budget projections, and ad-hoc special analyses, such as projecting the cost of Medicaid expansion.
d) Role and Budget	Sole Contractor, with a budget of approximately $450,000 - $600,000 annually, excluding special projects.
e) Risk Adjusted Rate Techniques	Rates are risk adjusted using CDPS+Rx. Substantial detail surrounding the Nebraska-specific risk adjustment methodology can be found under SOW 1, in the subsection beginning on page 92.
f) PIHP Experience	**Optumas** developed the capitation rates for Nebraska's historical Behavioral Health PIHP program. The full-risk Behavioral Health PIHP program was implemented in September 2013 to allow the Department to deliver Behavioral Health Medicaid services to eligible recipients under a mandatory managed care framework via one managed care entity, Magellan Behavioral Health. **Optumas** used a combination of fee-for-service (FFS) data and emerging encounter data to develop the Behavioral Health capitation rates. Although the Department and **Optumas** aimed to develop annual capitation rates, **Optumas** updated the capitation rates as needed to reflect new policy changes. Most notably, **Optumas** used developed estimates for the implementation of Applied Behavior Analysis (ABA) and Behavioral Modification services for children with an Autism Spectrum Disorder (ASD) or a Developmental Disability (DD) diagnosis. Nebraska's Behavioral Health PIHP program was effective 9/1/2013 through 12/31/2016. As of 1/1/2017, Behavioral Health services were transferred to Nebraska's integrated care program, Heritage Health.

Project	Nebraska Medicaid – Optumas
g) PACE Experience	**Optumas** has developed the PACE UPLs for the Department since 2013. More detail surrounding our PACE experience in Nebraska is described under SOW 4, in the subsection beginning on page 186 of this proposal.
h) MLTSS Experience	Although the Department has not yet implemented MLTSS, **Optumas** has participated in strategy discussions surrounding the future program design of MLTSS with Department staff. After winning Nebraska's MLTSS RFP in 2013, **Optumas** conducted multiple onsite presentations, which were aimed at educating state staff on nuances surrounding MLTSS implementation. **Optumas** looks forward to continuing these program design discussions with the Department to the extent we are awarded this contract.
i) Evaluating Plan Encounter Data	Throughout the course of our relationship with the Department, **Optumas** has received and validated multiple types of data. During the pre-Heritage Health timeframe, an analysis of the MMIS Encounter database indicated that many services and expenses were underreported. This data shortage was confirmed with Department leadership. Due to this, data extracts came directly from four managed care plans. These extracts were aggregated with FFS data to create an aggregate view of the Medicaid program expense for data validation. Each individual data extract as well as the combined aggregate experience was validated using referential integrity checks, durational analysis, financial template comparison, historical consistency, utilization rate changes, and service-level cost changes. Under the Heritage Health program, **Optumas** has continued applying the same encounter data validation techniques. Using this process, we have identified multiple areas of concern that have been brought to the attention of the Department. These concerns are being addressed with combined work from the Department, **Optumas**, MMIS management, and contracted MCOs with the goal of conducted rate setting based entirely on robust encounters that have passed our rigorous validations process.
j) Staff Risk Adjustment Experience	**Optumas** developed and implemented CDPS+Rx risk adjustment for the Heritage Health program. Risk adjustment was a new facet of the program in year two of operationalization, so it was not something that was specified to the MCOs during the procurement process. Because of this, **Optumas** and the Department had a blank slate to design the risk adjustment program that we felt was most appropriate for Heritage Health. To assist in this development, **Optumas** conducted detailed analysis of statistical correlation to help the Department choose the appropriate risk adjustment tool, weight base, enrollment threshold, and risk-adjusted cohorts. This work was presented to the MCOs along with a phase-in concept to gradually introduce risk adjustment over the course of a year, resulting in bringing disease-based payments to Heritage Health to align each MCOs payment with the risk of their enrollees. The proposed personnel, outlined in the subsection beginning on page 77, were the key members responsible for the risk adjustment design, calculation, and implementation.
k) Client Reference	Michael Michalski Chief Financial Officer DHHS Medicaid and Long-Term Care

Project	Nebraska Medicaid – **Optumas**
	P.O. Box 95026 Lincoln, NE 68509 402.471.6719 Michael.michalski@nebraska.gov **Proposed Staff (and Role Assigned) on Reference Project:** Steve Schramm – Strategist Tim Doyle – Senior Actuary Barry Jordan – Actuary Chris Dickerson – Senior Actuarial Consultant Cassie Williams – Senior Actuarial Analyst Stephanie Taylor – Actuarial Analyst

Figure VI.A.2.v shows **Optumas'** Corporate Experience with Kansas Medicaid

Figure VI.A.2.v – Optumas Corporate Experience with Kansas Medicaid

Project	Kansas Medicaid – **Optumas**
Narrative Description	Overview: **Optumas** was originally engaged to set actuarially sound capitation rates for the HealthWave program. That engagement quickly expanded into providing strategy assistance to secure an 1115 Waiver for the KanCare program – a comprehensive reform of the entire Kansas Medicaid program. The HealthWave capitation rates set by **Optumas** covered acute, primary, and specialty care, pharmacy, and transportation services as well as rates for separate managed care organizations that provide mental health and substance abuse services to most Medicaid enrollees. In addition, **Optumas** assisted Kansas on its Program for All-Inclusive Care for the Elderly (PACE) which covers all Medicare and Medicaid acute care and long-term services and supports to individuals aged 55 and older who meet a Nursing Home level of care. In 2012, **Optumas** helped Kansas develop their comprehensive managed care program called KanCare, to provide all Medicaid services to nearly all Medicaid and CHIP beneficiaries, including Long-Term Services and Supports (LTSS). We negotiated with CMS to create concurrent 1115(a) and 1915(c) Waivers to provide Home and Community Based Services (HCBS) through a managed care delivery system. The State eventually included the Intellectual/Developmental Disability (1915(c) Waiver in managed care after originally carving it out of KanCare for the first year of implementation). **Optumas** helped write the concept paper, presented at public meetings, worked with CMS on the waiver authorities, the expenditure authority, budget neutrality, and the special terms and conditions (STCs). One of the most important components of the KanCare Waiver was the structure of the additional funding pools that **Optumas** built in collaboration with the KS Medicaid team. The funding pools were crucial to maintaining and expanding the

Project	Kansas Medicaid – **Optumas**
	existing non-Federal-share funding streams that were contributed by other public/quasi-public entities in Kansas. Kansas is currently undergoing a procurement process to solicit bids from managed care entities for the CY19 contract period. The Kansas Department of Health and Environment (KDHE) requested **Optumas** develop potential policy options for the rate bid/submission process for KDHE to consider regarding the upcoming RFP. **Optumas** conducted strategy discussions with the State on various options for soliciting cost proposals from prospective bidders. **Optumas** is currently assisting the State in reviewing competitive bids from the prospective MCOs. **Optumas** is conducting thorough analyses on the bidders' cost proposals and is advising the State on the potential risks associated with each bid. Successes Achieved: • Through **Optumas'** assistance, the KanCare 1115 Waiver was approved in an extremely expedited manner, allowing Kansas to completely shift from a hybrid FFS/managed care environment to almost 100% managed care in near-record time. • KDHE and **Optumas** received approval from CMS/OACT on all submitted capitation rates as well as buy-in from the KanCare MCOs. This level of support from all stakeholders was directly correlated with the emphasis on transparency through all aspects of the policy and rate development. • **Optumas** is assisting the State in reviewing competitive bids from MCOs for the CY19 contract period. Through **Optumas'** assistance, the State will be able to select the MCOs that best meet their needs in terms of quality and cost.
a) Time Period of Project	2009 – 2014 and 2016 – Present
b) Scheduled and Actual Completion Dates	Scheduled: November 2017 Actual: November 2017
c) Contractor Responsibility	**Optumas** serves the Kansas Department of Health and the Environment (KDHE) with the development of actuarially sound capitation rates for the state's KanCare Program and Waiver support. Capitation rates include the LTSS populations and services, and non-long-term populations are risk adjusted using CDPS+Rx.
d) Role and Budget	Sole Contractor, with a budget of approximately $800,000 - $1,000,000 annually.
e) Risk Adjusted Rate Techniques	Rates are risk adjusted using CDPS+Rx. **Optumas** develops risk scores using validated encounter data and applies them prospectively in a budget neutral manner. Risk score methodology is unique to each program, and in Kansas risk adjusted cohorts include cohorts such as Foster Care. The appropriateness of risk adjustment for each cohort was evaluated by testing the correlation of risk scores with member expensive, including statistical analysis such as the calculation of the coefficient of determination. The Foster Care cohort, which is frequently not risk adjusted due to poor predictive ability of standard risk adjustment tools, demonstrated strong correlation between medical spend and risk scores, allowing it to be included among the risk adjusted cohorts.

Project	Kansas Medicaid – Optumas
f) PIHP Experience	KDHE does not currently operate under a PIHP, making this section non-applicable. Even though KDHE's managed care program does not include a formal PIHP, it does include a full-service managed care contract, incorporating every medical service under an at-risk contracted arrangement.
g) PACE Experience	In partnership with the Kansas Department of Aging, **Optumas** has developed the UPLs for the State's Program of All-Inclusive Care for the Elderly since 2009. Separate PACE UPLs are developed for the Medicaid only and Dual populations. When developing the PACE UPLs for Kansas, **Optumas** complies with the CMS' PACE UPL checklist. **Optumas** develops the UPL using FFS data from a comparative frailty population to reflect the cost of the member in a FFS environment. **Optumas** performed a regional analysis to determine cost differences across the state and determined that four region-specific UPLs were necessary. The capitation payment to the PACE Organization (PO) must be less than the UPL. **Optumas** is currently developing the SFY20 UPLs for Kansas.
h) MLTSS Experience	LTSS populations and services are covered under KDHE's KanCare program. Detailed narrative surrounding our MLTSS experience in Kansas is described under SOW 1, in the subsection beginning on page 98 of this proposal.
i) Evaluating Plan Encounter Data	**Optumas** receives encounter data through MMIS. Encounter data is validated using various checks and analyses, including referential integrity, durational analysis, financial template comparison, historical consistency, utilization rate changes, and service-level cost changes.
j) Staff Risk Adjustment Experience	The **Optumas** team conducted risk adjustment on behalf of KDHE. **Optumas'** first task was determining the appropriate risk adjustment tool. The availability of key data fields was considered, and since both diagnosis and pharmacy data was available **Optumas** proceeded with CDPS+Rx. Next, **Optumas** determined the appropriateness of national weights for the Kansas Medicaid program. Correlation between national weights and the Kansas population were tested, and **Optumas** determined that national weights had valid predictive ability on the Kansas population. Finally, **Optumas** considered which populations were appropriate to risk adjust. Some, specifically the duals and the LTSS populations, were clearly inappropriate since the risk adjustment tool applies to only acute care services, which are incomplete or immaterial to the populations' total cost. Other populations, such as Foster Care, were less of a clear-cut decision. Correlation between risk scores and future expense was tested for each population to help KDHE decided which populations should receive risk adjustment, and the final decision to risk adjust a population like Foster Care was made by taking program goals, operational realities, and statistical analytics into consideration.
k) Client Reference	Paul Endacott Senior Finance Manager Kansas Department of Health and the Environment Division of Finance and Policy 905 SW Jackson Ave Landon Office Building, Suite 900 Topeka, KS 66612 785.291.3169

Project	Kansas Medicaid – **Optumas**
	Paul.endacott@ks.gov **Proposed Staff (and Role Assigned) on Reference Project:** Steve Schramm – Strategist Tim Doyle – Senior Actuary Seth Adamson – Actuary Co-Lead Cassie Williams – Senior Actuarial Analyst Stephanie Taylor – Actuarial Analyst

Figure VI.A.2.vi shows **Optumas'** Corporate Experience with Iowa Medicaid

Figure VI.A.2.vi – Optumas Corporate Experience with Iowa Medicaid

Project	Iowa Medicaid – **Optumas**
Narrative Description	Overview: **Optumas** serves Iowa Medicaid as the actuarial consultants in charge of developing rates for all managed care programs, including Health Link, Dental managed care, and PACE. Health Link is a comprehensive managed care program that includes virtually all populations and all services, including LTSS. **Optumas** took over the Iowa managed care work amid a difficult transition – the rates set by the previous actuarial vendor caused massive financial losses for the managed care plans, forcing one plan to exit the market. **Optumas** approached this transition by working closely with the state to understand the issues with the previous rates and building trust with the managed care plans with transparent communication and file sharing. The Health Link managed care program includes LTSS populations and services, making it a very relevant program for the direction Nebraska Medicaid would like to move. **Optumas** has developed the LTSS capitation rates for Health Link and can apply the lessons learned in this process to the Heritage Health program if the Department transitions to managed LTSS. Specifically, the mix of different acuity levels within LTSS subpopulations is very important; low Waiver utilizers, high Waiver utilizers, and Nursing Home residents represent very different cost profiles. The blending of these subpopulations can be used to drive MCO efficiency and incentivize efficient care delivery, but it is important to consider that an institutional level of care population is not capable of quickly adapting to new management procedures. Changes must be made slowly for the good of the enrollees, allowing care delivery to transition rather than abruptly change. The enrollment of these groups can also vary from one plan to another, so setting a global LTSS rate is often inappropriate. **Optumas'** wealth of experience developing managed LTSS rates benefited the Iowa Health Link program and can similarly benefit the future design of the Heritage Health program. **Optumas** also develops rates for stand-alone Dental and PACE programs in Iowa, much like we currently do in Nebraska. This provides us with a very relevant geographic reimbursement, utilization, and trend comparison for our Nebraska

Project	Iowa Medicaid – Optumas
	work, and can ensure that Nebraska receives the best value from their dental managed care and PACE programs. Successes Achieved: • IME requested that **Optumas** review the Health Link SFY18 capitation rate development that was completed by another actuarial contractor. **Optumas** was then asked to replace the existing actuarial vendor and under extremely short time-frames, develop SFY19 capitation rates for the Health Link program and the Dental Wellness program. • **Optumas** assisted IME in developing risk corridors for the MCOs participating in the program during the SFY18 contract period and assisted in evaluating the impact of transitioning members from one MCO to another due to termination of an MCOs contract. The outcome of our assistance was a risk corridor that retained the MCOs and allowed the state to continue its managed care program.
a) Time Period of Project	2018 – Present
b) Scheduled and Actual Completion Dates	Draft Rates - Scheduled: 4/15/18 Draft Rates – Actual: 4/15/18 Final Rates – Scheduled: 6/1/18 Final Rates – Actual: 6/1/18
c) Contractor Responsibility	**Optumas** serves the Iowa Medicaid Enterprise with actuarial support for managed care programs, capitation rate development, risk adjustment, managed care efficiency analyses, PACE UPL development, budget projections, and ad-hoc budget analyses.
d) Role and Budget	Prime Contractor, with a budget of approximately $1.5 million annually.
e) Risk Adjusted Rate Techniques	Rates are risk adjusted using CDPS+Rx. **Optumas** develops risk scores using validated encounter data. Risk scores are applied to account for differences in enrollee acuity across the MCOs participating in the Health Link program. Risk adjustment is developed to be applied prospectively in a budget neutral manner, meaning that the state does not pay out any additional funds and no reconciliation needs to take place. **Optumas** applies a few best-practice applications, such as the exclusion of diagnoses that do not originate from a doctor, in order to make sure that Iowa's risk adjustment process is consistent with industry standards. In addition to standard risk adjustment, **Optumas** developed an experience-based relative cost adjustment to apply to LTSS populations. This is necessary because standard risk adjustment tools do not apply well to the LTSS populations, so an alternative approach was required in order to appropriately compensate MCOs for the risk of their enrollees.
f) PIHP Experience	Similar to Nebraska, Iowa historically provided all inpatient and outpatient Behavioral Health and Substance Abuse services through a PIHP to all Medicaid beneficiaries. However, as of 2016, Behavioral Health and Substance Abuse services are provided under the integrated care delivery system. Since **Optumas** was awarded the Iowa contract in 2018, **Optumas** does not have significant experience with Iowa's historical PIHP program.

Project	Iowa Medicaid – **Optumas**
g) PACE Experience	**Optumas** develops PACE UPLs for Iowa. Our work here will be substantially similar to what we have done for Nebraska for the past five years. We have a very applicable regional reference point if the Department wanted to review PACE practices, contact PACE Organizations about program expansion, or review the reimbursement for Waiver Service providers and Nursing Facilities.
h) MLTSS Experience	**Optumas** has developed the LTSS capitation rates for Iowa's Health Link program. Substantial detail surrounding our MLTSS experience in Iowa can be found under SOW 1, in the subsection beginning on page 98 of this proposal.
i) Evaluating Plan Encounter Data	Encounter data validation was a particularly challenging aspect of our work with Iowa Medicaid. The rate development project was conducted under a very compressed time frame, so **Optumas** needed to process and validate five years of encounter data in a very efficient manner. As issues were discovered they were instantly communicated to the Iowa Medicaid team so that timelines were not jeopardized.
j) Staff Risk Adjustment Experience	**Optumas** developed and implemented CDPS+Rx risk adjustment for the Health Link program. A unique aspect of this project is that **Optumas** desired to conduct and apply risk adjustment differently than our predecessor. Some decisions that were previously made were not in line with what we consider to be best practices and required updating to uphold our standards. Making these changes required detailed statistical review of the applicability of risk scores to show why certain populations should not be risk adjusted.
k) Client Reference	Michael Randol Medicaid Director Iowa Medicaid Enterprise 100 Army Post Road Des Moines, IA 50315 515-256-4640 mrandol@dhs.state.ia.us **Proposed Staff (and Role Assigned) on Reference Project:** Steve Schramm - Strategist Zach Aters – Client Lead and MLTSS Lead Actuary Barry Jordan – Actuary Stephanie Taylor – Actuarial Analyst

Figure VI.A.2.vii shows **MSLC's** Corporate Experience with the Louisiana Department of Health

Figure VI.A.2.vii – MSLC's Corporate Experience with the Louisiana Department of Health

Project	Louisiana Department of Health – **MSLC**
Narrative Description	Since 2012, **MSLC** has worked closely with the Louisiana Department of Health and the state's managed care and care coordination networks participating in the Healthy Louisiana program. Services include: • Perform audits of medical loss ratio (MLR) reports submitted by each MCO. This includes requesting supporting documentation from each MCO, trial balance, claim lag reports, and other claim and financial information; and

Project	Louisiana Department of Health – MSLC
	performing analyses to ensure the definitions and assignments of medical and administration expenses are appropriate. • Perform a bi-monthly reconciliation of the submitted encounters to ensure completeness and accuracy. Work with the MMIS contractor to identify issues with accurately storing and reporting health plan submitted encounter data and recommend operational changes in order to enhance the reliability of the encounter data. • Provide encounter validation and EQR (External Quality Review) services following CMS Protocol 4. • Perform analyses of health plan-submitted cost reports to assist with the monitoring of MLRs and administrative costs, and to aid with the development of capitation rates. • Conduct analyses to measure the reliability and accuracy of encounter and member data used to establish capitation rates (i.e., inaccurate encounter and member data could lead to higher than necessary capitation rates). • Assist the Department's actuarial vendor in reconciling and understanding the encounter data being used for capitation rate setting purposes Successes Achieved: • By utilizing information supplied by the MCOs to the FAC and LDH, the analysis of the encounter processes and documentation utilized by the MMIS and/or the FAC determined the accuracy and effectiveness of the encounter processes and documentation utilized by MCOs and/or the FAC. • We have worked with Molina to identify issues with accurately storing and reporting health plan submitted encounter data and recommended operational changes in order to enhance the reliability of the encounter data.
a) Time Period of Project	2012-present
b) Scheduled and Actual Completion Dates	All work has been completed within scheduled timeframe.
c) Contractor Responsibility	Managed Care and Care Coordination Consulting
d) Role and Budget	Prime Contractor, with a budget of approximately $800,000 - $1,000,000 annually.
e) Risk Adjusted Rate Techniques	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
f) PIHP Experience	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
g) PACE Experience	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
h) MLTSS Experience	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
i) Evaluating Plan Encounter Data	Yes, please see Narrative Description above.

Project	Louisiana Department of Health – **MSLC**
j) Staff Risk Adjustment Experience	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
k) Client Reference	Marisa Naquin, Program Manager Louisiana Department of Health 504.568.8280 marisa.naquin@la.gov

Figure VI.A.2.viii shows **MSLC's** Corporate Experience with the Georgia Department of Community Health

Figure VI.A.2.viii – MSLC's Corporate Experience with the Georgia Department of Community Health

Project	Georgia Department of Community Heath – **MSLC**
Narrative Description	Since 2007, we have assisted the DCH with nearly all aspects of their Medicaid managed care initiative, the Georgia Families program. This Medicaid managed care program serves nearly two million members statewide, through four national health plans and a large number of delegated vendors and/or subcontractors. We conduct managed care compliance consulting, including encounter reconciliation and validation; performance testing; on-site audits and recommendations for process and contractual improvements; financial reconciliations; review of internal controls; MLR audits; and the development of policies and procedures. Our experience also includes the following: • Post-payment review of claims for accuracy and contract compliance. • On-site readiness reviews of four care management organizations (CMO) in 2017. These reviews included assessing call center operations readiness; determining system readiness for claim processing and timely provider payments; determining readiness to submit encounter claims following Go Live; assessing subcontractor readiness; and assessing other systems readiness, including coordination of benefits and provider appeals, ability to receive and track complaints, and other contractual requirements functions. • Assistance to DCH with new CMO contract open enrollment activities in 2017. These activities included development of management reports and dashboards related to CMO open enrollment activities; development of an open enrollment communication plan for internal and external stakeholders, including providers/provider organizations, consumers, consumer advocates, sister agencies, legislators, DCH taskforces, vendors, and others; and support in the development of contingency plans and options around any CMO failing to meet statewide network access requirements prior to open enrollment. • Conducting testing for network adequacy and availability, including conducting secret shopper calls and appointments. • Monitoring and reporting on health plan compliance with contractual and regulatory provisions. • On-site financial audits and performance audits. • Preparation of written and oral reports, including presentations to the DCH and the Board of Community Health in Georgia and legislative committees.

Project	Georgia Department of Community Heath – MSLC
	• Bi-monthly reconciliation of the encounters being submitted by the health plans and their subcontractors to ensure completeness and accuracy. Work with the MMIS contractor to identify issues with accurately storing and reporting health plan submitted encounter data. Recommend operational changes to enhance the reliability of the encounter data. • Analyses to measure the reliability and accuracy of encounter and member data used to establish capitation rates. • Aid the DCH's actuarial vendor in reconciling and understanding the encounter data being used for capitation rate setting purposes. • Reconcile and test required payment changes in compliance with state and federal statutes. • Conduct review of International Statistical Classification of Diseases and Related Health Problems – tenth edition (ICD-10) readiness and identify potential red flags to be addressed by the health plan and the DCH. This Georgia engagement demonstrates our ability to support states with a number of fiscal as well as operational needs. Our work at the claims review level and our support of the state's actuary demonstrates our fiscal integrity experience. This engagement also reveals our ability to assist the State with operational aspects of the program, with its multi-layer complexities involving patients, claims, payments, vendors, policies, and compliance. These operational aspects and complexities include: ensuring compliance with contractual requirements; adherence to state and federal requirements; contractor monitoring and oversight; developing dashboards and reports; ensuring access to care is maintained through alternative delivery system models; and assessing performance of delivery system models, among many others. Successes Achieved: • Supported onboarding and go-live of four CMOs through development of a Command Center strategy with clear lines of reporting, accountability, and authority across the CMOs and state staff. These reviews included assessing call center operations readiness; determining system readiness for claim processing and timely provider payments; determining readiness to submit encounter claims to DCH following go-live; assessing subcontractor readiness; and assessing other systems readiness, including coordination of benefits and provider appeals (ability to receive and track complaints, etc.). These activities included development of management reports and dashboards related to CMO open enrollment activities; development of an open enrollment communication plan for internal and external stakeholders, including providers/provider organizations, consumers, consumer advocates, sister agencies, legislators, DCH task forces, vendors, and others; and support in the development of contingency plans and options around any CMO failing to meet statewide network access requirements prior to open enrollment. • Myers and Stauffer identified inappropriate neonatal intensive care unit (NICU) payments; inaccurate and untimely encounter data; untimely submission of hospital statistical and reimbursement (HS&R) reports;

Project	Georgia Department of Community Heath – **MSLC**
	inaccurate processing and payment of claims; inadequate provider networks and provider directories; and risks and weaknesses in internal controls through on-site audits. DCH utilizes the findings and recommendations provided in all analyses and reports to ensure the CMOs are operating in accordance with contractual requirements. DCH has revised policies and updated contractual language with CMOs through contract amendments and a subsequent re-procurement.
a) Time Period of Project	2007-present
b) Scheduled and Actual Completion Dates	All work has been completed within scheduled timeframe.
c) Contractor Responsibility	Care Management Organization (CMO) Compliance and Consulting: **MSLC** was engaged to assist the Georgia Department of Community Health (DCH) with its Georgia CMO analysis project. This project assesses the policies and procedures of the program, as well as oversight and monitoring of the Georgia Medicaid CMOs which includes contract compliance; subcontractor oversight; encounter reconciliation and validation; performance testing; on-site audits; recommendations for process and contractual improvements; financial reconciliations; review of internal controls; medical loss ratio (MLR) audits; and claim repricing
d) Role and Budget	Prime Contractor, with a budget of $10,042,708 (current contract 2014 – 2019).
e) Risk Adjusted Rate Techniques	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
f) PIHP Experience	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
g) PACE Experience	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
h) MLTSS Experience	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
i) Evaluating Plan Encounter Data	Yes, please see Narrative Description above.
j) Staff Risk Adjustment Experience	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
k) Client Reference	Georgia Department of Community Heath John Upchurch Director of Financial Analysis 404.657.0229 jupchurch@dch.ga.gov

Figure VI.A.2.ix shows **MSLC's** Corporate Experience with the New Jersey Department of Health

Figure VI.A.2.ix – MSLC's Corporate Experience with the New Jersey Department of Health

Project	New Jersey Department of Health – MSLC
Narrative Description	As an outcome of the state of New Jersey's negotiations with CMS for the State's Comprehensive Waiver under Section 1115(a) Medicaid and CHIP demonstration program, the State developed and implemented a DSRIP program which drove the state's movement toward value-based purchasing and implementation of alternative payment models. **MSLC** has been leading New Jersey's Delivery System Reform Incentive Payment (DSRIP) initiative since its inception in October 2012. We had the lead role in developing the Planning Protocol, the Funding and Mechanics Protocol, and assisted the State in the amendments to the Special Terms and Conditions of the 1115 Waiver. We have represented the State in hundreds of hours of meetings and discussions with both CMS and the provider industry. We spearheaded the Quality and Measures subcommittee of the New Jersey DSRIP Steering Committee, tasked with developing hospital quality projects and associated DSRIP project metrics. **MSLC** led the design of the New Jersey DSRIP attribution model. New Jersey is the first state in the nation to utilize such a model in their DSRIP program. Additionally, we managed all activities related to creating benchmarks and improvement targets. **MSLC** is also hosting the state's DSRIP website. We are utilizing our proprietary information technology solutions for exchanging data with participating hospitals. **MSLC** designed the DSRIP application and toolkit and developed the application approval approach that was approved by CMS. Since October 2012, the State, CMS, and **MSLC** have been developing the processes and procedures that hospitals utilize to complete DSRIP projects. **MSLC** conducts training sessions with the hospital industry; this includes maintaining frequently asked questions and other reference materials needed by the hospital industry, and an innovative web-based training approach that has been successfully used on several occasions. Using the **MSLC** DSRIP application and toolkit, participating hospitals developed a hospital-specific DSRIP Plan (HDP), consistent with the State's DSRIP Planning Protocols and rooted in intensive learning and sharing to accelerate meaningful improvement. Each HDP was developed based on the hospital's mission and quality goals, as well as CMS' goals for improving health care through quality and efficiency. In partnership with the State, **MSLC** evaluates hospitals' quarterly progress reports which document their achievements for the preceding quarter. Upon completion of the review, questions are sent back to a hospital if it is determined adequate documentation was not provided. **MSLC** is available to address

Project	New Jersey Department of Health – MSLC
	questions regarding the inquiry. Once a determination is made that all required documentation was received, and the review is complete, the reports are also sent to CMS for their review. The **MSLC** staff responds to any inquiries from CMS and/or their vendor upon completion of their review of the reports on a quarterly basis. Over the years, the findings from CMS and/or their vendor have been in agreement with those from **MSLC** in nearly all cases. As part of the scope of work, **MSLC** provides educational services to hospitals to understand the expectations of the DSRIP program, both from perspective of the State and CMS. We led and served as moderators for monthly technology-based Learning Collaborative sessions where hospitals provided presentations on their projects, as well as shared best practices, lessons learned, and challenges encountered. Hospitals have been encouraged to work in partnership to build their programs outside Learning Collaborative meetings. Additionally, **MSLC** leads quarterly on-site Learning Collaborative workshops. Our responsibilities include leading the development of the meeting strategy, securing presenters (and sometimes ourselves serving as presenters), serving as meeting moderator, leading breakout sessions, and generating an evaluation survey for hospitals to complete after the meeting. Data collected from surveys is analyzed by **MSLC** and used to provide feedback to the State on process and performance improvement opportunities for the DSRIP program. The New Jersey DSRIP engagement is a great example of our work with a state to design, implement, and provide ongoing services to support the implementation of value-based payment and alternative payment programs as part of a delivery system transformation initiative. <u>Successes Achieved:</u> The New Jersey DSRIP engagement is a great example of our work with a state to design, implement, and provide ongoing services and support to a delivery system transformation initiative. We were at the table with New Jersey during the early years of designing and negotiating the final program with CMS. Today, we are still helping with the daily operations and future planning of the program. After supporting the design and federal approval of the DSRIP program, we provided hands-on support to New Jersey during the implementation and refinement of the program. These activities include development of a patient attribution model; establishing baseline performance and targeted improvement goals; assessment of performance; and calculation of incentive payments. The success of this project is due in part to our assistance with continuous stakeholder engagement. We have engaged advisory committees, the hospital industry, sister agencies, and CMS. Our engagement of the hospital industry includes the creation of an environment of continuous learning through training and Learning Collaborative sessions.

Project	New Jersey Department of Health – **MSLC**
	Throughout the engagement, we provide technical assistance to both the state and providers. The website, frequently asked questions, help desk, training, and one-on-one consultation with DSRIP hospitals are examples of our success in providing technical assistance services. The DSRIP program in New Jersey has received widespread local acclaim for its successes in improving quality and its true impact to individual patients. We are honored to have contributed to such a meaningful initiative.
a) Time Period of Project	2013-present
b) Scheduled and Actual Completion Dates	All work has been completed within scheduled timeframe.
c) Contractor Responsibility	Delivery System Reform Incentive Payment (DSRIP) Consulting:
d) Role and Budget	Prime Contractor, with a budget of approximately $8.2M (2013 – Present)
e) Risk Adjusted Rate Techniques	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
f) PIHP Experience	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
g) PACE Experience	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
h) MLTSS Experience	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
i) Evaluating Plan Encounter Data	Yes, please see Narrative Description above.
j) Staff Risk Adjustment Experience	Not applicable - this is not a task anticipated to be subcontracted to **MSLC** in this RFP response.
k) Client Reference	New Jersey Department of Health Michael Conca Health Care Consultant 609.633.7531 michael.conca@dhs.state.nj.us

i. *Summary of Bidder's Proposed Personnel/Management Approach*

One of the many characteristics that sets **Optumas** apart from our competitors is our flat team structure. We have found that our 'flat' structure is extremely beneficial to our clients, as every **Optumas** team member is able to answer questions about all aspects of a project. Our team consists of analysts, consultants, and actuaries who will manage the entire project from start to finish – the person who imports and summarizes the

> ***Optumas** is a very 'flat' consulting firm – we do not have layer upon layer of administrative hierarchy that inhibits flexibility and responsiveness.*

Department's data will be the same person presenting the final capitation rates to the stakeholders. We purposefully do not have a separate data intake group within **Optumas**, as this too often leads to misunderstandings and inefficiency amongst the data analysts, actuaries, and consultants/project managers. Instead, we train all staff to be able to manage every step of a project, so the same group of individuals see the project through from start to completion. This is done to make sure that the team members talking to the Department and the MCOs are fully informed and know every possible nuance of the program, data, and analyses.

Everyone at **Optumas** is actively involved in consulting on a day-to-day basis. We know that Medicaid agencies regularly get unrealistic deadlines imposed upon them and so we are organized such that anyone within **Optumas** can step up and pitch in to whatever client has the most pressing need. **Optumas'** project management approach reflects this 'flat' approach to consulting: we utilize dedicated client teams with as few of layers of administrative overhead as possible, which not only makes us more efficient, but also makes us more effective.

Optumas has developed a successful partnership with the Department over the last five years and has formed a dedicated project team that is:

- **Experienced – Optumas**, as a firm, has five years direct experience with the Department's rate development process.
- **Qualified –** Our core Nebraska team has over 80+ combined years of experience calculating actuarial sound rate ranges for Medicaid, CHIP, Medicaid expansion, and Medicaid Long-Term Care populations.
- **Seasoned** – In addition to being technically qualified to calculate the actuarial sound rate ranges, our team consists of seasoned professionals who have the poise necessary to succeed in stressful, complicated, and/or public situations.
- **Credentialed – Optumas** has four credentialed actuaries, all of whom have experience consulting to the Department:
    - Tim Doyle, Fellow in the Society of Actuaries (FSA) and a Member of the American Academy of Actuaries (MAAA)
    - Barry Jordan, Associate in the Society of Actuaries (ASA) and a Member of the American Academy of Actuaries (MAAA).
    - Zach Aters, Associate in the Society of Actuaries (ASA) and a Member of the American Academy of Actuaries (MAAA).
    - Seth Adamson, Associate in the Society of Actuaries (ASA) and a Member of the American Academy of Actuaries (MAAA).
- **Efficient** – We do things right the first time with heavy peer review, which is important given the Department's intricate rate development process, detailed trend calculations, and various programmatic changes.
- **Effective** – Our focus is calculating capitation rates for public payers, so we understand the Medicaid payment process, which allow us to identify operational bottlenecks and potential delays. We understand the process and calculations and will share 'lessons learned' with you, in order to meet the Department's goals and objectives.
- **Accessible** – We pride ourselves on our responsiveness; we can (and have) made ourselves available on extremely short notice. We have provided the Department with our cell phone numbers and have rapidly responded to questions posed by the Department, including on nights and weekends. We know running a Medicaid program is a 24/7 job and so we are available 24/7.

Optumas recommends maintaining the Personnel already assigned to the Department's projects. These dedicated team members have worked with the Department for five years and have developed an extensive knowledge of Nebraska's Medicaid program as well as key Department staff. Maintaining the status quo in terms of staffing will allow all a seamless transition from the old contract to the new contract. **Optumas'** Personnel look forward to continuing to build on the strong relationship with the Department. As such, we have structured our response to highlight our commitment to maintaining our relationship with the Department, first and foremost by proposing to use that same team for this contract term. **Optumas'** proposed team members are outlined below:

Steve Schramm, MScHE – Managing Director/Lead Strategist
Steve will serve as the Lead Strategist for the Department. He will provide overall direction and ensure deliverables exceed expectations. Steve has incorporated his input into the actuarially sound rate development methodologies for the Department over the last five years. Steve also has vast experience with the CMS rate setting process, including providing substantial input to CMS during creation of the Rate Development Checklist, which is used to evaluate Medicaid managed care rates and determine if they are actuarially sound. Steve has been involved in multiple years of actuarially sound rate development for Medicaid managed care programs in Arizona, Alabama, Arkansas, Delaware, California, Colorado, Connecticut, Iowa, Louisiana, Kansas, Kentucky, Kentucky, Maine, Maryland, Massachusetts, Nebraska, New Hampshire, New York, Nevada, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, and Vermont.

Tim Doyle, FSA, MAAA – Senior Actuary/Principal/Project Manager
Tim will serve as the Principal for the Department, where he will oversee all projects included in this RFP. Tim will be actively involved in all meetings and deliverables performed by **Optumas.** Tim will focus his efforts on developing the methodology most appropriate for the Department's specific needs and desires. Tim has worked with the Department since 2013 and has over 18 years of experience with Medicaid. He has done work in Alabama, Arizona, California, Colorado, Kansas, Louisiana, Maine, Maryland, Nebraska, New Hampshire, New Mexico, New York, North Dakota, North Carolina, Oregon, and Pennsylvania. The projects in these states spanned all types of populations as well as benefits. The types of projects included developing actuarially sound rates and rate ranges, 1915 and 1115 Waiver assistance, preparing costs and savings estimates for Medicaid expansion populations, and health care reform.

Barry Jordan, ASA, MAAA – Actuary
Barry will serve as the certifying Actuary for the Department, where he will be responsible for performing rate calculations, participating in stakeholder meetings, making decisions regarding rate-setting methodology, and defending rates/rate methodologies. Barry has worked with the Department on various programs within the State of Nebraska since 2013. Barry began his work with the Department during the stand-alone Physical Health program and is now the certifying actuary for the Department's Heritage Health and Dental programs. He has actuarial experience with healthcare work in 12 states and has certified Managed Care rates for various state Medicaid programs' Physical Health, Behavioral Health, Integrated Care, and PACE programs.

Zach Aters, ASA, MAAA – Peer Actuary /MLTSS Lead Actuary
Zach will serve as a peer actuary and the lead actuary for MLTSS rate setting should the Department incorporate that service package in a managed care contract. Zach has a wealth of experience with MLTSS, including working with Kansas and Iowa MLTSS programs at **Optumas** and multiple other MLTSS programs at previous employers (including New Mexico and Delaware). Even though MLTSS populations typically represent a small portion of the total Medicaid enrollees, their service needs typically make MLTSS programs one of the biggest programs in the state in terms of dollars spent. Zach is familiar with the nuances that must be considered when developing MLTSS rates and can make sure the Department's fledgling MLTSS program is implemented in a manner that positions the Department for success.

Seth Adamson, ASA, MAAA – Peer Actuary /MLTSS Supporting Actuary
Seth will serve as a peer actuary and MLTSS supporting actuary. Seth has well-rounded experience with public programs, including MLTSS rate development in Kansas and standard Medicaid population rate development in Colorado and Kansas. Seth's experience will help ensure all methodologies proposed to the Department are well thought out and consistent with the highest actuarial standards. Seth also has experience working with non-Medicaid populations, 1115 Waivers, and 1915(b) Waivers, making him a valuable source of information for the Department's non-traditional projects.

Chris Dickerson – Senior Actuarial Consultant
Chris will serve as the Senior Actuarial Consultant for the Department. Chris's main responsibilities will include overseeing all project management, data validation and analytics, development of actuarial rating adjustments (e.g., program changes, trend, and non-medical load), as well as communication with the Department and the Managed Care stakeholders. Chris has four years of direct experience with the Department and has worked on projects for other state Medicaid programs, county-level public health programs, and quasi-public managed care plans operating under Medicaid managed care contracts. Most recently, Chris has served as the Senior Actuarial Consultant for the Department's Heritage Health and PACE programs. Chris has also been an instrumental member in developing the Department's 1915(b) and 1115 Waiver projections.

Cassie Williams – Senior Actuarial Analyst
Cassie will serve as the Senior Actuarial Analyst for the Department, where she will be responsible for analyzing data, designing the rate model, and providing analytic support. Cassie as an in-depth working knowledge of certification of actuarially sound capitation rates for Nebraska, as she has been involved in the rate development for the Department for the past five years. More specifically, Cassie has been involved in the rate development for the Department's Behavioral Health PIHP, Heritage Health, and Dental programs. Additionally, Cassie has applied her analytical skills in preparing the 1915(b) cost effectiveness template for the Department. During Cassie's time at **Optumas**, she has worked on a wide variety of Medicaid projects, including behavioral health capitation rate development, physical health rate development, and integrated care rate development.

Stephanie Taylor – Actuarial Analyst/Additional Support
Stephanie will serve as Additional Support for the Department, where she will be responsible for manipulating detailed data, running PROMETHEUS, and conducting technical peer reviews. Stephanie has worked with the Department for the last three year and has extensive experience with PROMETHEUS. Stephanie has performed the extensive data scrubbing and manipulation necessary for Heritage Health rate development and has processed all Nebraska Medicaid claims through PROMTHEUS. Stephanie's career has also included developing managed care capitation rates for both physical and integrated care programs in Colorado, Kansas, and Iowa.

Detailed information related to the experience and qualifications, including education and training, of the Proposed Personnel is included in the resumes submitted for each staff person in Appendix I(A). Appendix I(B) contains required certificates for the Proposed Personnel. Please note, Optumas has significant additional resources available, should they be needed by the Department. This includes six additional consultants, one clinician, 10 additional analysts, two IT staff, and one CFO. The organizational chart below, labeled as Figure VI.A.2.x illustrates the reporting relationships:

Figure VI.A.2.x – Optumas Organizational Chart

Secondary Contact

State of Nebraska
Department of Health and Human Services

Primary Contact

Barry Jordan
Actuary

Chris Dickerson
Sr. Actuarial
Consultant

Cassie Williams
Sr. Actuarial
Analyst

Stephanie Taylor
Actuarial Analyst

Tim Doyle
Senior Actuary
Principal

Steve Schramm
Managing Director
Lead Strategist

Zach Aters
Peer Actuary
MLTSS Lead
Actuary

Seth Adamson
Peer Actuary
MLTSS Supporting
Actuary

Additional Consultants:
Dr. Art Pelberg
Megan Frenzen
Gabriela Charles
Joe Costa
Martin McNamara
Scott Campbell
Jessica Grado

Additional Analysts:
Kyle Butler
Kris Welch
Elrycc Berkman
Joshua Laventis
Rachael Rhodes
Seth Aters
Tomas Aorate
Julie Tang
Michael Schmidt
Maja Stefanovic

IT/Finance:
Carol Dawson
Dave Velde
Andrew Wilson

j. *Project Planning and Management*

The **Optumas** team has a dedicated Principal, Tim Doyle, who will oversee all Scope of Work projects proposed and accepted in this RFP. He will actively participate in all scheduled meetings and deliverables in conjunction with all projects. Tim will have overall responsibility for leading the **Optumas** team in providing the Department with all required and requested analyses and actuarial certifications. Tim is one of the Senior Actuaries at **Optumas** with a proven record of leading actuarial teams. Tim has successfully led the **Optumas** team on all projects associated with the current Nebraska contract. Tim has worked with the Department since 2013, most notably certifying the Behavioral Health PIHP capitation rates, developing the PACE UPLs, assisting in the Heritage Health procurement process, and strategizing on the MLTSS implementation. He has excellent communication skills to go along with a stellar reputation within the Medicaid arena. Tim has successfully developed actuarial sound rates and served as project manager for other state programs including Alabama, Arizona, California, Colorado, Kansas, Louisiana, Maine, Maryland, Nebraska, New Hampshire, New Mexico, New York, North Dakota, North Carolina, Oregon, and Pennsylvania. Tim has over 18 years of consulting experience in governmental managed care programs.

Tim will make himself available 24 hours a day, seven days a week. Department leadership has all the appropriate contact information necessary to be able to reach Tim and the **Optumas** team whenever necessary and that will continue through this contract. This level of responsiveness is consistent with the level that **Optumas** has established with the Department over the last five years, during which there were many impromptu discussions and meeting necessary to complete the rates and actuarial analyses in a timely manner.

Additionally, as outlined in the "Proposed Personnel/Management Approach" subsection beginning on page 77, **Optumas** has assigned the following dedicated personnel to perform the work required under this RFP:

- Steve Schramm, MScHE – Over 30 years professional experience with five years of experience in Nebraska
- Barry Jordan, ASA, MAAA – Actuary: Over six years actuarial experience with five years of experience in Nebraska
- Zach Aters, ASA, MAAA – MLTSS Lead Actuary: Over 19 years actuarial experience with five years of experience in Nebraska
- Seth Adamson, ASA, MAAA – MLTSS Supporting Actuary: Over seven years actuarial experience with five years of experience in Nebraska
- Chris Dickerson – Senior Actuarial Consultant: Over 10 years actuarial experience with four years of experience in Nebraska
- Cassie Williams – Senior Actuarial Analyst: Over five years actuarial experience with five years of experience in Nebraska
- Stephanie Taylor – Actuarial Analyst: Over three years actuarial experience with three years of experience in Nebraska
- Additional Support – Six additional consultants, 10 additional actuarial analysts, one clinician, two IT staff, and one CFO: Combined 80+ years actuarial experience

To maintain the streamlined communication process established over the last five years, **Optumas** proposes the same core team members for all Scope of Work projects included in this RFP. These individuals will be coordinated through the Principal, Tim Doyle.

k. *Subcontractors*

Optumas is committed to exceeding the expectations in this RFP and we have chosen a subcontractor, Myers and Stauffer LC (**MSLC**), that not only shares our vision but also has a proven track record in working for Medicaid programs. **Optumas** has established a collaborative relationship working with **MSLC** in other states. **MSLC** has extensive cost reporting, auditing, and data collection/warehousing experience that will be invaluable to the rate setting work covered by the RFP scope of work.

Name: Myers and Stauffer LC
Address:
700 W. 47th Street, Ste 1100
Kansas City, MO 64112
Telephone Number: 816-945-5344
Specific Tasks: Section V.E.1 (SOW 2.1 – Policy and Financial Management Consulting) and Section V.K (SOW 8 – Special Projects) of the RFP.
Percentage of Performance Hours Intended for each Subcontract: 4% – 6%
Total Percentage of Subcontractor(s) Performance Hours: 4% – 6%

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A.3. Technical Approach

A.3. Technical Approach

Within this section of our RFP response we have provided a detailed response to subsections a-e contained in "VI.A.3. Technical Approach" on page 33 of the RFP. ***Optumas*** *has provided a Technical Approach response for each SOW contained under "V.D. SOW 1 – Capitation Rate Setting" through "V.K. SOW 8 – Special Projects (Optional)" on pages 25-29 of the RFP.*

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SOW1-Capitation Rate Setting

SOW 1 – Capitation Rate Setting

To fully and completely address the topic of capitation rate setting, **Optumas** has split our response into two subsections: Heritage Health and Managed Long-Term Services and Supports (MLTSS). We have addressed our project understanding, proposed approach, and technical considerations separately for each of the major capitated programs the Department currently operates or plans to operate in the near future. We first discuss the Heritage Health program, followed by MLTSS. These two programs have different nuances and approaches that must be considered, so to fully address the Department's questions and demonstrate our qualifications to serve as your actuarial consultants, it is necessary to speak to the two programs individually in this section.

Heritage Health

A. Understanding of the Project Requirements

Optumas understands the project requirements of capitation rate setting as described on page 25 of the RFP and has significant experience with capitation rate setting for programs of similar size and scope as Nebraska Medicaid. We are currently the actuary of record in eight states (Alabama, Colorado, Iowa, Kansas, Maryland, Nebraska, North Dakota, and Oregon). Several of these states operate under integrated care (Physical Health, Behavioral Health, and LTSS) programs.

Optumas has had the privilege of serving as the actuarial consulting firm for the Department since 2013, beginning with the development of capitation rates for the historical Physical Health and Behavioral Health programs. As Nebraska transitioned to its Heritage Health program, effective January 2017, the rate development process for the Physical Health and Behavioral Health services was combined into one process with the integration of these services under Heritage Health. **Optumas** was given the opportunity to assist the Department with the Request for Proposal to solicit bids from Managed Care Organizations. **Optumas'** assistance resulted in an effective procurement of managed care contracts and the launch of Heritage Health.

B. Proposed Development Approach

Within this section of our RFP response we will discuss items a through d as outlined under "V.D SOW 1 – Capitation Rate Setting" on page 25 of the RFP.

a. Capitation Rate Methodology Development and Determination

In developing Medicaid Managed Care capitation rate methodologies, **Optumas** ensures that capitation rate updates comply with the applicable ASOPs and CMS requirements, such as 42 CFR 438.4, CMS annual rate setting guidance. The methodology used to develop the Heritage Health rates includes the following steps:

Base Data:
Optumas works with the Departmetn to determine the most recent data available and to identify the appropriate populations and services per the Heritage Health contract. This includes all relevant encounter and claims data, as well as any other data for payments made outside of MMIS, such as supplemental payments or provider reconciliation payments

(e.g. subcapitated arrangements or Critical Access Hospital settlements). Currently, **Optumas** receives quarterly claims data extracts from the Department's data vendor, Truven, and monthly eligibility data extracts from the Department. The MCOs also provide quarterly financial information through the completion of a Medicaid Reporting Template (MRT). **Optumas** designed the MRT for Nebraska and completely customized it to the Heritage Health program. **Optumas** uses the detailed claims data, eligibility data, and MCO MRTs to form the base data used for rate setting.

Optumas designed a detailed and customized reporting template for evaluation of the Department's Medicaid Managed Care Organizations.

All data collected is reviewed for reasonableness and is extensively reviewed as part of **Optumas'** data validation process. This is done to ensure the certifying actuary, Barry Jordan, is comfortable with the quality of the data, as is required per ASOP 23 – Data Quality. The data validation analyses include referential integrity checks to ensure that only claims that were incurred when a member was deemed eligible are included in rate setting. **Optumas** has provided an in-depth description of our data validation processes, including our step-wise approach, in SOW 2 in the subsection beginning on page **146** of this response.

The data validation process has highlighted data issues in the MMIS encounter data in the current Heritage Health rate setting cycle, which is most notably driven by claims submission issues with the implementation of the new Heritage Health program. **Optumas** has not felt comfortable using the incomplete MMIS encounter data as the base for actuarially sound rate development and thus requested supplemental data extracts from each of the participating MCOs. These supplemental data extracts will be a pivotal component in ensuring that the base data is an accurate starting point for rate development. By incorporating this supplemental data extract, the Department can feel confident knowing that the revised base data better aligns payment to risk and more appropriately captures the true cost of services under the Heritage Health program.

IBNR and Program/Policy Changes:

Optumas then accounts for any applicable base data adjustments, such as Incurred but Not Reported (IBNR) claims, as well as any applicable historical or prospective program changes. In addition to Department staff actively communicating upcoming program changes with **Optumas, Optumas** also regularly checks the provider bulletin listings on the Department's website to ensure that all policy changes are considered. **Optumas** works closely with the Department and MCOs in a collaborative manner to identify any future program changes that will be in effect for each future contract period and to confirm that all applicable changes are reflected. These include items such as changes in reimbursement or changes in covered services.

A specific example of considering future program changes is the expected transition of the reimbursement method for Outpatient services from a percent of billed charges (cost-to-charge ratio) approach to reimbursement using the Enhanced Ambulatory Patient Grouping (EAPG) 3M software. This is a program change that **Optumas** recently calculated in

Colorado's Medicaid program, and is anticipated to go live in Nebraska in 2019, so **Optumas** has recent, real-life practical experience in a neighboring state estimating the impact of the EAPG program change. **Optumas** will continue to work with the Department to develop an estimated impact for this change once the final go-live date is determined.

Trend Projection Factors:
Optumas then develops trend factors that are applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors are used to project the costs from the base period to the future contract period. **Optumas** develops trend by first normalizing the base data for programmatic and reimbursement changes, to ensure that the impact of these changes is not duplicated as both a rating adjustment and as trend.

After normalizing the historical encounter data for programmatic changes, **Optumas** arrays the data by rating cohort, category of service, and month of service, so that historical utilization, unit cost, and PMPMs can be reviewed. The data will be arrayed so that three month-moving-averages (MMA), six MMA, and 12 MMA can be calculated. In general, a combination of these three metrics is used to determine prospective trend, but there is not a pre-determined algorithm in place and final trend weighting varies based on nuances with a specific population or service. Prospective trends will be applied from the midpoint of the base data to the midpoint of the contract period.

Since actual Heritage Health experience was not available during the CY17 and CY18 trend development, the trends used in the original Heritage Health capitation rates were developed using encounter data from the prior Physical Health/Behavioral Health MCOs and historical FFS data for the new populations/services. Once trends were developed for the Heritage Health program, **Optumas** benchmarked the resulting projection factors to historical trends used in the Physical Health and Behavioral Health rate development for reasonableness. Trends were also reviewed to programs in other states in which **Optumas** develops rates and adjusted for programmatic differences. **Optumas** also reviewed recently published Medicare unit cost trends for certain services, to ensure consistency for dual-eligible populations.

Managed Care Savings Assumptions:
Optumas then conducts analyses to determine reasonable and achievable managed care savings assumptions for each rate cohort by category of service, based on actuarial as well as clinical input, and the use of efficiency tools such as PROMETHEUS, which is discussed in more detail in SOW 1.1 in the subsection beginning on page 117 of this response. Due to the recent implementation of Heritage Health, **Optumas** and the Department did not feel comfortable assuming aggressive managed care savings in the original development of the Heritage Health capitation rates. Now that enrollment has stabilized, and provider contracts are up and running, **Optumas** is working with the Department to implement an efficiency adjustment in the CY19 rate development. The goal of the managed care savings adjustment

> ***Optumas** possesses innovative tools, such as PROMETHEUS, that can assist in data-driven evaluation of managed care savings.*

is to recognize the efficiencies that should be gained by transitioning to an integrated care program. The combination of actuarial and clinical expertise, as well as the review of the clinically-based PROMETHEUS analytics, provides us confidence that our managed care efficiency adjustments are reasonable, appropriate, and attainable for the time period in question.

Non-Medical Load:
Optumas develops non-medical loading assumptions in the development of capitation rates to apply reasonable non-medical expenditures to the projected medical costs. Non-medical load is comprised of general administration, case management, profit margin, risk and contingency margin, and applicable taxes and fees. During the development of the initial Heritage Health capitation rates, **Optumas** utilized reported administrative and profit levels in the financials submitted by the previous managed care entities to develop the non-medical load. By applying this methodology, the assumed implication is that the Heritage Health MCOs can operate at a level that is at least as efficient as the previous contracted MCOs. Experience in other states and similar programs on both a PMPM and percentage basis were also reviewed to ensure reasonableness. Now that emerging administrative expenditures for the Heritage Health MCOs is available, this information will be reviewed and considered as part of the non-medical load development for the CY19 rates.

Risk Adjustment and Other Contract Provisions:
Optumas then considers applicable risk adjustment to account for the relative health status differences between the Heritage Health MCOs. Currently, **Optumas** works with the Department and the three Heritage Health MCOs to risk adjust capitation rates using the CDPS+Rx risk adjustment model. Extensive detail surrounding **Optumas'** application of risk adjustment in the Heritage Health program is discussed on page 105. In addition to risk adjustment, any other contractual provisions are considered, such as incentive or withhold arrangements, risk corridors, and MLR requirements.

Optumas provides the Department and MCOs with a rate model that is both flexible and transparent, allowing **Optumas** to make efficient changes to the rate development based on stakeholder feedback. One significant improvement that **Optumas** introduced into the Nebraska Medicaid rate development process in 2013 was transparency. **Optumas** has found that transparency at the stakeholder and state level facilitates understanding of the methodology from all levels. Having this understanding mitigates any anxiety that may stem from not understanding the mechanics related to the actuarial analyses, essentially getting rid of the "black box" approach to developing capitation rates. Our transparent communication with the MCOs benefits the Department because it facilitates a more collaborative working environment between the Department, the MCOs, and **Optumas**. We have found that providing this level of transparency results in fewer MCO questions, which leads to more Department staff productivity. Additionally, examples of MCOs suing state Medicaid agencies due to inaccurate rating assumptions are increasing each year. By treating the MCO

Transparency in rate development and sharing models with all Medicaid managed care program stakeholders harbors trust, mitigates anxiety, and encourages collaboration.

relationships as a partnership we are able to protect the Department from adverse outcomes and ensure the MCOs are aware of the changes occurring in Nebraska Managed Care. On multiple occasions, the Heritage Health MCOs have provided positive feedback to the Department regarding **Optumas'** transparency. Although the MCOs may not always agree with our approach, they appreciate our ability to substantiate and document all aspects of our analyses.

Once rates are agreed upon between the Department and the MCOs, **Optumas** then produces an Actuarial Certification for the Heritage Health program that describes the rate development methodology in detail. The actuarial certification letter is consistent with the communication standards discussed within ASOP 41 - Actuarial Communications as well as consistent with the expectations of CMS/Office of the Actuary (OACT) and recent CMS annual rate setting guidance. **Optumas** has established a reputation with CMS/OACT of providing very detailed rate certifications, allowing the rate reviewer to better understand the program and the actuarial analysis. This facilitates a quick and efficient rate review process which leads to timely CMS approvals.

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

With the implementation of the Heritage Health program, **Optumas** worked closely with the Department to determine the key risks underlying the program. Some of the primary changes between the historical programs and the Heritage Health program include the integration of Physical Health and Behavioral Health services, the addition of Pharmacy services into managed care, and the inclusion of new populations into managed care that had previously received Physical Health services through a FFS delivery system. One result of this was a change in geographic Rating Regions to group areas based on similar cost and proximity with the purpose of minimizing MCO geographic enrollment mix risk. The Rating Regions differ from the previous Physical Health managed care program's Service Areas due to the new populations and services covered under the Heritage Health program. Rating Regions were developed by reviewing the FFS, encounter, and supplemental data used to develop capitation rates. Upon conclusion of the regional analysis, it was determined that two new regions would exist, one with 41 counties (Rating Region 1) and the other with 52 counties (Rating Region 2); this is in contrast to the previous rating structure, which included one region comprised of 10 counties (Service Area 1) and another comprised of 83 counties (Service Area 2).

In addition to the changes in geographic rating, changes were made to the underlying rating cohorts. Most notably, the addition of Dual eligible, as well as populations receiving Long-Term Services and Supports (LTSS), required a fundamental review of the rating cohorts that had existed under the prior Physical Health program. While the LTSS services are not part of the Heritage Health benefit package, these populations reflect members with unique risk profiles. One unique aspect is that this includes members dually eligible for both Medicaid and Medicare, which reflects a fundamental difference between the remainder of the population in that there are multiple payers for these members. This means that the costs expected to be reimbursed by Medicaid reflect only a portion of the total cost of medical care for the members; the state's medical expenses being primarily the amount of Medicare's cost share (copays, coinsurance,

and deductibles). Another difference with this population is the fact that the setting of care for the LTSS populations comprises a mix of Nursing Facility residents and Waiver Service recipients. This reflects a unique set of services and member risks. For these reasons, it was determined that five new rating cohorts needed to be included specifically for these populations. The complete set of rating cohorts currently in place for the Heritage Health program is shown in Figure VI.A.3.i below:

Figure VI.A.3.i – Heritage Health Categories of Aid

Categories of Aid	
AABD 00-20 M&F	Healthy Dual
AABD 21+ M&F	Dual LTC
AABD 21+ M&F-WWC	Non-Dual LTC
CHIP M&F	Dual Waiver
Family Under 1 M&F	Non-Dual Waiver
Family 01-05 M&F	Katie Beckett 00-18 M&F
Family 06-20 F	599 CHIP - Cohort
Family 06-20 M	599 CHIP - Supplemental
Family 21+ M&F	Maternity
Foster Care M&F	

c. **Develop a risk adjustment methodology**

With combined staff experience of 80+ years, **Optumas** has extensive experience with a wide variety of risk adjustment tools, including but not limited to:

- Chronic Illness and Disability Payment System (CDPS),
- Medicaid Rx,
- CDPS + Rx,
- Clinical Risk Group (CRG),
- Adjusted Clinical Group (ACG), and
- Hierarchical Condition Category (HCC).

Optumas has used these tools for a variety of purposes within the context of Medicaid, Medicare, and Commercial Insurance. Specifically, these tools provide a resource for gaining insight into the risk of the population underlying our rate development for our various clients, including Medicaid Managed Care programs. This is important in determining differences in premium payment between MCOs that may be necessary, as well as important in determining the relative efficiency with which the contracted MCOs in those states operate.

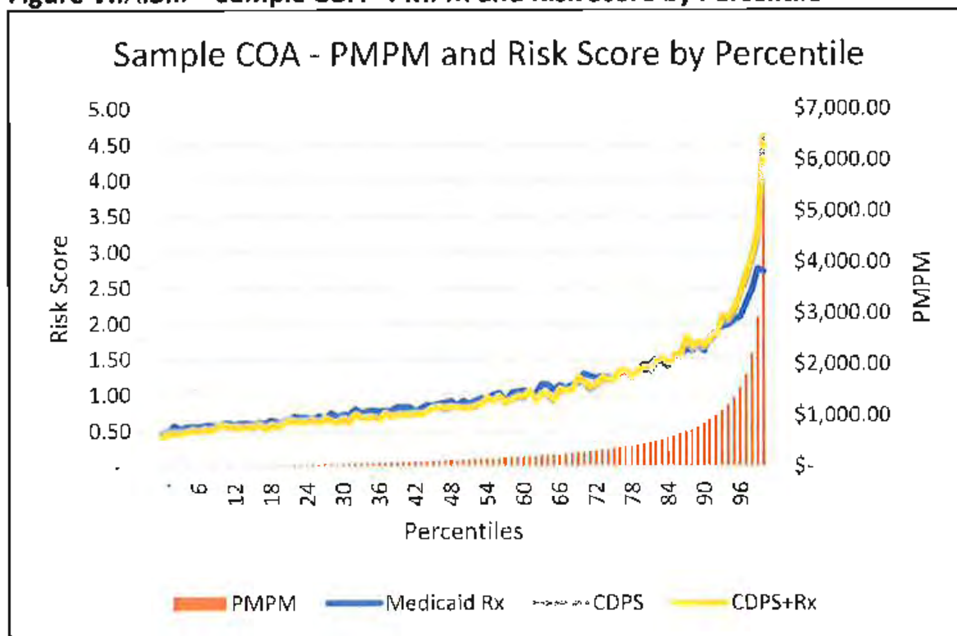
As previously mentioned, **Optumas** designed, calculated, and implemented risk adjustment for the Heritage Health program. Since Heritage Health was a new program with new MCOs, risk adjustment was not an established component to the rate development methodology. **Optumas** worked diligently with the Department and the MCOs to develop the most appropriate risk adjustment methodology for the Heritage Health program, with the goal of better aligning payment to risk for each participating MCO.

Specifically, in Nebraska, **Optumas** worked with the Department to outline various options as to how risk adjustment could best be handled in the Nebraska program from an actuarial and operational perspective. These considerations included the following:

1. **Which tool should be used (Medicaid Rx, CDPS, or CDPS+Rx) and for which populations?**

   Optumas ran historical Encounter and FFS data through Medicaid Rx, CDPS, and CDPS+Rx. Using the results from each tool, **Optumas** conducted a correlation analysis to determine which tool had the best predictive power and to understand which populations showed positive correlation (i.e. high cost members have high risk scores in the model selected, and that the low-cost members have low risk scores). Figure VI.A.3.ii below illustrates our results for a Sample COA:

   Figure VI.A.3.ii – Sample COA - PMPM and Risk Score by Percentile



   In this analysis, **Optumas** grouped members into percentile bands within a given Category of Aid (COA). These percentile bands were determined based on each member's PMPM within the experience period. **Optumas** then calculated the PMPM and raw risk score associated with each percentile. The risk scores were normalized across all percentiles, such that the aggregate risk score across all percentile bands weighted to a 1.0. The same process was followed for all three risk score tools. This analysis allowed **Optumas** to review the correlation between PMPM and normalized risk score within each COA. The outcome of this type of analysis is that the Department can be assured that the application of risk adjustment within the Heritage Health program is not only compliant with Actuarial Standards of Practice, but also appropriate for the population to which it is being applied.

After reviewing the results of this correlation analysis for each COA for Nebraska, **Optumas** determined that CDPS+Rx had the best correlation amongst the three risk score tools. As such, **Optumas** proposed proceeding with CDPS+Rx as the risk adjustment tool used in rate development. Additionally, **Optumas** used the correlation analysis as a mechanism to assist in determining which populations are appropriate to risk adjust. After reviewing the results of these analyses, a determination was made as to which COAs showed strong correlation between average PMPM and normalized risk score, and therefore would be risk adjusted. This analysis was reviewed with the Department and the MCOs, to ensure that the key stakeholders had access to the same information and understood the analyses.

2. Which weights should be used? National or State-Specific? Prospective or Concurrent?

An important consideration that needs to be made when applying risk adjustment, is determining which specific weights will be used. The first consideration is whether weights will be based on national data or state-specific data. One of the primary benefits of utilizing national weights, is that these weights have already been developed and are commonly used industry-wide, and therefore require less administrative resources than developing state-specific weights. The benefit of using state-specific weights is that the weights can be customized to the specific services and practice patterns that exist within a state. The decision was made to utilize the national weights, at least initially. This approach assists in a well-informed transition to risk adjusted rates, since the weights are industry standard weights, and provide a level of comfort that leads to fewer questions and methodology nuances that would exist with the implementation of state-specific weights in the first year of risk adjustment.

Another consideration in the application of health status-based risk adjustment for the Heritage Health program was whether the application would be done concurrently or prospectively. Both are commonly accepted approaches to implementing risk adjustment within a Medicaid Managed Care program:

Concurrent:
Risk adjustment is conducted after the experience period is complete. Membership and diagnosis information is used from the experience period and then budget-neutral adjustments are made to shift dollars between MCOs based on relative risk. Risk adjustment calculations and reconciliation would typically occur at least four to six months after the experience period to ensure adequate time for claims to be paid and included in data extracts. For example, risk adjustment for the CY18 rating period would likely be calculated in April 2019 or later.

Prospective:
Risk adjustment is calculated prior to the capitation rate development and rates are adjusted for each MCO prospectively. This requires the use of historical data and enrollment, along with a recent "attribution" or "snapshot" period to determine the relative risk scores for each MCO. For example, under the current approach for the CY18 Heritage Health rates, claims and enrollment data from CY16 was used with an attribution month of April 2017. The underlying assumption is that the relative risk

between MCOs based on membership from April 2017 is a reasonable indicator of the relative risk that will occur in CY18.

The decision was made to select the prospective approach to risk adjustment in Heritage Health. The key benefits of this approach are that MCOs know in advance what their capitation rates are and an additional reconciliation after the experience period is not required.

3. **Will there be a phase-in approach, or 100% risk adjustment the first year?**

One consideration outlined in ASOP 45 is whether the use of a phase-in to risk adjustment is warranted. A few key dynamics led to the exploration of using a phase-in approach to risk adjustment for the Nebraska program. The two predominant considerations are noted below:

Maturity of the Program – Risk scores needed to be calculated for the 2018 rates at a point in time when the latest enrollment information available reflected less than six months of data for the new program. The first few months of enrollment in the new program was impacted by the auto-assignment of members into each of the three MCOs operating within the program. This resulted in a disproportionate share of new Medicaid enrollees being assigned to one MCO at the start of 2017, the first year of the program. Given that risk scores are based on the use of historical data, this resulted in a larger share of "unscored" members for this MCO; enrollment dynamics at play in the first year resulted in these members by default receiving the program-wide average score for their respective region and rating cohorts. Additionally, the first open enrollment period was expected to occur late in 2017, which had the potential to shift members between MCOs and thereby changing the relative risk between the MCOs. While **Optumas** and the Department did not believe that these dynamics would preclude the use of risk adjustment, the dynamics did create additional unknowns around what level of member movement would occur between MCOs. Given that there had not previously been an open enrollment period in Nebraska, there was no experience available at the time to indicate whether the impact of enrollment changes would be large or small. **Optumas** and the Department determined that the use of a phase-in approach to risk scores would help mitigate the potential impact of drastic enrollment shifts due to this open enrollment period.

Data quality and changes in enrollment between MCOs is important to recognize to ensure that the resulting risk scores are reasonable and not skewed by these external influences.

Reliance on Data from Historical MCOs – The data used to calculate risk scores for the 2018 rates was based on the historical experience of the prior Physical Health and Behavioral Health MCOs, as well as State fee-for-service data. While the Department and **Optumas** did not have concerns with the validity of this data, it did reflect data that is not derived from the new program. The historical MCOs were not

subject to risk adjustment, so there is potential that coding differences could occur under the new MCOs. This leaves the new MCOs at the liberty of the coding practices of prior MCOs. While this was not expected to have a material impact on risk adjustment, the phase-in approach helps mitigate this concern to the extent it is present.

The considerations above, along with discussion with the Department and its MCOs, were all factors in determining whether a phase-in approach was warranted. The ultimate decision was that a 50% phase-in was used for the first half of 2018; upon receiving emerging experience post the open enrollment period in 2017, it was determined that the impact due to members transferring between MCOs did not materialize to the degree that was initially thought possible. As a result, and upon validation of relative risk scores using more recent pharmacy data and the use of Medicaid Rx, **Optumas** and the Department made a mid-year adjustment to shift to 100% risk adjustment for the second half of 2018.

In addition to our successful implementation of risk adjustment in Nebraska, the proposed **Optumas** team has recent experience in other states, such as Oregon and Colorado, exploring and developing approaches to risk adjustment. While the core software tools used to develop risk scores for each population have remained the same, there are a variety of ways in which the results of risk scores tools can be used.

d. Develop a range of rates that are actuarially sound

Optumas currently develops actuarially sound capitation rate ranges for each of the states in which we are the certifying actuaries. However, per the CMS regulations released in 2016, the specific capitation rates selected within the applicable rate range are what actually get certified and submitted to CMS and OACT, rather than the actuarially sound rate ranges.

In the development of the Heritage Health capitation rates, **Optumas'** development of rate ranges provides flexibility for the Department to select a payment rate that is within an actuarially sound range. The rate range is developed independently of any State budget constraints, once the range is developed the Department can select a rate that best aligns with its programmatic situation. This is helpful both from a State program perspective, but also allows flexibility for the Department to reimburse MCOs at higher levels when appropriate as well as providing an opportunity to mitigate year to year rate shock.

Rate ranges are developed by varying key assumptions underlying the rate development process. This typically includes varying assumptions surrounding prospective trend forecasts as well as assumptions related to non-medical load and managed care efficiency assumptions. The goal in developing a rate range is to capture a reasonable expectation in the variation of assumptions that could occur in the contract period.

C. Technical Considerations

As a result of CMS' Final Rule released in 2016, CMS requires that each state provide the most complete recent three years of data to the certifying actuary for consideration in capitation rate

development. The certifying actuary must provide rationale as to which data within this three-year period is appropriate to use in rate setting. While mid-year rate updates are fairly common due to program changes that may occur part way through the contract period, it is generally expected that rates be re-based annually, so that rates consistently reflect the most recent complete data available. To the extent that rates are not re-based, it will be necessary to consider emerging encounter data and financial experience as part of the rate update process, as a method for determining which rating adjustments may need to be revised during the update.

Also resulting from CMS' 2016 Final Rule, a fundamental change is that CMS requires states to eventually end any current pass-through arrangements; this includes Nebraska's University of Nebraska Medical Center (UNMC) physician pass-through arrangement. CMS has provided opportunities to convert these arrangements into one of several allowable mechanisms, such as a qualified directed payment arrangement that must be defined for a specific class of providers. This will be an important consideration as the current pass-through arrangement is only permitted until the contract period beginning on or after July 1, 2022 so an alternative arrangement will be necessary if the Department chooses to continue a similar arrangement with UNMC. **Optumas** has recently assisted the Department in technical assistance calls with CMS and was instrumental in suggesting a temporary solution for the current capitation rates in effect.

D. Detailed Project Work Plan

Please see Appendix II(A) for a sample SOW 1 Capitation Rate Setting detailed project work plan regarding Heritage Health rate development.

E. Deliverables and Due Dates

Please see Appendix II(A) for deliverables and due dates associated with Capitation Rate Setting. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department. Per our interpretation of page 25 of the RFP we have created a detailed project plan with deliverables and due dates on a state fiscal year basis. However, the project work plan and due dates can be adjusted to fit a calendar year basis to match the current structure of the Heritage Health managed care program contract period.

Long-Term Care Managed Care

*Although the Long-Term Care Managed Care section is listed as "Optional", **Optumas** has chosen to provide documentation illustrating our expertise in setting capitation rates for Managed Long-Term Services and Supports (MLTSS) programs. **Optumas** recognizes that any MLTSS work will be billed under Scope of Work 8 – Special Projects per responses submitted via the RFP Q&A.*

As noted on page 24 of the RFP, Nebraska's MLTSS program will include Physical Health services, Behavioral Health services, and LTSS, with Dental services excluded from the program. Because of the interaction between these services, the contracted actuary will need to understand the unique needs of the Nursing Home Certifiable population with respect to each service in the Nebraska Medicaid program. Having been the Department's actuaries for the last five years, our team is more familiar than any other prospective bidder with the Nebraska Medicaid program. **Optumas** has extensive experience analyzing detailed data for all populations and services within Nebraska's current FFS and Managed Care

programs. **Optumas'** in-depth working knowledge of the Nebraska Medicaid program, coupled with our in-house data warehousing system containing over 12 years of detailed Nebraska Medicaid data, will allow us to support the Department in a quick, efficient, and seamless manner when developing the initial MLTSS capitation rates once the program goes live.

A. Understanding of the Project Requirements

Optumas understands the project requirements of capitation rate setting as described on page 25 of the RFP as pertains to the development of MLTSS capitation rates. **Optumas** has been involved in developing capitation rates for MLTSS programs as well as assisting clients in evaluating the risk surrounding Nursing Home Certifiable populations across the country. Our team has over 80+ years of experience analyzing the risk associated with Long-Term Care populations. This includes developing integrated MLTSS programs, designing and reviewing various Dual Demonstrations that include LTSS, and providing guidance with regard to Home and Community Based Waiver Services (HCBS) programs and populations. We have a successful track record of assisting our clients with rate setting and negotiation projects related to Long-Term Care populations. We have included our most recent experience and successes for each in Figure VI.A.3.iii below:

Figure VI.A.3.iii – Optumas' Recent LTSS Experience

Client	Dates of Services	Responsibilities/Successes Achieved
Alabama: Alabama Medicaid Agency (AMA)	2012 – Present	**Actuary of Record** **Optumas** is currently assisting AMA in developing a patient-centered Case Management system, designed to better integrate the medical and LTSS needs of beneficiaries. Using our extensive MLTSS experience, **Optumas** is developing a Per Member Per Month (PMPM) associated with the care management of the Long-Term Care population. The goal of this new program is to shift the percentage of the LTSS population residing in the HCBS setting to reduce Nursing Home stays and to provide more comprehensive care to these individuals. **Optumas** successfully assisted the State in creating the Request for Proposal (RFP) related to this new program and was the sole creator of the Cost Proposal contained within. Through **Optumas'** assistance, the State will be able to select the Contractor that best meets their needs in terms of quality and cost.
Colorado: Colorado Department of Health Care Policy and Financing (CO HCPF)	2012 – Present	**Actuary of Record** In our role as CO HCPF's actuaries, we set annual capitation rates for each of the Department's core programs. This includes setting rates for managed care plans operating in the Child Health Plan Plus, fully capitated Medicaid Managed Care plans, Behavioral Health plans, and organizations operating under the Program of All-inclusive Care for the Elderly (PACE). In addition, **Optumas** has provided actuarial support and strategy input for Colorado's Dual Demonstration proposal to CMS. **Optumas** conducted a thorough

Client	Dates of Services	Responsibilities/Successes Achieved
		actuarial analysis on the Nursing Home Certifiable population and associated Waivers. As part of the proposal to CMS, **Optumas** developed benchmarks for each Demonstration year, which can later be used to compare the actual cost associated with the Demonstration to evaluate savings due to care integration. These benchmarks reflected the estimated cost across Medicare and Medicaid for the Dual population in absence of the Dual Demonstration. **Optumas** identified four sub-populations within the base data: • Nursing Facility Population – These members reside in a Nursing Facility and have a Nursing Facility level of care. A member must have at least three consecutive months of Nursing Facility service to be considered as part of this population. This results in members with less than three months of Nursing Facility service to be considered "short term." Short-term members are captured in one of the other sub-populations. **Optumas** discusses the importance of excluding short-term members from the Nursing Home Certifiable cohort in more detail under "Proposed Development Approach" below. • Waiver – These members are not living in a Nursing Facility but are utilizing Waiver Services on a consistent basis. A longitudinal study was conducted to tease out any members receiving sporadic Waiver Services. • High Waiver – These members are also not living in a Nursing Facility but are very high utilizers of Waiver Services. These members had to have an average PMPM of greater than $4,800 in Waiver Services to be considered as part of this sub-population. • Community Well – These members are not Nursing Home Certifiable and do not live in a Nursing Facility, nor do they use Waiver Services on a consistent basis. The reason for splitting these sub-populations is due to the unique risk associated with each one. Community Well members have the majority of their coverage provided through Medicare funding due to their cost being acute in nature, whereas the Nursing Facility and Waiver populations have the majority of their coverage provided through Medicaid funding. Separating these into the appropriate sub-groups allowed **Optumas** to make varying assumptions surrounding changes in mix and potential savings opportunities. Relying on the **Optumas'** staff experience with the LTSS populations, Colorado has made great strides toward getting their proposal approved by CMS.
California: Medi-Cal MCOs	2012 – 2014	**Optumas** provided consulting and actuarial services regarding the State's Dual Demonstration (Coordinated Care Initiative). The

Client	Dates of Services	Responsibilities/Successes Achieved
		Demonstration was an integrated care initiative across Medicaid and Medicare, aimed at members that are eligible for both Medicaid and Medicare benefits, dual eligible population. **Optumas'** experience with MLTSS allowed for actuarial insight in to how the Medicaid and Medicare actuaries were designing the initiative. In addition to identifying the risk associated with rate development, **Optumas** was able to identify potential operational risk inherit in the demonstration. Understanding these risks associated with the demonstration allowed **Optumas** to point out potential areas of concern for each of the MCOs and assist them in determining whether they should participate in the demonstration. As an example, when reviewing the LTSS rate build-up provided by the State, **Optumas** noticed the utilization/1,000 for the Long Term Care population was not consistent with the utilization/1,000 that we are accustomed to seeing through our extensive experience developing capitation rates for the Nursing Home Certifiable population. After discussing this observation with the Medi-Cal MCOs and the State, the State's contracted actuarial firm acknowledged that there was a data issue underlying the rate development that needed to be fixed. Through **Optumas'** insight, the State reevaluated their rate development and ultimately offered the Medi-Cal MCOs a rate that better matched the risk of the underlying population. Working on both the MCO side and State's side in other markets, such as California, allows **Optumas** to have a very good grasp of what is needed as far as transparency in the rate development process and allows **Optumas** to have meaningful conversations with both the State and MCOs.
Iowa: Iowa Medicaid Enterprise (IME)	2018 – Present	**Actuary of Record** IME requested that **Optumas** review the Health Link SFY18 capitation rate development that was completed by another actuarial contractor. The services included in the Health Link program include LTSS, physical health, behavioral health, and pharmacy. Based upon our review of the SFY18 rates, **Optumas** was asked to replace the existing actuarial vendor and develop SFY19 capitation rates for the Health Link program and the Dental Wellness program. In addition, **Optumas** assisted IME in developing risk corridors for the MCOs participating in the program during the SFY18 contract period and assisted in evaluating the impact of transitioning members from one MCO to another due to termination of an MCO's contract. The outcome of our assistance

Client	Dates of Services	Responsibilities/Successes Achieved
		was a risk corridor that retained the MCOs and allowed the state to continue its integrated managed care program. Pertaining specifically to the LTSS populations, **Optumas** has recommended a modification in how the existing Waiver cohorts are aggregated. The current approach blends high cost Waiver members, such as Traumatic Brain Injury (TBI) populations, with less acute Waiver populations, thereby creating mix risk issues within the aggregated cohort. This mix risk creates significant cross-subsidization amongst the Waiver cohorts, resulting in the potential for health plans to gain or lose money based solely on whether they enroll more members in the high-cost or low-cost Waiver cohorts. **Optumas** has provided IME with strategic recommendations on how to restructure the LTSS cohorts within their integrated Health Link program. **Optumas** provides solutions to nuanced MLTSS program designs such as this via thorough analyses aimed at identifying the risk differentials amongst covered MLTSS populations and services.
Kansas: Kansas Department of Health and the Environment (KDHE)(Medicaid)	2007 – 2014 and 2016 – Present	**Actuary of Record** **Optumas** helped the State of Kansas fundamentally reform their Medicaid program in 2013 with the implementation of KanCare The KanCare program allows the State to deliver Medicaid services to eligible recipients under a mandatory managed care framework via an 1115 Waiver. This is a comprehensive program, covering the majority of Medicaid eligible members in the State, and approaches the delivery of health care services in an integrated manor by combining physical health, behavioral health, pharmacy, and LTSS. LTSS are provided via a 1915(c) Waiver. Now that the program has been up and running for years, **Optumas** uses actual data submitted by the MCOs to develop the KanCare rates. **Optumas** applies extreme rigor and performs detailed analyses when projecting the mix between Long-Term Care and Waiver members, a fundamental piece of any MLTSS rate development. During the MLTSS rate development, KDHE notified **Optumas** that a portion of the Intellectually/Developmentally Disabled (I/DD) population had historically been underserved when they were under the FFS delivery system. As part of the resolution to this issue, all underserved DD members were provided the opportunity to be assessed for additional services. These members were to immediately begin receiving additional LTSS services if the assessment identified gaps in their plan of care. This required an adjustment to the managed care capitation rates being developed,

Client	Dates of Services	Responsibilities/Successes Achieved
		and **Optumas** worked with the MCOs to identify the impact of increasing the LTSS services provided to the previously underserved I/DD members. The MCOs provided detailed information on the plan of care for each I/DD member that was identified as being potentially underserved. **Optumas** analyzed this detailed member-level information in conjunction with the historic utilization levels and determined an appropriate adjustment to ensure that the capitation rates were in line with the updated plan of care for the previously underserved DD members. In addition to standard MLTSS rate development, **Optumas** has been successful in designing a variety of risk mitigation strategies in KanCare including: MLR risk corridors, Long-Term Care mix risk corridors, cost adjustment for I/DD rate cells to reflect variation in costs across MCOs and mix adjustment for specialized high cost TBI hospital admissions. These risk mitigation strategies provide necessary support and stabilization for a statewide comprehensive care program that covers nearly all populations and services, especially in the early stages of the program. **Optumas** also assists Kansas on its PACE program which covers all Medicare and Medicaid acute care and long-term services and supports to individuals aged 55 and older who meet a Nursing Home level of care.
Nebraska: Nebraska Medicaid	2012 – Present	**Actuary of Record** As the State's actuary and strategy consultant, **Optumas** develops actuarially sound capitation rates for the Heritage Health, Dental, and PACE programs. Additionally, **Optumas** successfully demonstrated our LTSS expertise by winning Nebraska's Request for Proposal to provide actuarial and consulting services to develop capitation rates for Medicaid Long-Term Care Managed Care in 2013. Although the program was never implemented, **Optumas** conducted multiple onsite presentations, which were aimed at educating state staff on nuances surrounding MLTSS implementation. Through **Optumas'** involvement, the Department was able to more effectively strategize key processes needed to successfully implement MLTSS in Nebraska Medicaid.

B. Proposed Development Approach

Within this section of our RFP response we will discuss items a through d as outlined under "V.D SOW 1 – Capitation Rate Setting" on page 25 of the RFP

a. Capitation Rate Methodology Development and Determination

For the initial capitation rate development, **Optumas** will work with the Department to ensure that the MLTSS rate development methodology is consistent with how the program will be operationalized. **Optumas** will follow all applicable Actuarial Standards of Practice and make certain that the capitation rate methodology used to develop the capitation rates complies with CMS guidance for the development of actuarially sound rates. The methodology will follow the same step-wise approach as mentioned in the Heritage Health section on page 87. Although very similar, we have highlighted a few key differences between the MLTSS capitation rate methodology and the Heritage Health capitation rate methodology below:

Base Data:
Optumas will work with the Department to identify members using long-term Nursing Home Services and/or Waiver Services inherent in the Department's detailed data. **Optumas** will define applicable sub-populations, such as Waiver types, members residing in a Nursing Facility, and members with limited Nursing Facility experience (short term stays). It is necessary to separately identify members with short-term Nursing Facility stays, as it is critical to exclude this experience from the base data used for rate setting. Since the Nursing Facility population included in an MLTSS program should represent members living in an institution, including members with short-term stays could artificially dampen the base data utilization. More specifically, one critical data validation step that **Optumas** always conducts during MLTSS rate setting is reviewing the utilization/1,000 for the Nursing Facility service for the Nursing Facility population. Since these members reside in the facility, the utilization/1,000 should be roughly 330k-350k, reflecting an average of 330-350 days out of a year spent in the Nursing Facility. To the extent the base data indicates less, **Optumas** would need to spend more time analyzing the detailed claims data to ensure that short-term stays are excluded.

As part of this process, **Optumas** will work with the Department to determine exactly which populations will be covered under the scope of the MLTSS program, as this will be instrumental in determining appropriate rating cohorts. For example, some MLTSS programs include the Intellectual/Developmentally Disabled (I/DD) population (e.g., ICF-DD, DD Waivers) as well as the Aged and Physically Disabled populations (e.g., Nursing Facility Residents, Aged Waivers, Physically Disabled Waivers). Others may exclude the DD population from managed care so that they remain in FFS or implement a phase in to include the DD population over time, after the program has been running for multiple years. Due to the differences in need and types of services between these populations, it is necessary to ensure that the covered populations are clearly defined to ensure the capitation rates are developed with the appropriate populations and services that will be present under the MLTSS program design.

Managed Care Savings Assumptions:
One key assumption in the MLTSS rate development that will need to be considered as a potential managed care savings opportunity, is the assumption regarding Nursing Facility diversion. Many MLTSS programs observe savings through the MCOs' ability to divert new enrollees to community-based settings, such that fewer members reside in a Nursing Facility due to the emphasis placed on community-based care. The significant difference in average cost of a Nursing Facility versus Waiver recipient member, means that this diversion effect can result

in substantial savings by keeping members in the community longer. While this is a significant savings opportunity, there are external factors that can determine the extent to which this diversion can occur. For example, there must be available Waiver slots for members to be able to transition to a community-based setting, otherwise MCOs are limited in the ability to divert members. Additionally, Department mandated requirements regarding an MCO's ability to quickly adjust member care plans will have an impact on the time horizon until savings can materialize.

It is important to consider external factors and have a thorough understanding of the operational practicality of Nursing Facility and Waiver aspirational mix assumptions to align rating adjustments with the Department's policies.

In the State of Alabama, we are assisting with an LTSS patient-centered case management system which focuses on individuals receiving LTSS services in the least restrictive setting of their choice. One of the major goals is to deflect individuals entering the program, who today would be referred directly into a Nursing Facility, into the HCBS setting. Working with the State and utilizing the Minimum Data Set (MDS) for individuals in the Nursing Facility in Alabama, it has been determined that a number of the current Nursing Facility residents are lower care needs individuals who, in the presence of this program, could have been deflected into the HCBS setting. With this in mind, assuming acuity levels are similar as individuals enter the LTSS system, we feel there is significant opportunity for this new program to create a shift in the mix of setting away from the Nursing Facility and into the HCBS setting. This program will pave the way for the anticipated rapid growth of the elderly populations in the coming years which will lead to a bending of the cost curve for the State and Federal budget and will improve the quality of care for the Alabama Medicaid LTSS enrollees.

Optumas will work closely with the Department to discuss various managed care savings opportunities and to further understand how the specific factors noted above will impact Nebraska's MLTSS program.

Non-Medical Load:
An emphasis will be placed on understanding a reasonable level of expenditures needed to facilitate care management/coordination for the LTSS population, as this generally drives a significant portion of the total non-medical costs for this population. **Optumas** will compare the non-medical load assumptions provided by the prospective MCOs to similar programs nationwide to determine reasonability and to develop the final rating assumptions that will be included within Nebraska's MLTSS capitation rates.

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

The first step in determining rating cohorts is to understand key indicators of risk for the populations enrolled in a specific managed care program, with consideration given to the covered services. Based on our extensive work in the Heritage Health program, **Optumas** currently uses the logic in Figure VI.A.3.iv to group the Long-Term Care populations enrolled in Heritage Health into broad rating categories:

Figure VI.A.3.iv – Heritage Health LTSS Cohort Logic

Cohort	Logic
Non-Dual LTC	LIVING_ARRANGE_CD in('12') and MEDICARE_COV_CD in('N')
Dual LTC	LIVING_ARRANGE_CD in('12') and MEDICARE_COV_CD notin('N')
Non-Dual Waiver	SPI_CD in('A' 'C' 'O' 'P' 'Q' 'R' 'W' 'X' 'Y' 'Z' 'B') and MEDICARE_COV_CD in('N')
Dual Waiver	SPI_CD in('A' 'C' 'O' 'P' 'Q' 'R' 'W' 'X' 'Y' 'Z' 'B') and MEDICARE_COV_CD notin('N')

Although these are the current Long-Term Care/Waiver cohorts used in the Heritage Health program, it is important to recognize that the introduction of LTSS into managed care may result in necessary changes to this rating cohort structures. LTSS makes up a significant portion of the total Medicaid spend for the populations noted above, and therefore may lead to proposed updates to population groupings for rate setting purposes. **Optumas** will review additional parameters, such as age, gender, level of care, and geographic location to determine if these cohorts are appropriate for the MLTSS program. As part of this review, durational analyses will be conducted to understand the volume of LTSS utilization for each of these populations; this will be conducted to validate that the populations identified using various criteria included in the eligibility files align with actual utilization of services such as Nursing Facility and Waiver services for this population. **Optumas** will work with the Department to determine the appropriate rating cohorts by analyzing summarized data and stratifying the population in a way that groups like risk and supports the overall strategy of the MLTSS program.

c. Develop a risk adjustment methodology

The majority of the expenditures for the LTSS populations are either Institutional room and board costs or Waiver Service costs. These costs are driven less by the presence of chronic conditions, and more by the need for assistance with Activities of Daily Living (ADLs), external support systems, and by the specific care plans designed for each member. This means that diagnosis and pharmacy-based risk adjustment used in a wide variety of non-LTSS programs, such as the current Heritage Health program, are typically not a good predictor of these LTSS cost drivers, as the data used to determine these weights (medical diagnoses and pharmacy NDCs) is not consistent with the experience to which the weights are applied (Nursing Facility and Waiver services). There are, however, alternative approaches for recognizing cost differences for the LTSS populations. For example, **Optumas** is currently working with the state of Iowa to implement a relativity factor adjustment; this adjustment will recognize the fact that there are differences in acuity and utilization for the LTSS populations between those enrolled in one MCO versus another. This is being developed with the intent to use historical utilization differences as observed in the MCO encounter data as the basis.

Optumas is currently working with Nebraska's Division of Developmental Disabilities, as well as the state of New York, on developing needs-based resource allocation approaches for DD Waiver populations. There are also tools in existence that may be of use, such as the InterRAI assessment tool. Implementing a similar type of approach for the Waiver populations underlying

the MLTSS program would take time to develop, adapt, and implement and may require at least one year of actual MLTSS experience to understand the initial member assignment between MCOs; however, this could be a viable long-term solution to addressing differences in both payments made to Waiver Service providers, as well as the difference in Waiver populations between MCOs.

Additionally, **Optumas** understands that Nursing Facilities in Nebraska are reimbursed using case mix adjustments resulting from the Resource Utilization Groups (RUG) grouper to differentiate payment for members with varying levels of care. While the levels of care may vary for an MCO from year to year based on the differences in members enrolled, the member-level information associated with the RUG grouper may be informative in developing either a concurrent (retrospective adjustment done after the contract period) or prospective (adjustment applied to the capitation rates prior to the start of the contract period) approach to risk adjusting the experience for the Nursing Facility residents between MCOs when developing capitation rates.

As noted in the response to part d below, a common approach to developing MLTSS capitation rates is to use a blended rate approach; under this scenario, one capitation rate is paid for both long-term care members as well as Waiver recipients. Under this approach, a key consideration is the assumed mix of long-term care versus Waiver recipients. The variance in the assumed mix between the two populations results in an impactful difference in the final capitation rate paid to each MCO. As a result, once initial program experience is available, these assumptions should be developed specific to each MCO. This is an additional mechanism that can be used to vary payment between MCOs, in lieu of a standard risk adjustment approach.

While standard health status-based risk adjustment methodologies are not generally appropriate for the LTSS suite of services, the alternatives above present opportunities for creating a variation of risk adjustment that can be applied in an MLTSS program.

d. Develop a range of rates that are actuarially sound

To develop actuarially sound capitation rate ranges for the MLTSS program, **Optumas** will follow a methodology that is consistent with CMS' Final Rule released in 2016 and all applicable actuarial standards of practice with respect to developing capitation rates. In developing actuarially sound capitation rates by rate cell, **Optumas** makes multiple actuarial assumptions. These assumptions are estimates of the impacts of various components of the rate development methodology. Multiple sources of program-specific information, industry information and in-house proprietary actuarial tools are relied upon to ensure that these assumptions are well-informed, unbiased, and as accurate as possible. **Optumas'** approach to developing actuarially sound rate ranges requires a review of all of the assumptions and adjustments used in the rate development process in order to determine PMPM costs at specific points in the rate ranges, including the lower and upper bounds.

The upper and lower bounds of the rate range are intended to represent amounts at which an appropriately managed health plan would be able to meet the access to care and quality of care standards as described in their contract. To determine the size of the rate ranges, **Optumas** examines variations in each component of the rate development process to determine these

specific points in the range. These variations, examined in isolation as well as in combination, result in a series of capitation rates that, when combined, define the rate ranges.

The components of MLTSS rate development that typically vary by lower bound and upper bound include:

- **Trend** – Assumed trend is smaller at the lower bound than the upper bound, reflecting more aggressive contracting and utilization management that can be undertaken by a health plan. **Optumas** usually varies the trend assumption for both utilization and unit cost; the magnitude of this variance is determined in part by looking at expected variance in trends from year to year and our review of trends used in other MLTSS programs nationwide.
- **Non-Medical Load – Optumas** typically varies the non-medical load assumption included in the rate range build-up. Non-medical load assumptions often have an inverse relationship with trend, meaning that a larger loading percentage is typically used at the lower bound, and a smaller percentage is then used at the upper bound. This approach is considered to reflect that a health plan will generally need to incur additional administrative expenses attempting to achieve the aggressive contracting and utilization management assumed in the lower bound trend rates. It would be challenging for a health plan to achieve trends commensurate with the values assumed at the lower bound and simultaneously have a non-medical spend in line with the lowest possible value. Therefore, it is common to pair the lowest, most aggressive trend assumptions with the largest reasonable non-medical load, and the larger, less aggressive trends with the lowest reasonable non-medical load.
- **LTC/Waiver Blend** – Many LTSS programs currently pay a blended rate, meaning that the MCOs are paid the same rate for members in an institution and those enrolled in a related Waiver program. This payment structure provides incentive for the MCOs to keep members in the community longer by using Waiver Services, as this setting of care is, on average, significantly less costly than an institutional setting of care. Particular consideration needs to be given to blending Nursing Facility and Waiver population rates. Through our experience developing capitation rates for MLTSS programs, **Optumas** has found that the assumed LTC/Waiver Blend is a major point of contention in negotiations with MCOs. Since there is not one correct answer for the appropriate LTC/Waiver blend, **Optumas** typically varies the blending assumption at the lower bound and upper bound to reflect a reasonable range of assumptions.

C. Technical Considerations

Due to the special nature of the LTSS population, key considerations need to be taken into account when developing capitation rates for an MLTSS program. We have listed a few technical considerations below:

Nursing Facility/Waiver Mix – The LTSS population will include members that receive Medicaid and Medicare benefits (Duals) as well as members only receiving Medicaid benefits (Non-Duals). In addition, the population will be made up of members receiving Waiver Services and members residing in a Nursing Facility. Each combination of these populations has a unique risk profile and utilize different services at varying levels. Because of this, it is very important to identify each of these populations separately and understand the mix of the sub-populations inherit in

the base data. Depending on how the program is operationalized and structured, an MCO could be assigned members that result in a different mix than other MCOs or that existed in the base data. This potential for mix differences will require **Optumas** to work with the Department and determine if an adjustment is needed for mix differentials by MCO.

Even if the decision is made to not vary the Nursing Facility/Waiver mix by MCO, the Department can still reflect a managed care efficiency adjustment through the assumed Nursing Facility/Waiver mix. More specifically, the Department has the ability to assume a higher percentage of members receiving Waiver services, reflecting the expectation that the MCOs will strive to keep members in the community longer through the use of Waiver services. This managed care efficiency adjustment is made to reflect a targeted diversion of Nursing Facility to Waiver that can be achieved through MCO population management. If this type of adjustment is conducted it is important that it be done in a way that considers external factors and limitations that MCOs may have in achieving this diversion. **Optumas** will work directly with the Department to understand how these factors relate to Nebraska's program when developing the LTC/Waiver blend used in the MLTSS rate development.

Nursing Facility Reimbursement – Despite rebalancing efforts, institutional care will continue to be a critical component of LTSS. One mechanism for states to ensure that Nursing Facility rates are fair and equitable is the use of a case-mix adjusted payment system, which reimburses providers according to the unique care needs of their residents, such as the RUG grouper that Nebraska currently uses in reimbursing Nursing Facility providers. Case-mix systems are proven approaches that have been implemented nationally for the Medicare Skilled Nursing prospective payment system, and in the majority of state Medicaid programs. As MLTSS programs continue to proliferate, states should consider MCO contract provisions retaining authority for both the methodology and function of rate setting for LTSS. This is critical as state-retained rate setting: (1) is administratively efficient; (2) minimizes access and quality issues for the state's most vulnerable populations; (3) mitigates potential market disruptions, thereby avoiding inequities and imbalances within health plans; (4) accurately and fairly accounts for variations in costs between providers; and (5) supports alignment of system incentives as well as compliance with federal law.

Total Cost of Care – It is important to capture the total cost of care in the initial data summaries so that **Optumas** can understand the true risk of the covered population. Traditionally, behavioral health services are very prevalent in the LTSS population. There are correlations between physical health and behavioral health for this population, for example, if the behavioral health needs are not met then typically these members end up having high emergency room or inpatient utilization. **Optumas** would like to review the total cost of care for these members and understand the current level of integration related to these services. Having a good understanding of the total risk associated with this population will allow **Optumas** to prepare a more robust rate methodology and assist in developing better actuarial assumptions.

D. Detailed Project Work Plan

Over the past five years, we have built a strong partnership with the Department and propose to maintain that partnership by utilizing the team members currently working with the Department for

this proposed contract. We have provided details of the key members on page 77 of this proposal. These members are already up-to-speed on all aspects of the Nebraska Medicaid program, and so they will be able to most efficiently develop the MLTSS capitation rates by relying on the institutional knowledge gained over the last five years.

Optumas recommends scheduling an onsite, kickoff meeting to discuss major tasks and outline expectations associated with the MLTSS rate development. This onsite discussion will allow **Optumas** to gain a deeper understanding of the program objectives and will ensure that **Optumas** is aware of the Department's expectations. As a result of this kickoff discussion, **Optumas** will create a project work plan, outlining key deliverables and timelines associated with the MLTSS rate development.

Optumas has included a sample of a detailed MLTSS Capitation Rate Setting project work plan for the State Fiscal Year 2020 (SFY20) contract period within Appendix II(B). Any additional analysis specific to MLTSS rate development that are not included within this sample project work plan will be reflected in the final project work plan developed at the start of the rate setting process along with any feedback from the Department.

E. Deliverables and Due Dates

Please see Appendix II(B) for deliverables and due dates associated with MLTSS Capitation Rate Setting. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department. Per our interpretation of page 25 of the RFP we have created a detailed project plan with deliverables and due dates on a state fiscal year basis. However, the project work plan and due dates can be adjusted to fit a calendar year basis to match the structure of the MLTSS managed care program contract period.

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SOW 1.1-Rate Data Analysis/Manipulation

SOW 1.1 – Rate Data Analysis and Manipulation

Since detailed FFS and encounter data are the basis of developing actuarially sound rates, **Optumas** recognizes the importance of comprehensive data analysis and manipulation. **Optumas** has extensive experience importing, manipulating, and analyzing Medicaid FFS and encounter claims, eligibility data, and financial template information for the State of Nebraska. Additionally, **Optumas** has performed the extensive data scrubbing and manipulation necessary to process all Nebraska Medicaid claims through PROMTHEUS and transformed the episode output into meaningful summaries. More details surrounding PROMETHEUS Analytics is provided below in the subsection beginning on page 117.

A. Understanding of the Project Requirements

Optumas understands the project requirements surrounding rate data analysis and manipulation outlined in the RFP on page 25. **Optumas** has extensive experience analyzing detailed and summarized data for State Medicaid programs. Figure VI.A.3.v below illustrates our experience with data analytics for various scope of services in other states:

Figure VI.A.3.v – Optumas Experience in Data Analytics by State

	State Experience																
Scope of Services	AL	AR	CA	CO	CT	KS	MA	MD	ME	MT	ND	NE	NH	NY	OH	OR	VT
Actuarial Analyses for Existing Pops	X	X	X	X	X	X	X	X	X		X	**X**	X		X	X	X
Actuarial Analyses for New Programs	X	X	X	X	X	X	X	X	X	X	X	**X**	X		X	X	X
Actuarial Analyses for New Pops	X	X	X	X	X	X	X	X	X	X	X	**X**	X		X	X	X
Program Design and Monitoring	X	X			X	X		X	X		X	**X**	X		X	X	X
Rate Dev Support	X	X		X		X		X			X	**X**			X	X	
1115 Waiver Assistance	X	X	X		X	X	X		X			**X**		X	X	X	
1915b/c Waiver Assistance	X	X			X	X	X					**X**	X			X	
Pub Meeting Supp and Facilitation	X	X			X	X	X	X	X		X	**X**	X			X	X
State GF Budget Modeling	X	X			X	X		X	X		X	**X**	X		X	X	X
Hosp Financial Modeling	X	X			X	X		X	X			**X**	X		X	X	X
Benefit & Reimb. Studies	X	X		X		X						**X**				X	
Rx Studies	X			X								**X**				X	
LTSS Assistance	X		X	X		X					X	**X**					

B. Proposed Development Approach

Within this section of our RFP response we will discuss items a through e as outlined under "1. Rate Data Analysis and Manipulation" on page 25 of the RFP.

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

Optumas takes great pride in our ability to create customized, comprehensive, program-specific financial templates. **Optumas** is responsible for creating the detailed, quarterly MCO financial templates used in Nebraska's Heritage Health and Dental programs from scratch. Prior to designing the financial templates, **Optumas** conducted several calls with the Department to gain an in-depth understanding of the Department's goals and objectives regarding the MCO financial templates. **Optumas** produced many iterations of the Heritage Health and Dental financial templates to ensure that the final template was fully customized to the Department's needs. After receiving feedback from the Department and MCOs, **Optumas** further tweaked the financial template such that it could be an effective tool for all participating stakeholders. The final product is a fully customized, quarterly financial template, which has been successfully used by the MCOs, the Department, and **Optumas** to:

- Benchmark encounters to the reported financial template to ensure that there is no missing data,
- Analyze IBNR estimates,
- Understand sub-capitation arrangements,
- Monitor category of service-level expenditures,
- Inform non-medical load, and
- Monitor health plan gains, losses, and potential risk corridor obligations.

We have included additional detail related to each bullet below:

Benchmark Encounters – The goal of rate setting is to match payment to risk, and validated financial reports are necessary for the actuaries to understand the underlying risk. During the rate development process, **Optumas** compares the encounter data to the MCOs' financial cost reports to identify any gaps in the data. **Optumas** then discusses any encounter data gaps with the health plans to make sure all parties understand the issues with the reported encounter data. The goal is to improve the data each rate setting cycle, so that there are no issues with developing actuarially sound rates. Since financial reports are so important in identifying gaps in the encounter data, it is essential that the financial reports are accurate and complete. We validate the financial reports against the National Association of Insurance Commissioners (NAIC) filings that health plans are required to submit quarterly and annually. In addition, CMS' Medicaid and CHIP Managed Care Final Rule requires that the MCO financial cost reports are audited from an independent accounting firm to ensure accuracy. We analyze quarterly and annual financial cost reports (benchmarking against the encounter data and NAIC filings) in all states that we certify rates (CO, IA, MD, ND, NE and OR; AL and AR are beginning the transition to managed care, so this analysis has not yet been performed but will in the near future). Optumas will supplement our experience by partnering with Myers and Stauffer, LC (**MSLC**). **MSLC** is an industry-leader in healthcare accounting services and will be able to conduct all of the plan oversight and on-site review required by the Department. The bulk of MSLC's responsibility will fall under SOW 2.1, beginning on page 157.

Analyze IBNR – Optumas reviews the IBNR reported in the MCOs' financial templates versus the actual expectation of IBNR for a particular time period. Generally, health plans report IBNR consistent with estimates used for regulatory filing, such as their NAIC statements. In our experience working with health plans as the actuary in multiple states, as well as in working for the health plan in certain states, these estimates typically include some level of PAD (Provision for Adverse Deviation). This is particularly important when analyzing total experience for more recent time periods. In our experience across the nation, including specifically in Nebraska, we have seen that the total claims costs reported in the most recent quarter or two quarters will reduce significantly once additional runout becomes available; in other words, once actual experience replaces IBNR estimates, it is clear that the initial IBNR estimate overstates what actually occurred. **Optumas** works with each state to discuss specific observations and analyze patterns that exist in their particular MCOs' reported financials. As part of this work, **Optumas** develops normalization techniques to adjust IBNR estimates to remove PAD and reflect a more realistic total expenditure estimate. In our work with the Department, we have seen that some MCOs show overall differences in medical expenses of over 10% due predominantly to overstated IBNR in quarters with little runout. When discussing comparisons with the Department, we create a normalized IBNR amount that is based on reviewing prior quarters' overstated amounts, IBNR amounts reported by other MCOs for the same categories of service, as well as independent IBNR estimates conducted by **Optumas**, based on reviewing payment lag triangles for the particular MCO's historical experience.

Understand Sub-capitation Arrangements – In addition to review of IBNR, another component of reported medical expenditures that needs to be reviewed is reported costs related to subcapitated arrangements. It is important to understand whether the subcapitated amounts reported include the underlying claim costs or if it reflects the premium that the MCO pays directly to the subcapitated entity. This may seem like a minor distinction, but as alternative payment arrangements become more prevalent health plans are moving towards business models that provide a large volume of services under subcapitation. As a result, it is important to understand what exactly is being reported to ensure that when these costs are considered in developing capitation rates, they are done so appropriately.

Monitor Service-level Expenditures – Optumas uses the financial template as a starting place for service-level analyses. The financial template is a summary document, so it collapses expenditures to higher-level service groupings. This collapsed summary is very convenient for MCO comparisons. For example, **Optumas** can array the spend of each MCO by service category and see where MCOs pay different amounts (on a PMPM basis). Differences in spend quickly emerge from summarized data and indicate where additional scrutiny may be beneficial. Since data is very summarized in the template it will not necessarily provide answers on what is causing spend differences, but it is a very useful tool for directing future data exploration.

Inform Non-Medical Load – Non-medical load includes items such as administrative costs, case management costs, reinsurance premiums, activities that improve healthcare quality, taxes, and fees. It is important to first recognize how these categories vary between health plans, to understand if there are any outliers and to identify which costs may require

additional questions to the health plan to further understand. Once this comparison is complete, further review and consideration will be conducted to determine how much of the reported non-medical load costs are appropriate for inclusion within rate development. For states that require premium recoupments for health plans that fall below specified medical loss ratios (MLR), it is important to define which non-medical expenses can be included in the numerator of the calculation. For example, certain case management costs as well as activities that improve healthcare quality can be included along with medical expenses in the numerator of the MLR calculation. Additionally, taxes and fees incurred by a health plan need to be considered in rate development but separate from other non-medical load categories. It is important to understand which taxes and fees are applicable and how they are reported, to ensure they are accurately included in the rate development process.

Monitor Gains, Losses, and Risk Corridor Obligations – The financial template summarizes health plan experience resulting in a quarterly gain or loss figure. This figure is subject to change as additional payments clear and are added in to subsequent templates, but it is a very helpful snapshot of MCO financial health, rate adequacy, and program stability. Since the Heritage Health program includes a risk corridor, it is also a helpful tool for monitoring the payment obligations MCOs or the Department may make when reconciling risk corridor payments. **Optumas** can apply the IBNR adjustment mentioned previously to correct the reported data and reflect a more accurate picture of the current standing of each MCO.

Since the MLTSS program will be new to Nebraska Medicaid, the selected contractor will need to have extensive experience designing MCO financial templates to help capture costs associated with claims and administration services. As the sole creator of the Heritage Health financial template, **Optumas** is very familiar with Nebraska's reporting measures and desired layout. If awarded this contract, **Optumas** will follow a similar process when designing the financial template for the MLTSS program (or updating the Heritage Health template to include services and populations relevant to MLTSS). **Optumas** understands the importance of creating a comprehensive, customized financial template for the MLTSS program since it is a crucial component of the MLTSS rate development process.

***Optumas** has extensive experience creating managed care program-specific financial templates for each of our clients, including those currently used by the Department for the Heritage Health MCOs.*

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

Program change adjustments recognize the impact of eligibility or benefit changes occurring in or after the base data period. CMS requires that program changes are accounted for in the development of actuarially sound rates. Program changes may consist of accounting for the financial impact of adding a new population or service that was not previously covered under managed care or may consist of changes in reimbursement levels or utilization limits for certain

services that have historically been covered. **Optumas** ensures that all programmatic changes are accounted for within the rate development process and has significant experience accounting for specific programmatic changes within Nebraska's managed care programs.

Figure VI.A.3.vi reflects a few examples of specific programmatic changes that **Optumas** incorporated into the development of the CY18 Heritage Health capitation rates, including the description and overall impact by Rating Region (RR) these had as described in the certification letter.

Figure VI.A.3.vi – CY18 Heritage Health Program Changes

Adjustment	Overview	Impact
FQHC and RHC Repricing	**Optumas** calculated and applied an adjustment to account for FQHC and RHC APM/PPS rate changes. **Optumas** adjusted the FQHC and RHC rates inherent in the encounter data and FFS data to be commensurate with the latest FQHC and RHC APM/PPS rates. This adjustment applies to all FQHCs and to RHCs with 50 or more beds.	CY15 - RR1: 0.30% CY15 - RR2: 0.17% CY16 - RR1: 0.11% CY16 - RR2: 0.15%
General Provider Fee Change	Effective July 2015 and July 2016, the State has implemented a 2.25% provider increase for Behavioral Health services and a 2.0% provider increase for Physical Health services. **Optumas** applied the increases to all applicable services, with the exception of FQHC/RHC/IHS providers, ACA enhanced primary care procedure codes, Outpatient Critical Access Hospital services, and Pharmacy services. There is no provider rate change effective July 2017 and it is expected that there will not be one for July 2018.	CY15 - RR1: 2.12% CY15 - RR2: 1.96% CY16 - RR1: 0.73% CY16 - RR2: 0.65%
ABA Service Addition	Beginning October 2015, the State required the coverage of applied behavior analysis (ABA) and Behavioral Modification services for children with an Autism Spectrum Disorder (ASD) or a Developmental Disability (DD) diagnoses. **Optumas** used the available emerging experience to estimate the costs of these services in the contract period.	CY15 - RR1: 0.11% CY15 - RR2: 0.04% CY16 - RR1: 0.05% CY16 - RR2: 0.02%

Programmatic changes are also necessary during the development of MLTSS capitation rates to ensure that historical experience reflects the most recent State and Federal policy (populations, services, and reimbursement) prior to its use in projecting rates. The following are specific examples of program change adjustments that we have successfully evaluated in our recent MLTSS rate development:

Fee Schedule Changes – Optumas calculated the impact of updates to the Medicaid fee schedules, such as Nursing Facility per diem changes, by comparing base data utilization at

the effective base rates to the rates that will be in effect during the contract period. In order to most accurately capture the effect of fee schedule updates, **Optumas** evaluated the reimbursement changes at the detailed, claim-line level by repricing each line to the latest fee.

Waiting List Reductions – Many Waiver programs have waiting lists where members are in a state of pending eligibility while access to care issues are addressed. Occasionally states focus on reducing the waiting lists for specific programs, which can result in a sharp increase in Waiver program enrollment. This can also represent a large group with a new level of need suddenly enrolling in MLTSS. A final complicating factor is that there is typically no service utilization data for this population that is pending Waiver enrollment. **Optumas** has addressed MLTSS-specific changes like this in multiple states where we set capitated long-term care rates. Our approach includes identifying the number of people currently on the waiting list, comparing that to the number of people enrolled, and constructing scenario models to determine the potential impact of new enrollees. Scenario models are built using a range of data sources to determine potential acuity changes. First, we will look back through the historical Medicaid data in an attempt to find current waiting list members as previous active enrollees. This frequently returns a very low match rate due to the nature of long-term care enrollees; once they enroll they very often remain enrolled for the rest of their life. Despite the low match rate, it is worthwhile because when successful it provides concrete information about the acuity of waiting list members. Next, we use reference data from neighboring programs who have waiting list criteria changes to study the impact new enrollees created in their program. We currently set the MLTSS rates for Iowa and Kansas and possess the LTSS data in Colorado (Colorado currently does not have an MLTSS program), so we have ample, relevant reference points for this task. Finally, we plug any remaining holes in our analysis by using financial reports compiled by other departments and survey data. These are imprecise sources, but they can provide a view of the population's potential need and service utilization.

***Optumas** has MLTSS rate setting experience and data for neighboring states and can use this regional experience for benchmarking purposes throughout capitation rate development.*

Prescription Drug Changes – **Optumas** recently modeled the impact of certain drugs moving from a 30-day prescription to a 90-day prescription halfway through the base data time period for the LTSS population. The impact of this policy was calculated by reviewing the utilization per 1,000 of these drugs longitudinally on a monthly basis. The utilization per 1,000 that was incurred prior to the effective date was compared to the utilization per 1,000 levels in the base data after the effective date of the policy. The change in utilization was applied to the dispensing fee effective during that period to reflect members only receiving one prescription for 90 days rather than three prescriptions for 30 days.

c. Analyze medical and pharmacy service utilization and cost profile patterns by category of service for all Managed Care cohorts

Optumas has worked with the Department to develop a detailed category of service (COS) logic for the Heritage Health program. The Heritage Health category of service logic uses a hierarchical approach to ensure that claims are not split across multiple categories. For example, if a claim has both an Evaluation and Management code (typically bucketed into the Primary Care Physician COS), and a Laboratory or Radiology code (typically bucketed into the Lab and Rad COS), the entire claim is considered PCP since it appears first in the hierarchy. **Optumas** applies the COS logic at the detailed claim-level. Once a COS is assigned to each claim, **Optumas** summarizes the information into a databook consisting of member months, dollars, units, utilization per 1,000, unit cost, and PMPM information by region, eligibility cohort, and category of service. This databook is then shared with the Department and the MCOs to help facilitate meaningful discussions surrounding the starting point for rate development.

Optumas analyzes trend separately by utilization and unit cost and typically develops trends by region, cohort, and categories of service. Due to the uncertainty surrounding new break-through drugs, such as Hepatitis C treatment, **Optumas** has paid particular attention to analyzing the split between brand drugs, generic drugs, and specialty drugs included in the Pharmacy data when developing trend projections. **Optumas** arrays the Pharmacy data longitudinally by these three drug classes to analyze the utilization and cost patterns by cohort across time. It is critical to separately identify the cost patterns inherent in the various drug classes since they represent vastly different services and have different cost drivers.

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

IBNR Claims Adjustments – As described in part a of this section, beginning on page 112 above, **Optumas** conducts reviews of MCO reported IBNR and compares this to multiples benchmarks. These include IBNR reported for other MCOs within a given market, historical IBNR provided by the MCO compared to what ultimately occurred in that time period once sufficient claims runout was present, as well as independent lag triangle-based IBNR development. When it comes to incorporating IBNR estimate for purposes of rate development, **Optumas** generally relies on its internal IBNR models, which include methodologies to omit payment outliers, recognize emerging payment patterns, and result in reasonable completion factors that can be applied to appropriate base data.

Non-Medical Loading (Administrative and Care Management Overhead) – Non-medical load (NML) measures the dollars associated with components such as administration, risk, contingencies, and profit and are usually expressed as a percentage of the capitation rate. CMS' 2017-2018 and 2018-2019 Medicaid Managed Care Rate Development Guides state that the non-benefit component must include reasonable, appropriate, and attainable expenses related to the following: administrative costs; care coordination and care management; provision for margin, taxes, fees, and assessments; other material non-benefit costs.

Optumas utilizes several tools in our NML development:

- Build the NML components by the categories required by CMS listed above by population. This requires a thorough understanding of the MCO requirements in the

contract. In addition, we meet with our clinician to assist in the development, who has 30+ years of experience in Medicaid Managed Care.

- Guidance provided by the Society of Actuaries in their paper "Medicaid Managed Care Organizations: Considerations in Calculating Margin in Rate Setting." Key items to consider for margin include insurance risk, contribution to risk-based capital, income taxes, investment in IT infrastructure, investment in care management infrastructure, and contributions to owners/shareholders for MCOs that are for-profit.
- Per the Final Revised Medicaid Managed Care Rule, actuarially sound rates are set to achieve at least an 85% medical loss ratio (MLR). This threshold should be considered for smaller PMPMs such as children rate cells to ensure an estimated 85% loss ratio may be achieved.
- Benchmark developed figures against other states' financial cost reporting templates by population group both on a PMPM and percentage of premium basis.

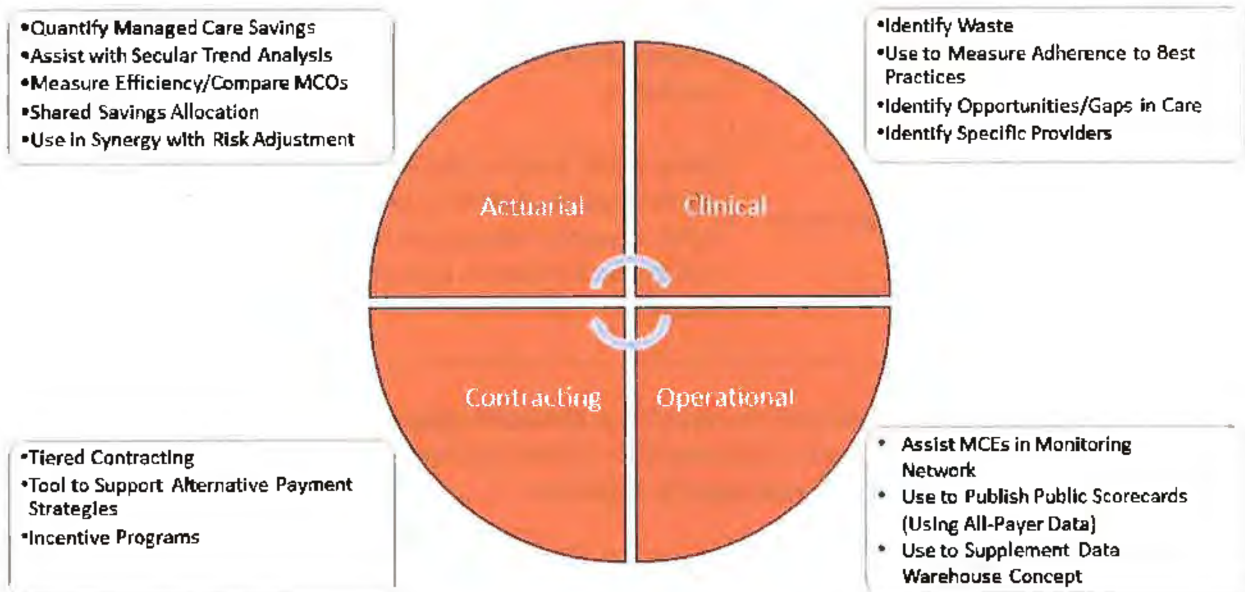
Appropriateness of Medical Costs Incurred – Optumas conducts various analyses to review the appropriateness of medical costs incurred in managed care programs. One of the primary tools that **Optumas** uses for several State clients is PROMETHEUS. Currently, **Optumas** has been working collaboratively with the Department to understand where areas for improved efficiency exists and to help understand the appropriateness of certain medical services based on the results of the PROMETHEUS tool. PROMETHEUS is an industry-standard episode of care grouper developed by its founders, Altarum, under a grant from the Robert Wood Johnson Foundation. Since its creation, it has been adopted by major payor groups, including Anthem, Cigna, and the New York State Health Foundation, as the definitive way to identify Potential Avoidable Complications (PACs). Altarum has since added modules that identify Low Value Care (LVC), Potentially Avoidable Services (PAS), and Network Efficiency/Effectiveness (NEE). **Optumas** has been designated a Chartered Analyst for the PROMTHEUS analytical package and is the only actuarial firm to achieve this status. We are the only actuarial firm able to use PROMETHEUS to assist the Department in identifying inefficiencies in care delivery. Our main goal is simple – use PROMETHEUS to help the Department improve healthcare for the Nebraska Medicaid recipients. **Optumas** has partnered with the tool's developer, as the developer was looking for a single actuarial partner with the technical expertise necessary to convert episode results into per member per month (PMPM) figures using detailed claims data, and **Optumas** was the only actuarial firm with the demonstrated proficiency. This tool uses detailed clinical algorithms to group claim and encounter data into episodes of care. It then compares the services provided, the outcomes, and the cost to clinical best practices to identify any inefficiency in the form of PACs, LVC, and NEE. **Optumas** is actively exploring additional applications of PROMETHEUS for measuring efficiency in both FFS and Managed Care delivery systems. The algorithm used by PROMETHEUS to identify PACs, LVC, PAS, and NEE creates the

The PROMETHEUS tool can be utilized by the Department to drive efficiency within its Managed Care Program(s).

***Optumas** is the only actuarial firm certified as a Charted Analyst by Altarum, the creators of the PROMEHTEUS Analytics software.*

potential for provider report cards, managed care efficiency adjustments, incentive payment structures, gain augmentation programs, and/or shared savings arrangements. The results from the PROMETHEUS tool can be used in actuarial, clinical, contractual, and operational settings. Figure VI.A.3.vii below illustrates a few potential applications of the PROMETHEUS analytics in each of these settings:

Figure VI.A.3.vii – Potential PROMETHEUS Applications



Optumas has worked extensively with the Department over the past 18 months to incorporate PROMETHEUS into the Heritage Health program. We have held numerous meetings with the Department and the contracted MCOs to ensure the application of PROMETHEUS is done as a partnership. PROMETHEUS implementation is scheduled for Calendar Year 2019 rates in the form of a managed care efficiency adjustment. The extensive background process has allowed **Optumas** to share actionable data elements with the MCOs, making sure that PROMETHEUS output is used to truly transform the care delivery in the state, rather than simply being a punitive rating adjustment.

Most recently, **Optumas** has applied, or is in the process of developing an approach to apply, the PROMETHEUS tool in Alabama, Colorado, Nebraska, and Oregon. Figure VI.A.3.viii demonstrates the various applications of the PROMETHEUS analytics in each state:

Figure VI.A.3.viii – PROMETHEUS Application by State

State	Objective	PROMETHEUS Application
Alabama	Quantify savings associated with moving from FFS to Managed Care	Analyze PAC rates by episode type (i.e. Chronic, Acute, Procedural, etc.). Discuss results with our internal clinician to determine which episodes and populations are most likely to achieve savings under Managed Care from a clinical perspective.

State	Objective	PROMETHEUS Application
Colorado	Compare quality and efficiency across hospitals	Review PAC rates and distribution of episode type by provider. Compare results across hospitals to determine which facilities are most efficient.
Nebraska	Analyze efficiency between MCOs	Review PAC for key episodes present within the population enrolled in Heritage Health and have discussions with internal clinician. The goal is to develop efficiency adjustments that reflect reduction in PAC that MCOs can reasonably achieve, by targeting to specific types of episodes.
Oregon	Develop Alternative Payment Methodologies	Review PAC rates across differing Alternative Payment Methodologies (APM) to help determine the success of each APM. Use this information to identify what kinds of reform will be most effective and where the reform should be focused.

As the figure above illustrates, for each State Medicaid program, **Optumas** is able to use the PROMETHEUS tool to better understand the underlying risk of each program and to assist each state in achieving their program-specific objective.

e. Analyze inflation, economic, and health related trends

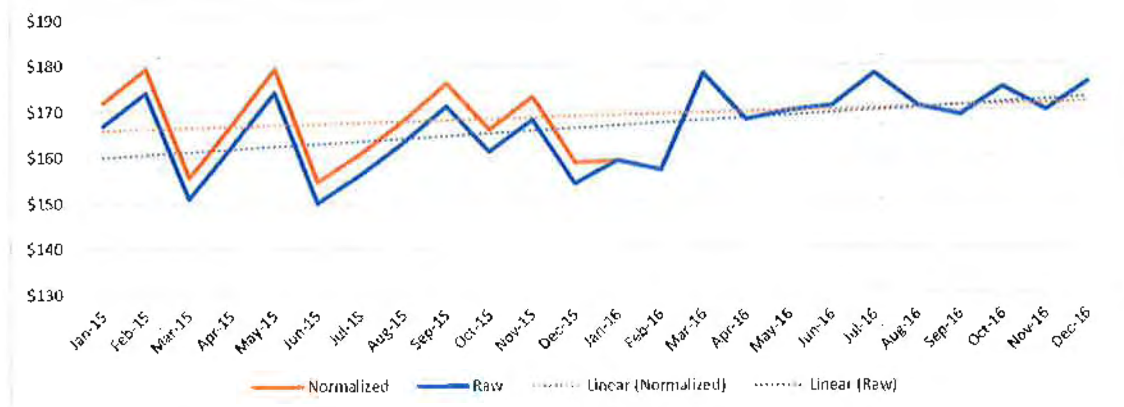
Optumas has extensive experience developing inflation, economic, and health related trends for capitation rate setting. The subsection of SOW 1 beginning on page 89 discusses our experience developing trends for the Nebraska Medicaid program in detail. Below we have included a few nuances to consider when developing healthcare trend:

Normalization:
To properly develop healthcare trend analyses, it is necessary to normalize historical data for geographic region, population, service, and reimbursement mix. Normalization is done by bringing all months of data to be on the same basis with respect to membership distribution and public policy decisions. For example, if a state passes a 2% provider increase effective 1/1/16, it is necessary to increase reimbursement for all data incurred prior to that date by 2% to control for the policy change. This allows for true, secular trend to be itemized and analyzed, and avoids double counting policy changes as trend.

Figure VI.A.3.ix has been created to illustrate the impact state fee schedule changes can have on trend development. This hypothetical data includes a 3% reimbursement increase effective 1/1/2016. The blue line represents raw summaries of expense PMPM for calendar years 2015 and 2016, and the orange line represents the normalization of 2015 expenditures by increasing the cost by 3% so it is on a comparable reimbursement basis as the 2016 experience. The dotted lines represent the corresponding linear trend estimate for both the raw (blue dotted line) and normalize (orange dotted line) data sets. As you can see, the raw data implies a much steeper linear trend rates, while the orange line, which has been properly normalized for fee schedule

changes, implies a smaller trend rate. As indicated by this example, failure to normalize data for state policy changes causes inaccurate trend development. **Optumas** will exhaustively review state policy changes with the Department to ensure all potential policy-based rate changes are normalized and accounted for during trend development.

Figure VI.A.3.ix – Impact of State Fee Schedule Changes during Trend Development



In addition to program change normalization, it is important to mix-control for demographic information, such as age, sex, rating cohort, and geographic region. This is accomplished by using the demographic distribution of a single "snapshot" month to summarize all months of service incurral data. This is necessary to ensure that changes in enrollment (e.g. a gradual transition to a population with an older average age) are not mistaken for service unit cost or utilization trend. By using a consistent demographic distribution to summarize data, secular trend rates can be analyzed and projected benefit costs are more accurate.

Normalizing data for public policy changes and demographic differences is essential for valid trend development.

Figure VI.A.3.x shows a simple example of the impact of data normalization on trend development. In this example, we have calendar year 2015 and 2016 data on three populations: Aged/Disabled, Adults, and Children. As the raw (prior to normalization) total shows, the aggregate cost of the program PMPM increases drastically from year one to year two. However, that is caused by a shift in enrollment increasing the portion of the total population that is in the Aged/Disabled cell. The normalized total, which uses 2016 enrollment to aggregate 2015 and 2016 cost figures, shows the true cost growth in the program. This type of population normalization is essential to distill true cost changes from shifts in the population enrollment mix.

Figure VI.A.3.x – Example of Population Normalization

	2015		2016		
Component	Enrollment	Cost PMPM	Enrollment	Cost PMPM	% Change
Aged/Disabled	1,500	$1,000.00	2,500	$1,020.00	2.0%
Adult	2,500	$500.00	1,500	$515.00	3.0%
Child	3,500	$200.00	3,500	$202.00	1.0%
Un-normalized Total	7,500	$460.00	7,500	$537.27	16.8%
Normalized Total	7,500	$526.67	7,500	$537.27	2.0%

Trend Methods:

Once valid data has been summarized by month and normalized for all policy and demographic differences, the data is arrayed by rating category, service type, and month of service, so that historical utilization/1,000, unit cost, and PMPMs could be reviewed. Typically, the data is arrayed so that three-month moving averages (MMA), six MMA, and 12 MMA can be calculated. Additionally, least squares trend estimates and linear regression are calculated on the data to provide data-based historical growth factors. In general, a combination of these metrics is used to determine prospective trend, but there is not a pre-determined algorithm in place. Instead, the trend estimate that is appropriate for a given managed care rate setting project varies based on nuances with a specific population or service type. Given that healthcare trend analyses are used as a projection of future experience, it is necessary to make adjustments to consider that historical trend experience may differ from what will materialize in the future. For example, certain populations and services may experience large increases or reductions in spend, but these large trend rates may not be appropriate to project into the contract period. Smoothing outliers is a benefit of incorporating reference data, which **Optumas** uses as necessary.

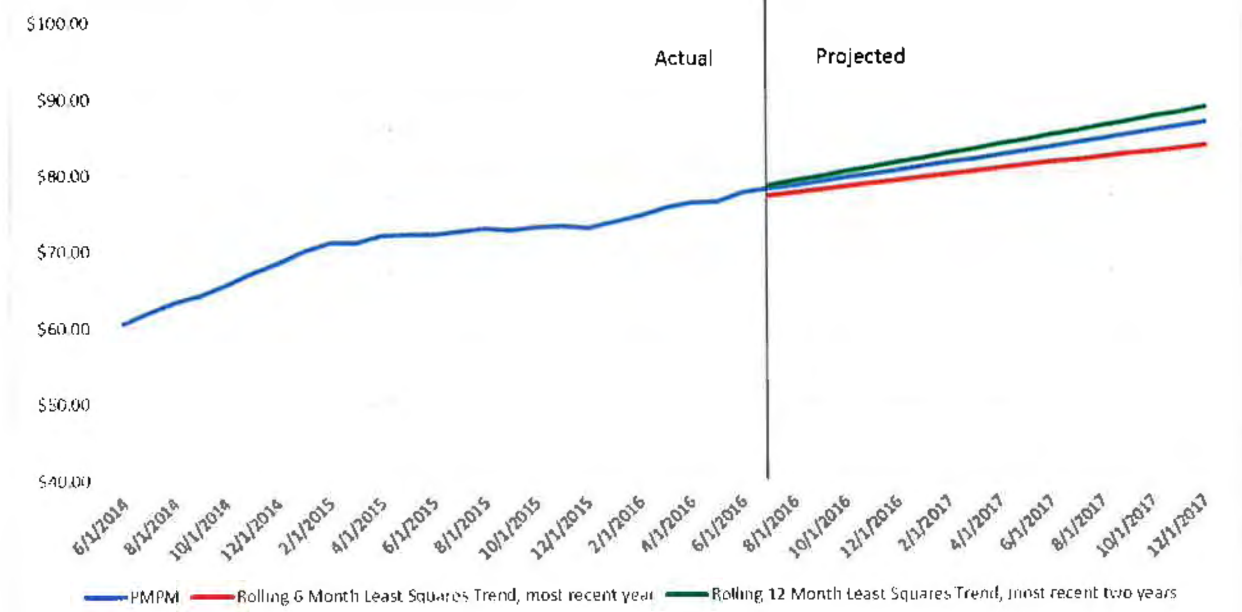
The following graph, labelled as Figure VI.A.3.xi, shows a sample of **Optumas**' trend calculations. As we have emphasized through this response, we create a customized approach to trend development based on each client's program design. This is one approach that was successful for a certain client, and the applicability of this would be analyzed for the Department, especially when considering the inclusion of the LTSS population/services, before using a similar approach. In the graph below, the blue line shows the cost PMPM for a specific service and population. The graph below contains the following lines/figures:

- The blue line is the actual program experience up until the solid vertical line, at which point it become **Optumas**' projection of future program experience,
- The green line uses a least squares linear regression applied to a 12 Month Moving Average of the most recent two years of data to project expenses, and
- The red line uses a least squares linear regression applied to a six Month Moving Average of the most recent year of data.

For the specific project depicted in the graph, **Optumas** uses the trend estimates created by the green and red lines in conjunction with our expertise and familiarity with reasonable benchmark trends to create an assumed projection rate. This projection rate is then applied to actual data and graphed (as the blue line in the "Projected" portion of the graph) to ensure reasonableness and consistency with actual program experience. As the graph indicates, application of

Optumas' chosen trend rate results in a reasonable estimate of future cost growth for the population and service currently being analyzed in the graph.

Figure VI.A.3.xi – Example of Trend Methods



Transparency:

A final component of trend development that **Optumas** incorporates when approved by our clients is transparent communication with participating Managed Care Organizations. Trend development is a fairly subjective component of actuarially sound rate development, so occasionally it is a point of disagreement between states and their contracted health plans. **Optumas** attempts to mitigate this by having frequent and transparent communication with stakeholders regarding the data that is used for trend, the primary calculation method employed, and the resulting trend selection. Even if these conversations end and each side still believes their approach is more appropriate, the discussion generally leads to an understanding of how the trend rates were calculated and why they are considered reasonable. These conversations are at the discretion of the state, but **Optumas** feels they are a very useful component of developing a successful managed care environment.

This has been particularly useful in the Nebraska Medicaid program. Over the past five years working with the Department, as well as working with these same MCOs in other states, we have developed a professional relationship with the Nebraska MCOs. Although the MCOs may not always agree with our assumptions, they appreciate our thoughtful analyses and unbiased opinion. The key here is the ability of the **Optumas** team members to effectively communicate the complex methodologies used in the rate development steps, such as trend development, in such a way that the MCOs and their actuaries can understand the how and the why behind our methodologies and calculations. It is not

Optumas has worked to inspire confidence, credibility, and trust with the MCOs and the Department through our experience over the past five years.

enough to do the math right – we need to be able to explain the math in a way that can be understood and inspires confidence, credibility, and trust by the MCOs and the Department. We have executed that role successfully for the Department in the past and will use the same **Optumas** team for this contract to ensure we can continue to execute in the future.

C. Technical Considerations

To efficiently and effectively complete data analyses, it is necessary for **Optumas** to receive standard data extracts. **Optumas** has set up the ability to automatically receive monthly and quarterly data extracts from the Department. Over the last five years, **Optumas** has worked with the Department and the Department's data vendor, Truven, to determine a standard data layout. **Optumas** then constructed a data warehouse based on the agreed-upon data format. **Optumas** then sets up repeatable protocols that allow for rapid data intake and validation, ensuring that new datasets and quickly imported and combined with historical information to create a full and complete data repository, without additional work or effort required by the Department staff or Truven. With the creation of a data library, **Optumas** can quickly complete standard analyses related to the MCO capitation rates and queue up any specific data analytics the Department might desire.

D. Detailed Project Work Plan

Please see Appendix II(A) for a sample SOW 1 Capitation Rate Setting detailed project work plan and the rate data analysis and manipulation involved in rate development.

E. Deliverables and Due Dates

Please see Appendix II(A) for deliverables and due dates associated with Capitation Rate Setting and rate data analysis and manipulation involved in the rate setting process. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department. Per our interpretation of page 25 of the RFP we have created a detailed project plan with deliverables and due dates on a state fiscal year basis. However, the project work plan and due dates can be adjusted to fit a calendar year basis to match the current structure of the Heritage Health managed care program contract period.

SOW 1.2-Interim Reporting
Other Deliverables/Rate
Setting Functions

SOW 1.2 – Interim Reporting and Other Deliverables for Rate Setting Functions

Throughout the capitation rate setting process, **Optumas** provides interim reporting and deliverables pertaining to rate setting to the various stakeholders involved, both the state Medicaid Department and MCOs. **Optumas** currently works with the Department to identify and provide the desired interim reporting and deliverables at the start of each rate setting process and will continue to do so to the extent we are retained as the consulting actuaries to the Department. These reports and deliverables are essential for maintaining a transparent and collaborative rate development process and are useful in ensuring timelines are met and all vested entities are given the opportunity to fully understand the components and outcomes of the rate development as well as the chance to ask questions and request additional details on any analyses **Optumas** performs in a timely manner.

A. Understanding of the Project Requirements

Optumas understands the project requirements of interim reporting and other deliverables for rate setting functions as described on pages 25 and 26 of the RFP. **Optumas** prides itself as a firm that is very transparent in all aspects of rate development and the supporting analyses involved in the rate setting process. We recognize the importance of regular touch points, as well as providing interim reporting and other deliverables as part of rate development, so everyone involved in the process is able to monitor progress and to the extent any potential issues or nuances arise, these can be addressed efficiently. Within the numerous states that **Optumas** develops capitation rates, including Nebraska, there are key components of the rate development process that we consistently report and provide deliverable analyses to our clients. These rate development components generally include, but are not limited to, the following items outlined in Figure VI.A.3.xii below.

Figure VI.A.3.xii – Example of Key Deliverables

Reports and Deliverables	Description
Questions Logs	Provides a running document of all question and response correspondence between the Department and **Optumas**, including a variety of questions regarding detailed data, general program change questions, and other policy/leadership decisions among others. An example of a questions log surrounding the Nebraska MMIS data is contained in Appendix IV(A).
Proposed Project Timelines	Project timeline with key milestones and estimated completion dates outlined with a brief description of the rate development component. **Optumas** has included sample work plans, inclusive of timelines and key milestones within Appendix II.
Data Validation Summaries	Longitudinal summaries, analyses, and additional checks performed during the data validation process for both claims and eligibility data. Please see Appendix IV(B) for an example of a data validation summary.
MCO Financial Comparisons	Comparison of MCO financial data to the encounter data used for rate setting. Appendix IV(C) contains an MCO financial comparison that we prepared for the Department in a prior rate setting cycle.
Base Data Summaries	Summaries of the base data used for rate development. This is often combined with a meeting between the Department,

	Optumas, and the MCOs to ensure everyone agrees with the starting point used for rate development. **Optumas** has included a sample base data summary from the CY18 Heritage Health rate development cycle in Appendix IV(D).
Policy Change Logs	List of key retrospective and prospective program changes that are applicable to the base data or contract period of the rate development. Appendix IV(E) contains a snapshot of our ongoing policy change log for the Department.
Risk Adjustment Analysis, Prevalence Reports, and Methodology Narrative	**Optumas** provides the detailed risk adjustment analysis and accompanying methodology narrative so MCOs can completely understand the application of health-based risk scores within the rate development. Additionally, MCO specific Prevalence Reports are provided so the plans can compare **Optumas'** risk score modeling with that of their internal reporting on the prevalence of certain conditions for their enrollees. Please see Appendix IV(F) for a snapshot of a risk score Prevalence Report that **Optumas** provided to the Heritage Health MCOs.
Meeting Minutes Log	A tool used to summarize key points discussed during meetings, as well as the associated action plan and member reasonable for each actionable item. Appendix IV(G) includes a sample meeting minutes log.
Program Information Dashboard	Program information dashboards are sophisticated data visualization tools used to show key health care reporting metrics across programs, categories of service, providers, and regions. A sample program information dashboard created by **MSLC** has been included in "Figure VI.A.3.xix –Dashboard Examples" in the subsection beginning on page 169.
Interim Rates Presentation	Typically, an onsite presentation between the Department and MCOs to discuss the status of the rate development at a pre-determined date during the creation of the project timeline.
Trend Discussion	Collaborative discussion between **Optumas**, the Department, and the MCOs where the MCOs are given the opportunity to provide insight into their estimates of the program's overall utilization and unit cost growth from the base data to the contract period.
Draft Rates Presentation	Presentation where the Department and MCOs provide feedback and ask any outstanding questions regarding any aspects of the rate development.
Final Rates Presentation	Final rates presentation sharing the final payment rates and contract exhibits with the MCOs and Department. Any remaining questions or concerns with the rate development are addressed.
Certification Letter	Certification letter from the actuary providing a detailed narrative on the rate methodology and the development of actuarially sound capitation rates.

B. Proposed Development Approach

Within this section of our RFP response we will discuss items a through j as outlined under "2. Interim Reporting and Other Deliverables for Rate Setting Functions" on page 25 and 26 of the RFP.

Optumas has never been, and never will be, your traditional actuarial/benefits consulting firm. We do not have 20 or 30 clients that we are responsible to manage out of a local satellite office that is then managed regionally, and then again nationally by different people who you may never meet. The founding partner, Steve Schramm, continues to lead **Optumas** and work on **Optumas** client teams, reaffirming daily our commitment to client service and furthering client pursuits of an efficient, more transparent, high-quality health care system. We continue to purposefully limit the number of major clients we have so that we can personally be involved and focus our consulting efforts on these select clients and ensure that all requested analyses, reports, supporting exhibits, and deliverables are met in a timely manner and with the high-level of rigor the Department requires.

> ***Optumas** intentionally limits the number of major clients we work with so we can focus our consulting efforts and provide exceptional services to all of our clients.*

Not only do we deliver analytics in an expeditious manner, we also make ourselves available for client discussions, stakeholder discussions, and onsite meetings upon request. We believe that the analytics are only as good as the subsequent communication. This emphasis on communication allows us to better understand the needs of the program and stakeholder concerns, as well as positions us to be in sync with the needs of the Department. Our combined team fosters an environment of transparency which facilitates efficiency within our client engagements.

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;

Optumas currently has an hour long standing meeting with the Department every Friday morning to discuss rate development and the other scopes of work we perform as the current consulting actuaries to the Department. These weekly meetings provide **Optumas** and the Department the opportunity to discuss the parameters, priorities, methodology, timelines, and ongoing results of capitation rate development during each rate cycle as well as discuss opportunities for continuous process improvements during off-cycles.

To the extent urgent requests come up that require a discussion or sharing analyses and information prior to our standing weekly call, **Optumas** and the Department have an understanding that either party can reach out and set up a meeting to collaborate and address any request or concerns in a timely manner and strategize to ensure the Medicaid program continues to operate as efficiently as possible. If retained as the consulting actuaries, **Optumas** will continue to participate in these meetings with the Department to guarantee that all parties have the chance to discuss the important aspects and milestones of capitation rate development and identify any analyses or concerns that should be prioritized or addressed.

To the extent the Department requires or prefers onsite meetings, the **Optumas** team is comfortable traveling and facilitating any meetings with the Department, state leadership, legislature, MCOs, or CMS/OACT. **Optumas** has experience attending and participating in such meetings in Nebraska and utilizes Skype for Business and WebEx technology to share analyses in real time during the regularly scheduled meetings that are not on-site. This real time sharing of information results in a level of transparency that ensures that all interested parties have the ability to ask questions and gain an inherent understanding of the analysis being shared. **Optumas** will also continue to leverage technology, such as Skype for Business and/or WebEx, during future rate setting cycles to facilitate discussions and ensure the **Optumas** team and Department are on the same page in all aspects of the rate development and maintain our seamless partnership. We believe this regular interaction with the Department has been critical to the current success of our historical rate setting cycles with Nebraska.

An open line of communication and regular interactions through weekly meetings and real-time sharing of information has been a key to the successful nature of our current consulting work with the Department.

b. Provide documents and data, as directed by Department staff, to discuss at these meetings;

Our standing meetings with the Department involve the collective creation of an agenda in advance of the meeting with specific items to be discussed. An agenda keeps the meeting focused on the topics that are a priority to both the Department and **Optumas** as well as provides documentation or minutes for the items discussed during the meeting. **Optumas** provides any supporting documents and data summaries as requested by the Department, or that we believe will provide a more structured and informative discussion and facilitate thorough understanding of the topics being discussed. **Optumas** has historically provided and will commit to continually providing all documents and data, as directed by Department staff, necessary for discussion during the periodic meetings throughout the capitation rate development process and off-cycle meetings.

c. Provide project management staff and project/timeline updates for all tasks associated with the capitation rate setting process;

As part of every capitation rate development **Optumas** has a client lead, or project manager, in charge of keeping the flow of the project in line with expectations and communicating with the Department when each component and interim steps of the rate development are complete. At the beginning of each rate setting cycle **Optumas** develops a project plan or timeline for all anticipated tasks associated with the capitation rate setting process. This timeline has detailed dates and analyses outlined with a brief description and the party responsible for completing or providing certain information (generally one or more of **Optumas**, the Department, and the MCOs). Project timelines are essential for both the Department and **Optumas** as it sets the stage for the rate setting process and everyone has the same understanding of when target dates and important analyses or milestones are expected to be met. To the extent unforeseen circumstances or issues arise on either the Department or **Optumas'** end, timelines will be updated so all entities involved have a clear understanding of the refined project timeline and

updated completion date. Please see Appendix II(A) for a sample project plan for capitation rate development.

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;

As the current vendors for actuarial consultant services for the Department, **Optumas** works collaboratively with Department staff to improve the accuracy and efficiency of the existing MMIS encounters and FFS data sources used within capitation rate development. In particular, **Optumas** has been monitoring the emerging encounter experience for the first year of Heritage Health. While reviewing the emerging experience **Optumas** noticed significant differences in the amounts reported within the pharmacy encounters for each of the three MCOs. Specifically, one plan reports encounter data net of pharmacy benefit manager (PBM) admin costs while the other two MCOs report gross of PBM admin costs (i.e., inclusive of spread pricing). Consistency among the MCOs is critical as future rate setting cycles will rely on the Heritage Health plan specific encounter data and an understanding of the nuances within the MMIS encounter data is essential. **Optumas** has been working diligently with the Department to identify such areas of inconsistency and work with the MCOs and Department to improve the efficiency of working with the data sources for capitation rate development.

Additionally, **Optumas** identified major differences in the payment patterns and completeness of timely encounter reporting as part of our data validation efforts and comparison to financial reports from the emerging CY17 Heritage Health experience. **Optumas** brings any differences and nuances within the data to the attention of the Department and provides feedback and suggestions on how processes can be improved upon to help ensure the encounter data is as complete and robust as possible for rate setting. **Optumas** has worked with Nebraska Medicaid MMIS encounters and FFS claims for the past five years and can leverage our knowledge and familiarity with the data to continue working collaboratively with the Department and existing MCOs to identify any additional areas where accuracy and efficiency of the data sources used for capitation rate development can be improved.

Our familiarity with Nebraska Medicaid MMIS encounters and FFS claims data will allow us to continue working seamlessly with the Department and existing MCOs to identify areas of data improvement without requiring additional time up front to get acquainted with the data.

e. Work collaboratively with Department staff and other Department vendors to improve the accuracy and efficiency of capitation rate development methodologies;

Optumas has been working collaboratively with Department staff and other Department vendors, such as the Heritage Health MCOs and data vendor, Truven, to improve the accuracy and efficiency of capitation rate development methodologies. A key focus we have been working on is validating the emerging CY17 MMIS encounter data experience for the first year of the Heritage Health program, so we can use actual plan experience to set the capitation rates. In particular, we are working with the MCOs and Truven to summarize the encounter data and compare to reported financials provided by the MCOs as well as to identify any missing data

fields that will be critical to dissecting the data in meaningful ways. Making sure the Heritage Health plan specific encounter data is robust enough for rate setting is critical as relying on actual experience will enhance the credibility and predictability of the base data used for rate setting. It is especially important for us to ensure that there are no gaps or missing encounters within our base data used for rate development.

As previously noted, **Optumas** has worked with the Department to develop a transparent approach to rate development, which includes frequent touch points with not only the Department, but also the MCOs. Through the open lines of communication that have already been developed, we will continue to work collaboratively with the Department staff and vendors to identify any additional areas where we may be able to improve the accuracy of rate development methodologies.

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;**

Nearly all of the exhibits and models produced during the rate development process that are provided to the Department and all of our clients are either derived from a more detailed model or consist of the actual detailed model itself. Throughout our partnership with the Department, these work products have commonly consisted of Excel summaries based on a particular analysis. Additionally, **Optumas** provides the Department with the detailed rate model with all formulas intact. Typically, the Nebraska MCOs receive a condensed version of the rate model at the category of aid and category of service level, as specified by the Department's direction.

Prior to the delivery or presentation of any exhibits, reports, or summaries, the **Optumas** team performs a detailed peer review process, unless explicitly stated otherwise. For example, in cases where immediate draft results are requested, the time required to peer review a draft result may exceed the time in which the draft results are being requested. Nevertheless, when it comes time to creating final deliverables, a thorough peer review is conducted. Additionally, since these are intended to be client deliverables and, in some cases, used to inform external stakeholders, it is important that these deliverables be presented in a clean, well-formatted layout, with details such as appropriate headers, footnotes, and comments to ensure that the information is properly communicated and interpreted. We believe that the results are meaningless, no matter how much peer review has been conducted if they cannot be properly communicated and understood by the intended audience. Therefore, we ensure that each deliverable is reviewed by the lead actuary and/or consultant to ensure the document is presented in an appropriate manner and is easy to understand.

As part of our goal for a collaborative and transparent approach to rate setting **Optumas** currently provides the Department with all exhibits, reports, and calculations in the format specified by the Department, including all formulae, databases, data sets, analyses, and documents relevant to the capitation rate setting process. MCO contract exhibits and federal match

> ***Optumas** tailors all analyses, reports, and deliverables to the format specified by the Department and proactively creates exhibits that have been historically requested by the Department each rating cycle.*

breakouts are key items that the Department requests within each rate development cycle. Since **Optumas** has performed rate development for the Department for the past five years, we anticipate that these requests will be made and proactively develop such exhibits to provide to the Department once the final rates are set. Figure VI.A.3.xiii below is an example of the federal match breakout exhibit that **Optumas** provides the Department each rate setting cycle.

Figure VI.A.3.xiii – Federal Match Breakout Exhibit

Heritage Health Federal Match Breakout - Rating Region 1							
COA	CY16 MMs	Portion of Rate at Regular FMAP (non-UNMC)	Indian Health Services	Family Planning 90% FFP	HIPF Funding	UNMC Pass-Through at Regular FMAP	Total
AABD 00-20 M&F	35,893	$ 1,164.20	$ 4.17	$ 0.49	$ 57.52	$ 20.77	$ 1,247.15
AABD 21+ M&F	115,633	$ 1,727.17	$ 8.07	$ 0.75	$ 85.65	$ 23.32	$ 1,844.96
AABD 21+ M&F-WWC	1,023	$ 3,305.62	$ 5.09	$ 0.47	$ 164.02	$ 70.12	$ 3,545.32
CHIP M&F	278,240	$ 179.36	$ 1.11	$ 0.34	$ 8.97	$ 1.50	$ 191.28
Family Under 1 M&F	112,649	$ 713.92	$ 4.27	$ -	$ 35.62	$ 20.36	$ 774.17
Family 01-05 M&F	347,781	$ 161.65	$ 2.69	$ -	$ 8.12	$ 1.75	$ 174.21
Family 06-20 F	330,891	$ 171.11	$ 1.81	$ 1.18	$ 8.60	$ 1.44	$ 184.14
Family 06-20 M	319,942	$ 191.38	$ 1.79	$ -	$ 9.54	$ 1.17	$ 203.88
Family 21+ M&F	258,285	$ 412.13	$ 4.20	$ 4.65	$ 20.80	$ 4.86	$ 446.64
Foster Care M&F	90,408	$ 501.50	$ 4.80	$ 0.77	$ 25.15	$ 5.41	$ 537.63
Healthy Dual	193,063	$ 263.59	$ 0.48	$ 0.25	$ 12.99	$ 5.71	$ 283.02
Dual LTC	58,118	$ 221.78	$ 0.56	$ 0.01	$ 10.96	$ 4.04	$ 237.35
Non-Dual LTC	5,711	$ 3,429.11	$ 7.33	$ 0.08	$ 169.05	$ 74.44	$ 3,680.01
Dual Waiver	51,688	$ 271.12	$ 0.25	$ 0.29	$ 13.38	$ 5.25	$ 290.29
Non-Dual Waiver	30,028	$ 1,668.99	$ 3.24	$ 1.15	$ 82.71	$ 40.26	$ 1,796.35
Katie Beckett 00-18 M&F	519	$ 13,305.61	$ -	$ -	$ 649.96	$ 19.15	$ 13,974.72
599 CHIP - Cohort	5,272	$ 398.99	$ -	$ 0.05	$ 19.84	$ 14.63	$ 433.51
599 CHIP - Supplemental	1,192	$ 4,572.05	$ -	$ 14.67	$ -	$ 105.79	$ 4,692.51
Maternity	6,725	$ 7,791.38	$ 48.46	$ 162.38	$ -	$ 190.41	$ 8,192.63
Total	**2,235,144**	**$ 409.56**	**$ 2.73**	**$ 1.37**	**$ 19.12**	**$ 6.34**	**$ 439.12**

g. Develop work plans for rates to be determined including milestones for completion;

Optumas creates work plans for the capitation rate development process through the development of project timelines at the beginning of the rate setting cycle. Each milestone within the rate development is itemized within the project plan and has an estimated date for completion as well as outlines which party is responsible for completion of the task. A sample project work plan for capitation rate development can be found in Appendix II(A).

Additionally, the **Optumas** team has multiple project management tools we have used in previous client engagements. These tools include RACI/Project Plan charts, program change logs, weekly call logs/meeting minutes, question and answer logs, program information dashboards, and other organizational and structural tools. We can adapt the layout and design of these tools to fit with any standards the Department would like to implement to monitor and oversee our work and ensure that projects are completed as desired. Appendix IV contains a sample of **Optumas'** project management tools.

h. Meet work plan milestones and timelines as agreed upon with the Department,

Optumas always aims to meet or exceed work plan milestones and timelines as agreed upon with the Department. In the rare event that unforeseen circumstances arise preventing the

completion of certain tasks by the estimated deadlines, **Optumas** will provide as much advanced notice as possible and will work collaboratively with the Department to update the timeline to reflect reasonable completion dates. Although interim deadlines may shift, **Optumas** has been able to meet all deadlines for final capitation rate submission as required by CMS.

i. Provide staff training in methodologies used to develop rates; and

As demonstrated over the last five years, **Optumas** is always open to providing Department staff training in methodologies used to develop the capitation rates and would encourage staff members to reach out regarding any specific analyses and adjustments for which they would like additional information or training. On multiple occasions, at the request of Department leadership, **Optumas** has provided general Nebraska managed care project background and rate setting methodology presentations to new Department staff members. These training sessions allow us to demonstrate that we are seasoned consultants with the ability to explain complicated actuarial adjustments with clarity and specificity, tailoring the explanation as appropriate for the specific audience. For example, two of our senior actuaries conducted an onsite training in January 2014 to key Department staff on the application of Medicaid Rx Risk Adjustment in the historical Physical Health program. Being that risk adjustment was a new adjustment within the Nebraska rate development process, **Optumas** held an onsite training session where we provided an overview of our risk adjustment methodology. Throughout this presentation, **Optumas** encouraged Department staff to ask any questions related to our approach, the Medicaid Rx tool in general, and the application of the risk scores specific to the Nebraska Physical Health program.

Upon request, **Optumas** will provide and present written communications, including handouts about related subject matter, presentation materials, graphics, guides, and reports to staff and stakeholders as directed by the Department. **Optumas** team members regularly present to CMS, MCOs, state leadership, and legislative representatives. The dedicated Nebraska Medicaid team within **Optumas** is extremely skilled in presenting complex ideas, topics, and analyses to all types of audiences in a manner that is easily understood by the audience. We have developed a reputation for being excellent communicators, and through regular interaction across the various Medicaid programs, we have developed professional relationships that facilitate productive and effective conversations. The **Optumas** team offers our extensive experience developing, facilitating and leading intensive learning forums in any manner desired by the Department.

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

When **Optumas** became the actuarial consulting firm to the Department in 2013, we assisted in redesigning the rate methodology by making it significantly more transparent than the previous process that was in place. We achieved this by focusing on incorporating additional touchpoints and input from both the Department and the contracted MCOs. In particular, **Optumas** required the MCOs to submit more detailed information, reconcile their financial and encounter data, and to provide specific justification for any requests for potential rate increases. Our experience setting rates in Nebraska and other states is that a more transparent and collaborative process

creates a stronger level of trust and respect between all the parties involved, so we can focus on improving the quality of care provided to the beneficiaries of the Medicaid program.

Optumas was intimately involved in the procurement and bidding process of the integrated care Heritage Health program within Nebraska that went live in January 2017. We leveraged our historical experience focusing on rate development transparency and collaboration to ensure all stakeholders involved had a complete understanding of the new program's rate development and to create a smooth transition between Nebraska's historical stand-alone Physical Health and Behavioral Health programs and the new integrated Heritage Health program.

Our successful collaboration working with the Department during the Heritage Health transition period should be reassuring to the Department and shows that we are able to successfully accomplish the necessary steps to ensure accurate development of rate methodologies for any new programs; specifically, the potential development of the Long-Term Care Managed Care program that is expected to be implemented in the coming years.

C. Technical Considerations

When delivering any interim reports and other deliverables associated with rate setting there are a few considerations **Optumas** must take into account prior to sending any information. One such consideration is the level of detail contained within the summary. Specific measures must be taken to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) when dealing with Medicaid member level information and medical claims. **Optumas** has worked with the Department for the past five years and is compliant with all HIPAA regulations regarding data privacy and security provisions for safeguarding medical information. If any deliverables contain member-leveled details or are summarized at such a granular level to where certain members or providers may be identifiable, **Optumas** makes sure that the data is transmitted via a Secure File Transfer Protocol website and encrypts files for additional security.

D. Detailed Project Work Plan

Please see Appendix II(A) for a sample SOW 1 Capitation Rate Setting detailed project work plan and the interim reporting and other deliverables associated with rate setting functions.

E. Deliverables and Due Dates

Please see Appendix II(A) for deliverables and due dates associated with Capitation Rate Setting and interim reporting and rate setting function deliverables. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department. Per our interpretation of page 25 of the RFP we have created a detailed project plan with deliverables and due dates on a state fiscal year basis. However, the project work plan and due dates can be adjusted to fit a calendar year basis to match the current structure of the Heritage Health managed care program contract period.

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SOW 1.3-Capitation Rate Finalization

SOW 1.3 – Capitation Rate Finalization

Optumas is responsible for ensuring that the capitation rate methodology used to develop the final capitation rates for each rating cohort complies with CMS guidance for the development of actuarially sound rates. The final stage in nearly all of our projects (particularly capitation rate development) is providing a supporting narrative or certification letter. **Optumas'** actuarial certification letters and rate development methodology documentation explicitly outline and explain how the calculated rates were developed and how they comply with guidelines set forth by CMS. In each of the states in which **Optumas** sets Medicaid capitation rates, we are required to submit an actuarial certification and memorandum providing a detailed description of the rate methodology and assumptions made as well as data and supporting documentation used in the development of rates.

A. Understanding of the Project Requirements

Optumas understands the project requirements of capitation rate finalization as outlined on page 26 of the RFP. The final stage of the capitation rate development process is creating an actuarial memorandum and rate certification detailing the data, actuarial assumptions, and methodology used in the development of the capitation rates. The actuarial rate certification clearly presents and describes the methodology, process, and results of the analyses that were conducted within the rate development and outlines any assumptions, nuances, caveats, and any applicable data reliance that the actuary made or used within calculating the final rates. In our work with each of our state Medicaid clients the certification is the most detailed supporting narrative developed as part of the rate development process and includes the final capitation rates developed for the Medicaid program in question.

Optumas conducts a thorough review of the rate development narrative, providing a significant amount of detail on the analytics and methodology behind the rate development. Additional supporting exhibits are typically included in the document's appendices to ensure that the CMS rate approval process goes as smoothly as possible and that the reviewer can clearly follow and quantify the impact of each step in the rate development process. All of the capitation rates **Optumas** sets are actuarially sound and the certification letter clearly describes the adherence to the definition of actuarial soundness and to the CMS rate setting consultation guide. Rates are submitted in a timely manner, at least 90 days prior to the contract year's effective date; this is to comply with CMS regulations and to allow sufficient time for CMS to review the rate development and ask follow-up questions as necessary, and ultimately achieve an efficient rate approval.

> ***Optumas** ensures that rates are set in a timely manner and will provide the Department with the rate certification letter outlining the entire rate development process at least 90 days prior to the contract effective date.*

Optumas views actuarial soundness as not only a federal requirement, but also as a fundamental guide in which all supporting analyses should be conducted. **Optumas** has a proven track record of developing actuarially sound rates, consistent with all applicable ASOPs and CMS guidance. **Optumas** ensures that all capitation rates are developed in a transparent manner, facilitating productive and efficient rate review conducted by CMS and OACT.

The actuarial certification letter is consistent with the communication standards described in ASOP 41 - Actuarial Communications as well as consistent with the expectations of CMS/OACT including recent CMS guidance. **Optumas** has established a reputation with CMS/OACT of providing very detailed rate certifications, allowing the rate reviewer to better understand the program and the actuarial analysis. This facilitates a quick and efficient rate review process which leads to timely CMS approvals.

B. Proposed Development Approach

Within this section of our RFP response we will discuss items a through g as outlined under "3. Capitation Rate Finalization" on page 26 of the RFP.

Through our partnership with the department for the past five years, **Optumas** has developed and will continue to develop all necessary documentation, exhibits, and presentation materials required to ensure all stakeholders involved in the capitation rate setting process, such as the Department, MCOs, and CMS, clearly understand the assumptions and methodologies used to develop the capitation rates. **Optumas'** approach to transparency, stakeholder feedback, and periodic communication with CMS/OACT, has ultimately led to CMS/OACT rate approval for Nebraska's Managed Care programs dating back to capitation rates effective July 2014 and most recently for the Heritage Health program.

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;

In developing all capitation rates for the Nebraska Medicaid program, **Optumas** adheres to guidance provided by CMS in accordance with 42 CFR 438.4, the CMS standards for developing actuarially sound capitation rates for Medicaid managed care programs. CMS defines actuarially sound rates as meeting the following criteria:

1. They have been developed in accordance with generally accepted actuarial principles and practices,
2. They are appropriate for the populations to be covered and the services to be furnished under the contract, and
3. They have been certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

Optumas specifically applies the CMS actuarial soundness criteria when developing the methodology for calculating capitation rates and describes adherence to each criterion within the certification letter. Our typical certification letter for actuarially sound capitation rate development presents the rate development process and its results in four sections, as described in Figure VI.A.3.xiv below.

Figure VI.A.3.xiv – Certification Letter Sections

Section	Contents
Background	Provides description of the Managed Care programs and context for rate development such as covered populations and services
Rate Development Process	Overview of methodology used when developing the capitation rates, including applicable data, base data adjustments, program changes, trend, managed care assumptions, risk adjustment, and non-medical loading
Rate Certification	**Optumas'** actuarial certification that the calculated rates comply with guidelines set forth by CMS
Appendices	Detailed tables showing compliance with the CMS Consultation Guide, as well as supporting exhibits showing the results of data summaries, analyses, and assumptions used within the rate development methodology

Included within the sections outlined above in each certification and methodology letter **Optumas** creates is a detailed description of the data underlying the rate development, the methodology used for developing the capitation rates, as well as any actuarial assumptions made, and all other data and supporting documents used in the rate development for the specific contract period.

The capitation rate certification letter undergoes several layers of peer review, both in terms of the narrative itself, but also the associated exhibits that accompany the narrative for support. The narrative and exhibits within the certification letter are typically first created by the analyst(s) and consultant(s) that have conducted much of the analytics and been part of the project from start to finish; there are typically two to four passes at this narrative between the analysts and consultants to review for content, flow/readability, and grammar/spelling (conducted after already having used the Microsoft Office built in spelling and grammar tool). Once this process has been completed, the certifying actuary on the project will review the document in its entirety to review for content to ensure that the descriptions of the methodology are complete, and to conduct his/her own review of the flow/readability of the document as well as grammar/spelling checks. Finally, a senior team member (strategist or another senior actuary) will conduct the strategic review. This example peer review process is specific not only to the development of the historical Nebraska managed care program rate certification letters **Optumas** has developed, but also is the level of review consistent with all other narrative deliverables produced by **Optumas**.

After **Optumas** sends the certification letter to the Department, we will incorporate any feedback from the Department regarding necessary changes in the final version of the rate certification letters. In addition, the **Optumas** team is available to provide ongoing support to the Department regarding our actuarial certifications after submission to CMS, as part of the CMS review process. **Optumas** is always available to meet via conference calls and provide written answers to any questions that CMS may have about the capitation rates or our certification letters. Consistent with the Medicaid Managed Care Federal Regulations set forth in 2016, we have enhanced the detail included in our rate certification letters significantly over the last few years which has resulted in far fewer questions and fewer rounds of questions from CMS. The

transparent approach **Optumas** takes with the rate development process with both the Department and its MCOs assists in expedited approval of rate submissions. This allows the Department to finalize other aspects of the Heritage Health and other programs in an efficient manner, such as contract language and financial forecasting.

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;

The Balanced Budget Act (BBA) of 1997 maintained the federal requirement that the MCOs entering into risk contracts with state Medicaid agencies be paid via actuarially sound capitation rates. **Optumas** complies with all requirements for managed care rate setting as described in the BBA by making sure the capitation rates are sufficient and appropriate for the populations, services, and anticipated utilization patterns covered under the MCO contracts and provide adequate compensation to the MCOs for reasonable benefit costs. By implementing a rate development methodology in a transparent manner and ensuring that the process is compliant with all applicable ASOPs and CMS guidance, **Optumas** is poised to defend any part of the process on behalf of the Department.

Optumas has always been able to provide robust substantiation for any component of a rate development process. The actuarial rate certifications written by **Optumas** provide sufficient detail, documentation, and transparency into the rate setting components in such a way that another actuary should be able to assess the reasonableness of the methodology and assumptions used to develop the final capitation rates. Recently, **Optumas** has been involved in the rate appeals process in Oregon for the CCO program. As part of this appeals process, **Optumas** has had to work with the Oregon Department of Justice as well as other independent actuarial firms in support of a third-party review of the rate development process. The third-party review found that the rate development approach used by **Optumas** was actuarially sound and transparent. **Optumas** has applied the same level of detail and transparency in all rate certifications created for the various managed care programs within Nebraska for the past five years and will continue to comply with all BBA, CMS, and OACT requirements for actuarially sound capitation rates

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

The actuaries at **Optumas** follow all applicable ASOPs when performing actuarial analyses and rate development for the Department to ensure that rates are developed according to actuarially sound practices. Each one of our rate certifications reference the following ASOPs outlined in Figure VI.A.3.xv below to the extent they are applicable to the program being certified.

Figure VI.A.3.xv – ASOPs Outlined in Rate Certifications

Actuarial Standard of Practice	Description
ASOP 5 – Incurred Health and Disability Claims	Provides guidance to actuaries estimating or reviewing incurred claims when preparing or reviewing financial reports, claims

Actuarial Standard of Practice	Description
	studies, rates, or other actuarial communications as of a valuation date under a health benefit plan.
ASOP 23 – Data Quality	Provides guidance to actuaries when selecting data, performing a review of data, using data, or relying on data supplied by others, in performing actuarial services. Also applies to actuaries who are selecting, preparing data, are responsible for the selection, or preparation of data that the actuary believes will be used by other actuaries in performing actuarial services or when making appropriate disclosures with regard to data quality.
ASOP 25 – Credibility Procedures	Provides guidance to actuaries when performing professional services with respect to selecting or developing credibility procedures and the application of those procedures to sets of data.
ASOP 41 – Actuarial Communications	Provides guidance to actuaries with respect to actuarial communications.
ASOP 45 – Use of Health Status Based Risk Adjustment Methodologies	Provides guidance to actuaries applying health status-based risk adjustment methodologies to quantify differences in relative healthcare resource use due to differences in health status.
ASOP 49 – Medicaid Managed Care Capitation Rate Development and Certification	Provides guidance to actuaries when performing professional services related to Medicaid (Title XIX) and Children's Health Insurance Program (CHIP or Title XXI) managed care capitation rates, including a certification on behalf of a state to meet the requirements of 42 CFR 438.4.

Additionally, **Optumas'** certification letters include narrative on the methodology of each component of the rate development process and contain supporting exhibits within the appendix of the certification letter. The supporting exhibits for capitation rate setting within the certification appendices allow CMS reviewers to easily identify the impact of each adjustment and step within the rate development process at the category of aid and category of service level. Specifically, the exhibits allow the reviewer to start with the base data PMPM costs for each rating category and then explicitly see the incremental impact each rating adjustment has, such that the reviewer can apply the adjustments to the raw base data to calculate the rates by cohort shown in the certification letter. Any actuarial assumptions made within the development of the actuarially sound final capitation rates are clearly identified within the narrative and appendices of the certification.

d. Provide necessary certification to meet the requirements of the CMS rate setting consultation guide;

Within every rate setting cycle **Optumas** provides all necessary documentation, in the form of a certification letter and rate methodology narrative, to meet the requirements of actuarially sound rates certified per CMS requirements. The first appendix in our certification narrative contains the CMS rate setting consultation guide checklist with adherence to each item and the applicable section of the certification letter which describes the item. Once we develop our

certification, we stand behind that unequivocally and are available to assist the Department by defending our rates to the contracted MCOs, and other stakeholders like CMS and OACT. In a few programs we have worked in, our certification letter has been detailed and thorough enough that we only received one follow-up question from CMS prior to rate approval. **Optumas** strives to clearly explain every aspect and component of the rate development in a manner that facilitates CMS' review to expedite the rate approval process. We aim to mitigate the number of follow-up questions received from CMS by clearly itemizing and describing our compliance with each section of the CMS rate setting consultation guide.

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

During the rate development and certification process, **Optumas** provides deliverable exhibits, models, and narratives related to each key project for the Department and participating MCOs, specifically tailored to the level of detail requested by the client. We understand the importance of these documents being constructed in an easy to follow manner, with accurate results and relevant commentary to promote an efficient rate approval process. For each of the rate setting projects we currently work on in Nebraska, Heritage Health and Dental, we have prepared all presentation materials, and attended and participated in both onsite and phone conferences with the MCOs and the Department. Typically, our rate setting processes involves numerous touchpoints with the MCOs and Department throughout the rate development process. This allows all entities the opportunity to have a sufficient understanding of how the rates are being developed throughout the entire rate setting project and have the opportunity to ask any questions with regards to the rate development process. During prior Heritage Health rate development cycles the MCOs provided positive feedback to the Department regarding **Optumas'** transparent communication and exhibits, in particular surrounding exhibits prepared to defend **Optumas'** risk adjustment methodology.

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

Throughout our current work with the Department regarding the CY18 Heritage Health and SFY19 Dental rates, **Optumas** has attended, participated, and provided support in the Department's rate setting discussions and meetings with CMS whenever requested. In particular, we have participated in discussions surrounding the University of Nebraska Medical Center (UNMC) pass-through payment for Heritage Health and UNMC directed payment preprint submission for the Dental Program. **Optumas** has been a key part of the strategic process as we work collaboratively with the Department, UNMC, and CMS to structure a plan to ultimately phase out the UNMC pass-through payment per federal guidance from CMS, with the goal of gaining CMS approval of an allowable alternative.

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

Per the RFP specifications, **Optumas** will develop and submit draft rates, proposed final payment rates, and methodologies to the Department at least 150 calendar days prior to the date the rates are to become effective. Upon the Department's approval of the draft rates and final payment rates, **Optumas** will begin work on the actuarial certifications and financial

impacts to Nebraska Medicaid program and ensure submission to CMS within the 150-day deadline described in the RFP. Historically, **Optumas** has always provided final rates to the Department within the 90-day deadline as required by CMS and will continue to develop and submit final rates within the specified deadlines as required by the Department.

C. Technical Considerations

When finalizing capitation rates **Optumas** must ensure that rates are developed in compliance with the CMS Managed Care Consultation Guide. **Optumas** strives to make the rate approval process as streamlined as possible, and therefore clearly outlines the entire CMS Managed Care Consultation Guide within an appendix in the rate certification. The appendix checklist clearly demonstrates compliance with each section of the guidance, when applicable, and notes the location in our certification where a description of the methodology and assumptions used within the rate development for each item can be found. By including a checklist version of the Consultation Guide, **Optumas** fosters a more efficient rate review for CMS and OACT and demonstrates that the capitation rates are developed in compliance with federal regulations and are actuarially sound.

Optumas writes the certification letter and develops all supporting exhibits with the intent to clearly explain every aspect and component of the rate development in a form that facilitates CMS review to expedite the rate approval process. Our goal is to proactively provide all necessary information to mitigate the number of follow-up questions received from CMS by clearly itemizing and thoroughly explaining each component of the rate development. When developing the certification for each subsequent rating cycle for a given managed care program, **Optumas** reviews CMS questions from prior years and includes narrative to address each question in order to further reduce the number of follow-up questions and ensure a more streamlined rate approval process.

D. Detailed Project Work Plan

Please see Appendix II(A) for a sample SOW 1 Capitation Rate Setting detailed project work plan and capitation rate finalization.

E. Deliverables and Due Dates

Please see Appendix II(A) for deliverables and due dates associated with Capitation Rate Setting and capitation rate finalization. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department. Per our interpretation of page 25 of the RFP we have created a detailed project plan with deliverables and due dates on a state fiscal year basis. However, the project work plan and due dates can be adjusted to fit a calendar year basis to match the current structure of the Heritage Health managed care program contract period.

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SOW 2-Capitation Rate Rebasing

SOW 2 – Capitation Rate Rebasing

As the consulting actuaries to Medicaid managed care programs, it is **Optumas**' responsibility to ensure that the capitation rate methodology used to develop capitation rates complies with the CMS guidance for the development of actuarially sound rates. **Optumas** will work with the Department to identify the rate development components for the contract period, accounting for the covered services and populations as described in the Heritage Health and potential Managed LTSS contracts. The final rates will be developed according to actuarially sound principles and will reasonably reflect the experience projected for the respective Heritage Health and Managed LTSS programs. When performing capitation rate rebasing, the same methodology for typical capitation rate setting applies as described within the SOW 1 subsection beginning on page 87. However, the rebasing process is unique in that it includes an analysis of updated data and adjustment to trends as well as a reevaluation of applicable program and policy changes that apply to the updated base data time period. Outside of these main components, the majority of rate development considerations and methodologies remain consistent between standard capitation rate setting and capitation rate rebasing.

A. Understanding of the Project Requirements

Optumas understands the project requirements of capitation rate rebasing as described on page 26 of the RFP. As outlined previously in the SOW 1 subsections beginning on page 87, **Optumas** adheres to guidance provided by CMS in accordance with 42 CFR 438.4, the CMS standards for developing actuarially sound capitation rates for Medicaid managed care programs when developing all Medicaid Managed Care capitation rates. Additionally, **Optumas** ensures that all applicable ASOPs are followed during the rate development and rate rebasing process. **Optumas** specifically applies these criteria in the development of the methodology for calculating each program's capitation rates, and also ensures that all considerations included in the latest Medicaid Managed Care Rate Development Guide published by CMS are followed.

Optumas has performed numerous capitation rate rebasing projects in over 20 states for which we have developed Medicaid Managed Care capitation rates. Within Nebraska alone, we have most recently performed rate rebasing exercises for the Heritage Health CY18 rates and Dental Program SFY19 rates.

B. Proposed Development Approach

Within this section of our RFP response we will discuss items a through g as outlined under "E. SOW 2 – Capitation Rate Rebasing" on page 26 and 27 of the RFP.

a. Analyze different types of rate methodologies and models used by governmental and commercial entities upon request;

In addition to its work in Nebraska, **Optumas** has experience developing Medicaid Managed Care capitation rates in over 20 states as well as experience developing Medicare Advantage and Individual Marketplace Exchange rates in multiple states. As a result, **Optumas** has broad experience with different types of models and program design structure from which to draw ideas from when analyzing different rate methodologies and models. Two specific examples of

state clients that **Optumas** has assisted in developing new rate setting methodologies and rate rebasing for subsequent years of rate development are described below:

Kansas:

Optumas helped the Kansas Medicaid program develop the KanCare program as a fast-tracked 1115 Waiver program in 2012, working collaboratively with the Kansas Medicaid leadership to design, develop, and implement the program from the 1115 Waiver Concept Paper all the way through CMS approval, RFP Development, Procurement, Implementation, and Member enrollment. We helped write the concept paper, provided all the Budget Neutrality calculations, participated in the Waiver Approval Negotiations and then, upon the fast-track approval, wrote all the bidding, financial, reporting, performance monitoring, risk-sharing, and actuarial portions of the RFP. **Optumas** conducted all the bidder's conferences for the RFP and the rate setting methodology, created the rate development methodology, developed and certified the final rates, and led the MCO financial negotiations on behalf of the state for successful selection of three MCOs to administer the KanCare program statewide. We then led the financial team and oversaw the successful transition of more than a million members from all categories of aid into the KanCare managed care program covering all Kansas Medicaid covered services for the first two years of the program.

The actuarially sound rate development of the program was complex for multiple reasons. In addition to helping develop the process and structure of the KanCare program, **Optumas** was tasked with developing the program strategy and conducting all the various actuarial analyses necessary to ensure an appropriate rate setting process. This program includes all populations and services covered under Kansas' Medicaid program, including Physical Health, Behavioral Health, and LTSS (Nursing Facility and Waiver). To incorporate each of these populations and services, first required detailed analysis of historical State FFS data and historical MCO encounter data. Additionally, this required in-depth knowledge of each population, as well as an understanding of how integration of these populations and benefits could impact future medical spend. Furthermore, specific considerations needed to be made for the LTSS population, including how a blended Nursing Facility and Waiver population rate could be developed in an actuarially sound manner and what risk mitigation strategies would be necessary to ensure a viable and sustainable program for the State and its MCO partners. As part of this process, **Optumas** followed all CMS guidelines, with constant communication with the State and MCOs, which resulted in approval by CMS for the capitation rates developed for the KanCare program.

A substantial amount of work and effort was put forth in the development of the initial KanCare program rates. Nevertheless, **Optumas** was able to leverage many of these analyses developed within the first round of rate development for KanCare in subsequent years of capitation rate rebasing. When performing capitation rate rebasing, not only does **Optumas** analyze updated data to use as the basis for rate development, but we take this opportunity to reevaluate all assumptions and projection factors as well as program and policy changes that impact the program from the base data to contract period. **Optumas** has used this rate rebasing methodology not only within

> ***Optumas** reevaluates all assumptions and projection factors as well as program and policy changes during the rate rebasing process to ensure all adjustments reflect the expected experience for the contract period.*

Kansas and other states, but has followed the same approach and level of scrutiny within the Nebraska Medicaid Managed Care program.

Oregon:
Optumas has worked with the State of Oregon, developing the capitation rates for its Coordinated Care Organization (CCO) program since the contract period effective January – December 2015 (CY15). While the State had already had a set of rates submitted to CMS/OACT for this contract period, developed by its internal team, significant concerns of CMS/OACT, as well as CCO stakeholders, led the State to contract with **Optumas** to re-develop the CY15 rates, with the goal of restructuring the approach to rate development. The Medicaid Managed Care program in Oregon is complex, with 16 CCOs managing the program across the state, predominantly operating in different geographic regions in the state. Each region has specific nuances related to its reimbursement of providers and further, each CCO has a unique business model, with significant variation in population size and population risk across each.

As a result of the complexity and nuances surrounding each CCO in the state, **Optumas** worked with the State, as well as the CCOs, to develop an actuarially sound rate setting process that would be defensible and would result in satisfying the concerns laid out by CMS/OACT, with the ultimate goal of developing a sustainable process that would gain rate approval from CMS/OACT. To create this transparent environment, **Optumas** maintained daily brainstorming and touch-points with the State, and weekly "Actuarial Workgroup" calls, in addition to monthly on-site visits with the State and CCOs, to keep an open line of communication along the way. Additionally, **Optumas** and the State maintained an open line of communication with CMS/OACT, conducting multiple productive calls throughout the process, to ensure that the new approach being developed was within the construct of what could be deemed "approvable"; this is an important part of the process, as it ensures confidence in the process, and allows CMS/OACT to be apprised of the methodology prior to rate submission.

The use of these touch-points resulted in a very productive rate setting process, which allowed for CCOs to provide feedback. In some cases, the feedback was used in a way that was able to refine the process that **Optumas** and the state proposed, and in other cases, feedback was provided and rationale was given as to why no changes would be made. The ultimate outcome was a new rate development methodology. The discussions started with an in-depth comparison of data that was reported by each CCO on its financial template (including all medically-related costs), as compared with MMIS encounter data; this opened the door for discussions around data quality and an appropriate starting base data to use in rate development. After these initial discussions, analyses were conducted around regional differences in costs/population risks. This led to rating regions being defined (CCOs were grouped into four regions throughout the state), which allowed for a regional-based rate development methodology to be employed. This resulted in a credible population size being used as the base, with adjustments to reflect differences in risk (based on risk scores using the CDPS+Rx tool), as well as differences in hospital reimbursement (DRG vs. cost-based hospitals).

As noted above, this approach to transparency, stakeholder feedback, and periodic communication with CMS/OACT, has ultimately led to CMS/OACT rate approval for the last four years, most recently for the rates effective January – December 2018 (CY18). Within each subsequent year of rate development for the Oregon CCO program following CY15, **Optumas**

performed capitation rate rebasing. The same in-depth data comparison between the CCO financials and MMIS encounter data applied to each year of rate rebasing. A complete and thorough analysis of the base data used for rate setting is critical because **Optumas** must be able to understand the driving forces underlying any changes in base data used within rate development. The same financial comparisons and detailed analyses surrounding base data have been applied within the historical Nebraska-specific rate rebasing projects.

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;

In the capitation rate rebasing development of the Heritage Health rates in Nebraska, **Optumas** has used a combination of data sources spanning the most recent two years of data available for each rate cycle as a result of the evolving dynamics of Nebraska's Medicaid Managed Care program. Depending upon the population and category of service, services were delivered between a combination of the previous Physical Health MCOs, the previous Behavioral Health MCO, and FFS. The most recent, CY18 rate rebasing for the Heritage Health program relied on the following data for each service and population:

- For the Physical Health acute care services, **Optumas** used CY15 and CY16 encounter data from the previous Physical Health program, paid through May 31st, 2017.
- For the Behavioral Health services, **Optumas** used CY15 and CY16 encounter data from the previous Behavioral Health program, paid through May 31st, 2017.
- For the populations and services that are new to managed care under Heritage Health, such as the Pharmacy benefit or the acute care services for the LTSS populations, **Optumas** used CY15 and CY16 FFS data, paid through March 31st, 2017.

Since the Heritage Health program began in CY17, **Optumas** intends to incorporate the emerging program-specific encounter experience into the base data used for the CY19 capitation rate rebasing. The use of this new encounter data will require **Optumas** to perform significant data analyses to ensure that the emerging CY17 experience represents an appropriate base for the developing rates for the CY19 contract period. This process is very familiar to **Optumas** and we will be able to leverage existing methodologies to perform a thorough, yet efficient, data validation and review process.

Optumas works with the Department to understand the processes available for data transfer, which typically includes data transfer through our Secure FTP site, or in some cases, a direct transfer of data via a secured password protected, encrypted external hard drive.

After data is collected, **Optumas** conducts a series of standard initial data processing protocols to ensure that the data received matches what the Department transferred and that we are interpreting all data fields appropriately:

1. Data Importing – Data that consists of raw, detailed data (e.g. detailed enrollment file, detailed encounter/claims files, or detailed provider files) is collected and stored in our internal data warehouse.

2. Control Total Checks – **Optumas** collects control total summary files from the party transferring the data (usually the Department), which contain information such as total record count, claim count, and dollar volume, contained in each file. This is then compared to summaries that the **Optumas** team creates using the detailed data, to ensure that no data truncation occurred between the time the data was pulled from its source (e.g. Department's MMIS data warehouse), to the time it gets collected and processed into **Optumas'** data warehouse. This is one of the first steps completed, so that if any inconsistencies exist between control totals and the comparison summaries created by **Optumas**, the issue can be corrected early, before any type of analytics are conducted.
3. Frequency Workbooks – **Optumas** then creates frequency workbooks, which contain a list of each key field within the data set, and the values populated in each field, as well as the number of occurrences of each value. For example, the "Revenue Code" page of this workbook would contain a list of all revenue codes included in the data and the number of times each revenue code occurs. This allows **Optumas** to review the data elements in a streamlined manner and can quickly show if a certain data element is fully populated, often unpopulated, or populated with values that do not make sense (e.g. procedure codes showing up in a field that should reflect a date). This is an efficient tool that is used as part of the data validation and is often referenced through the duration of a project.
4. Review of Data Over Time – **Optumas** conducts initial summaries to review key information such as membership, expenditures, and utilization over time. The goal of this step is to identify potential data gaps that could exist, any large fluctuation in spend from year to year, or large changes in enrollment. This gives **Optumas** early insight into additional considerations that may be needed, for example supplemental data to fill any gaps, adjustments to smooth missing or incomplete data (in lieu of supplemental data being available), and consideration for valid changes that may have occurred in the program. For example, large increases or decreases in costs or enrollment may translate into program change adjustments needed during rate development. Examples of what this type of data review may look like in practice, in addition to a brief description of what this review indicates, are shown in Figure VI.A.3.xvi below:

Figure VI.A.3.xvi – Data Review Outcome Examples

5. Review Data for Denied, Duplicate, Reversed, or Zero Paid Capitated Claims – **Optumas** reviews the data for additional items that need to be "scrubbed." In some cases, datasets include claims that were ultimately denied or reversed, and these should typically be omitted from the calculation of utilization, when considering what would be covered by MCOs in the future. Duplicate claims or services should also be identified, to

the extent they exist in the data, to ensure that services provided are not duplicated when counting expenditures and utilization. Additionally, there are instances where claims may be valid services, but due to a capitated arrangement for a certain provider, no financial amount is provided; these claims may be required to be re-priced at the Medicaid fee schedule or another benchmark fee schedule in order to use these claims in rate development.

6. Comparisons of Encounters to Financials – **Optumas** works collaboratively with the Department and the MCOs to validate the encounter data to the provided financial data, after the steps noted above have been completed. This is a vital step in the process, as it allows all parties to ensure that the data provided, and the data used in the rate setting process, are consistent. To the extent that differences exist, all parties work together to validate whether the differences are appropriate, or if underreporting adjustments are necessary to ensure that the base data includes all valid program expenditures.

The steps above reflect the general process that is undertaken for data validation, but additional review is often conducted, based on the findings of the initial validation process. Given the magnitude of the validation phase, there are multiple touch-points and Q&A sessions between stakeholders, to ensure that data is being interpreted correctly, and that questions are not left unanswered prior to capitation rate development and rate rebasing.

In addition to updating the base data underlying rate development as part of capitation rate rebasing, another major component of rebasing is the reevaluation of trend assumptions using the updated base data. Adjusting historical claims data to reflect what is expected in the contract period through the application of inflationary trend factors is critical for developing appropriate capitation rates when rebasing. As part of the trend development process, **Optumas** first creates a trend model that arrays historical data by month for the prior two to three years of data. This data is split out by population and category of service and shows utilization, unit cost, and PMPM metrics. One of the key components of developing this model is to ensure that the data is all on the same basis regarding program and policy changes. This ensures that changes observed within the historical data are driven by factors outside of known program changes, e.g., increases in reimbursement that occur on an annual basis, which we would not want to consider as trend.

After review of historical data over time, **Optumas** then develops trend factors that can be applied prospectively. It is important to note that while historical trend experience is reviewed as part of this process, trend projections are not based purely on an empirical calculation of historical changes in data. Rather, it is based on a review of what has occurred in prior years, with consideration of trends observed in other markets for similar populations and services, as well as with consideration of expected changes in practice patterns and utilization patterns in the future.

Trend projections are developed on an annualized basis, meaning that they reflect the expected percentage change from one year to the next. These projections are often applied for multiple years, projecting the base data to the contract period. For example, if the base data is CY16 and the contract period is CY18, then that reflects two years' difference between the base and contract period. Therefore, the annualized trend factors would be compounded for two years.

The same rigor in developing trends for an initial capitation rate setting project applies when performing capitation rate rebasing.

As a result of the trend analyses and data validation techniques that **Optumas** employs, a range of possible capitation rates can be developed. As previously discussed, CMS no longer allows for the submission of rate ranges, but **Optumas** will still develop a range of assumptions for the Department to consider. Using this information, the Department can determine a target rate that meets all the requirements of actuarial soundness, and this rate will be the final product submitted to CMS.

c. **Analyze rate cell alternatives for identification of various groupings for the population** (e.g. **age, gender, eligibility);**

When creating a rate development process, **Optumas** first works with its clients to understand the current rating structure and discuss any areas the client would like to update to align with program operational goals. In particular, when rebasing **Optumas** discusses whether the Department would like to consolidate or break out any rate cells into further demographic distinctions such as age, gender, or eligibility type.

Optumas discusses and considers operational challenges with the Department prior to developing rating cohorts to ensure that capitation payments for the Managed Care Programs are not operationally burdensome for the Department.

If the rate development process is for a new program, **Optumas** will conduct several analyses to determine a rating cohort structure that is appropriate for the program in question. First, **Optumas** will determine a reasonable set of rating cohorts based on industry standards. We will rely on our experience with similar programs in other states to identify a rating cohort structure that is commonly used and easy to operate. Once a general set of rating cohorts is determined, **Optumas** will then conduct state-specific analyses to understand if the rating cohorts make sense for Nebraska. First, an age and gender analysis will be conducted to identify cost differentials by age and gender and also to understand the enrollment volume by age and gender. This allows **Optumas** to understand how much of the cost differential is due to actual underlying risk differences or due to small sample size. These analyses also generally include breakouts by major eligibility criteria, such as AABD Duals, AABD Non-Duals, CHIP, Foster Care, and TANF; additionally, a program that includes LTSS populations will have breakouts to distinguish the setting of care of the population, such as Nursing Facility Resident versus Waiver recipient. The results of these analyses will be reviewed by **Optumas** and used to determine a proposed set of rating cohorts to the Department. **Optumas** will then share the results of the analysis, including key findings and proposed rating cohorts. From there, **Optumas** will work with the Department to determine if there are other unique risks or populations that may need to be considered, or if there are any operational challenges that occur from the rating cohorts as proposed (e.g., some states cannot determine which members reside in an institution in real time, so a separate institutional and non-institutional rate will require retrospective rate reconciliations once these members are identified).

Once cohorts have been established they remain as flexible as the Department's operationalization constraints allow. **Optumas** proposes to continually monitor the rating cohort structure to ensure that emerging population adjustments are considered and any potential cohort changes are evaluated by the Department.

Optumas makes the following key considerations when structuring an alternative rating cohort:

LTSS Blended Rate – In many cases, a blended rate for the Institutional and Waiver populations underlying a particular LTSS population is appropriate. While the setting of care and underlying costs between these two subpopulations vary substantially, the populations are somewhat related. Developing a blended rate provides incentive for the MCO to manage the care in a way that delay members moving into an institutional setting as long as possible, since the capitation rate does not change regardless of the setting of care. For example, in the State of Iowa, **Optumas** develops four LTSS blended rates: LTSS Elderly, LTSS Physically Disabled, LTSS Intellectually Disabled, and LTSS Children's Mental Health. Each of these blended rates consist of members in Institutional settings and Waiver populations (e.g., LTSS Elderly includes Custodial Care members age 65+ as well as the Elderly HCBS Waiver members). However, the specific needs of the four blended rate populations vary in nature (e.g., LTSS Elderly member needs vary from LTSS Intellectually Disabled). It is important to recognize underlying differences in population needs, prior to determining which populations should be blended together.

Credibility of Population – The membership volume and overall credibility of each population being considered for separate rating cohorts should be considered in the final determination of rate cohorts. The goal of developing rating cohorts is to group 'like risk' together for rating purposes; however, this needs to be done with consideration for the size of the population. Except in the case of very unique, expensive populations (e.g., Katie Beckett in Nebraska), developing a rating cohort with too few members could lead to too much volatility. The AABD 0-20 cohort is a good example; this population generally has relatively low enrollment compared to the TANF children population. It may make sense to break a newborn population out in the TANF children population but doing so in the AABD 0-20 population may result in fewer than 100 members driving the base data for the newborn population. This opens the door for year to year volatility to enter rate development if there are a few high cost members that exist in one or two years of the base data. Therefore, keeping the newborns combined with the remainder of the AABD 0-20 population generally makes sense and should lead to less rate shock for the population.

Relationship with Risk Adjustment – There are certain risks that may on the surface support an adjustment to rating cohorts but may actually be addressed through a well-developed risk adjustment process. For example, it is common to develop multiple rating cohorts for the TANF population based on age and gender. While this is an appropriate approach and one that **Optumas** generally follows in other markets, the CDPS+Rx risk score model used in Nebraska takes into account differences in age and gender when developing risk scores. Therefore, even though the Family 21+ cohort in Nebraska encompasses a large age range (21-64), the application of CDPS+Rx risk adjustment allows for this large cohort to appropriately account for potential age and gender enrollment differences.

Optumas believes that it is important to periodically review the underlying risks of each program to determine if adjustments to rating cohorts are warranted. Consideration needs to be given to multiple aspects when making these decisions. Asking the following questions is important when determining if changes should be made:

1. Does the risk in question reflect an ongoing risk that will occur going forward, or is it a one-time outlier?
2. Are differences in cost driven by the risk in question already accounted for by another rating mechanism, such as risk adjustment?
3. What operational concerns would be present if a change were made to the rating cohorts, and does the risk warrant a change even with those concerns in mind?

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

Reimbursement analyses provide insight into MCO reimbursement structures to ensure the Department is an effective purchaser of capitation services and identify areas of potential savings and efficiencies.

As part of the rate setting process, **Optumas** conducts varied levels of reimbursement analyses for managed care programs. Often, reimbursement analyses are conducted to review the underlying reimbursement for the states' MCOs for major categories of service; for example, Inpatient Hospital, Outpatient Hospital, and Professional services. These are typically conducted to review the differences in reimbursement between MCOs, but also to review the difference in reimbursement between the MCOs and a specific benchmark such as Medicaid FFS reimbursement or Medicare reimbursement. In some cases, states set a maximum allowable level of reimbursement that it will include in capitation rate reimbursement. For example, a state may set this maximum at 105% of Medicaid FFS; in this case, an MCO may pay more than 105% of Medicaid FFS to its contracted providers, but the claims will be re-priced to the 105% maximum so that the excess reimbursement is not included within the capitation rate development. As part of the reimbursement analyses conducted by **Optumas**, this difference between reimbursement and policy would be identified and adjusted for within rate development to ensure that the rates are in compliance with Federal and State laws, rules, and regulation regarding reimbursement.

Another example of a reimbursement-related analysis specific to Nebraska is the recent change the Department implemented to its reimbursement of Medicare Crossover claims for dual-eligible members. The Department historically paid the difference between the Medicare Allowed Amount and the Medicare Paid Amount for Crossover claims. Moving forward, the Department will pay the minimum of:

1. The difference between the <u>Medicare</u> Allowed Amount and the Medicare Paid Amount
2. The difference between the <u>Medicaid</u> Allowed Amount and the Medicare Paid Amount

Given that this program change occurred after the end of the base data period used to develop the CY18 Heritage Health capitation rates, an adjustment to the capitation rates was necessary to reflect this reimbursement policy change. **Optumas** relied on both its own re-pricing analysis, as well as a review of the impact of this policy change in other state Medicaid programs, to determine the value of this adjustment within the CY18 Heritage Health rate setting process.

Optumas works with the Department, and each of its clients, to understand all applicable reimbursement rules and regulations. This may include policies already in place such as those noted above or may include providing recommendations for changes in policy to better align with program goals. Additionally, this may include other contractual policies such as state-mandated risk corridors or profit caps/maximums, as well as medical loss ratio (MLR) requirements.

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;

Optumas has built a reputation of developing a transparent rate setting process with each of its clients, providing various summaries, detailed analyses, and rate models in addition to various standing touch points that serve to achieve goals ranging in scope from initial brainstorming to presentation of final rates to all key stakeholders. This approach is designed to ensure that the rate setting process and methodology is clearly communicated and understood in an easy to follow manner.

During our weekly meetings with the Department, **Optumas** shares various summaries of the results of key analyses. In some cases, a walkthrough is provided for a detailed analysis or a full-blown rate model, and the files themselves are shared with the Department after the call. In these meetings, **Optumas** presents all methodology in an orderly manner, in a way that ensures that Department staff understand the steps taken and considerations made for each adjustment and analysis. We also provide written documentation that serves as a reference to further understand the general process and specific details surrounding an analysis. In addition to standard discussions of ongoing analyses, Optumas values these meetings because they allow us to hear what is going on within the Department. Hearing the concerns, pressures, and changes being discussed allows us to better serve the Department and understand the context behind requests that we receive. We also value hearing the concerns MCOs are raising to the Department and brainstorming with the Department on the validity of each concern. We believe that this helps to foster engagement with all stakeholders and creates a strong understanding of intradepartmental dynamics when we are completing our work.

Optumas is always willing to conduct technical assistance calls for the Department staff either during the rate development process or once the process is completed. If the Department requests a call to further review the general rate development process, or to discuss a certain adjustment or set of adjustments in further detail, we can do so either via a conference call or in-person meeting.

f. Provide an actuarial certification as to the soundness of the rates the contractor develops; and

Optumas provides detailed substantiation as part of the rate certification. In addition, **Optumas** provides CMS/OACT additional models/summaries upon request in order to address various questions surrounding specific aspects of rate development. **Optumas** has an outstanding relationship and reputation with CMS/OACT due to the rate development work completed in various programs, including Nebraska. **Optumas** has an open line of communication with the actuaries and policy members within CMS, which results in getting expedited resolutions to any issues identified during the rate development process.

The actuarial rate certification and documentation process is described in substantial detail in SOW 1.3 in the subsection beginning on page 136 of this proposal. The same level or rigor and process for rate certification applies to capitation rate rebasing.

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

Optumas will prepare all necessary presentation materials and participate in MCO meetings as requested.

The devoted Nebraska team has experience participating with and presenting to a broad array of audiences in multiple states. In many cases this includes regular touch-points with Medicaid leadership, contract managers, and analysts. This also frequently includes presenting to Medicaid Directors, MCO Actuaries and Executive (e.g., CEOs, CFOs, COOs), and in some cases presenting to members at legislative hearings. As a result, **Optumas** has significant experience gearing each presentation towards its intended audience, focusing on the appropriate goals, concepts, and level of detail accordingly.

In our current Nebraska work, **Optumas** coordinates meetings between **Optumas** and the Department for regular touch-points. During these meetings, topics range from status updates, new policy developments, MCO questions, as well as strategizing and preparing for meetings directly with the MCOs. In preparation for MCO meetings, **Optumas** first develops a version of relevant meeting materials that is presented to the Department. Once this is presented, discussed, and approved by the Department, these materials are typically provided to the MCOs at least one day in advance of the meeting. This process has worked well, as it ensures that the Department and **Optumas** are in agreement with the strategy, approach, and deliverables being proposed. It ensures that MCOs have an opportunity to review materials ahead of time, so that they are prepared enough to be able to follow the presentation and ask intelligent questions throughout.

__Optumas__ strives to provide meeting materials and exhibits ahead of time to ensure the Department and MCOs have a chance to review and meetings can be as productive as possible.

The meetings themselves generally consist of a combination of the Department and **Optumas** presenting or discussing certain topics, depending on the particular agenda. By preparing well ahead of time, we ensure that the meeting is well-coordinated, and that the messaging is

consistent between the Department and **Optumas**. This has resulted in successful meetings with the MCOs and has particularly been productive when presenting topics that are new to the Heritage Health program, such as risk adjustment approaches. Our frequent communication with the Department and MCOs enables all parties involved in rate development and rebasing to have a thorough understanding of the methodologies underlying the final capitation rates and promotes an expedited review process from CMS as we are able to clearly outline the methodology in our certification letter and supporting exhibits by leveraging materials already presented to the Department and MCOs.

C. Technical Considerations

Certain technical considerations are important to account for when rebasing capitation rates. Two specific examples are provided below:

Data Selection – The selection of data is dependent upon the delivery system(s) in place and the validity of the available data sources. CMS' preferred approach is to use multiple years of data. However, it is common for encounter data to contain some level of underreporting, meaning that certain encounters do not pass various MMIS edits and therefore never make it into the data warehouse. While this is an operational issue that needs to be addressed, it is important to recognize from a rate setting perspective, that all reasonable, appropriate, and attainable costs must be considered in rate development. In this case, it is necessary to supplement the encounter data with an external data source; this often includes receiving reported financial data from MCOs that contain their total expenditures, as well as potentially a supplemental data extract directly from the MCOs to ensure that all appropriate costs are included in the rate build up. If encounter data is taken at face value without consideration for the level of underreporting that may be present then the final rates may be inaccurate due to the base data being understated, even if all other aspects of the rate setting process are done correctly.

> ***Optumas** has a very thorough data review and validation process to ensure that the base data used for rate development is complete and appropriately reflects the service costs and utilization of the specific managed care program.*

Once the data source and relevant supplemental data sources are determined, the Department and the actuary must determine which years of data will be used for rate development. CMS requires that the most recent three years of data be requested and provided by the Department to its actuary; however, depending upon consideration such as data quality and circumstances surrounding underlying changes to the program, fewer than three years of data may be more appropriate for developing base data.

Rating Cohort Structure – It is important that the rating cohorts developed in capitation rate development reflect a structure that is possible to operationalize from an administrative standpoint. For example, in an LTSS program the definition of a Nursing Facility Resident versus a Waiver recipient or non-LTSS population is an important distinction. It is important to ensure that the definition being used to categorize these populations in rate development is consistent

with what will be used to categorize members for capitation payment purposes. If a member is technically not a long-term Nursing Facility resident and instead has a short-term stay, but it is known that the eligibility system would identify this type of members as a Nursing Facility resident, then the capitation rates should be developed in such a way that the experience for this member be included in the Nursing Facility Resident cohort. Even though this may not technically be an accurate description, that is how rates will be operationalized and therefore the two processes must be in alignment for payment to appropriately match the risk of the population underlying the rates.

D. Detailed Project Work Plan

Please see Appendix II(A) for a sample SOW 2 Capitation Rate Rebasing detailed project work plan.

E. Deliverables and Due Dates

Please see Appendix II(A) for deliverables and due dates associated with Capitation Rate Rebasing. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department.

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SOW 2.1-Policy/Financial
Mgmt. Consulting Services

SOW 2.1 – Policy and Financial Management Consulting Services

After reviewing the scope of the services mentioned in this RFP and specifically this section, **Optumas** felt it was in the Department's best interests for us to partner with **MSLC** to ensure the Department continues to receive outstanding results from industry recognized experts. The **Optumas/MSLC** team provides unmatched policy and financial management services across the nation. Collectively, we have worked in every state in the nation and bring a wealth of experience to benefit the Department. **Optumas** and **MSLC** have worked together previously in multiple markets and have developed communication and project management strategies that allow us to operate seamlessly. The Department will receive the intellectual capital of two expert firms while experiencing the ease of communication inherent with a sole-source contract.

A. Understanding of the Project Requirements

Optumas and **MSLC** understand the project requirements of policy and financial management consulting services as they pertain to capitation rate rebasing as described on pages 26 and 27 of the RFP. The **Optumas/MSLC** team brings Nebraska a wealth of industry experience with both policy and financial management consulting services. Collectively, we have experience working in every state in the country to help solve some of the toughest Medicaid challenges. We bring this experience and the expertise of our staff to assist Nebraska with identifying and creating solutions that meet the Department's specific needs.

B. Proposed Development Approach

Within this section of our RFP response we will discuss items a through j as outlined under "1. Policy and Financial Management Consulting Services" on pages 26 and 27 of the RFP.

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.

MSLC has meaningful experience collaborating with our Medicaid clients on strategic planning and transformation of delivery systems and payment models. We support numerous Medicaid agencies in evaluating alternative payment models (APMs) and Value Based Payment (VBP) approaches. Through this work, we are well prepared to support the Department with all aspects of evaluating Nebraska's current VBP program and exploration of potential models suited to the state's goals and objectives. In the state of New Jersey, for example, we supported the state's Delivery System Reform Incentive Payment (DSRIP) program and VBP model which has resulted in improvement of specific hospital performance measures and outcomes. For the state of Nevada, we assisted in the development of their State Health System Innovation Plan (SHSIP) which served as a multi-year roadmap for sustainable delivery system and payment transformation. The Plan can be found here: Nevada SHSIP (http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/Rates/Nevada%20State%20Health%20System%20Innovation%20Plan(1).pdf).

The approach we describe below addresses our plans to understand the Department's goals, evaluate potential VBP models, and develop actionable recommendations.

- Our approach to this work will begin with ensuring our staff have a detailed understanding of the history of value-based contracting in Nebraska. We will work with the Department to understand the policy history, MCOs' experience with VBP, and VBP models currently under consideration by the Department. This data will supplement our research of the state's VBP environment and give us some perspective on whether certain models should be considered. We will also work with Department staff to understand any operational challenges that might impact the implementation of the VBP strategy.
- We understand the Department has some experience with VBP through its efforts with Patient Centered Medical Homes (PCMH), the current MCO contracts, and other projects like the Home Health Value-Based Purchasing program. For this engagement, the Department has expressed its desire to implement VBP using MCOs, ACOs, and/or Independent Practice Associations (IPAs). We have worked with states in developing VBP strategies that empower the provider community in developing VBP programs, while minimizing the administrative complexity for Department staff. As such, we will work with the Department to consider the provider networks, access, and resources to consider which provider structure or combination of provider structures would be most suitable to the Nebraska health care community. In doing so, we will rely on the combination of our knowledge from other clients who have embarked on similar work, our wealth of knowledge and research related to industry best practices, as well as the knowledge of the Department about the provider community, including any regional, political, social, or cultural considerations.
- In conjunction with determining the right provider configurations, we will work with the Department to determine the appropriate payment models to implement. For this engagement, the Department has outlined that it would consider shared savings, bundled payment mechanisms based on an episode of care, and other total cost of care models. There are quite a few examples of how states have implemented payment models through different delivery systems. For instance, in the managed care arena, some states have gone with a standardized approach that dictates which APMs contracted MCOs must implement, using standardized payment and incentive methodologies, metrics, and reporting requirements. Other states have required that MCOs develop their own projects for State approval with limited to no standardizing parameters. We can help the Department think through these aspects, using a practical approach that looks at the level of effort on the Department's part, the administrative burden on the part of participants, the regulatory requirements for each, and other important factors.
- The Department is undertaking a major task in reforming its delivery system. Stakeholder buy-in, especially around payment, system requirements, and changes in delivery methods, is important. We will work with the Department to solicit and incorporate stakeholder input, as appropriate. Our approach will be to ensure the Department has a strategy for engagement that brings the right amount and level of information to the right stakeholders at the right time.
- Our approach includes bringing an element of innovation to the Department that will be supported by our experience and VBP expertise. For instance, an important aspect for

consideration in Nebraska is the participation of rural providers in VBP strategies and APMs. We believe there may be creative options for the Department to consider in coordinating the program with initiatives related to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). We see this as an effort that can position the Department as an innovative leader, as achieving alignment of strategies and metrics will work towards increased efficiencies and less burden for providers. We will work with the Department to determine if there is opportunity to align its reforms in a manner that will result in those payment models being eligible to qualify as MACRA Other Payer Advanced APMs.

As we discuss the VBP models with the Department and in defining our recommended approaches, we will be mindful of the challenges and barriers that have been identified, as well as the common challenges of VBP programs (listed below), in an effort to develop methods to overcome those challenges. Based on our experience, in addition to MCO contracting issues, other potential issues/themes that must be considered as part of our evaluation and recommendations include:

- Providers want predictable, adequate payments.
- Relative risk of the provider's population.
- Competing priorities of providers and level of administrative burden.
- Availability of health information technology (health IT) tools.
- Payer standardization.
- Cost to sustain practice and system level changes.
- Ensuring proper program administration, claiming, and payment.

We will review all the above areas, among others, from which to base our recommendations for internal criteria for administering the VBP program. We will strive to identify sustainable practices that will allow for oversight of clinical and financial accountability between MCOs and their provider networks. We will present those recommendations within the forum required by the Department (e.g., to Department staff, subcommittee, workgroup, etc.), and make revisions as agreed upon. Based on final criteria and decisions, we will support the Department with the development of an implementation plan which supports a new administrative infrastructure and auditing functions. The implementation plan will address the following:

- Developing an administrative manual for Department staff to use internally, as well as to distribute to MCOs.
- Developing a charter and facilitating an ongoing VBP workgroup that includes Department staff, MCOs, and potentially, provider representatives.
- Developing standardized reporting requirements for use by MCOs.
- Providing training to Department staff about administering the VBP program, including conduct of ongoing oversight activities.
- Creating models that support the Department's stated policy objectives and that align strategically with CMS policies and priorities.
- Validating accuracy of MCO data.
- Analyzing data provided by MCOs to calculate payments.
- Performing data analysis to provide MCO-specific findings and statewide comparisons.
- Identifying opportunities to maximize provider benefits by aligning across programs.
- Designing payment methodologies and calculating payments.

- Supporting selection of strategic and well-aligned quality metrics, and trending MCO progress to determine when new measures should be implemented.
- Facilitating meaningful stakeholder and provider engagement to get qualitative feedback on the program.

Optumas and **MSLC** will provide the Department with the expertise to evaluate VBP models meeting the unique requirements of Nebraska Medicaid. Our extensive experience and expertise provides us with the ability to support Nebraska in its transformative initiatives.

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.

A significant portion of the nation's health care system is governed by the Social Security Act, as well as associated regulations and sub-regulatory guidance designed to implement and operationalize federally-funded health insurance programs for the nation's most vulnerable populations. As these programs have grown and become more complex, so too, have the federal statutes and regulations that govern them. In addition, there are the added complexities of state legislation, rules, and policies developed to align with and implement federal guidance.

MSLC has significant experience supporting clients in this aspect. We will 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. We regularly assist clients with navigating the complexity of federal and state law in a number of ways. Our approach will include, but will not be limited to, the following:

- Our subject matter experts identify and analyze statutory and regulatory developments daily, using both public and private research databases, observing the "policy cycle" (i.e., agenda setting, drafting, implementation, monitoring, and enforcement), and regularly communicate with other clients and stakeholders. We will support the Department with compliance, impact analysis, trend watching, and intelligence gathering.
- Supporting the Department's decision-making by analyzing the impact of potential statutory or regulatory changes on existing programs, existing programs that are being re-designed, and new programs. For example, the Department would not want to pursue a new program or program design that is cost prohibitive, administratively burdensome, or would not likely be approved by CMS.
- Our team will support the Department's review of potential statutory or regulatory changes to help draft state, as well as stakeholder impact summaries. This may involve helping to draft summaries of impacts to the state's Medicaid program should legislation or rules under consideration pass. We also help facilitate meetings with stakeholders regarding potential impacts to them. Our subject matter experts regularly

raise the need for consideration and analysis of statutory and/or regulatory changes and will support necessary programmatic changes to address such changes as requested.

- We will provide staff training on existing and new statutes or regulatory changes, communicating impacts to both associated programs and staff responsibilities. Our subject matter experts regularly develop content and facilitate training for clients, providers, and other key stakeholders, and have served as presenters at numerous health care and industry conferences and meetings.
- Our team will support the Department in effectively communicating decisions, by assisting with stakeholder identification, creating outreach plans, supporting change management, and facilitating stakeholder meetings and/or public hearings, in a manner that is respectful and responsive to the health beliefs and practices of diverse population groups.

In addition to assisting states with navigating the complex health care regulatory environment, our team has considerable experience designing, implementing, and supporting state administration of federal health care programs. This requires a thorough understanding of the mechanisms by which states can modify existing programs to meet the needs of their state and the population(s) they serve or test new or existing ways to deliver and pay for health care services. Our team has worked closely with states to prepare federally-required materials including State Plan Amendments (SPAs), waiver applications, waiver amendments, and reports, as well as grant applications and reports, among others. In addition, we have facilitated or supported state negotiations with CMS regarding a variety of state Medicaid program design changes and reform initiatives.

*Both **Optumas** and **MSLC** have significant experience in supporting states in negotiations and discussions with CMS and can assist the Department with any program design changes or reform initiatives and communications with CMS.*

As requested, **MSLC** will prepare or assist with preparation of federally-required materials in alignment with state strategic goals and objectives. Our team's deep knowledge of federal pre-prints and templates, familiarity with the CMS Waiver Management System and submission protocols, as well as our understanding of CMS expectations, will ensure any such materials are properly developed, tracked, and submitted in accordance with state and federal requirements.

The **Optumas/MSLC** team offers the Department our extensive experience and expertise in support of Nebraska's transformative initiatives.

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.**

Optumas and **MSLC** have considerable experience in developing and supporting a variety of rate structures. We have developed specialized tools that help us to build and update rates, including bundled payments, for various health care models and programs. We also have knowledge of data and processes necessary to compile utilization and cost components to develop total cost of benchmarks.

Measuring the total cost of care requires a mix of complex factors, including patient illness burden, market-specific fluctuation, utilization, and prices. As a result of these complexities, cost measures need to be flexible enough to support different levels of analysis, to be reviewed individually or aggregated. Our approach to helping the Department develop total cost of care benchmarks will include a robust measurement system that measures both cost and utilization. In addition, we will help the Department develop reporting requirements that support the efficient analysis at the population, provider, condition, procedure, and patient levels.
Our approach to this task will include the following activities:

- Designing and updating bundles using the appropriate billing codes and related information.
- Developing and updating utilization and cost trend data.
- Analyzing associated cost data.
- Helping the Department consider key challenges for bundled rates, including which providers are authorized to initiate an episode of care.
- Supporting stakeholder outreach and engagement on bundled payments and total cost of care benchmarks, including incorporation of critical feedback into the payment methodology.
- Assisting the Department in considering implications for whether and how participant providers will be reimbursed for services based on quality outcomes.
- Assisting the Department in considering the quality metrics associated with payment and outcomes measurement.
- Determining the appropriate case mix adjustment for rates.
- Monitoring utilization trends.

Optumas and **MSLC** are committed to providing Nebraska with the benefit of our expertise and experience in the development and maintenance of bundled payments and the setting of total cost of care benchmarks.

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;

MSLC has significant experience assisting state Medicaid programs with program design for transforming delivery system and payment models, and oversight of their managed care plans, including contract monitoring, program review, compliance, and financial monitoring activities. These efforts are designed to assist our Medicaid clients in realizing the goals and objectives of their managed care programs and to ensure MCO contractors are fully aligned with these goals and objectives. With the implementation of Nebraska's integrated managed care program, Heritage Health, and its plans for the Long-Term Care Managed Care program, it is imperative that the three currently contracted MCOs and related-entities/subcontractors are fully aligned with the Department's goals.

Optumas and **MSLC** understand the importance in gaining a thorough understanding of the MCOs' management agreements and contracts between related parties as they pertain to cost sharing and cost allocation methodologies. **MSLC** has experience supporting Medicaid clients with MCO contract analysis and development of recommendations for future MCO contract language or MCO Request for Proposal (RFP) language. In the state of Georgia, for example, we conduct annual in-depth on-site reviews of each MCO and key subcontractors (e.g., Pharmacy Benefit Managers (PBMs), Dental Benefit Administrators, Behavioral Health Organizations, etc.) to determine compliance with the contract with Georgia Medicaid. Based on our findings, we make detailed recommendations for MCO contract amendments or corrective action plans, and then support the State in addressing the recommendations or findings with the MCOs. For the state of Nevada, we conducted a review of the MCO contracts and reporting requirements to identify opportunities for improvement and possible contract amendments. Based on our review, Nevada plans to amend the MCO contracts to promote stronger MCO alignment with the state's goals for monitoring, oversight, and transparency. The approach **MSLC** employed in Georgia and Nevada to evaluate MCO contracts and to provide technical assistance with be customized to meet the requirements set forth by Nebraska in this RFP.

MSLC has significant experience supporting states through in-depth review and analysis of MCO and subcontractor contracting to ensure compliance with Medicaid contract requirements and promote transparency and alignment with the Department's goals.

Based on a preliminary review, the recent MCO RFP (#5151 Z1) defines "related-party" as "The parent company of an MCO or an entity partially or wholly-owned by the MCO or the MCO's parent company that receives any revenue from the MCO for Medicaid contracted services. Examples of related parties include a clinic wholly or partly owned by an MCO or its parent company that provides services covered by Nebraska Medicaid and subcontractors to the MCO performing services under this contract." The current MCO contracts disclose high-level details on existing related-party agreements and management contracts. While this information will be the basis for our analysis and recommendations to the Department, it is as important to understand the Department's vision and goals for MCO contracting, especially as related to cost sharing and cost allocation methods. The approach we describe below addresses our plan to obtain critical information from the Department and MCOs to support our findings and recommendations.

MSLC will begin our analysis by first requesting and reviewing the Medicaid MCO contractual arrangements to gain a detailed understanding of cost sharing/cost allocation methods and requirements that are in place, how thorough they are across all operational areas, and where there may be gaps or outdated requirements as related to Heritage Health and the potential Long-Term Care Managed Care program. We will review data analyses, if necessary, to better understand the current state of the MCO contractual arrangements to further inform our recommendations.

We will interview key Department staff about cost sharing/cost allocation methods and the current MCO contractual arrangements to determine if there are challenges that might be

addressed through strengthened contracts. We also recommend interviewing MCO staff and related contractors to gain additional perspectives on challenges within the program. For these interviews, we will not only address topic areas of particular importance, but also issues that we have identified during our materials review for which more information is needed. For efficiency, and where possible based on necessary involved parties, we will work to address all issues with the interviewees during one meeting (e.g., we will work to coordinate one meeting with an MCO and related contractors to address topic areas). We will provide discussion topics and questions ahead of time to assure the appropriate attendees are available. As needed, we will also be flexible to conduct separate meetings. The interviews with Department and MCO staff may be conducted on site or telephonically.

As a result of our materials review and interviews, we will provide our findings, recommendations, and key considerations to the Department. Key considerations will address optimal cost sharing and cost allocation methods and contracting language. **MSLC** will meet with the Department to discuss our recommendations and proposed next steps for implementing approved recommendations.

Timeline

The high-level timeline for technical assistance in evaluating the MCOs' management agreements and related entities agreements is provided below. The proposed timeline for completing these activities is shown in Figure VI.A.3.xvii. The timeline is contingent upon the availability of requested MCO documentation and key MCO staff for interviews.

Figure VI.A.3.xvii – Proposed Timeline for Technical Assistance

Task	Parties Involved	Timeframe
Request and review MCO contractual arrangements and information related to cost sharing and cost allocation methods.	**MSLC** MCOs	21 calendar days
Conduct interviews with key Department staff and MCOs. Includes preparation of all meeting materials.	**MSLC**	28 calendar days
Draft findings, recommendations, and key considerations for discussion with the Department.	**MSLC**	28 calendar days
Reach agreement on recommendations and next steps.	Department **MSLC**	10 calendar days
Conduct meetings with the Department and MCOs to discuss recommendations and the implementation of changes to MCO contractual arrangements. Includes preparation for the meetings.	Department **MSLC** MCOs	Five calendar days

In summary, **Optumas** and **MSLC** can provide the Department with the expertise to evaluate management agreements, related-entity contracts, and cost sharing and cost allocation

methods impacting the MCOs. Our extensive experience and expertise provides us with the ability to support Nebraska efficiently and effectively.

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;

MSLC is at the forefront of assisting states with monitoring and oversight of their managed care contractors and can bring this direct experience to the Department by assigning staff that have already performed similar work in other states. We bring to this project an expert knowledge of industry practices related to managed care operations, including financial monitoring tools, on-site monitoring experience, and encounter data validation reporting and comparison. We understand the challenges that complex contractual relationships can pose for our state and federal clients. As a result, we approach each engagement with a proven framework that allows us to gain a full understanding of the performance, compliance, and financial reporting aspects and needs of each contract.

We are currently assisting more than 10 Medicaid programs and CMS with audit, consulting, and monitoring efforts related to their managed care programs. These efforts are designed to assist our Medicaid clients in realizing their goals and objectives for their managed care programs. Our work includes:

- Advisory services related to regulatory reporting needs and requirements, including financial monitoring tools, for states to collect from the MCOs.
- Encounter data validation and reconciliation including CMS External Quality Review (EQR) Protocol 4.
- Financial reviews, including medical loss ratio (MLR) examinations and monitoring of MCO administrative costs, to ensure only allowable costs are charged to the program.
- Oversight and monitoring training and support to Department staff, ensuring related-party transactions are reported in accordance with program requirements.
- Operational performance audits including on-site monitoring.
- Contract compliance reviews to ensure health plans are operating in accordance with both the contract with the regulatory agency and with the provider community.
- Utilization management reviews to ensure that recipients have access to needed health care services and that our agency clients have prompt access to the data they need to manage these expensive health care programs.
- Monitoring of third-party liability (TPL) payments and recoveries to ensure these are properly offset against costs.
- MCO readiness reviews.
- Review of medical costs to ensure overpayments are not passed through to the state.
- Compliance audits of PBMs and third-party administrators.
- Risk assessments.

MSLC is a seasoned evaluator of programs from both financial and operational perspectives. This work includes performing cost effectiveness and budget neutrality analyses, process evaluation, and consulting to bring best practice expertise to create efficiencies regarding

various waiver elements. We also have extensive experience assisting our clients with identifying and solving implementation opportunities and challenges.

In recent rule-making activities, CMS has indicated its recognition of the importance of strong and effective oversight and monitoring of managed care plans to the overall success of the Medicaid managed care program. **MSLC** is at the forefront of assisting state Medicaid programs with analysis, monitoring, and oversight of their managed care contractors, and can bring this direct experience to Nebraska by assigning staff that have already performed similar work in other states. We bring to this project an expert knowledge of industry best practices related to managed care operations and approach each engagement with a proven framework that allows us to gain a full understanding of performance, compliance, and financial reporting aspects of each contract. This proven framework has led us to identify material areas of contractor non-compliance which has resulted in millions of dollars contractors have had to pay back to the state, as well as the assessment of liquidated damages against the contractors.

Our scope of comprehensive services helps ensure that MCOs are on track to achieve intended performance goals. The combination of skills and expertise we bring to this project are truly unique. We bring a level of expertise that is extraordinary and draws on the total resources of the firm when performing our services. Not only do we have exceptional Medicare/Medicaid contract compliance knowledge and experience, we have equivalent knowledge and experience in the Medicaid consulting, data management, and vendor oversight areas. Often, issues currently being addressed in one state have previously been encountered and addressed in another state. Our experience has indicated a need for strong contract language between the Department and the MCOs. We are prepared and able to assist the Department in conducting a broad contract analysis with a focus on areas such as:

- Reporting requirements.
- Encounter data requirements including completeness and accuracy targets.
- MLR and other financial reporting requirements.
- TPL payments and recoveries.
- Provisions for state's right to audit.
- Provisions for addressing non-compliance.
- Provisions for addressing overpayments and excess profits.
    - *Related-party transactions.*

Encounter Data

All states must conduct or contract for an independent audit of the encounter and financial data submitted by MCOs, prepaid inpatient health plans, and prepaid ambulatory health plans at least every three years, per the Medicaid Managed Care Final Rule. One approach that will comply with 42 CFR §438.242 is completing EQR Protocol 4, per 42 CFR §438.358(c)(1). CMS strongly encourages states to contract with qualified entities to implement EQR Protocol 4 Validation of Encounter Data Reported by the MCO due to the need for valid and reliable encounter data as part of any state quality improvement efforts. As the final rule states, there are other requirements relating to the accuracy of encounter data (§ 438.242) that impose more frequent validation or audit requirements. The optional EQR activity at § 438.358(c)(1) would satisfy the periodic audit requirement for encounter data. Additionally, in doing so, the Department will receive increased funding, upon CMS approval, as all EQR-related activities

described in §438.358 are eligible for the 75 percent match rate, provided they are conducted on an MCO by an EQR organization (EQRO) which satisfies the requirements of §438.354.

An EQRO must meet the requirements in the regulation specific to competence and independence. **MSLC** meets both of these requirements, as demonstrated below.

MSLC meets the competency requirements for this engagement as outlined in 42 CFR §438.354(b). **MSLC** has a rich amount of experience with Medicaid recipients, policies, data systems, and processes as this is the basis of our 40-year business. We have staff members with direct managed care experience, with some having worked at a health plan or state agency with managed care oversight responsibilities or having been involved in managed care compliance, financial, or system reviews. **MSLC** knows the policies and procedures, data, organizational structure, and financing of the managed care entities. **MSLC** also has an impressive group of clinical staff, including a medical director with more than 30 years of experience, available for this project who have quality assessment and improvement methodology experience in all health care environments: clinical, health plan, and consulting. We have been involved in DSRIP and State Innovation Model programs in several states. As part of these engagements, there is a focus on quality and design of projects and programs to provide structure for outcome measurement as it relates to payment methodologies.

MSLC has extensive experience working with Medicaid programs both on behalf of state agencies and managed care health plans and has clinical staff that provide medical expertise and consulting on new program design or policy change developments.

MSLC meets the independence requirements set forth in the CFRs related to EQROs. We do not contract with MCOs or providers to ensure our independence is not compromised for the work that we engage in with states, federal government, or other government entities. **MSLC** is independent from the state Medicaid agency, and from the MCOs that will be reviewed under any resulting contract, in accordance with 42 CFR 438.354(c). In addition, we do not:

- Exert control of an MCO nor does any MCO exerts control over **MSLC**.
- Have a present, or known future, direct, or indirect financial relationship with an MCO.
- Deliver any health care services to Medicaid recipients.
- Conduct, on the state's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO services, except for the related activities specified in §438.358.

EQR Protocol 4, while not federally mandated, has been identified by CMS as an excellent management tool to assist states in the monitoring of the encounter data submissions and to assist with meeting new federal mandates regarding encounter data validation. The basis of the encounter data validation is to assess the level of completeness and accuracy of the encounter data submissions. It provides the ability to assess whether the encounter data can be used to determine program effectiveness, accurately evaluate utilization, identify service gaps, and make sound management decisions. In addition, the protocol evaluates both departmental policies, as well as the policies, procedures, and systems of the MCO to identify strengths and opportunities to enhance oversight and program integrity needs.

The purpose of the EQR Protocol 4 is to provide states, their Medicaid and Children's Health Insurance Program (CHIP) MCOs, and EQROs with instructions for performing EQR activities. They fulfill the requirement found in 1932(c)(2)(a)(iii) of the Social Security Act for a governing protocol for EQROs to use for EQR activities with MCOs. Activities performed under these protocols may be eligible for enhanced federal financial participation upon contract approval.

The success of the review depends on a complete understanding of specific needs and coordination between the MCOs and the EQRO. Early and constant communications with the MCOs help mitigate possible impediments to timely review completion.

Planning activities include the following subtasks:

- Communicating with the Department to review the audit approach and seek Nebraska-specific needs.
- Revising the approach based on Department feedback.
- Communicating the plan to the MCOs and seeking their input.
- Seeking Department approval for any MCO-requested modifications, if appropriate.
- Compiling MCO-specific information.
- Scheduling MCO document review (desk review) and potential on-site visit dates.
- Scheduling appropriate review team members.
- Establishing the agenda for the visits.
- Providing instructions and guidance to the MCOs for the visits, if deemed necessary.

Federal regulations at 42 CFR Part 438 allow states some freedom in setting standards for MCOs. The decisions made by the Department will be incorporated in the approach before the review initiates. After these decisions are made, tools for data collection will be revised to match Nebraska-specific standards.

The EQR Protocol 4 engagement consists of five sequential activities, illustrated in Figure VI.A.3.xviii:

1. Review state requirements for collecting and submitting encounter data.
2. Review the MCO's capacity to produce accurate and complete encounter data.
3. Analyze MCO electronic encounter data for accuracy and completeness.
4. Review of medical records for confirmation of findings of analysis of encounter data.
5. Submission of findings.

Figure VI.A.3.xviii – EQR Protocol 4 Engagement

Our support and experience with Nebraska and numerous other state Medicaid programs will facilitate a comprehensive monitoring program and will provide a contractual basis with the MCOs for each requirement, as well as potential consequences for failing to meet the requirement or targeted goals.

f. Develop dashboard reporting with benchmark comparisons by category of service for the Managed Care programs;

MSLC has extensive experience in analytics and informatics, especially around Medicaid data. We will work with the Department to determine the best way to display the quality metrics and report card dashboards. We expect this to be a highly interactive and iterative process, which provides frequent feedback loops between **MSLC** and the Department during the design phase of the dashboards. The dashboards and reports can be displayed in a number of different ways, ranging from downloadable reports to interactive reports with graphs, charts with drill-down capabilities, and geospatial maps that are interactive. As an example, one might start with a map of the state, click down to a county level, and then produce a tabular report of all providers in that county that can be printed to a PDF report or downloaded as an Excel file. All of this data would be available through the web portal framework.

MSLC has developed dashboards for a variety of audiences that seek to quickly and easily inform on what the project means to them. We build these dashboards by incorporating feedback from the Department, key stakeholders, and subject matter experts. Sophisticated data visualization tools are then used to show key health care reporting metrics across programs, categories of service, providers, and regions. Multiple data sources can be blended to show these results as a "single source of truth" to ensure that stakeholders are driving decisions based on accurate and valid data.

Data visualization dashboards developed by MSLC will allow the Department to quickly and easily monitor reporting metrics across managed care programs and identify program cost drivers by category of service and region.

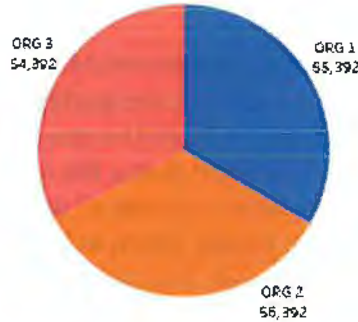
Examples of dashboards that can be produced or that have been produced for other Medicaid programs follow in Figure VI.A.3.xix.

Figure VI.A.3.xix –Dashboard Examples

Health Care Performance Summary - 2017

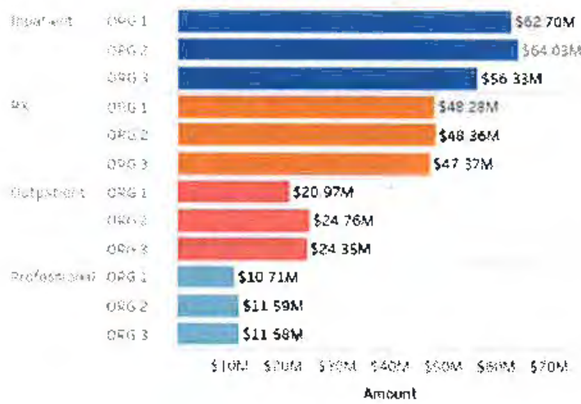
Total Annual Expenditure	Total Annual Enrollment	Total PMPM
$431.03M	**166,175**	**$54.04**

Average Enrollment

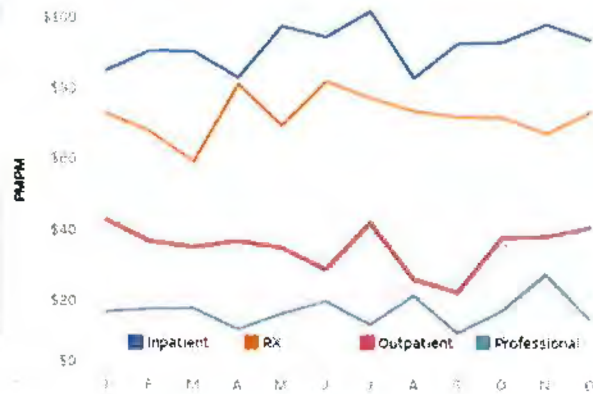


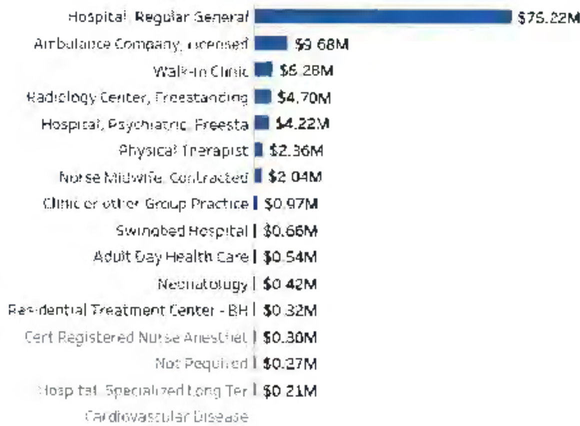
MYERS AND STAUFFER LLC
CERTIFIED PUBLIC ACCOUNTANTS

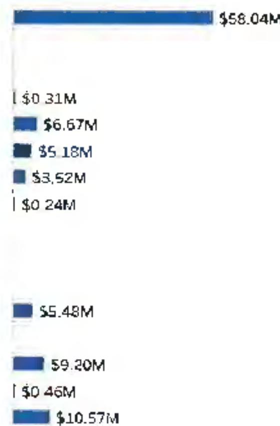
Total Expenditure By Service

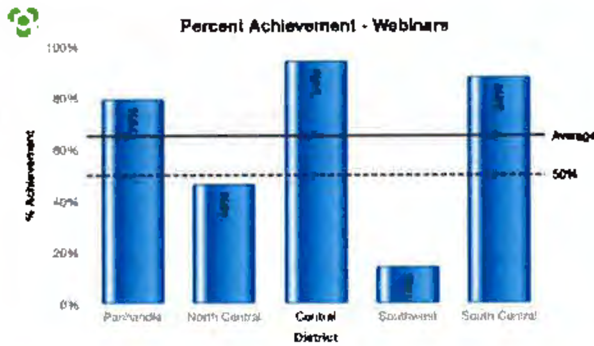


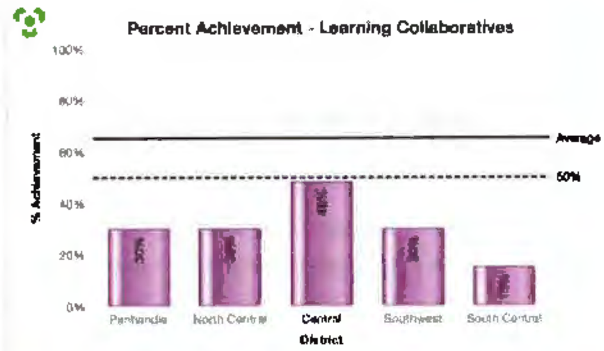
Per Member Per Month (PMPM)











g. Analyze the accuracy of MCO premiums based on overall MCO financial performance, retrospectively;

MSLC provides our managed care clients with a wide variety of programmatic and financial reports to assist in operating their Medicaid programs. With the evolution of Medicaid managed care, the need for industry expertise in reporting has increased due to the program and data complexities. **MSLC's** ability to produce programmatic and financial reports to assist the Department in operating its Medicaid program in a managed care dominated environment requires the reliability and availability of managed care data from the MCOs. We possess expert knowledge of industry practices related to managed care operations and finances, including such issues as the complex organizational and operating structures employed by large affiliated group corporations that are typical to the industry. We have identified that these complex contractual relationships can pose issues for our state and federal clients in receiving accurate data to be used in programmatic and financial reporting. **MSLC** works with states to identify inaccuracies in their managed care data, and we assist in improving data received from the MCOs through enhanced communications and contract requirements.

We have performed financial reviews to determine the adequacy of capitation rates and eliminate excess MCO profits through year-end settlement with managed care plans, as well as MLR examinations required by the Medicaid and CHIP Managed Care Final Rule for contracts beginning after January 1, 2017. Our experience has allowed us to evaluate the actual incurred cost of the MCOs for medical loss, Health Care Quality Improvement (HCQI), Health IT, Health Insurer Fee, and non-claims cost (administrative). We have identified issues and reported findings for each of these areas.

The initial phase of the process will be to obtain the necessary information from the state agency and the MCOs, organizing each MCO's documents into an electronic work paper. The financial reports, including premium revenue and plan expenses, central to the entire process, will be checked for mathematical accuracy and completeness. The reported financial elements will be traced to supporting detailed documents included in the initial request. This will include, but not be limited to, the following:

- Audited financial statements.
- Complete Working Trial Balance (WTB) for the reporting period.
- Complete general ledger detail for period under review.
- Crosswalk of WTB to reported expenses and revenues.
- Allocation schedule from home office or related parties.
- Listing of all related parties and support for claims paid or expenses claimed.
- Claim lag reports.
- Board meeting minutes.
- Copy of all contract agreements with third-party vendors.

Prior to the initial request letters going out, an entrance conference will be set up with each selected MCO and to introduce and explain the entire examination process. This helps ensure the MCOs know what to expect throughout the examination process. The detailed data will be reviewed for consistency with the time periods under examination, and to identify any improper capitation revenues, medical expenses, or HCQI-related expenses reported. Adjustments will be made for any identified items and revised financial statements will be calculated.

We understand the importance of transparency with all MCOs and with the Department. Therefore, at the completion of all examination work, we will supply each MCO and the Department with a copy of all proposed adjustments, as well as adjusted financial statements. This serves an educational purpose in addition to giving each MCO a chance to dispute any proposed adjustments.

h. Provide on-site plan audit reviews as necessary including but not limited to financial, clinical and operational assessment;

Our managed care experience includes assisting states in developing comprehensive monitoring processes over their managed care programs. We have been in the forefront of assisting states with monitoring and managing their managed care contractors. We first assisted the state of Texas in 2004 by developing a monitoring program that includes 20 MCOs. We also have hands-on experience in helping states like Louisiana develop effective monitoring practices from inception of their programs, through conducting ongoing compliance reviews and audits. These monitoring processes include financial-related audits (including MLR audits), operational performance audits and risk assessments for both Medicaid and Medicare. We have audited large (revenues in excess of $100 billion), complex health plans in several states and on behalf of CMS. Our previous state Medicaid experience includes on-site reviews, including

> ***MSLC** has created comprehensive monitoring and reporting processes for states with up to 20 MCOs for a single managed care program.*

financial, clinical, and operational assessments at each of the current health plans operating in the state of Nebraska.

Work Plan
Our work plan begins with a dedicated staff that is both trained and knowledgeable in monitoring Medicaid managed care programs. As a firm, we have assisted several states in monitoring their Medicaid managed care programs. These include Georgia, Iowa, Louisiana, Maryland, Mississippi, Nevada, New Mexico, Pennsylvania, Texas, Virginia, and Washington. We also have extensive experience in helping our state clients with all aspects of operating a Medicaid Managed Care program, including conducting on-site reviews. This knowledge and experience will be made available to program officials during the entire term of this contract to assist the Department to address and resolve any program obstacles that may arise in the future.

Planning, Development, and Implementation Stage
MSLC recognizes that each Medicaid managed care program is unique and our approach is dependent on each state's specific program service areas and needs. Based on our experience, we have identified a team of professionals who are capable of working with the Department to plan, develop, and implement a variety of approaches to monitor Medicaid MCOs. During the planning, development, and implementation stage, we will work in concert with the Department to identify the specific needs, scope of work, resource requirements, and project plan to ensure each engagement is successful and completed in a timely manner. The planning, development, and implementation stage takes the engagement from inception of an idea, identification of a concern or need of the Department, through to a defined engagement project with objectives, approach, budget, and timeline of project deliverables.

MSLC understands that each Medicaid managed care program is unique and will collaborate with the Department on planning and development prior to implementation of MCO monitoring to ensure the Department's needs and requirements are appropriately met.

As an initial task, senior management, will thoroughly evaluate all the Department's needs and assist in identifying the scope of work to be completed, resource requirements, and engagement deliverables. Our team includes multiple associates with different backgrounds and experiences that, as a group, are capable of meeting the variety of service needs identified in this request.

The assigned associates will manage the process during the planning, development, and implementation phases. They will report to the project director in charge of this project. This team will ensure that ongoing project activities are performed timely and in accordance with direction from the Department. They will serve as the firm's lead in planning, developing, and implementing new contract duties/activities, as necessary.

MCO Audit Stage

We recognize the importance of being a professional representative of our state Medicaid agency clients. While we could generate unnecessary disputes between the Medicaid program and the MCOs, and then assert that it is a by-product of doing thorough engagements, the truth is Medicaid programs are better served by having their engagements conducted professionally with as few disputes as possible. Our operational process has been developed with this understanding. The operational stage is where the services of a defined engagement project are performed.

As an initial task, senior management will conduct an engagement kick-off meeting with the Department, engagement team, and the entity under review. Dependent upon the engagement, these are conducted as a series of meetings or as one meeting where the engagement objectives, approach, and timeline are discussed. These informational meetings are conducted up front to ensure that everyone is informed regarding the engagement, and to work out the logistics of conducting the engagement.

Our engagement teams include multiple levels of staff with a variety of specialties and experiences that are assigned to engagements based on the specific engagement objectives. Our teams have an established structure to ensure operational success and quality control for all engagement types. Each team will have a senior manager who ensures ongoing project activities are performed timely and meet the engagement objectives. Additionally, they keep the project director and the Department aware of the project status on a regular basis. The engagement team structure will include staff to perform the work and adequate senior-level staff and/or managers to coordinate day-to-day staff activities. The team's senior leaders are responsible for ensuring quality control and professional standards are adhered to in the performance and reporting of all engagements.

Methodology

MSLC recognizes the Department is seeking a firm that is capable of providing a variety of different services to assist them with monitoring the MCOs. This variety of service may be a different service type based on the scope of services and the related specific needs of the Department. Some examples of the different types of services include financial related audits, agreed-upon procedures, performance audits, clinical reviews, and consulting type engagements. Regardless of the type of service, we employ a similar method to develop the engagement parameters.

Audit Objectives

Our method of defining and establishing an objective for each of the different types of services is based on our vast experience in auditing Medicaid MCOs. When we collaborate with the Department about a specific monitoring need, we typically have specific experience with that managed care program area and can guide how to define the objective to be effective. In defining the objective, we consider the risk characteristics of the managed care program area, the MCO, the Department's concerns, budget resources, and the type of deliverable. Our experience has included developing objectives within the different service types to provide. Examples of potential objectives of the Department may be:

- An opinion on the completeness and accuracy of an MCO's contractors reported financial or performance data.

- Reviews of provider enrollment, provider credentialing, claims processing, member and provider complaints, and appeals processes.
- Analysis and report of findings regarding MCO policies, procedures, reimbursement systems, information systems contracting processes, contract requirements, and program compliance.
- Completion of toolkit for readiness reviews for newly operational health plans.
- Network adequacy assessments for access to care based on geographic location and provider type and managed care contract.

Audit Procedures

The engagement procedures developed to meet each specific objective will be designed to obtain sufficient evidence to support our conclusions. We will develop these procedures in collaboration with the Department and based on our experience within the specific Medicaid managed care area. The developed procedures will be specific enough to support the objective but allow the flexibility needed to be applied to the operational environment of the MCO. Some examples of our experience in performing a variety of different procedures to support our prior work in Medicaid managed care includes:

- Reviewing provider claims detail to support reported financial and performance data, to validate payment accuracy, member eligibility, and provider eligibility.
- Reviewed claim support for prior authorizations, adequate support for claims denials, adequate support for claims paid, and accuracy of provider and member information.
- Reviewed processed member complaints, grievances, and appeals to ensure accuracy in reporting, adequacy of the support, and compliance with reporting timelines.
- Review subcontractor monitoring tasks and procedures for adequacy and compliance with regulatory and contractual requirements.
- Use of analytical procedures and sample testing to evaluate accuracy and completeness of reported financial and performance data

Audit Instructions

Once we identify the specific procedures to be used that support the engagement objective, we will produce instructions (program) for the Department's review and comment. These instructions serve as a checklist for the engagement team staff when performing the various procedures. Included within the instructions are narrative comments that explain the purpose of the step. We will collaborate with the Department on these instructions and ensure they are designed specifically for Nebraska Medicaid managed care. The instructions provide a reference guide for resolving issues in accordance with Department guidelines and ensuring consistent treatment of issues when the engagement is performed on multiple MCOs. These instructions include such things as:

- Copies of programs.
- Copies of interview questionnaires.
- Relevant regulatory support.
- Policy clarifications or directives from the Department.
- Reference material such as limits or ceilings on allowable costs.

Prior to use, a copy of the instructions will be provided to the Department for review and approval. We will update the instructions as changes/revisions are approved by the Department.

Audit Forms

We develop work papers for use in completing our engagements based on the defined audit objective and associated procedures. These work papers include comparative analysis (profiles) and work papers designed to document the substantive testing performed for each engagement.

In our effort to create a paperless environment, we utilize ProSystem FX Engagement software and maintain an electronic work paper file that contains all relevant documentation for each Medicaid managed care audit. The filing system centers on the engagement procedures. MCO binder files are created in ProSystem FX Engagement and there are designated sections (tabs) and place holders in each binder for the reference material, such as the MCO contracts, summaries of walkthroughs, process maps, interview summary memos, MCO financial reports, etc.

MSLC's electronic MCO binder files allow contract information and summaries to be easily referenced and transferred should the Department require information with a quick turnaround.

MSLC will maintain all files and work papers utilized in performing the tasks covered by this RFP. Prior to destroying any documents, we will review a listing of potential items and obtain Department approval.

Reporting Audit Results to the Department

For each Medicaid managed care engagement, we will provide the Department with a report that meets the needs of the Department. If modifications to existing reporting formats are necessary to provide the engagement information in a format that is more useful to the Department, we will work closely with Department officials to develop a more appropriate format in accordance with professional standards.

We recognize the Department is seeking a firm that can provide a variety of different services to assist them with policy and financial management of the MCOs. This variety of service may be a different service type based on the scope of services and the related specific needs of the Department. Regardless of the type of service, we employ a similar method to develop the engagement parameters and have the tools and staff to successfully complete the assigned tasks.

i. Track and analyze financial impacts of populations transitioning from service based payments programs to Managed Care;

The transition of populations from a traditional fee-for-service delivery system model into a managed care arrangement is accompanied by a number of variables. These variables include how care is delivered, paid for, and an often include a refocus on wellness and prevention versus "sick" care. These differences make the analysis of the fiscal impact of the transition difficult to discern. **MSLC** recognizes these challenges and incorporates methodologies for financial impact analysis that account for these nuances. We will customize our approach to

meet the unique features of the Nebraska Medicaid program; however, we bring the advantage of our established standard approach as a starting point. This approach includes:

- **Establish baseline financial and key utilization statistics.** Our approach includes analysis of up to two years of historical utilization and financial data specific to the transition population. Our work will be done in collaboration with **Optumas'** rate setting work to ensure the statistics are measured consistently. Inclusion and exclusion criteria will be defined based on the specific population(s) and the population's unique characteristics. This baseline will serve as the comparator for fiscal impact analysis.
- **Apply growth, market, and inflation factors to baseline.** As we start our analysis, we will make considerations regarding inflation, market factors, and changes to standards of care. After consulting with the **Optumas** team, Baseline expenditures will be brought forward using inflation indices and other considerations. For example, changes in the periodicity for screening using certain expensive procedures for high prevalence disease states will be considered. Another example includes the use of a high cost pharmaceutical for certain high prevalence disease states such as the advances in recent years for the treatment of Hepatitis C. These and other factors will be considered in the growth of the baseline comparator figure.
- **Encounter data completeness and accuracy. MSLC**, working with **Optumas**, will advise the Department as to the completeness and accuracy of the MCO encounter data. Our approach is to include only complete data whose accuracy is within acceptable limits. Should the accuracy and completeness of encounter data be outside acceptable limits, **MSLC** will work with the Department and the MCOs to resolve these issues and offer recommended alternative suggestions.
- **Measure financial performance (actual versus baseline).** With the above factors considered, the comparison of the adjusted baseline financials with the actual expenditures is conducted.
- **Confounding considerations.** There are several confounding considerations the Department may wish to consider in the customized methodology **MSLC** will develop. These may include features such as, but not limited to the following:
  - The loss of federal supplemental payments resulting from the transition to managed care.
  - Reductions in supplemental drug rebates.
  - Increased revenue from any applicable MCO premium based tax in the state.
  - Managed care investments in wellness and prevention that may have longer term return on investment. The Department may wish to establish an offset or include assumed return on investments for certain key MCO investments in wellness or prevention (e.g., increased expenditures in prenatal care designed to decrease neonatal intensive care unit days).

The methodology to evaluate the fiscal impact of the MCO transition requires a customized approach. **MSLC** will work with the Department to ensure the methodology developed is truly reflective of the Nebraska program and is a methodology that is endorsed by the Department.

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.

MSLC routinely requests financial and programmatic data from MCOs on behalf of our clients. For Nebraska, we will utilize these established and proven processes, making any necessary Nebraska-specific modifications based on consultation with the Department and **Optumas**. We will utilize this data and our analysis of this data to provide the Department with multi-layered insight into the financial and operational efficiency of its contracted MCOs.

The financial efficiency evaluation will include organizing each MCO's documents into an electronic work paper. This process will be very similar to the creation of an electronic work paper that is described in SOW 2.1 in the subsection beginning on page 171. The list of requested documents will match to the bullet list provided in that same subsection. We recommend the Department require signed attestations as to the accuracy of the submitted financial information from the Chief Financial Officer or equivalent position within each MCO.

These inputs will be utilized to evaluate the financial efficiencies of each MCO. We will provide our analysis in a manner that allows the Department to compare the performance of the MCOs with each other across key and meaningful data points and metrics. This will include but will not be limited to financial and medical management efficiency, MCO MLR, profitability and financial solvency, and net worth per member. As part of our process, we will present any calculations from the submitted data back to the MCOs for their review as an opportunity for any disputes to be addressed before submission of the final analysis back to the Department. Where publicly available, **MSLC** will assist the Department with comparing the performance of the Nebraska MCOs with other Medicaid MCOs across the country.

C. Technical Considerations

In order for the Department's managed care program to be successful, there is a balance between innovation and best practices that must be struck. The Department does not want the programs that are implemented to be the exact same programs that have been implemented elsewhere, but also may be hesitant to introduce untested concepts that have never been used in a Medicaid environment. The **Optumas/MSLC** team can help the Department strike the necessary balance between these two extremes. We can use our national experience with VBP arrangement, plan management, oversite, and performance to make sure the Department's programs are performing to their maximum ability.

Our national background allows us to bring in concepts that have been shown to be successful in other markets, and our Nebraska-specific knowledge allows us to customize these concepts to be applicable to the Department's program. We also have many new tools (such as PROMETHEUS and financial evaluation tests, and quality metrics) that we test internally and can introduce to bring a cutting-edge review of plan performance and medical management to the Department. Introducing these new tools in an established program framework that has been proven successful in other markets is the best way for the Department to manage plans to achieve the best outcomes for Nebraska. The **Optumas/MSLC** team can bring these strengths to bear on behalf of the Department, creating an environment that blends established concepts with new, innovative approaches.

D. Detailed Project Work Plan

Please see Appendix II(A) for a sample SOW 2 Capitation Rate Rebasing detailed project work plan and the policy and financial management consulting services associated with this scope of work.

E. Deliverables and Due Dates

Please see Appendix II(A) for deliverables and due dates associated with the policy and financial management consulting services that relate to capitation rate rebasing. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department.

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SOW 3-1915(b) Waiver

SOW 3 – 1915(b) Waiver

The 1915(b) Waiver cost-effectiveness process in many ways mirrors that of a traditional capitation rate setting process, with a few material differences that we will identify in the proposed development approach below. To develop the cost-effectiveness template for the 1915(b) Waiver(s), **Optumas** follows a methodology that is consistent with the CMS pre-printed 1915(b) template and actuarial standards of practice.

A. Understanding of the Project Requirements

Optumas understands the project requirements of 1915(b) Waiver submissions as described on page 27 of the RFP. 1915(b) Waivers must meet a cost-effectiveness standard – said simply, the managed care program covered by the waiver can spend no more than what was projected, over either two years for initial waivers, five years for renewal waivers, or five years for combined 1915(b)/1915(c) Waivers. Additionally, waiver projections and cost-effectiveness chapters need to be amended or updated for material changes in the underlying program design, population, benefits, or service delivery network. **Optumas** and its State clients work closely with the local CMS Regional office to determine when an amendment is necessary.

Optumas has extensive experience providing 1915(b) Waiver support to state Medicaid programs nationwide. Most recently, **Optumas** has assisted Alabama, Colorado, Nebraska, New Hampshire BH, New York OPWDD, and North Dakota with 1915(b) Waiver projections. **Optumas** has assisted the Department with the submission of the 1915(b) Waiver for the Nebraska Medicaid program for last five years.

Optumas has unique insight into the Department's 1915(b) Waiver. We have implemented many new ways of aggregating data and summarizing program changes to improve the efficiency with which we can complete the Waiver cost effectiveness template. The initial waiver work that we performed was timely and difficult as we worked to understand the nuances of service and population delivery systems. The protocols we have introduced, which will be described in detail in the following section, have drastically reduced the time it takes **Optumas** to conduct waiver renewals. **Optumas** brings an efficiency and understanding of the Department's 1915(b) Waiver that cannot be matched by competing firms.

B. Proposed Development Approach

Within this section of our RFP response we will discuss the activities described under "F. SOW 3 – 1915(b) Waiver" on page 27 of the RFP.

Optumas follows the steps summarized below when developing Nebraska's 1915(b) Waiver projections:

1. **Identify Target Population/Covered Services:**
   Optumas has worked closely with the Department over the last five years to gain an in-depth understanding of the populations and services currently included in Nebraska's 1915(b) Waiver. Due to the complexities surrounding the target population, **Optumas** created an illustrative grid for CMS, shown below, outlining the populations and services

included in Nebraska's 1915(b) Waiver. This grid has been updated for every waiver renewal as populations and services change, with a recent example shown below in Figure VI.A.3.xx:

Figure VI.A.3.xx – Waiver Populations and Services Grid

BASE DATA PERIOD: JULY 2014 - JUNE 2015

	CSHCN and AI/AN					All Other Populations[1]				
Services	**FFS**	**MCO**	**DBMP**	**PIHP**	**Not Included in Waiver**	**FFS**	**MCO**	**DBMP**	**PIHP**	**Not Included in Waiver**
PH Services										
Dental					X					X
Hospice					X					X
School-Based Services					X					X
NEMT	X									X
PH Pharmacy[2]	X									X
PH Services Excluded from PH Managed Care[3]					X					X
All Other PH Services		X								X
BH Services										
BH Pharmacy[2]	X					X				
1915(b)(3)[4]				X					X	
Other BH Services				X					X	

[1] State-fund-only populations will be excluded from the Waiver

[2] Pharmacy costs are adjusted for rebates.

[3] These include services such as HCBS Services, ICF-DD, LTC NF, etc.

[4] Although 1915(b)(3) services are provided via BH Managed Care, they are *not* reported in the PIHP section of the waiver template and are instead reported in the 1915(b)(3) section.

This grid was instrumental in discussions with CMS, as it allowed for more productive conversations surrounding the waiver projections, rather than getting hung up on the waiver design.

2. **Summarize Base Data:**
   Optumas identifies the target population and covered services within the detailed claims and eligibility data provided by the Department. **Optumas** categorizes members into Medicaid Eligibility Groups (MEGs), which are used to group populations with similar risk profiles. Historical MMs, dollars, and units are summarized for each MEG to create the starting point for the waiver projections. Due to the overlap in the waiver cost-effectiveness calculations and rate setting processes, **Optumas** benchmarks the data to the base data used for rate setting and discusses our observations/findings with the Department.

3. **Base Data and Program Change Adjustments:**
   As with rate development, there are several traditional adjustments that are necessary to ensure the base data is an accurate proxy for the contract period, including estimates for the incurred but not yet reported (IBNR) expenditures. **Optumas** builds data completion triangles for both the encounter and FFS data underlying the base, consistent with the methodology used for capitation rate development

   Optumas then quantifies the impact of prospective program changes. Program change adjustments recognize the impact of eligibility or benefit changes occurring in or after the base period. CMS requires that program changes are accounted for in the development of 1915(b) projections. **Optumas** works with the Department to determine all adjustments

needed to ensure that the adjusted base data is an appropriate proxy for the expected years' experience.

4. **Trend:**
   Trend factors are applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. Trend development methodology for waivers is substantially similar to approach described above for capitation rate development. These trend factors are used to project the costs from the base period to the future contract period and they are done on a MEG-specific basis. Since the data used to develop the 1915(b) projections is largely comprised of MCO encounter data, **Optumas** ensures that the trends used to develop the waiver projections are consistent with those used in the Department's capitation rate development.

5. **Non-Medical Load:**
   Identical to the process used to develop capitation rates, non-medical load (NML) measures the dollars associated with components such as administration, risk, contingencies, and profit and are usually expressed as a percentage of the capitation rate. **Optumas** utilizes our experience with non-medical expenses in other states, on both a PMPM and percentage basis, in deriving the waiver NML estimates.

6. **MM Projections:**
   Optumas works with the Department to estimate the number of individuals that will enroll in the waiver. Note that in 1915(b) Waivers, all cost-effectiveness calculations are done on a per member per month (PMPM) basis, so the Department is not at risk for the accuracy of these enrollment projections.

C. Technical Considerations

There are a couple crucial considerations to make when developing projections for the 1915(b) Waiver:

MEG Construction – The use of MEGs is intended to provide the Department protection for changes in the underlying mix and resulting risk of the enrolled Waiver population. We work with our State clients to determine the enrollment, mix, and risk trends in the underlying sub-populations that make up the various managed care program rate cohorts to determine the appropriate level of MEGs that the Department should be considering from an actuarial perspective. We then work with the Medicaid program's Finance/Fiscal Reporting team to determine the Department's ability to effectively aggregate data and submit Federal claiming reports using the potential 'actuarial MEGs'.

The Department historically used four MEGs to group members in the 1915(b) Waiver submission but recently transitioned to five MEGs with **Optumas'** assistance. **Optumas** conducted several analyses for the Department, detailing the impact of this transition. More specifically, since the prior waiver projections were developed under the previous four MEG structure, **Optumas** conducted detailed analyses to prove cost effectiveness to CMS under both MEG designs.

Optumas conducted detailed analyses to prove cost effectiveness to CMS under historical and prospective MEG designs.

Cost Effectiveness Test – The creative problem-solving skills that the **Optumas** possesses are extremely beneficial for cost effectiveness tests. There is a great deal of flexibility in calculating the future cost-effective threshold, and **Optumas** knows how to use that flexibility to benefit the Department. There is flexibility in prospective trend calculations, capitation rate selection, service allocation, and administrative cost projection. For the past five years **Optumas** has taken advantage of these areas of flexibility to ensure the Department's 1915(b) Waiver is cost effective. Despite initial cost effectiveness issues under the previous contractor, the Department has consistently passed the 1915(b) cost effectiveness test using **Optumas'** projections.

D. Detailed Project Work Plan

Please see Appendix II(C) for a sample SOW 3 1915(b) Waiver submission detailed project workplan.

E. Deliverables and Due Dates

Please see Appendix II(C) for deliverables and due dates associated with a 1915(b) Waiver submission. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department.

SOW 4-PACE Rate Setting

SOW 4 – Program of All-Inclusive Care for the Elderly (PACE) Rate Setting

PACE is a unique long-term care delivery model in that is uses a multi-disciplinary team to assess the needs of each member and deliver a comprehensive array of services for members eligible for the program. The intent behind the Upper Payment Limit (UPL) development is to identify members receiving care via a FFS delivery system who are comparable in terms of frailty to the population enrolled in PACE. Once these members are identified, the cost of their state plan medical services is summarized and projected to the contract period. The UPL PMPM amount is the highest allowable payment rate to the PACE Organization. This rate development approach, relying on data for PACE-comparable individuals rather than actual PACE enrollees, is commonly done due to the unique nature of PACE Organizations (POs) and the services they provide. Data for PACE enrollees is typically unavailable and POs frequently provide services that are not part of the standard Medicaid benefit package, so the use of a proxy population served via FFS is a standard procedure nationwide. **Optumas** has significant experience setting or reviewing PACE rates in multiple states and thoroughly understands the unique nuances of the PACE environment.

A. Understanding of the Project Requirements

Optumas understands the project requirements of PACE rate setting as described on page 27 of the RFP and has developed PACE UPLs on behalf of the Department for every contract period since State Fiscal Year 2015 (SFY15). During this time, we have developed a comprehensive methodology that accounts for the nuances of the institutional level of need population that is served by PACE as well as the specifics associated with Nebraska's long-term care service delivery network. **Optumas'** methodology combines traditional aspects of actuarial rate setting that have been discussed previously, such as trend and IBNR, with analyses that are specific to the institutional level of need population. These LTSS-specific analyses include durational analyses, share of cost review, and Nursing Facility and Waiver reimbursement analyses. **Optumas'** analytic approach has been refined while developing or reviewing UPLs for California, Colorado, Iowa, Kansas, Nebraska, and North Dakota, as well our involvement in the National PACE Association's 2016 Medicaid Rate Setting guide.

Optumas' experience on both sides of UPL development gives us unique insight and the ability to proactively address any areas of concern the Department and POs may have.

Optumas has developed our PACE UPL development approach by working with six states over the past 10 years. These states include PACE Organizations larger than Nebraska (e.g. Colorado), smaller than Nebraska (e.g. North Dakota), and direct experience with Nebraska. To round out our general PACE experience, **Optumas** has worked on behalf of PACE Organizations in California. This has been very helpful for our Medicaid rate setting work, as we have become very familiar with the concerns of PACE Organizations, the cost containment options available to them, and the most effective communication/negotiation strategies. Our work with PACE Organizations is concentrated solely within California and does not involve any PACE Organization operating in Nebraska, so there is no conflict of interest. Additionally, some of the PACE Organizations we represent operate in other markets where we set rates on behalf of the state, and we have taken extra precaution to split our teams to ensure no conflict of interest ever arises. Our work with PACE Organizations has been very beneficial to our state clients, as we have been able to work with PACE

Organizations on the level of data they can provide and share best-practices for data collection and submission based on the experience of PACE Organizations across the nation. Data collection is a consistent challenge for PACE programs since the majority of services are non-standard services provided to clients as part of the added value of the program and do not generate an encounter or have a state fee schedule reimbursement amount. These services are typically provided at adult day centers, or PACE centers, where it is very difficult for POs to track the wide variety of services and their associated costs that may be provided in a single day. This limits the Medicaid agency's ability to oversee and manage the PACE program. By improving data collection processes **Optumas** has given our clients greater insight into their program and a better understanding of how the Medicaid payment rate is being used for services that improve the quality of life for PACE beneficiaries. For example, in Colorado we have worked with the State and PACE Organizations to begin collecting additional data as part of the PACE Organization financial template submission, which includes monthly penetration rates of utilization for unique members at a PACE Center. Given the challenges that are present with collection of encounter data within PACE programs, this level of information is a start at gaining better insight into the utilization patterns underlying each PACE Organization's business model.

B. Proposed Development Approach

Within this section of our RFP response we will discuss the activities described under "G. SOW 4 – Program of All-Inclusive Care for the Elderly (PACE) Rate Setting" on page 27 of the RFP.

Optumas' approach to PACE UPL development will incorporate all of the actuarial rate setting tasks discussed previously (e.g. trend, IBNR, program changes, etc.). Rather than reiterate these tasks, the remainder of this section will focus on development tasks that are unique to PACE rate setting and differentiate UPL development from other forms of capitation rate development. An important feature of PACE UPL development is that it typically does not incorporate the actual data for the population enrolled in PACE. Instead, it requires the actuary to identify a population believed to be comparable to the PACE enrollees. This unique application of actuarial principles makes PACE UPL development substantially different that most capitation rate developments and requires the actuary to take into account the following considerations in order to create appropriate UPLs.

The most impactful step in PACE UPL development is the identification of the PACE-comparable population. PACE eligibility requirements include:

- Member must meet the state's criteria for Nursing Home level of care;
- Member must be at least 55 years of age;
- Member must live in an area that offers PACE; and
- Member must have the ability to live safely in the community.

To identify PACE-comparable populations, **Optumas** performs custom durational analyses that are unique to institutional level of need populations. PACE enrollees are typically either high-need Waiver service recipients or Nursing Facility residents. Both of these criteria exceed the level of detail provided in typical eligibility data warehouses, so it is necessary to construct a definition based on

The most important part of PACE UPL development is identifying a PACE comparable population that matches the PACE eligibility requirements.

service utilization. **Optumas** achieves this by separately arraying Nursing Facility and Waiver service utilization by member and month. We then look through the detailed expenditure and utilization amounts for every member and month to determine when someone is either living in a Nursing Home or dependent on Waiver services in order to live at home. The figure below, labelled as Figure VI.A.3.xxi, shows a sample of **Optumas'** durational analysis as well as a sample designation of each member as a Nursing Facility resident or short-term utilizer. This is a summarized example; in reality the test covers multiple years of data, and months of low Nursing Facility spend are investigated to determine actual causes instead of likely causes.

Figure VI.A.3.xxi – Nursing Facility Durational Analysis Example

	Amount Spent at a Nursing Facility by Month							
Member	Jan	Feb	Mar	Apr	May	Jun	Jul	Conclusion
123	$2,000	$2,000	$0	$0	$0	$0	$2,000	The member is not an LTC resident. The member likely had two separate health setbacks but was discharged and lived at home in between.
456	$2,000	$2,000	$2,000	$2,000	$2,000	$0	$2,000	The member is an LTC resident. The month with $0 is likely a hospitalization, but after being discharged from the hospital the member returned to an LTC facility.
789	$2,000	$0	$2,000	$0	$2,000	$0	$2,000	The member is not an LTC resident. Despite frequent utilization there is not a consistent enough pattern to indicate the member lives at an LTC facility.

Another key component of PACE UPL development is appropriately analyzing the non-Medicaid payment sources. PACE enrollees and the PACE-comparable population are predominately dually eligible for Medicaid and Medicare, which means that Medicare pays for a large portion of their acute care medical service expense. Additionally, this population typically has substantial cost sharing and spenddown obligations that must be fulfilled before Medicaid pays for medical services. **Optumas** has developed our methodology to ensure these various payment sources are treated appropriately throughout the rate development. We have three primary considerations regarding the treatment of patient payment in UPL development:

1. **Base data should represent the total cost of care.** It is appropriate to include the total cost of care in the rate development base data. This allows for the appropriate projection of future expenses. For example, if inpatient hospital expenses are expected to grow at a rate of 3% annually, it is necessary to apply that growth rate to the total cost of the service, not just the Medicaid-covered portion of the service cost to appropriately reflect service growth and not understate the projection of the base data.

2. **Medicare payments should be trended and removed from rate development.** Medicaid will only pay for the expenses that are not paid by Medicare. Per consideration #1, **Optumas** includes Medicare payments in the base data for UPL development, however these payments must be removed after all relevant projection factors have been applied to the base data. It is not sufficient to remove only the known dollars that occurred during prior to rate finalization, instead it is necessary to project past Medicare payments to the contract period using changes in the Medicare benefit package to estimate future payments. Once the projection has been completed estimated Medicare payments can be subtracted from the UPL, leaving a rate that includes only Medicaid expenses and patient liability.
3. **Patient payments should be handled consistent with program operationalization.** State policy on patient payments with respect to PACE enrollees varies from one program to the next. There are two main approaches states take with respect to patient payments: either a) develop UPLs by excluding the average patient payment amount; or b) develop UPLs including historical patient payments and subtract the actual patient payment of each PACE enrollee prior to submitting payment to the PACE Organization. Both of these approaches result in a payment by the state that excludes patient payment obligations, but each has calculation nuances and provides advantages and disadvantages to the PACE program. In our experience, there is no "right" answer, and either approach can be implemented effectively. Nebraska currently uses option a), and **Optumas** has developed UPLs for the Department consistent with this program operationalization.

A final general consideration in PACE UPL development is reimbursement changes associated with LTSS services. These services typically have legislatively-mandated reimbursement changes in addition to any cost inflation. To appropriately handle these reimbursement changes **Optumas** conducts a detailed repricing of Nursing Facility services using updated per diem rates. Waiver services are also repriced, using the hourly rates, per-visit rates, or other units of service as appropriate per state policy. These repricing exercises are typically very detailed and require a claims-level analysis of the FFS data underlying UPL development. After services have been repriced so the entire base data period reflects the same reimbursement policy, other inflation analyses such as trend development can be reviewed. **Optumas** never assumes that legislatively-mandated reimbursement changes are the only source of cost change over time, as unreasonably low or high legislative rate changes can cause providers to shift billing practices to emphasize services with alternative reimbursement structures. Additionally, as emphasized in the trend development for standard actuarial rate setting, it is necessary to account for reimbursement changes prior to conducting trend development to ensure that rate changes are not double counted and considered as unit cost trend. **Optumas** applies this rigorous approach to our UPL development projects to ensure that projected LTSS reimbursement is appropriate for the services being provided and consistent with legislative/Medicaid policy.

Reimbursement changes, such as legislatively-mandated Nursing Facility per diem rate updates are necessary to account for prior to conducting trend development to avoid duplication in projections assumptions.

Once UPLs have been developed and projected forward to the contract period (incorporating for both standard inflation as well as specific policy and reimbursement changes), it is necessary to blend UPLs for Waiver recipients and long-term care residents together to create an aggregate UPL.

There are multiple approaches to UPL blending, but the most established process is to use the membership mix that is prevalent in the FFS data for these two subpopulations to create the blended rate (this is the approach currently used by the Department). Other options include evaluating PO enrollment to determine membership mix using either PO-provided metrics or a level of care assessment tool. These approaches can be contentious, as a standard interpretation of PACE program requirements argues for the use of the prevalent FFS membership mix. However, if the Department would like to consider changes to the UPL methodology, **Optumas** has experience with other cohort blending techniques that could be used.

C. Technical Considerations

In addition to the general PACE knowledge **Optumas** has attained through a decade of experience spanning multiple states, we also possess a level of Nebraska-specific knowledge that cannot be matched by competitors. We have developed rates for every contract period since SFY15 and have conducted the necessary rate developments in multiple ways to accommodate the wishes of the Department. We have done comprehensive UPL development including a re-base of the underlying data (e.g. moving base data forward a year or two to a more recent time period, which helps minimize projection errors), and we have also met compressed deadlines from the Department by finding room in the PACE regulations that allow us to update rates without rebasing. This option was used recently when the Department was under a tight timeframe for UPL submission and looked to **Optumas** to come up with ways to develop rates quickly, accurately, and compliant with applicable regulations. **Optumas'** up-to-date knowledge of Nebraska's PACE environment makes us the ideal actuarial consulting firm to serve the Department in PACE UPL development.

During the past five years of PACE UPL development **Optumas** has become very familiar with nuances related to the Department's delivery of LTSS services. For example, **Optumas** has conducted detailed repricing of the Nursing Facility utilization at updated fee schedules. Per the Department's operating procedures, this repricing was done by facility and Level of Care, since the Department pays the same facility different rates for various room types. **Optumas** has built pricing logic to accurately and efficiently apply the Department's updated fee schedule to the previous experience, using all components that determine service reimbursement (facility name, Level of Care, and month of service). Our precision and expediency allowed us to develop the most recent UPLs under a compressed timeframe, completing the entire project for the Department in three weeks.

***Optumas** can leverage past models, making revisions as necessary, to accomplish UPL development in condensed timeframes.*

Optumas also possesses an unmatched understanding of Nebraska's PACE program. When we were first brought on as the Department's actuarial consultants, the existing UPLs were not developed consistent with the PACE program's handling of member share of cost. Patient payments were deducted from UPL development, and then deducted again prior to capitation rate payment. **Optumas** met with the Department to discuss payment processes, discovered the inconsistency, and changed our methodology to ensure all the rates we developed for the Department are appropriate for the program's payment policy.

While working with the Department on Nebraska's PACE UPL development, **Optumas** has conducted two different styles of UPL development: Rate Rebasing and Rate Update.

- **Rate Update**: Per our review of PACE regulations, the Department does not have to update the base data used in UPL development every year. Some years, if the base data is within five years of the contract period and rates were re-based the previous year, the existing rates can be projected to the next contract period. This can save the Department consulting expenses and allow for compressed timelines, since rate updates can be completed more quickly than a full rate re-base. **Optumas** can conduct rate updates in as short a time as two or three weeks, and in the past year has conducted a UPL rate update for the Department in three weeks. This approach is viable since the PACE population reflects a level of service needs with utilization patterns that remain fairly consistent over time, with the majority of rate change stemming from underlying service costs.
- **Rate Rebase:** A rate rebase is the more traditional rate development methodology. Under this approach, the UPL is developed on entirely new base data, typically updated to use a time frame closer to the contract period. All subsequent rate adjustments (trend, program changes, reimbursement adjustments, etc.) are calculated using the updated base data. This is a more time-consuming process as new data must be analyzed, verified, and summarized. However, **Optumas** can complete this very efficiently due to our data warehousing process that aggregates and stores all Nebraska Medicaid data since 2006. In previous UPL development projects **Optumas** has completed a rate rebase in approximately five weeks.

A final technical consideration for the Department's UPL development is the regional analysis. Currently, separate cost factors are developed for Urban and Rural counties. Cost factors are developed for Nursing Facility and Waiver cohorts since these two cohorts have very different drivers of spend and can vary independently from region to region. The regional split is appropriate for the current status of the PACE program, but if Nebraska were to expand the PACE program in would be necessary to look at cost differences within regions, particularly within the expansive Rural region. Waiver service access and reimbursement is known to vary drastically from one area to another, so more finite regions may become necessary. This is a future consideration for the Department, but as program expansion occurs **Optumas** will be available to assist with the analyses necessary to make a determination on rating regions.

Optumas brings an unmatched level of Nebraska-specific knowledge, flexibility within regulations, and well-rounded experience to PACE UPL development. We have served the Department's UPL development needs for the past five years and are excited about the opportunity to continue in our role assisting the Department with PACE UPL development and further identifying opportunities for program and UPL development efficiencies.

D. Detailed Project Work Plan

Please see Appendix II(D) for a sample SOW 4 PACE Rate Setting detailed project workplan.

E. Deliverables and Due Dates

Please see Appendix II(D) for deliverables and due dates associated with PACE Rate Setting. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department.

SOW 5-1115 Waiver
Development/Submission

SOW 5 – 1115 Waiver Development and Submission

Section 1115 Waivers pose somewhat unique challenges in actuarial consulting. They require a difficult pairing of very detailed analytics, creative data use, policy understanding, and problem-solving abilities. These are areas where **Optumas** excels and can provide the Department with the best possible outcomes. Our approach to 1115 Waiver work has been refined while working for Nebraska, Alabama, Arkansas, California, Connecticut, Kansas, Maine, Massachusetts, New York, Ohio, Oregon, and Vermont. This includes **1115** Waivers that are more traditional, as well as those that are creating new eligibility groups, care delivery systems, and other complex, high-profile, and highly scrutinized topics. Our proposed team for the Department's **1115** Waiver work is the core team currently serving the Department. We have additional resources we can bring to bear if necessary.

***Optumas** prides itself on being a flexible and responsive firm with strong analytic and problem-solving abilities and has experience assisting many states with both standard and unique 1115 Waiver development and submissions.*

The remainder of this section will discuss **Optumas'** approach to 1115 Waiver development. Each 1115 Waiver is very unique, and work for one client is substantially different from work for another client. The remainder of this section will focus on core skills that are necessary and examples of other states where we have worked on 1115 Waivers. **Optumas**

A. Understanding of the Project Requirements

Optumas understands the project requirements of 1115 Waiver development and submission as described on page 27 of the RFP and has extensive experience in 1115 Waivers. Known as "Research and Demonstration waivers", 1115 Waivers are intended to allow states significant flexibility in changing the service delivery mode of their programs, but most significantly it also allows states to waive certain eligibility provisions within Title XIX. Recently, the current Federal administration has entertained a broad range of innovations under the specter of 1115 Waivers, including expanded work requirements, and potential limitations on benefits or coverage for non-payment of premiums. **Optumas** has worked with 12 states, aiding our clients with 1115 Waiver policy decisions, program and reimbursement design, and program administration. This experience includes supporting states from writing the initial waiver concept paper to facilitating public meetings soliciting public feedback, CMS submissions, CMS approval, waiver implementation, ongoing program maintenance, and reporting. Specific tasks include:

- designing and developing the waiver concept paper
- describing the potential funding mechanisms,
- outlining the Federal authorities sought,
- conducting budget modeling and neutrality calculations,
- writing policies to support the waiver implementation,
- developing methodologies for wavier budget neutrality monitoring,
- waiver reporting to CMS,
- actuarially sound rate setting to support newly-implemented managed care populations, services, and programs,
- access to care monitoring and oversight, and

- quality monitoring and reporting within the 1115 Waiver.

To further demonstrate our understanding of 1115 Waiver requirements and the importance of budget neutrality, our experience working on Arkansas' 1115 Waiver is provided as a case study example.

Arkansas pursued and implemented a unique 1115 Waiver expanding Medicaid eligibility in 2013 by purchasing commercial health plans for newly eligible, non-medically frail adults. **Optumas** was deeply involved in the initial waiver concept, design, and approval, and also supported all actuarial aspects of the waiver. **Optumas'** work on the waiver began in earnest with legislative support and cost estimates in early 2013. This work required **Optumas** to estimate the utilization levels of the expansion population using data from existing Medicaid populations. Since the expansion population consisted of adults with too high income to receive Medicaid but too little income to purchase health insurance coverage, there was no data available on their service utilization levels. However, **Optumas** was able to estimate utilization based on significant amounts of research, iterative modeling, and discussions with clinicians and medical professionals who work with the uninsured population. In addition to health care utilization, **Optumas** needed to estimate the cost of services under a commercial reimbursement structure. Commercial plans consider their reimbursement information proprietary, so once again this process involved significant amounts of research and modeling to create reasonable estimates. By applying our actuarial principles and detailed, rigorous analytic skills, **Optumas** created reasonable estimates of populations and services that had previously never been covered. Despite the scarcity of data surrounding this population and commercial reimbursement levels, **Optumas'** initial expense projections are less than one tenth of a percent different than the actual experience under the 1115 Waiver after three years of experience.

*The original Medicaid Expansion cost projections created by **Optumas** are less than a tenth of a percent different than the actual experience through three years.*

Following the initial waiver application and approval, **Optumas** has supported aspects of the 1115 Waiver including budget neutrality, plan benefit design, and Advanced Cost Sharing Reduction (ACSR) reconciliation. Budget neutrality is a critical component of the 1115 Waiver, since lack of compliance with budget neutrality can cause state Medicaid programs to pay significant portions of total program costs. **Optumas'** budget neutrality work and has positioned DHS to be successful with three key groups: CMS, state legislators, and participating commercial health plans. Balancing the varied, and often conflicting, interests of these three groups has been a significant challenge, but **Optumas'** consulting expertise has allowed a delicate balance to be maintained.

The actuarial work under Arkansas' 1115 Waiver contains other projects that are more straightforward. The plan and benefit design and ACSR reconciliation are two such projects. The plan and benefit design required **Optumas** to create a cost sharing plan design that meets federal Medicaid standards as well as regulations imposed by the Health Insurance Exchange. This required utilization modeling, claims probability distributions, and the use of tools such as the Actuarial Value calculator. ACSR reconciliation requires **Optumas** to aggregate cost sharing data submitted by commercial carriers participating in the 1115 Waiver. This data was validated and compared to expenditure data estimated at the beginning of each year, with any difference being paid out by

either the commercial carrier or the State. These analytics are much more typical and are additional ways **Optumas** demonstrates its actuarial expertise with regard to 1115 Waiver analyses that can be leveraged for Nebraska.

B. Proposed Development Approach

Within this section of our RFP response we will discuss the activities described under "H. SOW 5 – 1115 Waiver Development and submission" on page 27 of the RFP.

To satisfactorily complete an 1115 Waiver submission, the following five steps must be completed:

Step 1 – Understand your 1115 Waiver Program
During our initial 1115 Waiver strategy discussions with our clients, we work to understand the current service delivery system, changes desired under the waiver, and impacted populations and services. **Optumas** accomplishes this by reviewing our "Four Determinants of Risk", which comprehensively capture delivery system changes and creation. The Four Determinants are:

1. Program Design – how the program's eligibility criteria are structured
2. Target Population – who enrolls in the program
3. Covered Benefits – what services enrollees are eligible to receive
4. Service Delivery Network – where members access covered services

As waiver work progresses, **Optumas** can also provide an environmental scan of recent 1115 Waiver submissions/approvals by other states for our clients to review. Based on this information, we will draft a work plan that outlines required activities, responsible parties, and dates for completion. The workplan will be a living document that is adjusted as needed, for example, to incorporate support over the course of the engagement if waiver amendments are identified at later dates.

Step 2 – Develop/Review Reports/Special Terms and Conditions (STCs) (as needed)
We coordinate with our clients to review and/or develop any required quarterly and annual monitoring reports per the waiver Standard Terms and Conditions (STCs). As with the waiver budget neutrality analysis, we will follow the detailed specifications provided by CMS to assure a thorough and comprehensive analysis for completion of the reports. We provide a data request to our clients detailing any claim, encounter, or supplemental data we need to comply with CMS reporting requirements.

Based on our analyses, we will provide information about actual performance compared to the targets incorporated in the STCs (e.g., prospective budget neutrality analysis provided in the approval waiver application). We propose to meet with our client (and others relevant stakeholders, such as the Governor's Office, service providers, etc.) to provide a walkthrough of our methodology and resulting calculations for inclusion in each required quarterly/annual report. We provide ongoing support to our clients by responding to CMS questions about each report, and if CMS requests STC or waiver amendments based on its review findings, we will work collaboratively with our client to address the CMS request.

Step 3 – Waiver Amendment/Renewal Cost Neutrality Narrative and Spreadsheets
For each waiver amendment or renewal, we will follow the below general approach to demonstrate budget neutrality of the waiver:

- **Optumas** works with our client to understand past or future amendments to the waiver, expenditure authorities, and/or changes to the STCs, if any, that could impact cost effectiveness and change the strategy for budget neutrality submissions. We will also want to understand areas where the Department has historically encountered challenges, if any, in achieving budget neutrality in other waivers. The goal of these checks is to make sure our budget neutrality calculations are accurate and strategically position our clients for success meeting the imposed cost standards.
- Typically, 1115 Waivers and the required reporting (quarterly/annual) are supported by standardized reporting produced by the Department's fiscal staff and/or the Department's MMIS vendor. We will work with our client's team to examine the underlying coding for each standardized report to ensure that claims, eligibility, access to care, and quality of care data specifications used are thorough/complete and produce an accurate report, fully satisfying the report's intent. This is a critical step that must be repeated regularly as we have found that MMIS vendors regularly tweak their coding for a variety of reasons and do not consider all of the unintended consequences of such tweaks.
- Updates to the budget neutrality template, quarterly/annual report, and/or STC reporting will be completed with the most recent data. **Optumas** will consider results to determine if they are reasonable. The **Optumas/MSLC** team will have a wide variety of data and reports to use as reasonableness checks to ensure that our clients only provide complete and accurate reports to CMS and key internal stakeholders.

Step 4 – Review Amendments/Renewals for Budget Neutrality/Reports (redesign as necessary)
Should our calculations indicate challenges with meeting budget neutrality or any of the STCs, we will discuss the identified challenges and potential changes with our client. We understand this process sometimes results in required redesign, and we provide support to our clients in meetings with CMS and stakeholders to discuss necessary changes and overall impact. We will then be available to answer questions and to adjust the modeling, if needed.

Step 5 – Produce Required Narrative, Sheets, and Documentation for Review and Approval
We will provide drafts of all required spreadsheets, narratives, and supporting exhibits to submit as part of the application (or amendment, as applicable) to our client's team for review and approval. To support this review, we propose to meet with our client's team representatives to provide a walkthrough of our methodology and resulting calculations for each report. We will then be available to answer questions and to adjust the modeling, if needed, and finalize the materials for submission to CMS with the application. We will also hold calls with our clients and CMS to respond to CMS questions and respond to CMS questions in writing as appropriate.

Together, the **Optumas/MSLC** team's 1115 Waiver experience gives us the in-depth understanding needed to most effectively document decisions and thoroughly outline the budget neutrality methodologies used. Documenting this information is helpful not only for context during discussions with CMS reviewers, but we structure our documentation and modeling such that it can be incorporated directly into the Department's budgeting process and the rate setting process with MCOs. As with our rate development models, we avoid confidential data manipulation to perform our waiver

__Optumas__ is transparent with all analyses and will provide the Department all models with active formulas and methodology narratives upon request.

calculations nor will we deem our models or data proprietary. We provide our clients with the budget neutrality models as live, active format Excel models, saving the Department or any future contractors significant time and effort in not having to rebuild the models.

C. Technical Considerations

Optumas is currently assisting the Department with data aggregation and budget neutrality submissions for the 1115 Waiver focusing on Opioid Use and Substance Use services provided in an Institute for Mental Disease (IMD). To accurately complete budget neutrality submissions it is necessary for **Optumas** to:

- fully understand the waiver concept and definition of services relevant to the waiver,
- aggregate data across the previous six years, combining multiple different delivery systems and data layouts, and
- perform detailed manipulations on tens of millions of claims and encounters to identify the subset of services relevant to Nebraska's proposed waiver.

To understand the waiver concept, **Optumas** held multiple background calls with the Department. In between calls, **Optumas** requested and received reports created by the Department and CMS templates for budget neutrality calculations. This information accelerated education about the specifics of the Department's proposed waiver and the items we would need to successfully complete the budget neutrality work. One additional call was necessary to allow us to go over the documents with the Department, discuss questions we had upon review, and confirm that **Optumas** and the Department had the same interpretation of various instructions and decision points. With detailed note taking, offline review of relevant documents, and our previous 1115 Waiver experience, a few thorough calls were sufficient to allow us to get up to speed and begin data work on Nebraska's proposed 1115 Waiver.

With appropriate background knowledge of what was required to complete the budget neutrality documents, **Optumas** began aggregating the necessary data. Our existing relationship with the Department, the claims data we already possess, and our understanding of the Nebraska Medicaid delivery system allowed us to perform this work more efficiently than any other firm. We did not need to request any new data from the Department (or the previously contracted MCOs who no longer operate in Nebraska Medicaid) because our lengthy history of working with Nebraska has allowed us to obtain data extracts covering all the necessary time periods and services. We assembled data from seven managed care plans, three different delivery systems, and thirteen data layouts spanning over six years to identify the services relevant to the proposed 1115 Waiver.

> ***Optumas'** existing relationship with the Department combined with our knowledge of the Nebraska Medicaid delivery system and MMIS data uniquely position us to perform additional 1115 Waiver work efficiently.*

Finally, once the data had been aggregated and relevant services were identified, **Optumas** performed detailed data manipulations to comply with the instructions provided by CMS and the guidance discussed with the Department. As discussed in the introduction to 1115 Waiver work, the manipulations required for each client's waiver are remarkably different. The key trait that **Optumas** brings is our detailed programming and data manipulation work. Since we use a dedicated, core

team, the same person going over waiver design questions on a call with the Department is coding those instructions into logic that will be applied to tens of millions of claims. This is then reviewed by another dedicated team member who has also been part of all the discussions and project background. This eliminates the possibility of mistakes and ensures that the intent, application, and result of the code are identical.

Optumas' involvement in Nebraska's proposed 1115 Waiver submission has given us the Substance Use and IMD background necessary to efficiently continue our role supporting the budget neutrality analyses and any subsequent actuarial work that arises under the waiver. No other firm can match our background, understanding, and data aggregation for the 1115 Waiver, making **Optumas** the most effective firm to provide waiver support services for the Department.

D. Detailed Project Work Plan

Please see Appendix II(E) for a sample SOW 5 1115 Waiver Development and Submission detailed project workplan.

E. Deliverables and Due Dates

Please see Appendix II(E) for deliverables and due dates associated with an 1115 Waiver Development and Submission project. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department.

SOW 6-Dental Capitation
Rate Setting

SOW 6 – Dental Capitation Rate Setting

Consistent with the Heritage Health rates, **Optumas** is responsible for ensuring that the capitation rate methodology(ies) used to develop the Dental Benefit Managed Care capitation rates comply with CMS guidance for the development of actuarially sound rates as defined in CMS' 2016 Medicaid and CHIP Final Rule. Just as with the Heritage Health rate development process, **Optumas** will work with the Department to identify the components of the rate development methodology that require any updates for the contract period, accounting for the covered services and populations as described in the Dental Benefit Manager (DBM)'s contract. The final results will be developed according to actuarially sound principles and reasonably reflect the experience projected for the DBM program.

A. Understanding of the Project Requirements

Optumas understands the project requirements of dental capitation rate setting as outlined on pages 27 and 28 of the RFP and has recently worked with the Department in the development of the capitation rates for the DBM that operates the Nebraska Dental Benefit Managed Care program. In Nebraska, dental benefits had historically been carved out of managed care and covered under a FFS delivery system. **Optumas** began working with the Department on developing a managed care program for its dental services in 2016, after the Department decided to pursue a stand-alone dental program. **Optumas** first assisted with various components of the Dental Managed Care RFP process, which included development of preliminary capitation rates for the program.

In addition to our work in Nebraska, **Optumas** has significant experience developing dental capitation rates in other programs. In the past three years, we have developed capitation rates specifically for dental programs, or programs that include dental as a covered service, for Arkansas, Colorado, Kansas, Nebraska, North Dakota, Iowa, and Oregon.

B. Proposed Development Approach

Within this section of our RFP response we will discuss items a through d as outlined under "I. SOW 6 – Dental Capitation Rate Setting" on page 27 and 28 of the RFP.

a. Capitation Rate Methodology Development and Determination

Optumas has recently worked with the Department in the development of the capitation rates for the DBM that operates the managed care dental program. As part of this process, **Optumas** ensures that capitation rate updates comply with CMS requirements, applicable ASOPs, and position the managed care program for continued success. The methodology will include the similar steps to those contained in the Heritage Health section above (beginning on page 87) to the extent they apply to the Dental program: Base Data, IBNR and Program/Policy Changes, Trend Projection Factors, Managed Care Savings Assumptions, Non-Medical Load, Risk Adjustment and Other Contract Provisions. Although very similar, we have highlighted a few key differences between the Dental capitation rate methodology and the Heritage Health capitation rate methodology below:

Base Data:
In **Optumas'** development of the capitation rates for the first two contract periods of Nebraska's Dental Benefit Managed Care Program, the data has consisted of FFS data, just prior to the implementation of the DBM Program. As emerging DBM data becomes available in the future, this will include all relevant encounter and claims data, as well as any other data or payments made outside of MMIS, such as any relevant supplemental payments. When considering future rate updates, the decision will need to be made as to whether a full re-base is necessary, or if the emerging experience of the most recent data will be accounted for as a rating adjustment instead.

IBNR and Program/Policy Changes:
Optumas has conducted program change impact analyses for the DBM program's entire existence, so we bring a robust understanding of the requirements and an established process to create results. On top of determining the impact of moving dental benefits to an entirely new delivery system, we have implemented state policy changes such as the reduction in the adult benefit maximum from $1,000 to $750 per year. This program change is discussed in more detail on page 201.

Optumas also has significant experience developing dental-related program changes in other states. In Oregon, benefit changes were recently made within their dental program to increase the frequency in which members could receive dentures, crowns, and other select preventive services for adults. **Optumas** worked with the State and its dental plans to develop an estimate of the expected utilization increase that this policy change would have on these services and incorporated this as an adjustment in the capitation rate development.

In Colorado, the Children's Health Plan Plus (CHP+) dental program recently increased its benefit limit from $600 to $1,000 per year, in addition to increasing the frequency of routine cleanings and coverage for additional services. In this case, it was important to recognize that with an increase in annual maximum, along with the addition of new services, there was potential for a significant increase in costs, as dental care plans had the ability to include additional optional dental services. The estimated impact of these changes was developed as a program change that was incorporated into the dental capitation rates.

Our understanding of dental programs nationwide, the Nebraska-specific Medicaid program history, immediate access to all the necessary data, and established lines of communication with the Department make us the ideal firm to perform ongoing DBM program change analyses.

Other Contract Provisions:
Currently, there is a withhold arrangement and MLR requirements that are applicable to the Dental program. Additionally, a new provision that was recently approved by CMS is the use of a minimum fee schedule for UNMC-affiliated dental providers, used to enhance payments for this class of dental providers. The UNMC arrangement is discussed in more detail in the SOW 7 subsection beginning on page 223.

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

Optumas worked with the Department to determine the appropriate rating cohorts, as well as to determine whether differences in rates by region would be necessary for the Dental program. To facilitate these decisions, **Optumas** conducted an analysis to review the average PMPM expenditures by age, eligibility criteria (e.g., AABD, CHIP, TANF, etc.), and region. The differences in cost were explained predominantly by the difference in age, rather than the eligibility criteria or geographic region. Further, since only one plan operates the dental program statewide, the mix risk of one plan receiving more members in one geographic region versus another is not present. As a result, **Optumas** suggested (and the Department approved) a statewide rating structure with cohorts split only by age band. Figure VI.A.3.xxii shows the final age bands used to develop capitation rates under this approach:

Figure VI.A.3.xxii – Dental Cohorts based on Age Bands

Dental Rating Cohorts		
0-1	19-24	55-64
2-5	25-54	65+
6-18		

c. Develop a risk adjustment methodology

While risk adjustment is a common component of Medicaid Managed Care Capitation rates, this is generally not the case with dental capitation rates. The use of dental services generally reflects an element of member choice that is not present for most other healthcare-related services, as opposed to being dictated predominantly by particular health conditions. For this reason, as well as the fact that only one DBM operates the dental program, a risk adjustment approach has not been developed for the dental program in Nebraska. If the program expands to include multiple plans **Optumas** can use our experience developing risk adjustment methodologies for Heritage Health to evaluate potential opportunities for dental risk adjustments, although the previous limits mentioned (such as voluntary service utilization) will still make this inconsistent with our best practices.

d. Develop a range of rates that are actuarially sound

In the development of the DBM capitation rates, **Optumas'** use of rate ranges provides flexibility for the Department to select a payment rate that is within an actuarially sound range and fits the program goals of the Department. While the rate range is developed independently of any State budget constraints, once the range is developed the Department can select a rate that best aligns with its programmatic situation. This is helpful from a State program perspective, allows flexibility for the Department to reimburse the DBM at higher levels when appropriate, and provides an opportunity to mitigate year to year rate shock.

Rate ranges are developed by varying key assumptions underlying the rate development process. This typically includes varying assumptions surrounding prospective trend forecasts as

well as assumptions related to non-medical load and managed care efficiency assumptions. The goal in developing a rate range is to capture a reasonable expectation in the variation of assumptions that could occur in the contract period.

C. Technical Considerations

In developing capitation rates for a dental program, certain technical considerations should be considered. One key consideration is the access to care for Medicaid dental programs, due to the relatively low reimbursement in Medicaid compared to commercial dental plans. As a result of this generally low reimbursement, many states observe poor dental care access. If a state opts to increase reimbursement for dental services, it is important to recognize that not only will the cost of services increase, but the volume of services will also likely increase due to increased access to care.

As **Optumas** observed with the development of the capitation rates for the first contract period of Nebraska's Managed Dental program (October 2017 – June 2018), dental costs are very susceptible to seasonality. This is particularly true when an annual limit is in place, as is the case in Nebraska. It is important to ensure that seasonality is considered, particularly if a rate update covers a partial year rather than a full twelve-month time period. **Optumas** has conducted the analyses necessary to develop non-annual rates, so if the Department would like to use unique rating periods in the future **Optumas** has all the processes established to calculate the required rating adjustment.

It is important to consider the effect of seasonality for managed care program contracts that are effective for only a portion of a year.

Optumas recently worked with the Department in its efforts with CMS to develop a directed payment approach for its University of Nebraska Medical Center (UNMC) minimum fee schedule arrangement. As of May 2018, this has been approved by CMS and will need to be accounted for and included in capitation rates prospectively.

D. Detailed Project Work Plan

Please see Appendix II(F) for a sample SOW 6 Dental Capitation Rate Setting detailed project work plan. Any analyses that are unique to Nebraska's Managed Dental program that are not included within the sample work plan will be reflected in the detailed project work plan developed at the start of the rate setting process along with the Department's feedback.

E. Deliverables and Due Dates

Please see Appendix II(F) for deliverables and due dates associated with Dental Capitation Rate Setting. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department. Per our interpretation of page 25 of the RFP we have created a detailed project plan with deliverables and due dates on a state fiscal year basis, which is consistent with the operationalization of Nebraska's Dental Program.

SOW 6.1-Rate Development Analysis/Manipulation

SOW 6.1 – Rate Data Analysis and Manipulation

The rate data analyses and manipulation, as well as overall rate setting methodology underlying the Dental rates, is consistent with our general rate setting approach as previously described within SOW 1.1 of this RFP, but the analytics are tailored to be specific for the dental benefit package. **Optumas** will continue to work with the Department to identify the components of the rate development methodology that require updates for future contract periods, accounting for the covered services and populations as described in the DBM contract, while continuously refining our rate data analysis and manipulation processes to produce actuarially sound Dental Benefits Managed Care capitation rates in an efficient and transparent manner.

A. Understanding of the Project Requirements

Through our experience the past two years setting the Nebraska Dental Benefits Managed Care capitation rates, combined with our experienced setting dental program capitation rates in other states, we fully understand the necessary rate data analyses and manipulation processes involved in setting actuarially sound dental capitation rates as described on page 28 of the RFP. The following sections describe the rate data analytics and manipulation processes involved in dental capitation rate development in greater detail.

B. Proposed Development Approach

Within this section of our RFP response we will discuss items a through e as outlined under "1. Rate Data Analysis and Manipulation" on page 28 of the RFP.

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

As mentioned in SOW 1.1 in the subsection beginning on page 111, **Optumas** takes great pride in our ability to create customized, comprehensive, program-specific financial templates and our efficiency and thoroughness analyzing the data the managed care entities report within the financial templates. **Optumas** is responsible for creating the detailed, quarterly DBM financial templates used currently in Nebraska's Dental Benefits Managed Care programs. While designing the financial templates, **Optumas** conducted several calls with the Department to gain an in-depth understanding of the Department's goals and objectives regarding the DBM financial templates and produced many iterations of the Dental financial template to ensure that the final template was fully customized to the Department's needs. After receiving feedback from the Department and the contracted DBM, **Optumas** finalized a fully customized, quarterly financial template, that is an effective tool for all participating stakeholders and has been successfully used by the DBM, the Department, and **Optumas.**

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

In addition to determining the impact of moving dental benefits to an entirely new delivery system, **Optumas** has conducted the program change impact analyses for the Dental Benefits

Managed Care program's entire existence, which means we possess a thorough understanding of the considerations that must be made when calculating program change adjustment factors to be applied to develop appropriate Nebraska dental capitation rates and ranges. We have an established process and methodology for some of the more standard annual program and policy changes that occur within each rate development and can adapt these models as necessary in future rating cycles to efficiently develop capitation rates. We have historically used Nebraska Medicaid FFS data as the basis for rate development and calculated adjustment factors for annual provider fee schedule changes, repriced Indian Health Services (IHS) to the latest federally mandated encounter rate, and the rating adjustment necessary to reflect the new state policy change, effective July 1, 2017, that reduced the adult dental service annual benefit maximum from $1,000 to $750 per year.

Optumas' approach to calculating the impact of the change in annual benefit limit for members 21 and over is a prime example of the detailed process we take in analyzing the impact of all program changes. To the extent possible, we rely Nebraska specific claims and encounter data to calculate and help inform the adjustment factors for all Nebraska capitation rate development. It is important to consider how the operationalization of multiple program changes will interact and impact the overall capitation rates and identify the appropriate order in which to apply the adjustments within the rate development. The State of Nebraska has historically implemented an annual benefit limit on dental services of $1,000 per fiscal year for adult (age 21+) Medicaid beneficiaries, except for certain cases that are pre-authorized and allowed to exceed this limit. Effective July 1, 2017, the annual limit was reduced to $750 per fiscal year for adult beneficiaries. To account for this policy change, **Optumas** sorted the FFS dental claims data, used as the underlying base data for rate development, by member and date of service to calculate a cumulative total of dental services by fiscal year subject to the benefit limit. This cumulative total was calculated after the detailed repricing of IHS encounters and the provider fee change adjustment because these updated reimbursement levels are representative of the service costs expected to occur during the contract period. Any dollars and units for dental services that were provided after the member's cumulative sum reached $750 were excluded from the base data. Services for children and for adult beneficiaries who were already authorized to exceed the original $1,000 benefit limit in place for SFY16 and SFY17 were not adjusted because children are not subject to the annual benefit limit, and it is anticipated that authorization for certain services in excess of the annual maximum will continue in the contract period.

When analyzing the impact of program changes within rate development it is important to consider the how the interaction of multiple policy changes affects the managed care program.

Optumas' experience working with the Department since the inception of the Dental Benefits Managed Care program to understand and model the program changes and nuances involved in Nebraska's dental program as well as vast experience from other states uniquely positions us with a deep understanding of dental managed care programs; we will continue to provide exceptional support and assist in any analytics the Department wishes to pursue within future rate development cycles. **Optumas** currently has access to information related to recent program changes in Nebraska and will work with the Department to identify any future program

changes that could impact the Dental Benefit Managed Care program, including changes in reimbursement or changes in covered services.

c. Analyze dental service utilization and cost profile patterns by category of service for all DBM rating cohorts

Within each rate development cycle **Optumas** reviews and analyzes dental service utilization and cost profile patterns by category of service for all rating cohorts. **Optumas** used the categories of service contained within Figure VI.A.3.xxiii within the base data underlying the most recent SFY19 rate development:

Figure VI.A.3.xxiii – Dental Categories of Service

Categories of Service
Adjunctive General Services
Endodontics
Oral and Maxillofacial Surgery
Orthodontics
Partial Dentures
Periodontics
Preventative
Prosthodontics
Restorative
IHS

As part of the data validation process prior to rate development, **Optumas** reviews the base data period as well as more recent emerging DBM experience longitudinally by major category of service and rating cohort. More specifically, **Optumas** looks at claims volume and costs over time as well as service utilization, unit cost, and per-member per-month (PMPM) expenses to ensure consistency in the data and identify and address any gaps prior to rate development. This durational review and validation process is essential to ensure that the base data is an adequate and appropriate starting point to use for the rate development and to ensure the certifying actuary is comfortable with the quality of the data, as is required per ASOP 23 – Data Quality. Additionally, this review of the data typically consists of comparisons to external data sources, such as reported financial data as described above in SOW 6.1.

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

Through **Optumas'** work with the financial template, we provide technical assistance to the Department in the evaluation of individual DBMs financial performance. **Optumas** does a detailed review of the IBNR reported within the financial template and compares the results to our own internal IBNR calculations that analyze the payment patterns of the submitted MMIS encounters. As previously discussed, most managed care entities typically provide an IBNR estimate that is intentionally overstated with PAD. As the Dental Benefits Managed Care program continues to mature, it will be important to review and benchmark the DBM's IBNR

estimate and normalize the IBNR estimate to remove excessive PAD, to the extent necessary, prior to analyzing the overall financial performance of the DBM for the reported time period.

As part of the rate development process, **Optumas** develops non-medical loading assumptions to apply reasonable, appropriate, and attainable non-medical expenditures to the projected medical costs. Non-medical load is comprised of general administration, case management, profit margin, risk and contingency margin, and applicable taxes and fees. As the Dental Benefits Managed Care program matures we will use reported administrative expenditure from the financial templates for the DBM to help inform and develop appropriate Non-Medical Load assumptions within rate development. Expenditures will be evaluated for reasonableness and compared to regional benchmarks and other states in which **Optumas** sets Medicaid dental capitation rates to ensure the Department does not overpay for administrative services.

Additionally, **Optumas** considers any other contractual provisions, such as incentive or withhold arrangements, risk corridors, and MLR requirements when evaluating the performance of individual DBMs. Currently, there is a withhold arrangement, with payment conditional on certain quality metrics being met, and MLR requirements that are applicable to the Nebraska dental program. With each quarterly submission of the financial template **Optumas** reviews the year-to-date standings and tracks the progress of the DBM and discusses the findings with the Department, having follow-up conversations with the DBM as necessary.

***Optumas** works with the Department to review and track the progress of the quality metrics tied to the DBM's withhold arrangement and monitor the portion of the withheld capitation earned by the DBM.*

In developing capitation rates for a dental program, it is important to review the appropriateness of dental costs incurred by the DBM. Within Nebraska the DBM is required to reimburse at no less than the FFS dental fee schedule but has the option to reimburse above FFS levels if it chooses. Upon review of emerging encounter experience as well as discussions with the DBM currently operating in Nebraska, it is understood that the DBM is currently reimbursing providers at the FFS fee schedule. Reimbursement levels have the potential to directly affect the access to care for Medicaid dental programs, due to the relatively low reimbursement in Medicaid compared to commercial dental plans. As a result, many states observe poor dental care access patterns due to low reimbursement. If a state opts to increase reimbursement for dental services, it is important to recognize that not only will the cost of services increase, but the volume of services will also likely increase due to increased access to care. Based on initial review of emerging DBM specific encounter experience for the October 2017 – June 2018 contract period, the DBM is reimbursing at Nebraska FFS levels so there are no concerns for restricted access to care within the managed care setting compared to the historical FFS access to care based on reimbursement, so the dental service costs incurred are

Service utilization patterns within Medicaid dental managed care programs can be very susceptible to reimbursement levels so it is necessary to thoroughly evaluate and consider the impact of reimbursement program changes.

reasonable and appropriate from a rating perspective. **Optumas** will continue to monitor the reimbursement levels of the DBM through review of financial statements and encounter data within future rate development cycles to ensure only appropriate dental costs as covered by the Dental Benefits Managed Care contract are included within the base data for rate development.

e. Analyze inflation, economic, and health related trends

Optumas analyzes and develops program specific trend factors as part of every rate development cycle and applies these factors within the rate setting process to estimate the change in utilization rate and unit cost of services over time. These trend factors are used to project the costs from the base period to the future contract period. Trend methodologies are discussed in more detail in SOW 1.1 in the subsection beginning on page 120.

In addition to our traditional trend analyses, **Optumas** possesses a wealth of reference data that can be used to analyze inflation, economic, and health related trends and help us develop and defend our program-specific trend estimates. It is always challenging to go before managed care plans with low trend estimates, as there are many publicly available sources that can be used to argue for increasing inflation and medical costs. **Optumas** is able to defend our trend estimates due to the robust network of geographically-relevant data we possess through our experience developing rates for other stand-alone dental programs. We house Medicaid dental data for Colorado, Iowa, Kansas, and North Dakota, which allows us to substantiate our trend estimates with regional experience, putting us in a unique position to understand dental costs changes from a macro perspective and defend trend estimates, helping ensure Nebraska remains an effective purchaser of dental services.

C. Technical Considerations

It is necessary for **Optumas** to receive standard claims and eligibility data as well as information from the Department regarding anticipated policy changes within the contract period in order to efficiently and effectively complete data analyses for rate setting. **Optumas** has set up the ability to automatically receive monthly and quarterly data extracts from the Department and has worked with the Department and the Department's data vendor, Truven, to determine a standard data layout over the past five years. Additionally, we have a weekly standing meeting with the Department where we discuss upcoming program changes. The standardized data transfer combined with our open line of communication with the Department allows **Optumas** to ensure that new datasets are quickly imported and combined with historical information to create a full and complete data repository and begin work analyzing standard analyses related to the Dental Benefits Managed Care capitation rates and queue up any specific data analytics the Department might desire.

D. Detailed Project Work Plan

Please see Appendix II(F) for a sample SOW 6 Dental Capitation Rate Setting detailed project work plan. Any analyses that are unique to Nebraska's Dental Benefits Managed Care program that are not included within the sample work plan will be reflected in the detailed project work plan developed at the start of the rate setting process along with the Department's feedback.

E. Deliverables and Due Dates

Please see Appendix II(F) for deliverables and due dates associated with Dental Capitation Rate Setting. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department. Per our interpretation of page 28 of the RFP we have created a detailed project plan with deliverables and due dates on a state fiscal year basis, which is consistent with the operationalization of Nebraska's Dental Program.

SOW 6.2-Interim
Reports/Deliverables/Rate
Setting Functions

SOW 6.2 – Interim Reporting and Other Deliverables for Rate Setting Functions

A. Understanding of the Project Requirements

Optumas understands the project requirements of interim reporting and other deliverables for rate setting functions as outlined on page 28 of the RFP and has provided actuarial and consulting services specifically for dental programs, or programs that include dental as a covered service, in the states of Arkansas, Colorado, Kansas, Nebraska, North Dakota, Iowa, and Oregon. In each of these Dental programs, **Optumas** has a proven track record of well-conceived and logical project management, technical support, and analytics tools to support the activities associated with capitation rate setting. Our successful project management design includes frequent meetings, instant access to dynamic documents/models, and detailed project timelines. **Optumas** prides itself on our ability to modify our project management strategies to best fit the needs of our clients.

B. Proposed Development Approach

Within this section of our RFP response we will discuss items a through j as outlined under "2. Interim Reporting and Other Deliverables for Rate Setting Functions" on page 28 of the RFP.

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

Optumas believes in promoting a very transparent process with regards to any actuarial analytics and analyses. This transparency facilitates partnerships between the Department and participating vendors as well as assists in documenting and substantiating the actuarial analysis. The key component to developing this level of transparency is frequent meetings and check-ins with the Department and DBM. Regarding the Dental Capitation Rate Development, **Optumas** recommends the following periodic meetings with the Department and/or DBM:

Kickoff Meeting with the Department:
Optumas recommends scheduling an onsite, kickoff meeting to discuss major tasks and outline expectations associated with the Dental Capitation Rate Development. This onsite discussion will allow **Optumas** to gain a deeper understanding of the Department's goals for the future Dental program and will ensure that **Optumas** is aware of the Department's expectations. As a result of this kickoff discussion, **Optumas** will create a project work plan, outlining key deliverables and timelines associated with the Dental Capitation Rate Development. **Optumas** has included a sample project workplan for the Dental managed care program within Appendix II(F).

Kickoff Meeting with the DBM:
Once **Optumas** fully understands the expectations and goals of the Department, **Optumas** recommends scheduling either an onsite or virtual meeting with the DBM. The purpose of this meeting will be to review the project workplan, to discuss the proposed rate development methodology, to outline any data requests, and to give the DBM an opportunity to voice any concerns related to the rate development process. **Optumas** believes that the key to DBM engagement is transparency. **Optumas** likes to receive feedback from the contracted DBM to help foster a collaborative working environment.

While we do not always incorporate their feedback, we have always found it useful to collaborate with DBMs on ways to improve the Dental Rate Development process.

Weekly Meetings with the Department:
Optumas currently conducts weekly check-in meetings with the Department. The purpose of these meetings is to discuss any outstanding items, to get clarification on program changes, and to walkthrough each piece of the rate development process as they are finalized. **Optumas** believes that these meetings are a crucial component of our successful relationship with the Department. They have been vital in our ability to stay up-to-speed on all aspects of the Dental Managed Care program. A weekly touchpoint provides **Optumas** with the opportunity to hear from the Department about policy considerations and budgetary constraints before they become urgent needs and allows **Optumas** to vet the consequences of any proposed policy decisions with the Department. This conversation and ability for **Optumas** to stay continuously plugged in to the challenges facing the Department creates a full understanding of the nuances of the Medicaid Dental Managed Care program, including decisions made and analyses requested by the Department.

Base Data Touchpoint with the DBM:
Once the base data is compiled, **Optumas** recommends conducting a meeting with the DBM to walk through the Base Data Model. The purpose of this meeting is to ensure that all stakeholders are comfortable with the base data. This meeting serves to identify any gaps or missing data to ensure that the proposed base data is an accurate starting point for rate development. Additionally, this touch point helps foster a collaborative working environment with the DBM, and illustrates the Department/**Optumas'** willingness to

Rate Presentation to the DBM:
Optumas recommends scheduling an onsite rate presentation, with the goal of walking the DBM through the entire rate development process, starting with the base data, moving on to any program changes and trend, and ending with non-medical load assumptions. The goal of this meeting is to give the DBM insight into all actuarial assumptions and analyses conducted as part of the rate development process. **Optumas** recommends a 1.5- to 2-hour meeting, allowing the DBM adequate time to answer any questions along the way. **Optumas** advocates for open dialogue during the rate presentation, as it has proven to foster a more collaborative partnership between the DBM and the Department.

b. **Provide documents and data, as directed by Department staff, to discuss at these meetings**

Optumas will provide the Department with all documents, data, and models necessary to discuss during the meetings described above. These files will be active-format, live-working models, allowing the Department to efficiently model various scenarios. **Optumas** will provide the documents in advance of the scheduled meetings with the goal of having a more productive discussion. Additionally, **Optumas** recommends using Skype for Business on these calls to more easily review and discuss documents/data with the Department and/or DBM. The screen-sharing capability has been instrumental in our weekly meetings with the Department over the course of our current contract. Through this tool, **Optumas** has been able to walk the Department through detailed analyses and modify assumptions on the spot.

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

Optumas has a dedicated project manager/Principal, Tim Doyle, who will oversee all scopes contained within this RFP. Tim has successfully overseen the development of the Dental Managed Care Rate Setting for the last five years and looks forward to continuing his relationship with the Department. Additionally, **Optumas** has assigned Barry Jordan, Chris Dickerson, Cassie Williams, and Stephanie Taylor to assist with the Dental Capitation Rate Setting. All four of these individuals have assisted with the development of the Dental capitation rates for the Department over the last five years. Each one of these dedicated **Optumas** team members will be responsible for communicating any project/timeline updates for all tasks associated with the Dental Capitation Rate Setting. To the extent an **Optumas** team member needs to take a leave of absence, our flat team structure allows for a seamless transition since every team member will already be "up to speed" on all aspects of a project. **Optumas** recommends using the weekly calls with the Department to help communicate project updates and to ensure all parties are aware of upcoming milestones/deadlines.

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

Since encounter data was not yet available for the initial DBM capitation rates, **Optumas** relied on detailed FFS data from MMIS. **Optumas** conducted several data validation checks on the FFS data to ensure that it was an adequate starting point for the Dental Capitation Rate Setting. For example, once the FFS data was compiled, **Optumas** shared the databook with Department staff with the purpose of benchmarking the summarized figures to internal reports. This benchmarking exercise was crucial to ensuring the accuracy of the base data used in rate development.

Now that emerging experience is available for the Dental Managed Care Program, **Optumas** intends to review the Dental encounter data contained in the MMIS system. **Optumas** will benchmark this new data source to the DBM's submitted financial report to ensure that the MMIS data is not significantly underreported. Ideally, **Optumas** would like to incorporate the emerging MMIS encounter data into the base used to develop the SFY20 Dental capitation rates. However, as noted in SOW in the subsection beginning on page 87 of this proposal, the encounter data contained within MMIS has historically been drastically underreported. To the extent this is the case for the Dental encounters, **Optumas** will work with the Department to brainstorm alternative approaches, similar to the approach taken in the Heritage Health program. **Optumas** looks forward to using our in-house data warehousing system to analyze the completeness of the emerging MMIS encounters for the Dental Managed Care Program.

__Optumas__ will use our in-house data warehousing system to analyze the completeness of the emerging Dental encounter data as the DBM continues to submit quarterly financial templates and will work with the Department to address any gaps or underreporting in the data.

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

If awarded this contract, **Optumas** would like to prepare a Recommendation Report for the Department at the end of each rate development cycle. This Recommendation Report would include a reflection of the previous rate development process and would identify any potential areas for improvement. Throughout the rate development process, our team will document any opportunities to improve the accuracy and efficiency of the capitation rate development methodology. Once the project is complete, **Optumas** will reflect on the documented opportunities and will outline these improvement areas in a report for the Department. **Optumas** has introduced the Recommendation Report to a wide variety of clients with great success.

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

Substantial data preparation work is necessary as part of many actuarial analyses and projects. However, this needs to be converted into meaningful information for the actuary, the Department, and the various stakeholders. This typically results in a significant amount of work being conducted through the development of, and use of, exhibits, reports, and Excel models. **Optumas** strives to keep models as straightforward and simplistic as possible, while still maintaining the necessary level of rigor to complete various actuarial tasks, so that stakeholders with varied levels of experience can follow the process. Depending on the complexity of the project, the level of simplicity may vary; however, the general approach of maintaining a transparent modeling approach remains consistent. **Optumas** will provide the Department with any exhibits, reports, and calculations in the format specified by the Department.

g. Develop work plans for rates to be determined including milestones for completion

The **Optumas** team will create a robust work plan which clearly identifies activities and milestones for the Dental Capitation Rate Setting. Our combined team will work with the Department to determine the areas of prioritization as well as areas of risk. We will meet with Department at the start of the project to determine how to best adapt our project management reporting style, content, and frequency to meet the specific needs and desires of the Department. Appendix II(F) includes a sample work plan for the Dental Capitation Rate Setting process.

h. Meet work plan milestones and timelines as agreed upon with the Department

Optumas prides itself on our ability to meet agreed upon timelines. Over the last five years, we have never missed a deadline that was agreed upon with the Department. **Optumas** is always willing to go above and beyond to ensure that milestones are reached and that the appropriate resources are assigned to projects. As a smaller consulting firm, **Optumas** is very

__Optumas__ is able to quickly react and respond to time sensitive client requests due to the smaller nature and flat structure of the firm.

nimble and able to react quickly to client requests. The Department has a dedicated team of **Optumas** individuals that are focused on the success of Medicaid in Nebraska. Our motivated, attentive team will be able to accomplish tasks in short order to ensure that aggressive timelines are met. Accuracy will not be sacrificed in order to meet deadlines; our team has experience across the nation with Medicaid programs, and can tap in to that expertise to make sure our methodology, approach, and results are well-reasoned, reliable, and completed in the most efficient way possible. We are not a rigid company that funnels communication through a strict hierarchy; rather our whole team will be at your disposal, and all team members will be able to contribute to the needs of the Department.

i. Provide staff training in methodologies used to develop rates

Optumas conducts staff training, as necessary, with our clients to ensure they fully understand the methodology used to develop capitation rates. **Optumas** will provide any necessary training and documentation to the Department on how the Dental capitation rates were developed, how to operationalize the rates, and any other rate setting questions. In addition to training on traditional rates setting methodologies, **Optumas** has extensive experience offering technical assistance and training to health care plans through state clients on such issues as cost containment strategies, reporting requirements, data utilization analysis, administration, and operational/financial reviews.

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

As mentioned above, the Department implemented a new Dental managed care program, which went into effect October 1, 2017. **Optumas** was involved in the procurement process used to determine the contracted DBM. This initially involved developing draft dental capitation rates for the RFP and assisting the Department in addressing various questions by prospective DBM entities. Once this process was complete and the final program start date was determined, **Optumas** developed final capitation rates for the contract period October 2017 – June 2018. Given the limited maturity of the program, **Optumas** is working with the Department to evaluate emerging experience as compared to the developed capitation rates and will continue to monitor results and refine the rate setting process as more experience becomes available. As demonstrated in this example, **Optumas** is well equipped to develop or assist in the development of rate methodology for any new programs that may be implemented during the contact period.

C. Technical Considerations

When creating deliverables and files for rate development, it is extremely important to create clear and concise deliverables that are easily understood by all parties. In addition to this being a more beneficial product, we have also found that this helps to minimize internal errors since various components of the analysis are laid out in a visible, transparent manner. **Optumas** team takes pride in the quality control process we use when conducting creative analyses for our clients. Our quality control process focuses on accuracy and quality and **Optumas** team members are trained from day one that all analyses must undergo multiple layers of peer review to achieve that accuracy and quality. Each analysis, model, and/or deliverable goes through the following peer review steps:

- First, real-time control total checks are done within the model; for example, if a detailed data paste is the source of data for a model, then as the team's analyst works through the analysis, checks are conducted to ensure that the total volume included in the paste matches the total volume that is summarized into an Excel table or report.
- Second, **Optumas** ensures that a technical peer review of the work is completed. This entails another team member independently replicating the work, typically using a slightly different approach. In other words, the analysis is completed independently and then the results are compared to ensure consistency and that both calculations are done accurately.
- Third, **Optumas** ensures that the analysis and results are reviewed from a high-level consulting perspective. This includes the lead actuary and consultant(s) reviewing the reasonableness of the results and ensuring that the proper steps were taken and that proper considerations were made in the development of the analysis.
- Finally, **Optumas** understands the importance of receiving strategic feedback from the Department and other appropriate stakeholders. While **Optumas** engages each of its clients through various interim touch points throughout each project, we also ensure that the completed product makes sense to the client, given the specific dynamics of the program. We believe that one of the keys to producing the most accurate and effective product is by engaging the client and its stakeholders such that projects are not done in a vacuum. In our work to date with the Department, we have found that both its various staff members' technical abilities and in-depth knowledge of the Nebraska Medicaid program have proven very helpful to delivering accurate and easily understood exhibits/reports.

D. Detailed Project Work Plan

Please see Appendix II(F) for a sample SOW 6 Dental Capitation Rate Setting detailed project work plan and the interim reporting and other deliverables associated with Dental rate setting functions.

E. Deliverables and Due Dates

Please see Appendix II(F) for deliverables and due dates associated with Dental Capitation Rate Setting and interim reporting and rate setting function deliverables. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department. Per our interpretation of page 25 of the RFP we have created a detailed project plan with deliverables and due dates on a state fiscal year basis. However, the project work plan and due dates can be adjusted to fit a calendar year basis to match the current structure of the Dental managed care program contract period.

SOW 6.3-Dental Capitation
Rate Finalization

SOW 6.3 – Dental Capitation Rate Finalization

Optumas' team of credentialed actuaries and consultants has a comprehensive knowledge of the tasks required to finalize, submit, and receive approval for dental capitation rates. This process involves first getting Department confirmation that the rates incorporate all applicable changes, then presenting to the DBM to receive and evaluate any feedback they might bring for consideration, and finally submitting capitation rates and required documents to CMS for federal approval. We have completed this process and received CMS approval for standalone dental rates in Arkansas, North Dakota, Oregon, and have developed and submitted the initial rates for Nebraska's new dental managed care program. During this time, we have developed a comprehensive process that allows for as easy a review process as possible. While CMS' review and timeliness are notoriously unpredictable, **Optumas** has worked with the Department to develop a process that puts Nebraska Medicaid in the best position possible. We look forward to continuing to implement and refine our process for the projects covered under this RFP.

A. Understanding of the Project Requirements

Optumas understands the project requirements of dental capitation rate finalization as outlined on page 28 of the RFP. Similar to the Heritage Health capitation rates discussed in SOW 1.3, the final step in our rate development process is the presentation of developed capitation rates and submission of a detailed rate certification letter to CMS. The first of these finalization tasks, rate presentation, is an incredibly important part of the actuarial consulting services that **Optumas** provides to our clients. In every market in which we work we strive to build a partnership relationship with the managed care organizations contracted by our state clients. This is not always possible, and occasionally difficult discussions need to occur regarding rating assumptions, benefit changes, or fee reductions. With our meticulously detailed rate development work supplemented by our professional and clear communication, we are able to ease the difficulty of rate presentations and negotiations to the benefit of our clients.

To satisfy federal oversight requirements, **Optumas** will produce a certification letter for the dental managed care program. The certification letter contains a description of the program structure as well as a walk-through of the entire rate setting process, allowing federal reviewers to understand the program, review the rates, and ultimately provide their approval. In addition to being compliant with all applicable actuarial and federal regulations, our detailed process has resulted in quicker rate approvals for our clients.

In addition to meeting all applicable federal and actuarial regulations, our finalization process results in quicker CMS approval and a partnership relation with the DBM.

Typically, our rate certification letter is submitted to CMS 90 days prior to the contract's effective date. This deadline can be flexible; CMS is known to provide additional time when a state has extenuating circumstances, and some states require earlier submissions for their own program management reasons. In our previous work with the Department, **Optumas** has maintained the 90-day submission deadline, positioning the Department for success by simultaneously allowing for CMS expedited review and using the most recent data possible during rate development.

B. Proposed Development Approach

Within this section of our RFP response we will discuss items a through g as outlined under "3. Dental Capitation Rate Finalization" on page 28 of the RFP.

At **Optumas** we pride ourselves on the transparency we bring to our rate development projects and our ability to communicate rate development methodologies and results to broad groups of stakeholders. These two traits are incredibly important in the development of rate finalization documents. This SOW section discusses rate finalization with respect to both the DBM and federal partners, and **Optumas'** transparent approach works well with both organizations. We are able to build partnership relationships between our state clients and their contracted vendors by sharing the details of rate development in a way that allows the DBM to understand what is expected of them from a care management and provider contracting approach. Our transparency also allows managed care plans to coordinate better with providers, as we will share details on services that are considered medically unnecessary that managed care plans can focus on for their utilization review.

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

Optumas has developed more than 20 actuarial memorandums for the Department over the past five years. Additionally, we develop actuarial memorandums for our other clients across the nation, giving us a unique combination of Nebraska-specific experience rounded out by national expertise. Our process has focused on satisfying core statutory requirements while adding in specific details to ease the review process. Specifically, in developing capitation rates, **Optumas** adheres to the guidance provided by CMS in 42 CFR 438.4, which contains the CMS standards for developing actuarially sound capitation rates for Medicaid managed care programs. CMS defines actuarially sound rates as meeting the following criteria:

1. They have been developed in accordance with generally accepted actuarial principles and practices,
2. They are appropriate for the populations to be covered and the services to be furnished under the contract, and
3. They have been certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

These are the minimum requirements of actuarial memorandums, and **Optumas** ensures they are fulfilled on every submission. In addition to this, we add details such as a rate methodology description, rate development exhibits, and a crosswalk of CMS' review checklist to our document, showing the exact place in the document where each of CMS' points of review is discussed. With these additional details we can reduce the number of follow-up questions CMS asks of us and receive approval more quickly.

> ***Optumas** received only one follow-up question from CMS prior to rate approval for one of our client's recent managed care capitation rate developments.*

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

Optumas' rate certifications attest that rates are compliant with the BBA of 1997. **Optumas** complies with all requirements described in the BBA when developing our capitation rates. This primarily involves ensuring that the rates we develop are sufficient and appropriate for the populations and services covered by the DBM.

Optumas achieves this compliance through the combination of three approaches. First, **Optumas** uses a rigorous rate development methodology that incorporates all paid claims, supplemental payments, and programmatic changes to project capitation rates. This rigorous process has been described in detail in the preceding sections of this RFP response. Second, **Optumas** regularly discusses the rate development process with the managed care entity (in this case, the DBM). By keeping the DBM informed on rate development we can ensure that the data underlying rate development is consistent with the DBM's experience and that all concerns the DBM has are either incorporated or assuaged. Finally, **Optumas** has regular (typically weekly) discussions with the Department. This allows us to stay apprised of the constantly changing policy that will be in place during the contract period. The concept of capitation rates being "sufficient and appropriate" is fully met by the constant involvement of stakeholders and the analytically rigorous approach **Optumas** applies. This approach is fully discussed and documented in our rate methodology reports, allowing CMS to confirm our compliance with the BBA.

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

As discussed in response to SOW 1.3, **Optumas** will provide a certification that capitation rate developed on behalf of the Department are in compliance with actuarial soundness requirements all associated ASOPs, including ASOPs 5, 23, 25, 41, 45, and 49. These ASOPs are described in detail in the response to SOW 1.3, so for the sake of brevity we will not repeat them here. The ASOPs are general guidance, so they are valid and essential for all rate development work that would be performed under this RFP, whether it is dental, acute care, or managed LTSS.

Optumas produces an actuarial certification as the conclusion of the memorandum that is provided to the Department and CMS. This certification includes everything required under this scope of work task, as it both certifies to the soundness of rates and contains supporting exhibits detailing the rate development. The exhibits produced by **Optumas** mirror the rate models we construct to develop capitation rates and allow reviewers to evaluate the starting base data values and itemize the impact of each adjustment applied to construct the final capitation rates. This level of transparency exceeds CMS' requirements and ensures that all documents **Optumas** submits on behalf of the Department will be compliant and receive the most straightforward path to review and approval.

d. Provide necessary certification to meet the requirements of the CMS rate setting consultation guide

As established throughout this section, every certification letter created by **Optumas** meets all applicable requirements established by CMS and the actuarial profession. This is true for the 20+ certification letters we have submitted throughout the duration of our current contract with the Department and will continue to be true for anything submitted under the scopes of work outlined in this RFP. What sets **Optumas** apart is the lengths we go to when demonstrating our compliance. We create a detailed crosswalk showing every item on the rate setting consultation guide and where it is addressed in our certification letter. This allows for federal reviewers to quickly highlight important parts of the letter, identify questions they might have, and confirm rate compliance. Expediting federal review is important to the Department, as rates are not paid until CMS provides its rate approval. While many parts of the CMS review are outside of our control, **Optumas** puts in substantial work and does everything possible to allow for an easy review by CMS and a quick rate approval.

e. Prepare all presentation material, attend and participate in DBM meetings as requested to promote approved recommendations

Optumas' role as strategic actuarial consultants is frequently on display during our meetings and presentations with the DBM and other managed care organizations. Our experience setting capitation rates across the nation has given us an idea how to effectively organize these conversations to be productive. Additionally, we have experience consulting to managed care organizations receiving Medicaid capitation rates, so we are aware what managed care plans look for and prioritize during these meetings. Combining these two aspects of our experience provides **Optumas** with an unmatched ability to communicate our findings to the Dental Benefit Manager.

Our expertise in this area has been proven recently in the DBM program. The initial DBM rates included an unorthodox 9-month contract period. This necessitated significant consideration of how to control for the significant seasonality that is inherent in all dental service utilization (service utilization increases drastically during summer months). On top of this, there was a change in the benefit limit for adults, dropping the maximum allowed benefit from $1,000 to $750. Either of these major program changes could have resulted in a contentious process with the DBM, as there are multiple approaches that could be used and assumptions that must be made. **Optumas'** rigorous process combined with our detailed, transparent communication allowed the DBM to feel involved in the process and accepting of our methodology decisions. This specific example is indicative of the presentation and meeting expertise that **Optumas** has brought to all Department projects and has allowed the Department to establish partnership relationships with managed care organizations where they know their concerns are taken seriously while the Department is able to implement the necessary policy goals.

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

Optumas is well-versed in supporting our client's communication with CMS. During the course of our previous work with the Department we have led technical discussions on behalf of the

Department regarding 1915(b)(3) Waiver cost effectiveness, 1115 Waiver budget neutrality, specific rating adjustments (crossover claim repricing, UNMC pass-through payments, etc.) and rate submission questions. We prepare simple exhibits for CMS in advance of these calls that highlight the issue under discussion and allow for effective communication. Also, we are aware of some of the limitations in place regarding CMS communications (e.g. they are typically unwilling to make policy commitments over the phone), so we react accordingly and follow-up with clear concise emails that can elicit a direct response from CMS.

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

As required by the RFP **Optumas** can prepare and submit rate exhibits five months prior to the effective date. **Optumas'** current process with the Department includes compliance with CMS' 90-day submission requirement, where rates are due only 90 days prior to effective date. The Department should consider maintaining compliance with the 90-day requirement, as it allows for more recent data to be incorporated into the rate development base data. **Optumas** has not missed any deadlines established by the Department during the course of our current contract, so regardless of the Department's decision on the rate deadlines we will be able to meet the Department's needs.

C. Technical Considerations

An important technical consideration for the Department to consider is the balance between seeking CMS guidance in advance or submitting what is thought to be a reasonable rate adjustment and expecting CMS approval. **Optumas** has helped the department strike this balance for the work covered by our current contract. There are occasions during our rate development work on behalf of the Department where we have proactively reached out to CMS or OACT to receive guidance on complex policy changes to ensure the policy would ultimately be compliant with CMS' requirements. Other times we have been able to skip time-consuming background calls with CMS/OACT because our national experience provides us with a comparable scenario where CMS has provided approval. The process of receiving CMS guidance can be very time consuming, so avoiding it when there is an established precedent for approval is a very appealing alternative. **Optumas** national experience can help the Department strike the necessary balance between asking advice and proceeding with an established precedent, and our contacts with CMS/OACT can make for a smoother process when feedback is required.

D. Detailed Project Work Plan

Please see Appendix II(F) for a sample SOW 6 Dental Capitation Rate Setting detailed project work plan and capitation rate finalization.

E. Deliverables and Due Dates

Please see Appendix II(F) for deliverables and due dates associated with Dental Capitation Rate Setting and rate finalization. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department.

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SOW 7-Dental Capitation
Rate Rebasing

SOW 7 – Dental Capitation Rate Rebasing

When performing Dental capitation rate rebasing, the same methodology for typical capitation rate setting applies as described within the SOW 6 subsection beginning on page 197. However, the rebasing process is unique in that it includes an analysis of updated data and adjustment to trends as well as a reevaluation of applicable program and policy changes that apply to the updated base data time period. Outside of these main components, the majority of rate development considerations and methodologies remain consistent between standard capitation rate setting and capitation rate rebasing.

A. Understanding of the Project Requirements

Optumas specifically applies all ASOP criteria in the development of the methodology for the Dental rate rebasing and also ensures that all considerations included in the latest Medicaid Managed Care Rate Development Guide published by CMS are followed.

Optumas has performed numerous capitation rate rebasing projects in over 20 states for which we have developed Medicaid Managed Care capitation rates and understands the dental capitation rate rebasing project requirements described on page 29 of the RFP. Within Nebraska alone, we have most recently performed rate rebasing exercises for the Dental Benefit Managed Care program's SFY19 rates.

B. Proposed Development Approach

Within this section of our RFP response we will discuss items a through g as outlined under "J. SOW 7 – Dental Capitation Rate Rebasing" on page 29 of the RFP.

a. Analyze different types of rate methodologies and models used by governmental and commercial entities upon request;

Including its work in Nebraska, **Optumas** has experience developing capitation rates for programs covering dental services in 10 states. As a result, **Optumas** has broad experience with different types of models and program design structure from which to draw ideas from when analyzing different rate methodologies and models. Two specific examples of state Medicaid clients that **Optumas** has assisted in developing new dental rate setting methodologies and rate rebasing activities are described below:

<u>**Arkansas:**</u>

Optumas worked with the State of Arkansas in rebasing capitation rates for the dental managed care program effective for CY18. **Optumas** worked with the State to develop capitation rates for the two dental vendors operating under the Dental Managed Care Program. One of the first decision points was determining which data would serve as the best source of base data for the program. Given that CY18 reflected the first year of managed care for dental services, two years of detailed FFS claims data and enrollment data (CY15 and CY16) were used as the base data.

Once the base data was established, **Optumas** conducted regional analyses to understand if significant differences in utilization and mix of services in various regions warranted rates being developed on a regional basis. Upon review of this analysis, it was determined that three separate regions were appropriate for rating purposes, due to the differences in underlying

costs between the three regions. A key contributor to this decision is the fact that there are two MCOs operating in this program; the uncertainty about the distribution of enrollment by region that would ensue in the contract period further opened the door for potential mix risk between MCOs.

An additional component of the rate development process was consideration for managed care savings. **Optumas** worked with its internal clinician, the State, and the prospective dental MCOs to determine which types of services may be impacted by the transition from FFS to managed care. This process resulted in an adjustment to reflect lower anticipated utilization of diagnostic and restorative services and an increase in preventive services due to changes in member outreach and management. The aggregate result of this adjustment reflected an expected overall reduction in dental service costs relative to FFS by transitioning to managed care.

Iowa:

Optumas has recently worked with the State of Iowa in developing and rebasing its capitation rates for its Dental Wellness Plan, the managed care program in place to provide dental services to Iowa's adult Medicaid population. **Optumas** began serving as Iowa's actuarial vendor in January 2018 and first developed capitation rates for its dental program for the SFY19 contract period.

The members eligible under Medicaid Expansion (referred to as the Wellness Plan population) have received dental services through managed care since SFY17, but non-Expansion adults did not begin receiving dental services through managed care until SFY18. Therefore, **Optumas** worked with the State to develop a SFY17 base data set comprised of a mix of FFS and Managed Care experience.

As a result of using SFY17 data there were two key program changes that needed to be considered when developing rates for SFY19:

1. **Data Re-Pricing** – Prior to SFY18, the reimbursement for dental services provided to Expansion members was paid at an enhanced fee schedule near commercial reimbursement levels. A policy change was made to reimburse all services provided for adult Medicaid beneficiaries at 101% of the Medicaid fee schedule. **Optumas** worked with the State and the dental plans to first ensure an accurate understanding of the historical reimbursement levels and second to review the impact to the base data of re-pricing the historical experience to 101% of Medicaid FFS.
2. **Annual Benefit Limit** – Iowa implemented a $1,000 annual benefit maximum for adult Medicaid enrollees for the first time effective for the SFY19 contract period. Certain dental services are excluded from accumulation towards this maximum, including preventive and diagnostic services. **Optumas** worked with the State to clearly identify which services are excluded from the annual maximum and then developed an adjustment to estimate the impact that moving from no limit to a $1,000 limit is expected to have on total dental service costs. In addition to determining specific services excluded from the maximum, consideration was given to the fact that there is a possibility that other services may receive prior authorizations and therefore cause members to exceed the $1,000 maximum in extenuating circumstances.

Given the significant impact that these two changes had on the projected costs included within the capitation rate development, multiple discussions were had between **Optumas** and the State, but also with each of the dental MCOs (via on-site meetings and conference calls). These discussions addressed specific policy to ensure that all parties were clearly aware of the changes being made and also addressed in detail, the analyses conducted to develop the impact of each program change.

In addition to the policy changes noted above, when **Optumas** began developing rates for Iowa, the two dental MCOs that were and are operating within the dental program had concerns regarding the prior capitation rates not matching the experience for either plan; one plan was experiencing costs significantly higher than projected, while the other was significantly lower. **Optumas** and the State worked with the plans to hear their concerns and begin discussion around potential resolutions. While rationale for the differences in experience between the two MCOs have been speculated upon thus far, definitive causes for the differences in experience are still being analyzed. Given the limited emerging experience available at the time of the SFY19 rate development process, a risk corridor has been put in place to mitigate the risk to both the State and the MCOs. This approach has been taken as a half measure to address the immediate concerns, with the intent to further analyze the cause for the differences and to determine whether these differences will continue to occur long-term, once the program becomes more mature.

> ***Optumas** has experience developing risk corridors and other risk mitigation strategies for managed care programs.*

In both of these client examples, the key to a successful rate development process has been a deep understanding of each program and the open lines of communication with the State and its MCOs. **Optumas** looks forward to continuing to bring our broad experience in dental rate setting as well as our transparent and open approach to rate development, to assist the Department in future rate development processes and capitation rate rebasing cycles for its DBM program.

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/mid/low full risk capitation rates;

Consistent with the approach described in the detailed response to SOW 2 subsections beginning on page 143, **Optumas** works with each of its clients to determine which data is most appropriate for the capitation rates being developed, including which sources and years of data will be used. **Optumas** requests the most recent three years of data for each managed care program, to comply with the requirements of CMS' Medicaid and CHIP Managed Care Final Rule. However, there are valid reasons why using three years of data as the base data source is either not practical or simply does not make the most sense given recent changes to the service

> ***Optumas** thoroughly reviews and analyzes all available data sources and time periods to ensure the most appropriate data is used as the basis for rate development and rating adjustments.*

delivery system. For example, **Optumas** worked with the Department to determine the appropriate base data to be used for ratesetting for Nebraska's DBM for its first two contract periods (October 2017 – June 2018 and July 2018 – June 2019); in both cases, the most recent two years of data (which reflected FFS in both cases) was used. However, it is expected that once the rate development process for the SFY20 rates begins, approximately one full year of managed care experience will be available for use as the base data set. In this instance, it may be most appropriate to rely on only one year of managed care data to reflect the recent changes in delivery system, as opposed to utilizing multiple years of data that would result in mixing one or more years of FFS data and one year of managed care data. In general, the most common base data used for a mature managed care dental program is a combination of two to three years of the most recently available complete and accurate data. This includes historical enrollment and encounter data, combined with the use of either audited or unaudited financial statements for the same time period. **Optumas** works with each State to understand the processes available for data transfer, which typically includes data transfer through our Secure FTP site, or in some cases, a direct transfer of data via a secured, password protected, encrypted external hard drive.

After data is collected, **Optumas** conducts a series of standard data processing protocols to ensure that the data received matches what the Department transferred and that we are interpreting all data fields appropriately. The following steps are described in more detail in the response to SOW 2 in the subsections beginning on page 143, but are briefly listed below for reference. These steps are currently conducted in our work in Nebraska as part of the rate development process for both the Heritage Health rates and the DBM rates:

1. Data Importing
2. Control Total Checks
3. Frequency Workbooks
4. Review of Data Over Time
5. Review Data for Denied, Duplicate, Reversed, or Zero Paid Capitated Claims
6. Comparisons of Encounters to Financials

The steps above reflect the general process undertaken for data validation; however, additional review is often conducted based on the findings of the initial validation process. Given the importance of the validation phase, there are generally multiple touch-points and Q&A sessions between stakeholders to ensure that data is being interpreted correctly, and that questions are not left unanswered prior to capitation rate development and rate rebasing. Thus far in the DBM program, the data validation phase has consisted predominantly of discussion between the Department and **Optumas**, with data summaries based on FFS experience being provided to its DBM, MCNA. However, to the extent provided the opportunity, **Optumas** intends to work with the Department and its DBM in these discussions at a more detailed level. This will be important as the base data moves away from using FFS experience and shifts to encounter data experience based on managed care data.

As discussed in the Heritage Health rebasing section in SOW 2 beginning on page 146, CMS no longer allows for the submission of rate ranges. Despite this, **Optumas** develops a range of actuarially sound rates for the dental program that allows the Department to pick a target rate for DBM reimbursement. This target rate is then submitted to CMS for the contract approval.

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

As previously discussed, **Optumas** worked with the Department to determine the appropriate rating cohorts, as well as to determine whether differences in rates by region would be necessary for the initial DBM capitation rates. While the proposed rating cohort structure makes sense under the DBM program as it currently operates, **Optumas** believes that it is important to periodically review the appropriateness of the rating cohorts based on emerging experience. To the extent that emerging experience suggests that a significant risk is not appropriately being considered under the current age band construct then additional review will be conducted to determine if other criteria such as eligibility group, region, or gender needs to be considered.

Additionally, it is important to review the rating structure to the extent that significant changes are made to the program's construct. For example, if another DBM were to be added to the market, consideration would likely be needed to develop separate rating regions, and potentially separate rates based on other criteria, as this would open the door for potential population mix risk that is not currently a material issue.

Optumas' goal is to ensure that the capitation rates match payment to risk, balanced with being reasonably operationalized. We will work collaboratively with the Department to proactively identify emerging changes that may warrant a rating cohort restructure, as well as respond to feedback provided by the Department or its DBMs, to ensure that reasonable rate cell alternatives are considered and operationalized to the extent that they improve upon the current DBM program's rating structure, can reasonably be implemented, and further the goals of the Department's future initiatives.

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

As described in the response to the SOW 2 subsection beginning on page 151, **Optumas** ensures that the rate development methodologies it conducts comply with CMS guidance for the development of actuarially sound rates; we currently do so for the Department in the Heritage Health rate development and the DBM rate development. This is done by ensuring that applicable components of the CMS Final Rule are followed for each rate setting process, as well as by ensuring that the latest CMS Managed Care Guide appendix is included within the certification letter for each program and all relevant components of the guide are referenced in the certification letter. In addition, the actuarial certification letter is consistent with the communication standards discussed within ASOP 41 - Actuarial Communications.

As part of the rate setting process, **Optumas** ensures that policies related to provider reimbursement are accurately reflected within the development of the DBM program's rates. Since rates are developed using historical Nebraska Medicaid dental data, this data is generally consistent with the policy that will be in place in the contract period; however, there are instances when policies or reimbursement amounts (state-mandated or federal-mandated) change between the base period and the contract period, which need to be considered in rate development and rate rebasing. In Nebraska's DMB program, **Optumas** has recently worked with the Department to ensure the following considerations were addressed:

1. **Annual Benefit Maximum** – Historically, the Department had imposed a $1,000 annual dental benefit maximum for adults. Effective July 2017, this has been reduced to $750. Since the base data used to develop recent DBM rates reflected experience prior to July 2017, **Optumas** worked with the Department to evaluate the impact of this change from a capitation rate perspective, and implemented an adjustment to account for this in rate development to ensure that capitation rates accurately reflect current policy.
2. **Medicaid Fee Schedule Changes** – The Department periodically revises the reimbursement amounts for dental procedure codes on its Medicaid FFS Fee Schedule. **Optumas** works with the Department to ensure that the most recent reimbursement amounts for all procedure codes are used when developing capitation rates for the DBM program.
3. **Indian Health Service (IHS) Clinics** – Each year, the per-visit reimbursement rate for services provided at an IHS clinic is set by the Federal government, and generally increases each year. **Optumas** has worked with the Department to identify dental services provided at these clinics to ensure that the appropriate reimbursement amount is built into the capitation rates.
4. **University of Nebraska Medical Center (UNMC) – Optumas** has recently worked with the Department to develop a rating adjustment to reflect the minimum fee schedule in place for dental services provided by a UNMC-affiliated dentist. This arrangement has been approved by CMS as an approved payment initiative per 42 CFR 438.6(c), and **Optumas** works with the Department to ensure that the development of the estimated cost of this initiative is consistent with this regulation.

While the examples noted above reflect recent specific examples applicable to the Department's DBM program, **Optumas** works with the Department and each of its clients on an ongoing basis to understand all applicable reimbursement rules and regulations. This may include policies already in place such as those noted above or may include providing recommendations for changes in policy to better align with program goals. Additionally, this may include other contractual policies such as state-mandated risk corridors or profit caps/maximums, as well as medical loss ratio (MLR) requirements.

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;

As part of the DBM rate development under the current contract with the Department, **Optumas** has provided documentation and training similar to the Heritage Health rate development process, which is described in further detail in the response to SOW 2 in the subsection beginning on page 152.

Optumas initially worked with the Department to lay the groundwork for the new DBM program beginning in 2016. This consisted of developing the rating cohort structure for the program, as well as assisting with the RFP process for potential DBM vendors. **Optumas** conducted several analyses which were shared with the Department to ensure that the Department and future bidders were well educated on the rate development process.

One analysis conducted by **Optumas** and shared with the Department was a reimbursement analysis, which compared the historical reimbursement levels paid under Nebraska's dental FFS program with reimbursement levels using other state and commercial benchmarks. This was used as a tool to illustrate how Nebraska's FFS reimbursement compared to other Medicaid programs. This analysis was instrumental in assisting the Department in making decisions about potential future reimbursement changes under the DBM program.

Additionally, **Optumas** developed an analysis to review dental expenditures by age and region to assist in the development of rating cohorts for the DBM program. **Optumas** shared summaries of this analysis, along with recommendations for proposed rating cohorts for the DBM program, with the Department. This helped to ensure that the Department was well-informed of the underlying cost differences by population when determining rating cohorts.

Optumas looks forward to the opportunity to continue providing documentation and training to the Department as the DBM program matures, via in-person meetings, conference calls, Excel-based summaries, and relevant reports.

f. Provide an actuarial certification as to the soundness of the rates the contractor develops

As described in the response to SOW 2 in the subsection beginning on page 153, **Optumas** provides detailed substantiation as part of the rate certification in all programs. **Optumas** provides CMS/OACT additional models/summaries upon request in order to address various questions surrounding specific aspects of rate development. **Optumas** has an outstanding relationship and reputation with CMS/OACT due to the rate development work completed in various Medicaid programs, including Nebraska. **Optumas** has an open line of communication with the actuaries and policy members within CMS, which results in getting expedited resolutions to any issues identified during the rate development process.

The actuarial rate certification and documentation process is described in substantial detail under SOW 6.3. **Optumas** applies the same level of rigor and process for rate certification to capitation rate rebasing.

g. Prepare all presentation material, and attend and participate in DBM meetings as requested to promote approved recommendations.

Optumas will prepare all relevant presentation material and participate in all DBM meetings requested by the Department to promote approved recommendations and to share information surrounding any actuarial analyses as requested. As discussed further in the response to SOW 2 in the subsection beginning on page 153, **Optumas** has significant experience preparing presentation material and presenting to a broad array of stakeholders in Nebraska and other states.

During the rate setting process, **Optumas** conducts meetings with the Department to discuss and present various analyses and materials supporting the rate setting process. In addition to meetings with the Department, several meetings are coordinated with the DBM to review components of the rate setting process at interim points during the process. In preparation for

DBM meetings, **Optumas** first develops a version of relevant meeting materials that is presented to the Department. Once this is presented, discussed, and approved by the Department, these materials are typically provided to the DMB in advance of the meeting to ensure that adequate time is provided to review.

These meetings have recently included calls with the DBM to discuss impacts of an alternative payment arrangement for UNMC dental providers, as well as a meeting to discuss an in-depth review of the rate development process for the SFY19 rates. In both cases, live models were shared with the DBM to help facilitate the discussion and to ensure that the impact of various modeled scenarios and adjustments were clearly understood. Our frequent communication with the Department and its DBM enables all parties involved in rate development and rebasing to have a thorough understanding of the methodologies underlying the final capitation rates. This facilitates an effective process in completing the rates and getting them approved by CMS/OACT.

C. Technical Considerations

Certain technical considerations are important to consider when developing a capitation rate rebase for managed care dental programs. Two examples are described below:

Benefit Design Changes – Given the relative elective nature of certain dental services as compared with most other medical-related services, changes in benefit design can have a significant impact on costs. For example, an expansion of covered services, or an increase in annual benefit limit has the potential to significantly increase the costs of services due to both pent-up demand as well as member and provider behavior. It is important to recognize the potential member and provider behavior aspects that could influence costs, as opposed to developing purely empirical calculations to estimate changes in expected service utilization.

Impact of Delivery System Changes – A change in delivery system (most commonly moving from FFS to Managed Care) can have a significant impact on service utilization and overall costs for a dental program. It is important to recognize this when evaluating emerging experience for a program that has recently experienced a change in delivery system, to ensure that these changes do not in-and-of-themselves get interpreted as trend that should be projected into future contract periods. A change in delivery system could result in service cost increases or decreases depending upon the program. For example, an increase in dental service costs could be experienced to the extent that a dental MCO provides improved access to care relative to FFS, therefore resulting in increased utilization for preventive and other dental services. In contrast, an example of a cause for a decrease in dental service costs could be as a result of stricter prior authorization practices implemented by a dental MCO relative to FFS. As the Department's DBM program continues to mature, it will be important to analyze any significant changes in service utilization experienced as a result of the shift to managed care, to understand the impact of the DBM program on dental utilization under Nebraska's Medicaid program.

D. Detailed Project Work Plan

Please see Appendix II(F) for a sample SOW 7 Dental Capitation Rate Rebasing detailed project work plan.

E. Deliverables and Due Dates

Please see Appendix II(F) for deliverables and due dates associated with Dental Capitation Rate Rebasing. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department.

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SOW 8-Special Projects

SOW 8 – Special Projects

One of the most valuable services **Optumas** provides to our clients is ad-hoc consulting and work on Special Projects. This includes a wide array of work, from budget projections, legislative support, managed care efficiency analyses, and data processing system support. These tasks are invaluable to our clients because we are able to quickly and accurately respond to a wide array of client's needs. We are confident that we can provide stellar results on all Special Projects included in this RFP due to our detailed and nuanced understanding of the Department's program and delivery system.

A. Understanding of the Project Requirements

Since inception, **Optumas** has been leading our clients through complex and innovative health reform concepts and understands the unique nature of project requirements associated with special projects as described on page 29 of the RFP. Our work has included developing new waiver concepts for serving new populations or providing new services, Alternative Payment Models that group and pay for risk in more cost-effective manners, and clinically informed efficiency adjustments designed to reduce waste and inefficiency from the health care delivery system. **Optumas** approaches all of our projects and clients as a blank slate, building customized models, methodologies, and solutions for each client based on their needs. Whether the goal is program expansion, budgetary reductions, quality improvement, or any other change, we will be able to help guide the Department through the process with innovative approaches and detailed analytics.

*The **Optumas** Nebraska core team members are always up to speed on all aspects of the Nebraska Medicaid program so the Department can reach out to anyone for ad-hoc requests.*

Optumas has an established history of providing ad-hoc assistance to the Department and our other clients. We are always willing to go beyond the established scope of work to benefit our clients. As a smaller firm, we also have the flexibility to begin work immediately if approved by the Department. **Optumas'** flat team design allows for the Department to easily access team members. Additionally, **Optumas'** staffing approach of having each individual on the team be completely informed on all aspects of the Nebraska Medicaid program means that the Department does not have to wait for team members to get up to speed on whatever special request is made. For example, on the afternoon of May 11th, 2018, the Department reached out to **Optumas** requesting the final payment amount for the Health Insurance Provider Fee (HIPF) for CY14 through CY16 for each of the previously contracted MCOs. Even though some of the current team members were not staffed on the Department's project during the requested time periods, our organization and team structure allowed us to quickly locate the information the Department needed. We were able to provide all the necessary information within two hours of receiving the request.

B. Proposed Development Approach

Within this section of our RFP response we will discuss items a through d as outlined under "K. SOW 8 -- Special Projects (Optional)," on page 29 of the RFP.

Optumas and **MSLC** have the breadth and depth of resources available to assist Nebraska in any special projects as needed. For example, we have extensive experience providing managed care-

related services for state Medicaid agencies. We bring to this project the technical knowledge and skills we have amassed from our experience and work providing managed care program administration, oversight, and rate development. We approach each engagement with a proven framework that allows us to gain a full understanding of the performance, compliance, and financial reporting aspects of each contract, in addition to each individual state's goals and objectives.

As a way to show the types of projects we can be of assistance, we are providing an example of a potential project related to managed care services including implementation, managed care support, and encounter claim validation. While the information provided below is representative our approach to performing this type of work, our team is uniquely qualified to assist Nebraska with a breadth of special projects that may arise.

a. **Contractor will provide the Department with financial analysis and actuarial consultation to assist the Department in the Request for Proposal process as the Department implements new managed care programs;**

Optumas has a proven history of assisting the Department with implementation of new Managed Care programs. As the Department's actuarial consultants for the past five years, **Optumas** was directly involved with the transition from separate Physical Health and Behavioral Health managed care programs to the current Heritage Health integrated care program. Our assistance included both standard actuarial analytic support as well as policy guidance and other tasks that are not traditionally associated with actuarial firms.

Our standard actuarial support included providing dozens of summaries of Nebraska Medicaid experience to prospective bidders. The goal in providing these summaries was to help bidders understand the risks and reward opportunities of working in Nebraska, incentivize their involvement in the Department's proposed Heritage Health program, and create a competitive bidding environment ensuring that the Department had a wealth of qualified vendors to choose from during the evaluation period. Summaries provided by **Optumas** included:

- Expense and frequency of transplants,
- Historical cost by population,
- Program spend by service category,
- Eligibility category logic,
- Eligible member counts by county,
- Historical summaries of new populations,
- Projections of historical experience to the present day at relevant trend rates,
- Risk corridor and Medical Loss Ratio (MLR) application examples,
- Ranges of reasonable administrative loading prospective bidders could anticipate, and
- Pharmacy-specific summaries.

In addition to providing these deliverables, **Optumas** also presented at two bidder's conferences. **Optumas** walked all interested organizations through our work and coding logic and answered questions on-site. Additionally, vendors were allowed to submit follow-up questions, and **Optumas** responded in writing to over 400 questions.

We also held regular calls with the Department's staff that went beyond providing actuarial support for the RFP process. During these calls we discussed general concepts within the RFP as well as specific nuances that needed to be addressed or considered. **Optumas** wrote specific sections on the appropriate language regarding risk corridors and Medical Loss Ratio (MLR) thresholds, reviewed sections discussing withhold arrangements, and consulted on program design aspects to incentivize bidders. **Optumas'** work in the Heritage Health procurement process helped attract six prospective bidders, giving the Department many options when choosing the plans that could best serve the Nebraska Medicaid population.

***Optumas** assisted the Department with drafting language to include in the Heritage Health RFP and can assist in any new procurement processes should the Department decide to implement a new managed care program such as MLTSS.*

In addition to the experience that **Optumas** brings, the **MSLC** team has experience supporting states with procurement activities for various Medicaid contracts required to administer managed care programs, such as contracts for MCOs, enrollment brokers, ASOs, EQROs, and Credentialing Verification Organizations (CVOs). In the state of Georgia, for example, **MSLC's** team members assisted the State with the development of an MCO RFP and related contract, planning meetings with the state department responsible for procurements, responses to bidders' questions, design of the RFP evaluation tool, and subject matter expertise during the RFP evaluation process.

To support the Department with procurements for managed care programs, we are equipped to provide the following consulting services:

- Develop Requests for Information and analyze responses to provide recommendations on design and procurement requirements.
- Draft procurement materials and support contract development (e.g., MCOs, enrollment broker, EQRO, etc.).
- Develop RFPs and related procurement materials, including support for vendor contract development, such as MCO, EQRO, or CVO contracts.
- Develop proposal evaluation tools for reviewing and scoring vendor RFP responses.
- Assist with responses to bidders' questions during the RFP process.
- Support proposal evaluations as non-scoring subject matter experts.
- Support vendor contract negotiations.

To provide the consulting services described above, our team will collaborate with the Department, sister agencies involved in the procurement, and workgroups or committees charged with executing the procurements required for managed care programs.

b. Provide detailed analysis and develop recommendations for potential modifications, improvements or enhancements to existing managed care plans and programs, in compliance with current State statute and Federal requirements;

Optumas was founded as a strategic consulting firm specializing in health care reform and delivery system changes. We have assisted many clients with program modifications and enhancements, from setting up managed care program framework in Alabama to smaller-scale

Primary Care Case Management programs in Arkansas. We are very adept at thinking outside of the box, as illustrated by our development of a form of Medicaid Expansion that supported the commercial insurance market and was implemented in Arkansas. Specific to Nebraska, we helped develop the rating structure for Heritage Health, including the geographic rating regions, population groupings, and service categorizations. We have the national experience to bring Nebraska new concepts that have been tested as pilot programs elsewhere, as well as the Nebraska-specific experience to understand what ideas could complement Nebraska's Medicaid program.

Another Nebraska specific example is our work with the Department surrounding the proposed Legislative Bill (LB) 1032 in 2016. This bill would have created a Medicaid Expansion program utilizing the Health Insurance Exchange (HIX), Employer-sponsored Insurance (ESI), and the existing Medicaid managed care framework to increase Medicaid eligibility up to 138% of the Federal Poverty Level (FPL). The proposed legislation would have expanded Medicaid through three different programs:

1. Premium Assistance to purchase Qualified Health Plans (QHPs) on the HIX
2. Premium Assistance to subsidize the employee's share of ESI premiums
3. Medicaid managed care enrollment for individuals deemed to be Medically Frail

Optumas worked with the Department to develop a 10-year forecast of projected enrollment and expenditures associated with this initiative. As a result of our work and familiarity with the current Nebraska programs, we were able to incorporate Nebraska-specific Medicaid data. As a result of our national experience, we were also able to use publicly available survey data, QHP premiums, and experience with Medicaid Expansion in other states as part of the forecast development. While this bill was ultimately not passed, **Optumas** was able to provide the Department with a well-informed projection from which decisions could be made regarding the Department's desired policy direction.

In our discussions with the Department and based on our recent work with the Heritage Health program, there are two specific areas we suggest for programmatic changes. First is outpatient hospital reimbursement. For the past four years outpatient hospital cost growth has been an area of concern for both the Department and the contracted managed care plans. The current cost-to-charge ratio reimbursement methodology prevents the Department and the MCOs from exerting direct influence over provider payments. Based on this ongoing struggle, the Department is undertaking a transition to Enhanced Ambulatory Patient Grouping (EAPG) reimbursement for outpatient services. This transition has been delayed but is critical to make sure the Department and MCOs can evaluate and control outpatient expense growth.

A second key area for program modification is Pharmacy Benefit Manager (PBM) experience. PBMs have become increasingly important in Nebraska Medicaid with the recent movement of pharmacy services from a FFS delivery system to Heritage Health. Because of this recent increase in importance, PBM experience is not yet standardized across the state. PBM contracting varies widely across the contracted MCOs and could drive MCO profits or losses. This could lead to MCOs experiencing gains or losses under regional capitation rates simply because they are paying different amounts to PBMs for the same prescription. It would be beneficial for the Department to have contracting oversight in PBM reimbursement to ensure that Heritage Health rates are not inflated due to PBM contracting and profits. **Optumas** currently possesses all data necessary to support analyses regarding PBM contracting and reimbursement differences, and when requested can immediately provide the Department with summaries to investigate the PBM contracting differences within the Heritage Health program.

***Optumas**' current experience working with the Department has allowed us to identify areas of potential improvement or modification within the Heritage Health program for services such as pharmacy that are newly covered by Nebraska managed care.*

In addition to the programmatic changes noted above, **Optumas** is currently working with the Department on the development of a directed payment arrangement for its UNMC dental providers. The Department has historically made a supplemental payment to dental providers affiliated with UNMC to enhance the reimbursement for these services to commercial reimbursement levels. With the transition of dental services into managed care, effective October 1, 2017, this arrangement would be classified as a pass-through payment per the definition in the CMS Final Rule released in 2016. Under the Final Rule, new pass-through payment arrangements are not allowable if they were not included in managed care rates submitted on or before July 5, 2016. In order to limit program disruption and maintain a payment structure that provides supplemental reimbursement to UNMC affiliated providers under the managed care program, an alternative method will be required, such as the directed payment arrangement. **Optumas** has assisted the Department in developing hypothetical modeling for this arrangement, as well as answering CMS questions related to implementing such an arrangement in the capitation rates. The approval of this arrangement has broader implications, as it may serve as a mechanism that can be implemented in the Heritage Health program in the next few years.

Optumas has also assisted the Department in the development an updated methodology for reimbursing Federally Qualified Health Clinics (FQHCs). Effective January 2016, the Department implemented an updated reimbursement policy for its Medical FQHC encounters to begin reimbursing via an Alternative Payment Methodology (APM) approach. **Optumas** worked with the Department to develop the APM encounter rate for each FQHC; this consisted of collecting and interpreting three years of FQHC cost reports for each clinic and developing projected encounter rates applicable to the 2016 contract period. The Department has recently requested **Optumas** to re-base the current FQHC encounter rates and to develop new FQHC encounter rates specific to dental services, which are currently reimbursed on a FFS basis.

c. Participate in the annual review of performance evaluations of managed care plans and provide analysis and recommendations; and

Our team has extensive experience supporting states with Medicaid managed care program evaluation activities. In both Georgia and Nevada, for example, **MSLC** assisted with the onboarding of new and incumbent MCOs, provider and Medicaid beneficiary communications, Frequently Asked Questions, readiness reviews, Command Center operations during the initial go-live period, oversight of MCO corrective action plans, and dashboard development to monitor MCO performance.

To support the Department with implementation of new managed care contracts, our team stands ready to provide the following consulting services:

- **Vendor Readiness Reviews.** Prior to program go-live, our experienced team is able to support the Department with conducting readiness reviews of vendors to ensure a smooth transition during the implementation phase. The components of the readiness review are as described below:
    - Work collaboratively with the Department to identify relevant program components for review and assessment of the ability of contracted MCOs/health plans, or other contractors (e.g., enrollment broker) and associated subcontractors to provide services to Medicaid beneficiaries, appropriately reimburse providers, and comply with state and federal requirements. For example, the readiness review incorporates vendor/subcontractor on-site demonstrations assessing call center operations, reviews of system readiness for claim processing and timely and accurate provider payments, procedures for care coordination and transition of care, access to behavioral health services, transition of pharmacy benefit services, and health plan staffing. During the readiness review of an MCO, our team will:
        - Obtain, review, and assess relevant managed care plan policies, procedures, and guidelines to determine compliance with contractual requirements and relevant state and federal requirements.
        - Request and review the MCO's documented systems testing results, such as test cases for the configuration of claims system edits and audits, system capacity and stress testing, and disaster recovery plans and testing. The team will conduct electronic data interchange testing for submitting encounter claims after go-live.
        - Conduct an evaluation of provider network adequacy and availability.
    - Develop readiness review tools to evaluate vendors/subcontractors and track readiness risks and issues.
    - Prior to readiness reviews, convene meetings with the vendors/subcontractors to discuss the readiness review process, on-site reviews and required materials and access, readiness review reports, and the corrective action process.
    - Conduct desk and on-site readiness reviews of vendors/subcontractors and submit written reports to the Department regarding findings and suggested corrective actions.
    - Support the Department in monitoring progress and outcomes of MCO corrective actions prior to go-live.

- **CMS Readiness Reviews.** In support of CMS readiness reviews, our team offers to conduct an organizational assessment of the Department's readiness, make recommendations, and support implementation of required changes prior to a CMS readiness review assessment. Other readiness activities might include:
  - Participation in Department meetings with CMS and development of agendas, talking points, meeting facilitation, and completion of identified action items.
  - Work with the Department to identify the Department-specific concerns around implementation, such as organizational infrastructure, modifications to the state's Medicaid Management Information System, and managed care program policies.
  - Develop readiness review tool to assess the Department's readiness level and risks and issues.
  - Conduct desk and on-site readiness reviews of Department and submit written reports to the Department regarding findings and suggested corrective actions.
  - Support the Department in monitoring progress and outcomes of corrective actions prior to go-live.
- **Command Center Development and Support.** Our team will leverage our demonstrated experience in other states to design, implement, and staff a Command Center for the Department to support the initial 30-day go-live phase and stabilization of risks and issues. The Command Center involves oversight of the MCOs, tracking of issues and risks, facilitation of issue escalation, as needed, and development of dashboards to monitor key MCO performance metrics. As needed, our team can support the development of contingency plans and options in the event an MCO fails to meet performance requirements during the go-live phase.
- **Stakeholder Communications.** We offer to develop and execute a comprehensive communication plan directed at Department staff, sister agencies, MCOs, advocates, Medicaid beneficiaries, providers, legislators, the Governor's office, and other identified stakeholders.
- **Organizational Assessment.** We will support implementation of organization changes required to implement and support the managed care program. We will assist with development or amendment of existing policies and procedures and workflows.
- **Monitoring and Oversight.** We will develop and/or further define the monitoring and oversight infrastructure, including tools (e.g., reporting templates and dashboards), training of Department staff in monitoring and oversight responsibilities, and developing detailed monitoring schedules.

Conduct MCO Network Adequacy Studies:

Our team has the experience to assist the Department with refining network access requirements in compliance with federal mandates. We suggest conducting MCO compliance reviews and network adequacy studies to identify compliance with geographic access standards for specific health care provider types and supporting the development of corrective action plans to ensure MCO compliance.

Evaluation of MCO Contract Compliance:

Our team is at the forefront of helping states develop and implement strategies and tools to monitor and evaluate MCO contract compliance. Our contract compliance services are designed to help states ensure the managed care contractors are meeting all the required program and

performance requirements of their contracts. This includes utilization of financial-related audits, operational and performance audits, and risk assessments for Medicaid managed care programs. In addition to the encounter data validation services and MLR examinations referenced in this proposal, we offer the Department the following support related to MCO contract compliance activities.

- Develop comprehensive MCO risk assessments to identify contract and operational risks and provide the Department with a unique management tool to identify and monitor contract compliance concerns. We recommend conducting performance audits to address the service and business risk areas identified in the comprehensive risk assessments.
- Monitor MCO administrative costs to ensure only allowable costs are charged to the program.
- Review medical costs to ensure overpayments are not passed through to the Department.
- Monitor TPL payments and recoveries to ensure these are properly offset against costs.
- Conduct contract compliance reviews to ensure that health plans are operating in accordance with the contract with the Department. These reviews address internal controls and processes related to claims adjudication, prior authorizations, and provider credentialing.
- Conduct utilization management reviews to ensure Medicaid recipients have access to needed health care services.
- Review compliance with protocols for provider and Medicaid beneficiary complaints, appeals, and grievances.
- Develop detailed recommendations for process and contractual improvements and offer recommendations and action plans based on findings. This process might include recommendations to strengthen and clarify managed care contract language.

MSLC has hands-on experience, for example, helping Georgia, Mississippi, Nevada, New Mexico, and Texas develop the processes to effectively monitor contract compliance on an ongoing basis. Additionally, our team is able to highlight best practices and provide comparative information from other state Medicaid managed care health plans to assist the Department with identifying opportunities for improvement and documenting successes.

The information obtained through many of our analyses has enabled our state clients to make informed decisions to monitor compliance, evaluate performance, and safeguard against overpayment to managed care contractors. Another equally important component of the compliance monitoring process is to ensure members are able to access and receive needed services in a timely manner, as well as to ensure members are not improperly denied care.

Ongoing Managed Care Operations:
Our team has experience assisting states with ongoing managed care program operations and related consulting needs. In Georgia and Nevada, for example, **MSLC** provided ad-hoc training to Medicaid staff on monitoring and oversight protocols and tools, supported development of performance metrics and dashboards, and conducted assessments of current managed care contracts to identify opportunities to ensure compliance with federal mandates.

To support the Department with ongoing managed care operations, our team offers the following consulting services:

- Serve as the monitoring and oversight contractor.
- Conduct secret shopper calls and appointments for primary care and key provider specialties.
- Train new or current staff, as needed, including develop training materials.
- Conduct ad-hoc reviews as requested.
- Conduct ad-hoc analyses, such as those requested by the state legislature.
- Support ongoing contract amendments (e.g., to incorporate new regulations), and related analysis for programmatic changes.

In summary, **Optumas** and **MSLC** can provide comprehensive subject matter expertise and support with the full life cycle of managed care services from design to implementation to ongoing operations. Our extensive subject matter expertise, academic training, and years of experience working directly with public health care and social service programs, including firsthand experience working with Nebraska, provides us the ability to support Nebraska efficiently and effectively. Should the Department request managed care assistance, we stand ready to help determine the level of support we can provide based on the status of program operations and specified need.

d. Managed Care encounter validation activities.

Experience Monitoring and Reporting:
MSLC has extensive technical experience with the encounter data processes and claims adjudication systems for both large national, multi-line health plans and small, single market health plans. Our approach centers around analyzing Medicaid encounter data that has been submitted by the MCOs to the fiscal agent contractor (FAC), and performing a comparison of the encounters to financial information provided by each MCO, in order to ensure complete and accurate encounter data is being received. On our state clients' behalf, we work closely with these health plans to identify deficiencies and propose solutions that will result in high-quality and reliable encounter data being submitted and available to the Department to use to manage its Medicaid managed care program. We have developed a comprehensive and proven process for systematically obtaining health plan encounters and monitoring the health plan's compliance with regulatory and contractual requirements related to encounter data submission, evaluating the encounters to determine areas of concern, and assisting in the development of corrective strategies.

Encounter data serves as a leading tool for stakeholders to make informed decisions about medical management, care coordination, program integrity issues, quality improvement, financial and actuarial calculations, and performance evaluations. CMS has established formal encounter data validation requirements because many states did not maintain a complete and accurate encounter data set to be utilized for these purposes.

Methodology and Specifications:
MSLC will analyze the encounter data in comparison to financial documentation provided by the MCOs. This documentation will include the cost reports that are already submitted by the MCOs. Additional enhancements to this documentation will be provided through requested

MCO financial payment details in standardized monthly extracts. These monthly extract files are detailed listings of payments and recoupments made by the MCO and delegated vendors to providers for Medicaid services rendered. The current MCOs in Nebraska are familiar with the reconciliation process in multiple markets and are accustomed to providing this financial documentation. This comparison is typically performed by payment date (i.e., the date the service provider is paid by the MCO or its delegated vendor) and reporting is aggregated on payment month for a period agreed upon with the Department. We will provide the Department summary updates of this completion analysis on a monthly basis with quarterly reports provided with more detailed compliance feedback.

Encounter Data Validation:
Verifying the integrity of the MCO encounter data files first requires verifying the completeness of the encounter data. In determining the completeness of the encounter data, the Department's current contract with the MCOs states that "the error rate for encounter data cannot exceed one percent (1%)" within 59 from the end of the month that the encounter data was due. **MSLC** will consult with the Department to define a completion threshold (e.g., 99 percent complete for a payment period ending two months prior to the last encounter submission extract **MSLC** receives from the FAC). For the purpose of our reviews, the percentage completion will be validated by utilizing the cost reports and other financial reporting provided by the MCO and its subcontractors. We will perform an initial analysis to reconcile the MCO's financial documents to the encounter paid amounts to determine the completeness of the encounter data which the MCOs submit to the Department.

MSLC will use two reporting mechanisms to communicate encounter data completeness to the Department. These two sets of reports, monthly and quarterly, will provide the Department will further transparency of the MCO's encounter submission performance.

Monthly Reporting:
The monthly report will summarize the encounter data completeness for encounter submissions through the prior month. We will perform monthly encounter data analyses and provide the Department with a status of the encounter submissions. The summarization will outline the encounter data completeness per month, and in aggregate, for the MCO and its delegated vendors. This monthly transparency will allow the Department and the MCOs to identify risk areas and potential encounter data submission issues (e.g., months with missing encounters when compared to the financial data).

Quarterly Reporting:
The quarterly report will be provided to detail the encounter data completion, utilization, and data issues noted from the most recently completed state fiscal year quarter. We will perform an encounter analyses quarterly and provide the Department with a detailed report of the encounter data completeness and potential issues noted in the data. We will analyze for potential duplicate encounter records and incorporate feedback solicited from the MCO.

Alternative Reporting Methods:
MSLC will provide the Department with an online portal, or other agreed-upon tool, with summaries of encounter data information in aggregate. This tool will allow the Department to summarize the encounter data based on agreed-upon data elements (e.g., claim types, categories of service, and rate cells) and provide some trend analysis. The portal will allow users, identified by the Department, to log in to view the aggregated data and modify the criteria for the summaries. We will work with the Department to provide reporting that meets its needs through the addition of data elements, visualizations of summaries, and new reports. Reports will be made available through the online portal while excluding and safeguarding protected health information. Furthermore, we will ensure this tool will be flexible so it meets the needs of the Department and allows for additional reporting throughout the contract period, as needed. Additional options to include public segments of the portal may be available for other reporting or documentation, if requested by the Department.

If the Department wishes public reporting portals may be created so MCOs, legislators, or the Nebraska community may review and gain insight into the Medicaid delivery system and operations.

C. Technical Considerations

An additional Special Project that **Optumas** is in a unique position to implement is PROMETHEUS Analytics. As previously discussed, PROMETHEUS is an industry-standard episode of care grouper developed by its founders under a grant from the Robert Wood Johnson Foundation. In our work reviewing this tool's output and applying it to actuarial analysis, **Optumas** has developed multiple ways to improve the efficiency of health care delivery systems and continues to develop new applications of this powerful tool.

PROMETHEUS has been under discussion in Nebraska for over a year, building toward the application of PROMETHEUS to managed care rates in CY19. The concept behind the deployment of PROMETHEUS is that PACs can be reduced by MCOs via more active and targeted care management. The result of applying PROMETHEUS to the managed care program is a reduction in the capitation rates the Department pays to MCOs, as well as activity in the provider community to achieve better outcomes for individuals. This application option was chosen after multiple brainstorming discussions between the Department and **Optumas** to determine which potential use of PROMETHEUS best aligned with the Departments goals. Figure VI.A.3.xxiv below shows a deliverable created for the Department summarizing a few potential uses of PROMETHEUS in the Heritage Health programs:

Figure VI.A.3.xxiv – PROMETHEUS Application Options

Potential Applications of Prometheus		
Name	Timing	Description
Efficiency Adjustment	Prospective, during regular rate setting period. • Likely could be done for several rate periods beginning with the CY19 rates	Optumas can determine the portion of costs associated with Potentially Avoidable Complications (PACs) that could reasonably be eliminated from the healthcare system by increased provider and health plan efficiency. This amount would be removed from the rate setting base data.
Gain Augmentation	Prospective, during regular rate setting period. • Pending further discussion and analysis could be done beginning with the CY19 rates	The cost associated with PACs in the pre-Heritage Health period would be compared to the cos associated with PACs in the most recent available Heritage Health data. A portion of the reduction in PAC costs would be shared with the MCO via an increase to the Profit/Risk/Contingency margin. The other portion of the reduction in PAC costs would be stat savings via cost avoidance in the base data. This has appeal as we aim to reduce the 1% Risk/Contingency margin, since we can pursue stat savings, slowly reduce the 1% load, all while incentivizing the MCOs to better manage their population.
Withhold	Retrospective, after rate period ends and allowing for sufficient runout • Calculation for CY19 rates would likely begin 9 months after the end of CY19, leading to a payment for CY19 experience in late-CY20 or early-CY21	This approach would incorporate Prometheus and each MCO's performance reducing costs associated with PACs in determining what portion of the withhold is paid back to the MCOs. Th state can determine how much of the withhold is tied to PAC reductions.
Incentive	Retrospective, after rate period ends and allowing for sufficient runout • Calculation for CY19 rates would likely begin 9 months after the end of CY19, leading to a payment for CY19 experience in late-CY20 or early-CY21	This is similar to the withhold, but rather than tying Prometheus to the existing withhold this would develop a new incentive payment to be paid retrospectively pending performance reducing costs associated with PACs. While this would represent a new payment to MCOs, it could be developed in a way that is cost neutral or benefits the State (e.g. a 1% reduction in costs associated with PACs results in an incentive payment of less than 1%).
Episode Bundled Payments	Prospective, but would require a change to capitation rate cells and rate development methodology. Pending contractual obligations with MCOs this might not be able to be implemented until later.	Optumas could develop capitation rates based on Prometheus-defined episodes of care. Members for selected chronic episodes would be carved out of their traditional rate cell and placed in to a rate cell specific to each episode. Rates would be developed excluding a portion of costs associated with PACs, achieving savings for the state. In addition to achieving savings b removing costs associated with PACs, this could address MCO concerns about the distribution c chronic members across health plans. This would require major operational changes so it migh not be feasible.

Even though the Department has selected the method for initially applying PROMETHEUS, there is significant flexibility moving forward. The Department can continue on the path of managed care efficiency adjustments until the PAC rate reaches an acceptable level. At this time, the Department may choose to shift the focus of PROMETHEUS to provider evaluation. In Colorado, **Optumas** is using output from Prometheus to develop hospital report cards, where each facility is evaluated on its efficiency, outcomes, and costs. This concept can be expanded to include more provider types. For example, the Department could evaluate their primary care physicians based on their ability to avoid PACs for their chronic patients and develop a shared savings/incentive/withhold structure accordingly. The PROMETHEUS tool is continually begin refined, and the potential applications are growing continuously due to the value behind rigorous clinical analysis at the detailed claims data.

Separate from PROMETHEUS, **Optumas** and **MSLC** have additional experience with technical assistance support that we can provide, ranging from implementing new MCOs, design and administration of Medicaid managed care programs, and compliance monitoring and oversight of MCO performance. Our team has considerable expertise in all aspects of managed care program design, delivery system transformation, communication, planning, implementation of managed care programs, as well as MCOs, monitoring and oversight, and financial reconciliations. The following provides examples of our consulting services and experience with managed care programs, MCOs, and monitoring and oversight. Our highly experienced team is uniquely positioned to help Nebraska with projects such as those outlined below.

Managed Care Program Design:

Our team has extensive experience supporting Medicaid clients in the implementation of new or revised managed care delivery models. In the state of Nevada, for example, **MSLC** assisted the State

in the design, development, and implementation of the Certified Community Behavioral Health Clinics model that impacted the delivery of behavioral health services to target populations. The project involved comprehensive stakeholder engagement, detailed communication plans, technical assistance to providers, input on MCO contract revisions, development of a prospective payment system methodology, stakeholder education, and reporting to federal agencies. Should Nebraska determine the need to implement program design changes, we stand ready to provide the following consulting services:

- Convene meetings with the Department's thought leaders to confirm goals, objectives, timelines, and key stakeholders.
- Research (including state surveys) and analyze potential reforms and develop program options and analyses including key considerations for program design.
- Review existing Medicaid programs for duplication or consideration of incorporation into the managed care model.
- Facilitate workgroups and support program design development. If needed, we can assist in the creation of workgroups or committees and charters to support the program design process. Examples of program design focus areas might include:
  - Incorporation of new services into an existing managed care model.
  - Analysis of financing and payment model options.
  - Identification of required changes to existing support contracts (e.g., health plans, enrollment broker, etc.).
  - Analysis and incorporation of new federal regulations (e.g., determination of network adequacy requirements).
  - Identification and implementation of administrative efficiencies to reduce provider abrasion.
- Conduct an organizational assessment and identify internal Department processes and opportunities to better support the program design.
- Review federal and state regulations to support program design discussions and to identify challenges and potential barriers.

Federal Authorities:
Our team has significant experience in assisting states with new or revised managed care models that require federal authorities. For example, we have experience providing support in New Hampshire, New Jersey, Texas, and Washington State with their 1115 demonstration initiatives and managed care programs.

To support our clients with obtaining required federal authorities, we offer the Department consulting services such as the following:

- Arm state leadership and staff with detailed analysis of permissible authorities for managed care models, particularly providing information about which program design features require an 1115 demonstration, 1915(b) Waiver, or SPA. For example, we will provide support in understanding of requirements should the Department decide to apply for a comprehensive 1115 demonstration to combine existing 1915(c) Waivers.
- Develop program concept papers as needed.
- Recommend when support from a CMS State Technical Assistance Team may be beneficial.
- Support state meetings with CMS throughout the program design process and negotiations. Support might include development of agendas and other meeting materials, talking points,

meeting facilitation, further research and analysis, and completion of identified action items.
- Draft required federal documents, including waivers and SPAs.
- Support required public input processes, such as the public comment period for 1115 demonstrations and public notice for SPAs.
- Support negotiations with CMS and ongoing updates to finalize program and federal documents required for approval.
- Support reporting to CMS as needed (e.g., if 1115 demonstration reporting).

D. Detailed Project Work Plan

Please see Appendix II(G) for a sample SOW 8 Special Projects detailed project workplan regarding the application of PROMETHEUS.

E. Deliverables and Due Dates

Please see Appendix II(G) for deliverables and due dates associated with the Special Project application of PROMETHEUS. The deliverables and due dates should be considered illustrative and will be finalized upon contract award and feedback from the Department.

Appendices

Appendices

The following figure, labelled as Appendix Crosswalk, contains a description of each Appendix provided as part of this response. It includes a brief summary of the Appendix contents and a page reference where the Appendix begins.

Appendix Crosswalk

Appendix Title	Description
Appendix I	Appendix I contains resumes for each of the **Optumas** and **MSLC** team members proposed to work on this contract. As stated in the Company Overview section, each firm has significant additional resources that can be added to the project if required. This Appendix also includes the credentials for **Optumas'** actuaries. Appendix I begins on page 245.
Appendix II	Appendix II contains project workplans for each SOW required by the RFP. Project workplans are considered placeholder documents, and **Optumas** proposes to finalize these work plans with the Department prior to beginning each project. Appendix II begins on page 287.
Appendix III	Appendix III contains the banking reference required by page 32 of the RFP. Appendix III begins on page 295.
Appendix IV	Appendix IV contains key deliverables and sample work products that have been produced by **Optumas** for the Department and our other clients. We wanted to give the evaluation committee the opportunity to envision what it is like to work with us, and providing sample exhibits, deliverables, and project management tools allows for further demonstration that we are the ideal choice to continue as the Department's actuarial consultants. Appendix IV begins on page 297.

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Appendix I-Resumes/Actuarial Credentials

Appendix I – Resumes and Actuarial Credentials

Appendix I(A) – Resumes

STEVE SCHRAMM, MScHE

Mr. Schramm has over 30 years of experience in the public health arena. He founded **Optumas** to be a leader in the health strategy and reform market, and actively pursues new opportunities to implement cutting edge healthcare initiatives. He also assists with development of models to generate rates and budgetary estimates for health care reform, uninsured initiatives, and expansion programs to inform health care program development, expansion, reform, and evaluation.

Mr. Schramm has assisted in designing and utilizing actuarially sound capitation rate-setting methodologies for a variety of health care providers serving publicly-funded populations and specializes in providing program, strategy and operational consulting services. He currently serves as the lead strategist for **Optumas** in the states of Alabama, Arkansas, Colorado, Iowa, Kansas, Maryland, Nebraska, North Dakota, and Oregon. Mr. Schramm reviews the calculations of various benefits and program changes including testing them for reasonableness and evaluates and compares various program criteria and rate assumptions. Mr. Schramm oversees the capitation rate development and supports stakeholder communication efforts by presenting actuarial results in a way that can be understood by both experts and laymen.

Mr. Schramm has also done work in Arizona, California, Colorado, Hawaii, Kentucky, Louisiana, Maine, Massachusetts, Missouri, Montana, New Hampshire, New Mexico, New Jersey, New York, North Carolina, Rhode Island, Ohio, Oregon, Pennsylvania, Tennessee, and Vermont. The projects in these states spanned all types of populations as well as benefits. The types of projects included developing actuarially sound rates and rate ranges, 1915 and 1115 Waiver assistance, developing per capita expenditure models, preparing costs and savings estimates for Medicaid expansion populations, and health care reform.

Steve Schramm, MScHE

Managing Director, Optumas

Education

B.S. Economics, Arizona State University

M.Sc. Health Economics London School of Economics

Experience

30 years professional experience

Core Competencies

Medicaid program strategy

Expert witness testimony

Public meeting facilitation

Cutting edge program design and implementation

Rate presentations and negotiations

Risk mitigation strategy, social determinants of risk, waiver design and negotiation, and CMS/MCO messaging

Mr. Schramm has overseen capitation rate development in over 20 states and has been on the cutting edge of health care reform projects. He helped set up the Low Income Health Program in California and was instrumental behind the design and implementation of Arkansas' Private Option Medicaid Expansion program. Mr. Schramm has an innovative and creative mind, capable of keeping his clients ahead of the health care curve.

Reference State	Address of Reference	Name of Contact	Contact Information
Kansas	State of Kansas Kansas Department of Health and the Environment 900 SW Jackson Street, 900 N Topeka, KS 66612	Jon Hamdorf, Medicaid Director	Jonathan.Hamdorf@ks.gov P: 785.296.7851
Iowa	Iowa Department of Human Services Iowa Medicaid Enterprise 100 Army Post Rd Des Moines, IA 50315	Michael Randol, Medicaid Director	mrandol@dhs.state.ia.us P: 515.256.4640
Alabama	Alabama Medicaid Agency 501 Dexter Avenue Montgomery, AL 36103	Kathy Hall, Deputy Commissioner, Program Administration	kathy.hall@medicaid.alabama.gov P: 334.242.5007

TIM DOYLE, FSA, MAAA

Tim Doyle, FSA, MAAA

Senior Actuary, Optumas

Education

B.A. Mathematics, Moorhead State University

Experience

18 years professional experience

Core Competencies

Total Cost of Care development

Rate presentations and negotiations

Actuarial analytics, including acuity and durational analyses, risk adjustment, efficiency analyses and episodes of care analytics, and modeling risk sharing mechanisms

Mr. Doyle has over 18 years of experience consulting actuary and specializes in providing program, strategy and operational consulting services. He currently serves as the senior actuary for the states of Alabama, Arkansas, Kansas, Maryland, and North Dakota, overseeing the capitation rate development and also supporting stakeholder communication efforts by presenting actuarial results in a way that can be understood by both experts and laymen.

Mr. Doyle has also done work in Arizona, California, Colorado, Louisiana, Maine, New Hampshire, New Mexico, New York, North Carolina, Oregon, and Pennsylvania. The projects in these states spanned all types of populations (e.g., TANF, Pregnant Women, CHIP, General Assistance, ABD, Developmentally Disabled, PACE, long-term care, and Medicaid Expansion) as well as benefits (acute, ambulatory, long-term care, home and community based, mental health, substance abuse, dental, transportation, and pharmacy). The types of projects included developing actuarially sound rates and rate ranges, 1915 and 1115 Waiver assistance, developing per capita expenditure models, preparing costs and savings estimates for Medicaid expansion populations, and health care reform.

Specific to Nebraska, Mr. Doyle worked on the Behavioral Health program since 2013 as the certifying actuary, until that program transitioned to Heritage Health. He works as a sounding board to the Heritage Health team to make sure that rates are set in an actuarially sound manner. This involves discussion with the broader team as well as one-on-one actuarial discussions with Barry. He also provides assistance with the 1915(b) Waiver.

To ensure that our clients are efficient purchasers of health care, Mr. Doyle is interested in tools that can identify gaps in care or management, make judgements on the appropriateness of care at many different levels, and identifies things like patient safety failures and hospital acquired conditions. One of the tools that he uses on behalf of various clients is Prometheus. The Prometheus tool identifies episodes of care and distinguishes the episodes into typical and routine services versus those associated with Potentially Avoidable Complications (PACs), Low Value Care (LVC), and Network Efficiency/Effectiveness (NEE). Results of the tool can be used in a variety of ways, including an explicit adjustment to the base data used to set capitation rates, varying the profit load in the capitation rates, and incentive pools.

Prior to joining **Optumas** in 2011, Mr. Doyle was a Principal for Mercer, where he served as senior actuary for their government practice.

We encourage you to contact Mr. Doyle's references to hear directly from them about his Medicaid consulting abilities:

Reference State	Address of Reference	Name of Contact	Contact Information
Kansas	State of Kansas Kansas Department of Health and the Environment 900 SW Jackson Street, 900 N Topeka, KS 66612	Jon Hamdorf, Medicaid Director	Jonathan.Hamdorf@ks.gov P: 785.296.7851
Maryland	The Hilltop institute University of Maryland Baltimore County 1000 Hilltop Circle, Sondheim Hall, 3rd Floor Baltimore, MD 21250	Duane Glossner, Director of Rate Setting	dglossner@hilltop.umbc.edu P: 410.455.1430
North Dakota	Division of Medical Services North Dakota Department of Human Services 600 E. Boulevard Avenue, Department 325 Bismarck, ND 58505-0250	Erik Elkins, Medical Services Division Assistant Director	eelkins@nd.gov P: 701.328.2246

BARRY JORDAN, ASA, MAAA

Barry Jordan, ASA, MAAA

Actuary, Optumas

Education

B.S. Mathematics, Northern Arizona University

Experience

Six years

Core Competencies

Total Cost of Care development

Client/stakeholder communication and rate presentation

Actuarial analytics including PROMETHEUS, risk adjustment, and reimbursement analyses

Mr. Jordan is an Associate of the Society of Actuaries (ASA), and a Member of the American Academy of Actuaries (MAAA) and has six years of experience working with **Optumas,** currently as a Consulting Actuary. He has actuarial experience with healthcare work (Medicaid, Medicare, Exchange) in 12 states and has certified Managed Care rates for various state Medicaid programs' Physical Health, Behavioral Health, and Integrated Care programs, as well as PACE UPLs.

Mr. Jordan has worked with a variety State Medicaid programs. This includes development of Managed Care capitation rates, Medicaid rate review (including MLTSS), savings projections related to State Innovation Model (SIM) initiatives for Dual Eligible initiatives including LTSS, State Medicaid program-wide projections, development of Medicare Advantage and Health Insurance Exchange bids, and stakeholder communication.

Within each of these actuarial projects, he has directly conducted or overseen the development of various healthcare analytics and use of commonly-used industry tools. This includes detailed data analytics such as analyzing fee-for-service and encounter data, reviewing and analyzing MCO financial statements, development of trend forecasts, and estimating the impact of programmatic/policy changes. This also includes the use of health-based risk adjustment, developing assumptions related to LTC/Waiver mix for LTSS programs, reimbursement analyses, and efficiency analyses within the Medicaid rate setting context. Specific tools that he has experience with are the UCSD CDPS, CDPS+Rx, and Medicaid Rx risk adjustment models, as well as PROMETHEUS analytics.

Mr. Jordan has experience communicating at various levels to clients and stakeholders. This often includes strategizing with clients via daily/ weekly touch-points and collaborating with other stakeholders such as MCO actuarial and finance teams. He has experience communicating the results of analytics and rate development to Medicaid Directors, MCO Actuaries, and MCO Executives via presentation and written methodology reports. His experience also includes presentations to members at Legislative Hearings.

Mr. Jordan has worked with the Department on various programs within the State of Nebraska since 2013. He began his work with the Department during the stand-alone Physical Health program and served as an actuarial analyst and consultant on the **Optumas** team that developed the Physical Health rates. Currently, he is the certifying actuary for the Department's Heritage Health and Dental Benefit Manager (DBM) programs. As part of this role, he oversees all project management, data validation and analytics, development of actuarial rating adjustments, as well as communication with the Department and the MCOs.

For the Heritage Health program, Mr. Jordan oversees the development of actuarially sound rates for the three MCOs that provide care within the program. He has leveraged his experience in other states in developing methodologies related to rate setting. In particular, he led the strategy and development of the current risk adjustment process that is in place within the program. Additionally, he is responsible for overseeing and developing strategy around the use of PROMETHEUS analytics within the Heritage Health program, to review opportunities for additional efficiency within the program.

For the DBM program, Mr. Jordan also oversees the development of actuarially sound rates for the DBM that operates in the program. He recently worked with the Department to incorporate a new qualified minimum fee schedule directed payment approach for its UNMC providers.

We encourage you to contact Mr. Jordan's references to hear directly from them about this Medicaid consulting abilities, ability to communicate results to managed care plans and state legislatures, Medicaid staff, and position his clients for success with strategic rate development methodologies:

Reference State	Address of Reference	Name of Contact	Contact Information
Colorado	State of Colorado Department of Health Care Policy and Financing Finance Office/Payment Reform Section 1570 Grant Street Denver, CO 80203	Shane Mofford, Rates and Payment Reform Section Manager	Shane.mofford@state.co.us P: 303.866.6742
Ohio	Joint Medicaid Oversight Committee of the Ohio Legislature 77 S. High Street, Concourse Level Columbus, OH 43215	Susan Ackerman Executive Director	Susan.Ackerman@jmoc.state.oh.us P: 614.644.2016
Nebraska	Nebraska Department of Health and Human Services 301 Centennial Mall South, Lincoln, Nebraska 68509	Jeremy Brunssen Deputy Director of Finance and Program Integrity	Jeremy.brunssen@nebraska.gov P: 402.471.3046

ZACH ATERS, ASA, MAAA

Zachary Aters, ASA, MAAA

Senior Actuary, Optumas

Education

B.A. Mathematics, Indiana University Southeast

Experience

19 years professional experience

Core Competencies

Thorough understanding of actuarial methods

Actuarial Rate Development

Client and Stakeholder communication

Traditional and creative approaches to risk adjustment

Efficiency analyses using PROMETHEUS analytics

Mr. Aters has over 19 years of experience developing capitation rates, assessing risk and providing strategy consulting within Medicaid managed care programs. Mr. Aters currently serves as the senior actuary and project manager for the states of Colorado, Iowa and Oregon, leading the various teams in actuarial sound rate development as well as assisting the clients with developing healthcare strategy and exploring creative approaches to risk evaluation that promote healthcare transformation.

In addition to the current clients mentioned above, Mr. Aters has worked on a variety of engagements throughout his career spanning the Medicaid arena, Medicare program, and the Commercial arena. He has served as lead actuary on various exchange rate setting projects across three states as well as filing Medicare rates and working with CMS to assist in reviewing Medicare rate filings across the nation. Over the last decade, Mr. Aters has assisted states such as New Mexico, Kansas, Nebraska, Oregon, Iowa, Delaware, California, Arkansas, North Dakota, Ohio, Maryland, and Colorado in evaluating the risk of their Medicaid programs.

Mr. Aters' experience encompasses Behavioral Health programs, Physical Health programs, MLTSS programs, PACE programs, and multiple Integrated Care programs. Mr. Aters has significant experience with MLTSS, including working with Kansas and Iowa MLTSS programs at **Optumas** and multiple other MLTSS programs at previous employers (including New Mexico and Delaware).

Mr. Aters has extensive management experience that allows him to successfully lead internal and external teams in a manner that creates synergies between all stakeholders and encourages creative approaches to address modern day healthcare issues.

Specific to Nebraska, Mr. Aters worked on the Physical Health program since 2013 as the certifying actuary, until that program transitioned to Heritage Health. Since then, he has provided assistance to the Heritage Health team to make sure that rates are set in an actuarially sound manner, consisting of discussion with the broader team as well as one-on-one actuarial discussions with Mr. Jordan.

Mr. Aters excels at effective communication, explaining complex analyses using large data extracts to all types of stakeholders including CMS, Legislature, State leadership, and MCOs.

We encourage you to contact Mr. Aters' references to hear directly from them about his Medicaid consulting abilities:

Reference State	Address of Reference	Name of Contact	Contact Information
Colorado	State of Colorado Department of Health Care Policy and Financing Finance Office/Payment Reform Section 1570 Grant Street Denver, CO 80203	Shane Mofford, Rates and Payment Reform Section Manager	Shane.mofford@state.co.us P: 303.866.6742
Iowa	Iowa Department of Human Services Iowa Medicaid Enterprise 100 Army Post Road Des Moines, IA 50315	Michael Randol Medicaid Director	Mrandol@dhs.state.ia.us P: 515.256.4640
Iowa	Iowa Department of Human Services Iowa Medicaid Enterprise 100 Army Post Road Des Moines, IA 50315	Elizabeth Matney, Iowa Medicaid Bureau Chief Managed Care Oversight and Supports	ematney@dhs.state.ia.us P: 515.974.3204

SETH ADAMSON, ASA, MAAA

Seth Adamson

Consulting Actuary, Optumas

Education

B.S. Mathematics, Arizona State University

Experience

7+ years professional experience

Core Competencies

Total Cost of Care development

Client/stakeholder communication and rate presentation

Actuarial analytics, including trend development, risk adjustment, reimbursement analyses, and episodes of care analytics

Mr. Adamson has over seven years of experience with Medicaid managed care rate setting and other actuarial analyses pertaining to public health programs. He is currently a Consulting Actuary at **Optumas** and is the project lead for Kansas' comprehensive managed care program and Colorado's CHP+ program.

Mr. Adamson's Medicaid managed care experience includes physical health capitation rates, mental health/substance abuse capitation rates, PACE UPL development, case rate development, 1115 Waiver budget neutrality calculations, and rate development for populations/services with limited Medicaid data. This work requires performing detailed statistical and actuarial analysis, such as risk adjustment, full credibility testing, programmatic and benefit changes – including 40+ programmatic and benefit changes for one managed care program, trend analysis, developing non-medical loading assumptions, and financial statement review to inform the appropriate actuarial adjustments for accurate rate development.

Mr. Adamson has experience in working with the following Medicare value-based purchasing (VBP) models: Pioneer ACOs, Next Generation ACOs (NGACO), Medicare Shared Savings Program (MSSP) ACOs, and the Bundled Payments for Care Improvement (BPCI) bundled payment model. His work with these programs includes developing financial performance reports to identify areas of potential improvement on an on-going basis, performing financial projections to estimate the future shared savings for an existing ACO, and assessing the best value-based purchasing program for a health care group to enter into across the various VBP programs and tracks within those programs. Mr. Adamson also performed analyses identifying the impact of overlap across the ACO and BPCI programs, which led to regulatory changes to improve the performance of the VBP initiatives.

An important role in performing detailed statistical and actuarial analyses is the ability to convey the results to a wide variety of audiences, and Mr. Adamson has performed this role many times. He has presented actuarial analyses to stakeholders and key personnel, including members of the State Medicaid team, and managed care plan CEOs, CFOs, and senior actuaries. As part of these conversations, he has been able to address and resolve both technical and high-level questions to ensure that all parties are in agreement and comfortable with the results.

We encourage you to contact Mr. Adamson's references to hear directly from them about his Medicaid expertise, creativity, responsiveness, and reliability:

Reference State	Address of Reference	Name of Contact	Contact Information
Kansas	Kansas Department of Health and Environment	Jon Hamdorf	Jonathan.Hamdorf@ks.gov P: 785.296.7851

	900 SW Jackson St Topeka, KS 66612	Medicaid Director and Director of Health Care Finance	
Colorado	State of Colorado Department of Health Care Policy and Financing Finance Office/Payment Reform Section 1570 Grant Street Denver, CO 80203	Adam Schafer, Payment Reform Analyst	Adam.schafer@state.co.us P: 303.866.5450
Iowa	Iowa Department of Human Services Iowa Medicaid Enterprise 100 Army Post Road Des Moines, IA 50315	Michael Randol Medicaid Director	Mrandol@dhs.state.ia.us P: 515.256.4640

CHRIS DICKERSON

Mr. Dickerson has 10 years of experience with Medicaid managed care rate setting and other actuarial analyses pertaining to public health programs. He currently serves as a Senior Actuarial Consultant at **Optumas** working on the Department's Heritage Health rate development, Dental Managed Care rate development, PACE UPL development, 1915(b) Waiver submission, and pending 1115 Waiver submission. He has vast experience conducting detailed analytics and explaining the results to diverse audiences. This experience can benefit the Department's rate development and negotiation, as Mr. Dickerson will be able to implement complex methodological changes while explaining them clearly to program stakeholders.

Chris Dickerson

Senior Actuarial Consultant, Optumas

Education

B.S. Mathematics, Arizona State University

Experience

10 years

Core Competencies

Nebraska-specific knowledge of managed care programs and waiver submissions

Client communication, rate presentation, and negotiation support

PROMETHEUS Analytics

Risk Adjustment Analysis

During his time at **Optumas**, Mr. Dickerson has worked on projects for state Medicaid programs, county-level public health programs, and quasi-public managed care plans operating under Medicaid managed care contracts. This experience has given him a depth of understanding in the public health arena and the ability to understand the points and arguments made on both sides of Medicaid managed care rate development. He uses this experience to proactively address common health plan concerns and argue for state policies and adjustments in ways that are effective with managed care organizations.

Mr. Dickerson's career with **Optumas** has included development of capitation rates in Arkansas, California, Colorado, Kansas, Nebraska, and Oregon, waiver cost effectiveness tests for Arkansas, California, Nebraska, and Ohio, rate setting for LTSS populations in California, Colorado, Kansas, and Nebraska, and PROMETHEUS Analytics for Arkansas, Colorado, Kansas, Nebraska, and North Dakota. These projects have required the use of various data sources, including detailed claims data, incomplete encounter data, and financial statements and other high-level summarized data. Mr. Dickerson can incorporate and utilize any available data to improve modeling outputs and meet the needs of his clients.

Recently, Mr. Dickerson has assisted with the operationalization and implementation of multiple new managed care delivery systems. He has developed managed care rates and assisted in the RFP process for Nebraska's Heritage Health program, served as the lead analyst and consultant for Arkansas' Private Option/Arkansas Works, PCCM, and PCMH programs, and has assisted the National PACE association with the development of new PACE rate setting guidelines. Mr. Dickerson continuously provides his clients with analytics exceeding their expectations by combining a detailed understanding of data and analytic techniques with an ability to condense the key points for concise presentations to leadership.

Specific to Nebraska, Mr. Dickerson has a wealth of experience with the Department's various managed care programs. Mr. Dickerson set rates for the previous Physical Health managed care program, including multiple on-site presentations of rates to managed care plans. Mr. Dickerson also served as an analyst on the Behavioral Health rate development team. When the Heritage Health program began the

procurement process, Mr. Dickerson assisted in drafting the MCO RFP by providing insight to the phrasing and description of actuarial components of the RFP. Mr. Dickerson also led presentations to potential bidders and helped educate vendors on the populations and risk underlying the Heritage Health program. After Heritage Health was established, Mr. Dickerson served as a Senior Consultant on ever rate development project. Mr. Dickerson has set the Department's PACE UPLs for the past five years, including providing all documentation to the Department and CMS. In addition to these traditional actuarial projects, Mr. Dickerson has served as an analyst and consultant on the Department's 1915(b) Waiver and 1115 Waiver. Throughout all this work, Mr. Dickerson has gained a thorough understand of the Department's programs, populations, services, and delivery system. This experience is incredibly useful for the Department and makes Mr. Dickerson and the entire **Optumas** team the ideal actuarial firm to serve the Department moving forward.

We encourage you to contact Mr. Dickerson's references to hear directly from them regarding his ability to perform detailed analytics, communicate results to managed care plans and Medicaid staff, and position his clients for success with strategic rate development methodologies:

Reference State	Address of Reference	Name of Contact	Contact Information
Colorado	State of Colorado Department of Health Care Policy and Financing Finance Office/Payment Reform Section 1570 Grant Street Denver, CO 80203	Shane Mofford, Rates and Payment Reform Section Manager	Shane.mofford@state.co.us P: 303.866.6742
Nebraska	Nebraska Department of Health and Human Services 301 Centennial Mall South, Lincoln, Nebraska 68509	Mike Michalski Chief Financial Officer	Michael.Michalski@nebraska.gov P: 402.471.6719
Nebraska	Nebraska Department of Health and Human Services 301 Centennial Mall South, Lincoln, Nebraska 68509	Jeremy Brunssen Deputy Director of Finance and Program Integrity	Jeremy.brunssen@nebraska.gov P: 402.471.5045

CASSIE WILLIAMS

Cassie Williams
Senior Actuarial Analyst, Optumas

Education
B.S. Applied Mathematics, Arizona State University

Experience
Actuarial, Five years

Core Competencies
Project Management
Detailed Data Manipulation
Rate Model Development
PROMETHEUS Analytics

Ms. Williams is currently pursuing her ASA designation while working as a Senior Actuarial Analyst at **Optumas**. She has over five years of experience working on the development of capitation rates for Medicaid Managed Care programs. Her main responsibilities at **Optumas** include project management, data analytics, rate model development, PROMETHEUS analytics, and client communication.

During Ms. Williams' time at **Optumas**, she has worked on a wide variety of Medicaid projects, including behavioral health capitation rate development, physical health rate development, integrated care rate development, and MLTSS rate development. Most recently, Ms. Williams has worked as a Senior Actuarial Analyst for Nebraska's Heritage Health Program, Dental Program, and 1915(b) Waiver.

Ms. Williams's main responsibilities on these programs have included analyzing detailed data sets, building actuarial models to assist in capitation rate development, and presenting results to the Department. Ms. Williams is responsible for preparing capitation rate development model spreadsheets that accommodate a variety of program-specific components, actuarial adjustments, and trend. Ms. Williams has extensive experience with project management responsibilities and stakeholder communication for Nebraska's managed care programs. She is responsible for creating detailed project plans for the Department that outline the responsible entity and due date for each of the key activities in the rate development process. Ms. Williams has participated and presented during in-person Rate Development Meetings for Heritage Health. She has experience discussing rate results with the Heritage Health plans' actuaries on the Department's behalf to resolve disconnects between state assumptions and plan expectations. In addition, Ms. Williams has experience organizing and producing detailed Actuarial Certifications and methodology narratives for these programs.

Ms. Williams has worked with the Department for five years since beginning her employment at **Optumas.** Ms. Williams' understanding of the Heritage Health and Dental programs and relationships with the Department's staff will continue to be an immeasurable asset to the rate development process.

We encourage you to contact Ms. Williams' references to hear directly from them about her Medicaid expertise, creativity, responsiveness, and reliability:

Reference State	Address of Reference	Name of Contact	Contact Information
Colorado	State of Colorado Department of Health Care Policy and Financing Finance Office/Payment Reform Section	Shane Mofford, Rates and Payment Reform Section Manager	Shane.mofford@state.co.us P: 303.866.6742

	1570 Grant Street Denver, CO 80203		
Colorado	State of Colorado Department of Health Care Policy and Financing Finance Office/Payment Reform Section 1570 Grant Street Denver, CO 80203	Adam Schafer, Payment Reform Analyst	Adam.schafer@state.co.us P: 303.866.5450
Nebraska	Nebraska Department of Health and Human Services 301 Centennial Mall South, Lincoln, Nebraska 68509	Jeremy Brunssen Deputy Director of Finance and Program Integrity	Jeremy.brunssen@nebraska.gov P: 402.471.5046

STEPHANIE TAYLOR

Stephanie Taylor

Actuarial Analyst, Optumas

Education

B.S. Mathematics, Arizona State University

Experience

Actuarial Analytics: Three years

Core Competencies

Medicaid Managed Care Rate Development

Data Validation and Manipulation

PROMETHEUS Analytics

Ms. Taylor has three years of experience with **Optumas** working on Medicaid managed care rate setting and other actuarial analyses for multiple state agencies. She currently serves as an Actuarial Analyst for Nebraska's Heritage Health and Dental program capitation rate development. Throughout her time at **Optumas** she has also provided analytic support for the Department's Physical Health program capitation rate setting and PACE UPL development. She is involved in the extensive data scrubbing necessary to run the Nebraska managed care encounter and FFS claims experience through the PROMETHEUS analytics with particular focus on analyzing and translating the output into meaningful results to share with the Department.

Ms. Taylor has considerable experience conducting detailed data validation and manipulation, actuarial analytics, and rate development for the Department and has intrinsic knowledge of the various Nebraska Medicaid managed care programs. This knowledge and experience benefits the Department's managed care capitation rate development process because she can implement complex methodological changes in an efficient manner by applying analytic techniques she has developed through her work with Nebraska managed care rate setting projects.

During her time at **Optumas,** Ms. Taylor has worked on projects for state Medicaid programs and Medicare health programs. Her superior data validation and analytical skills coupled with her knowledge of the Department's Heritage Health and Dental managed care programs will allow Ms. Taylor to continually provide the Department leadership with insight into the risk of their Medicaid program. She is involved in developing robust actuarial models used within rate development for each of her clients, such as analyses quantifying the impact of policy changes and the calculation of Risk Corridor and MLR reconciliation payments.

Ms. Taylor's career with **Optumas** has included developing capitation rates for physical health, integrated care, and long-term services and supports managed care programs in Colorado, Kansas, Iowa, and Nebraska. She is proficient in PROMETHEUS analytics and has introduced these analytics within each of her state clients. She has worked to stratify costs associated with Potentially Avoidable Complications by episode, rate cell, and category of service to help identify areas in which the Department and MCOs can focus on developing care coordination and intervention plans to increase quality and lower the cost of care for Nebraska Medicaid beneficiaries. Each of her projects have required the use of various data sources, including detailed claims data, incomplete encounter data, financial statements, and other supplemental data. Ms. Taylor's strong analytical skills gives her the ability to incorporate and utilize any available data to improve modeling outputs and continue to exceed the Department's expectations.

We encourage you to contact Ms. Taylor's references below to hear directly from them about her Medicaid expertise, technical skills, reliability, and responsiveness to client needs:

Reference State	Address of Reference	Name of Contact	Contact Information
Colorado	State of Colorado Department of Health Care Policy and Financing Finance Office/Payment Reform Section 1570 Grant Street Denver, CO 80203	Shane Mofford, Rates and Payment Reform Section Manager	Shane.mofford@state.co.us P: 303.866.6742
Iowa	Iowa Department of Human Services Iowa Medicaid Enterprise 100 Army Post Rd Des Moines, IA 50315	Elizabeth Matney; Iowa Medicaid Bureau Chief Managed Care Oversight and Supports	ematney@dhs.state.ia.us P: 515.974.3204
Nebraska	Nebraska Department of Health and Human Services 301 Centennial Mall South, Lincoln, NE 68509	Jeremy Brunssen Deputy Director of Finance and Program Integrity	Jeremy.brunssen@nebraska.gov P: 402.471.5046

Jerry Dubberly, PharmD

Dr. Dubberly, principal/partner, leads the Integrated Care Model practice area within the firm. Since joining Myers and Stauffer in 2015, Dr. Dubberly has focused on assisting our clients with delivery system and payment transformation initiatives which include SIM; DSRIP program; Certified Community Behavioral Health Clinics (CCBHC) programs; managed care design, implementation and monitoring; and other consulting activities. Prior to joining Myers and Stauffer, Dr. Dubberly served as Georgia's Medicaid Director for over six years, where he was responsible for health care coverage for 1.9 million Georgians and an annual benefits budget of $10 billion. Dr. Dubberly brings a wide range of experience with Medicaid policy and financing; pharmacy services, clinical practice, with other state and federal health care programs; and health IT.

Jerry Dubberly, *PharmD*

Principal, Myers and Stauffer LC

EDUCATION

PharmD, Pharmacy, University of Arkansas Medical Sciences
2005

M.B.A., Health Services Management, University of Tennessee
1995

B.S., Pharmacy, University of Georgia
1990

EXPERIENCE

28 years

professional experience

CORE COMPETENCIES

Medicaid managed care

population health

delivery system and payment transformation

health plan management

public policy and program design

former state Medicaid director and state Medicaid pharmacy director

pharmacy benefit management

Certifications

Registered Pharmacist, in good standing, Georgia and Tennessee Boards of Pharmacy

Affiliations

Academy of Managed Care Pharmacy
American Institute of Certified Public Accountants
Georgia Academy of Managed Care Pharmacy
National Association of Medicaid Directors (Alumni)
Georgia Society of Certified Public Accountants

Relevant Client Experience

New Jersey Department of Health (2015 – Present)
Delivery System Reform Incentive Payment (DSRIP) Program Support and Consulting
Scope of Work:
Myers and Stauffer has been leading New Jersey's DSRIP initiative since its inception. We have represented the state in hundreds of hours of meetings and discussions with both CMS and the provider industry. We have had the lead role in developing the Planning Protocol, Funding and Mechanics Protocol, and assisted the state in the amendments to the Special Terms and Conditions of the 1115 Waiver. Additionally, we spearheaded the New Jersey DSRIP Quality and Measures subcommittee tasked with developing the menu of hospital quality projects to support achievement of the demonstration goals. Myers and Stauffer designed the DSRIP application and audit approach that was approved by CMS to confirm DSRIP eligibility and to provide ongoing monitoring of performance through quarterly reporting procedures and conducting the semiannual DSRIP project assessments. We conduct these required reviews to confirm milestone achievement and submit findings for state and CMS approval for incentive award payment. Myers and Stauffer uses the

CMS and state approved findings to generate payment for distribution to the participating hospital providers.

Responsibilities:

- Serves as the partner in charge of this engagement with ultimate internal accountability for the firm's performance and delivery of services.

Washington Health Care Authority (HCA) (2017 – Present)

Delivery System Reform Incentive Payment (DSRIP) Program Independent Assessor

Scope of Work:

Myers and Stauffer has been contracted to support HCA's DSRIP program which is composed of nine Accountable Communities of Health (ACHs). Through this engagement, responsibilities include but are not limited to: receipt and evaluation of ACH project plans; provision of technical assistance regarding project plan improvement opportunities; conducting semiannual assessments of ACH projects; performing a midpoint assessment of the DSRIP program; assessing value based purchasing goal attainment by ACHs and MCOs; assisting with CMS reporting; collaboration with other HCA contractors; and assisting with certain training and communication efforts.

Responsibilities:

- Serves as the partner in charge of this engagement with ultimate internal accountability for the firm's performance and delivery of services.

New Hampshire Department of Health and Human Services (2017 – Present)

Delivery System Reform Incentive (DSRIP) Program Learning Collaborative

Scope of Work:

Myers and Stauffer is providing professional services necessary to develop, operate and lead the Learning Collaborative – a required element of the Department 's Building Capacity for Transformation, Section 1115 Medicaid Demonstration Waiver, #11-W-00301/1.

Responsibilities:

- Serves as the partner in charge of this engagement with ultimate internal accountability for the firm's performance and delivery of services.

Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP) (2017)

Managed Care Organization (MCO) Onboarding and Business Process Reengineering

Scope of Work:

Myers and Stauffer assisted with the implementation and onboarding of four Medicaid MCO contracts; the development of a managed care information strategy; and reviewed key business processes for redesign and reengineering to improve the effectiveness and efficiency of the Medicaid Division.

Responsibilities:

- Served as partner in charge of this engagement and subject matter expert.
- Ensured proper staffing and quality of consulting services and work product delivered to DHCFP

Vermont Department of Vermont Health Access (DVHA) (2016 – 2017)

Vermont Health Care Innovation Project (VHCIP)/State Innovation Model (SIM) Sustainability Plan

Scope of Work:

Myers and Stauffer supported the DVHA's efforts to conduct and facilitate stakeholder meetings, key informant interviews, and review projects and efforts implemented as part of the state's SIM project. We drafted the SIM Sustainability Plan to help the state identify innovation elements of the SIM that should be continued after the end of the project. This work included a review of the operational and fiscal sustainability components.

Responsibilities:

- Served as the partner in charge of this engagement with ultimate internal accountability for the firm's performance and delivery of services.

Nevada Department of Health and Human Services, Division of Public and Behavioral Health (2015 – 2017)

Certified Community Behavioral Health Clinics Planning Grant

Scope of Work:

Myers and Stauffer provided full service administrative and operational support for Nevada's CCBHC planning grant and supported the state in designing a model to improve the behavioral health of Nevada's citizens.

Responsibilities:

- Advised on integration of physical and behavioral health, delivery system models, criteria for CCBHCs, and value-based payment (VBP) models within a CCBHC environment.

Work History

Myers and Stauffer LC (2015 – Present), Director, Principal

Georgia Department of Community Health (2004 – 2015), Medicaid Director, Deputy Director Medical Assistance Policy Section, Director of Pharmacy Services

Consultec, Inc. also DBA Affiliated Computer Services, Inc. (1996 – 2004), Director Client and Clinical Services, Clinical Services Manager

Reference	Address of Reference	Name of Contact	Contact Information
Georgia	Georgia Department of Community Health 2 Peachtree St, 36th Floor Atlanta, GA 30303	Lynnette Rhodes, JD Associate Chief, Medicaid Operations	lrhodes@dch.ga.gov P: 404.656.7513
NorthStar HealthCare Consulting	NorthStar HealthCare Consulting 1121 Alderman Dr; Suite 112 Alpharetta, GA 30005	Emily Baker, PharmD, BCPS, MBA, MHA	Emily.baker@nhc-llc.com P: 678.672.4210
Nevada	Nevada Department of Health and Human Services Division of Health Care Financing and Policy Procurement and Performance Management 1000 E William St, Suite 200 Carson City, NV 89701	Debra Sisco Management Analyst IV	dsisco@dhcfp.nv.gov P: 775.687.8407

Catherine Snider

Ms. Snider is a senior manager with Myers and Stauffer and has extensive experience in public policy management, including Medicaid eligibility; claim adjudication and payment processes; managed care oversight and performance reporting; rate setting; program integrity; and audit functions. Ms. Snider specializes in value-based payment, and delivery system reform models, including design, implementation, development and execution of performance measurement and payment methodologies, stakeholder engagement, learning collaboratives, and program evaluations.

Catherine Snider

Senior Manager, Myers and Stauffer LC

EDUCATION

B.A., Political Science and Criminal Justice, Indiana University

1996

EXPERIENCE

21 years professional experience

CORE COMPETENCIES

Medicaid eligibility, adjudication and payment processes

public policy management

contract development and rate setting reviews

managed care performance analysis, oversight and reporting

Myers and Stauffer Client Experience

Idaho Department of Health and Welfare (2015 – Present)
Patient Centered Medical Home Training and Technical Assistance
Scope of Work:
Myers and Stauffer assists in the development and implementation of a patient-centered medical home (PCMH) training and technical assistance program that includes an incentive payment system as part of the State Health Innovation Plan (SHIP) model test.
Responsibilities:

- Oversees the Myers and Stauffer team responsible for implementation and management of the Incentive Payment Accounting System (I-PAS) system to 1) calculate PCMH incentives based on pre-defined qualifications, 2) report and 3) reconcile incentive achievement to accessible web-based reporting dashboards.

Nevada Department of Health and Human Services (2015 – 2016)
State Innovation Model (SIM)
Scope of Work:
Assisted the State with the preparation of a Round Two State Innovations Model (SIM) Funding Application and the creation of a State Health System Innovation Plan (SHSIP).
Responsibilities:

- Served on the team to support Nevada stakeholder engagement at all levels including health care payers, providers and community advocates in the development and drafting of the State Health System Innovation Plan (SHSIP) as a part of Nevada's SIM design award. The SHSIP defines statewide value-based delivery system reform goals driven by all payers to improve health for all Nevadans.

- Facilitated the Delivery System and Payment Alignment Workgroup and the Policy and Regulatory Taskforce, offering presentations and collecting stakeholder feedback and driving support for statewide improvement initiatives.

New Hampshire Department of Health and Human Services (2016 – 2016)
Delivery System Reform Incentive Payment (DSRIP) Program Independent Assessor
Scope of Work:
As New Hampshire's contracted DSRIP independent assessor, Myers and Stauffer was engaged in completing detailed reviews of applications and project plans submitted by regionally-based Integrated Delivery Networks seeking to leverage local resources to implement interventions to meet DHHS' goals of improved access to – and quality of – both behavioral health services and the physical health services for those with behavioral health diagnoses. Myers and Stauffer scored each submission based on detailed documentation requirements using our comprehensive evaluation criteria tools.
Responsibilities:

- Led industry training sessions and oversaw desk review procedures required by the contract for application and project plan reviews.
- Convened an Independent Review Panel to offer a non-partisan assessment of the quality and completeness of the firm's review processes and the IDN preparedness to fulfill DSRIP activities.
- Prepared and presented a project plan findings report capturing statewide observations, summarizing IDNs' project plan submissions, identified strengths and opportunities per region and panel feedback to provide a statewide portrait of the DSRIP implementation plan.

New Hampshire Department of Health and Human Services (2017 – Present)
Delivery System Reform Incentive Payment (DSRIP) Program Learning Collaborative
Scope of Work:
Myers and Stauffer is providing professional services necessary to develop, operate and lead the Learning Collaborative – a required element of the Department of Health and Human Services' Building Capacity for Transformation, Section 1115 Medicaid Demonstration Waiver, #11-W-00301/1.

Responsibilities:

- Responsible for monthly and quarterly program formats, identification of learning topics, development and delivery of presentations, selection of national and local speakers, creation of training tools and materials, and use of best practices for a robust learning system.
- Provide direction and support to Innovation Agents to develop technical assistance materials requested by IDN members.

New Jersey Department of Health (2013 – Present)
Delivery System Reform Incentive Payment (DSRIP) Program Support and Consulting
Scope of Work:
Myers and Stauffer has been leading New Jersey's DSRIP initiative since its inception in October 2012. We have represented the state in hundreds of hours of meetings and discussions with both CMS and the provider industry. We have had the lead role in developing the Planning Protocol, Funding and Mechanics Protocol, and assisted the state in the amendments to the Special Terms and Conditions of the 1115 Waiver.

Responsibilities:

- Actively engaged in all aspects of this initiative, including the development of the quality improvement projects, performance measurement methodologies and databook, facilitation of the Quality and Measures Committee, learning collaboratives, and stakeholder engagement on behalf of the Department of Health.
- As Project Manager, responsible for communications on behalf of the team with the client, CMS, industry at large, association leads and Executive Leadership updates.
- Responsible for the development of the New Jersey attribution model and performance measure databook that provides the detailed measure specifications that monitor performance metrics as the basis for incentive award.
- Overseen and supported the quarterly payment processes based on industry achievement totaling $166.6 million dollars annually.

Work History

Myers and Stauffer (2012 – Present), Senior Manager
State of Indiana, Family & Social Services Administration, Office of Medicaid Policy and Planning (2005 – 2012), Compliance Manager
State of Indiana, Family & Social Services Administration (2000 - 2005), Policy & Procedures Analyst
Marion County Justice Agency (1996 – 1999), Supervisor, Conditional Release Office

Presentations

"Learning Collaboratives," America's Essential Hospitals' Leadership Summit on Medicaid Waivers, 2015.

Reference	Address of Reference	Name of Contact	Contact Information
Indiana	Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204	Ann Alley, Director, Chronic Disease, Primary Care and Rural Health	aalley@isdh.in.gov P: 317.233.7451
Indiana University Health Plans, Inc.	Indiana University Health Plans, Inc. 950 N. Meridian Street, Suite 200 Indianapolis, IN 46204	Tammy Chadd, CHC, CHPC, Delivery System Administrator	tchadd@iuhealth.org P: 317.371.2241
Indiana	Indiana FSSA/ICES 402 W. Washington Street Indianapolis, IN 46207	Matthew P. Cesnik, MPA, Sr. Systems Business Consultant	Matthew.Cesnik@fssa.IN.gov P: 317.234.6548

Claudia Chitu, CFE, PMP

Ms. Chitu manages Medicaid managed care projects that focus on analysis of encounter claims data to assess data quality and completeness. She has experience in the implementation, evaluation, and monitoring of Medicaid managed care encounter data submissions. As part of this work, she performs encounter data reconciliations, on-site encounter process reviews and data validation. In addition, she has reviewed plans for contract and reporting compliance and has identified relevant best practice standards for consideration. Other projects she has worked on have included assisting with the implementation of a new Medicaid Management Information System (MMIS) by creating and submitting test claims and encounters, in electronic data interchange (EDI) 837 and National Council for Prescription Drug Programs (NCPDP) formats, to evaluate system edits and processing issues, as well as performing benefits testing and claims reimbursement analysis.

Claudia Chitu, *CFE, PMP*

Senior Manager, Myers and Stauffer LC

EDUCATION

B.A., Economics and Mathematics, Emory University

2005

EXPERIENCE

Nine years professional experience

CORE COMPETENCIES

benefits testing and claims analysis for SCHIP

MCO analysis

recovery audit contractor engagements

Myers and Stauffer Client Experience

Georgia Department of Community Health (2009 – Present)

Care Management Organization Compliance

Scope of Work:

Myers and Stauffer assists the Georgia Department of Community Health with providing oversight and monitoring of the Georgia Families Care Management Organizations (CMOs).

Responsibilities:

- Manage the encounter reconciliation work for evaluating Georgia Medicaid CMOs' compliance with contractual obligations for encounter data submissions.
- Assist in the development of the data analysis plan for CMO on-site encounter process reviews and data validation work.
- Provide enhanced member and encounter data extracts and analysis for the State's actuarial firm rate setting process and to identify data issues and potential adjustments and corrections to the data that may be duplicated as part of rate-setting and program reporting.
- Reviewed CMO payments to providers for primary care rate increases under the Affordable Care Act for accuracy and appropriateness. Identified and helped address data issues with provider enrollment and CMO claims payment processing.
- Assisted with CMO readiness reviews, prior to a new contract starting date, in order to evaluate the CMOs' abilities to provide services for members according to state program polices, pay provider claims and comply with state and federal reporting requirements.
- Perform ad-hoc data analyses to estimate impact of potential changes in policy, legislation and program budget.

Georgia Department of Community Health (2009 – 2010)
Benefits Testing

Scope of Work:
Myers and Stauffer assists the Georgia Department of Community Health to evaluate the accuracy of benefit payments made through the Medicaid program and Children's Health Insurance Program (CHIP).

Responsibilities:

- Developed fee-for-service and encounter test claims and reviewed the MMIS system for processing and payment accuracy.
- Developed 837I and 837P claims for MMIS process testing and served as EDI subject matter expert during testing.
- Evaluated fee-for-service claim reimbursement and policy compliance and developed automated testing processes for several categories of service.

Georgia Department of Community Health (2015 – 2016)
Inpatient Hospital Rebase

Scope of Work:
Georgia Medicaid engaged Myers and Stauffer to update their prospective payment system for inpatient hospital services and to implement an outpatient hospital reimbursement system.

Responsibilities:

- Assisted the Department with the implementation of an updated inpatient hospital payment system and reimbursement review methodology that effectively incorporated relevant best practices and addressed potential risk areas identified as part of the engagement's work.

Georgia Department of Community Health (2014 – Present)
Recovery Audit Contractor

Scope of Work:
Myers and Stauffer provides recovery audit contractor (RAC) services to the Georgia Department of Community Health.

Responsibilities:

- Help develop and review algorithms utilized in the engagement to identify potential over- and under-payments to health care providers for fee-for-service and encounter claims.

Louisiana Department of Health (2012 – Present)
Managed Care Organization Audit

Scope of Work:
Myers and Stauffer assists the Louisiana Department of Health with providing oversight and monitoring of the Bayou Health MCOs.

Responsibilities:

- Manage the encounter reconciliation work for evaluating Louisiana Medicaid MCOs' compliance with contractual obligations for encounter data submissions.
- Serve as a subject matter expert for encounter submissions and assisted in the development of the data analysis plan for MCO on-site encounter process reviews and data validation work.

Mississippi Division of Medicaid (2017 – Present)
Outsourced Financial Reviews Mississippi Coordinated Access Network (MississippiCAN) and Health Information Technology/Health Information Exchange (HIT/HIE)

Scope of Work:
Myers and Stauffer provides services to the Mississippi Department of Medicaid including encounter data validation and reconciliations (to include Protocol 4), capitation and rate reviews, review of duplicate member capitation payments to CCOs, third party liability reviews, analysis of CCO claims denials and reporting, evaluation of risk adjustments, consultation on the Mississippi hospital access program transition, consulting services, and health insurance providers' fee calculation review.

Responsibilities:
- Assist the Division in reviewing and evaluating high rates of claim denials by a CCO. This project includes a review of the CCO's internal processes, claims adjudication and system edits configurations, provider and member communication and encounters reporting.

New Mexico Human Services Department (2015)
Medicaid Managed Care Compliance Reviews

Scope of Work:
Myers and Stauffer assists the department in assessing the compliance of the Medicaid MCOs with contract requirements.

Responsibilities:
- Assisted in the development of the data review plan for New Mexico Medicaid MCO hospital encounter claim payment reviews.

Work History

Myers and Stauffer (2009 – Present), Senior Manager

Reference	Address of Reference	Name of Contact	Contact Information
Mississippi	Office of the Governor, Division of Medicaid 550 High St., Suite 1000 Jackson, Mississippi 39201	Keith Heartsill, CPA, FHFMA, Healthcare Consultant	keith.heartsill@medicaid.ms.gov P: 601.359.3904
Georgia	Georgia Department of Community Health 2 Peachtree St., 36th Floor Atlanta, Georgia 30303	Lynnette Rhodes, JD Associate Chief, Medicaid Operations	lrhodes@dch.ga.gov P: 404.656.7513
Georgia	Georgia Department of Community Health 2 Peachtree St., 36th Floor Atlanta, Georgia 30303	John Upchurch, Director, Reimbursement	jupchurch@dch.ga.gov P: 404.657.0229

Randolph Rehn, CPA, CFE

Randolph Rehn, CPA, CFE

Senior Manager, Myers and Stauffer LC

EDUCATION

B.B.A., Accounting, University of Georgia

1996

EXPERIENCE

22 years professional experience

CORE COMPETENCIES

MLR examinations

recovery audit contractor engagements

quality assurance for AUP

trains and supervises staff

Mr. Rehn, a manager with Myers and Stauffer, has 22 years of auditing experience. Mr. Rehn manages the wide-ranging contractual compliance assessments and financial analyses and examination services requested by the Mississippi Division of Medicaid's coordinated care program. In addition, he is responsible for performing quality assurance procedures for agreed-upon procedure engagements performed on behalf of the state of Georgia and performs periodic reviews of work papers to ensure compliance with AICPA and engagement standards and regulations.

Prior to joining Myers and Stauffer, Mr. Rehn worked for the Georgia Department of Audits and Accounts (GDOAA) from 1996 until March 2010. During his tenure at GDOAA, Mr. Rehn served in numerous roles and positions. His last two years at GDOAA were spent maintaining GDOAA's Medicaid claim data warehouse, implementing new auditing software, and providing technical assistance and claims data queries to GDOAA's audit staff. He served the previous 11 years with GDOAA in both supervisory and auditor capacities conducting various types of engagements throughout his career with GDOAA ranging from financial audits of large and complex multi-million dollar revenue producing Nursing Home chain organizations, to agreed-upon procedure work performed on numerous hospitals participating in Georgia's Indigent Care Trust Fund program and Georgia Nursing Home liability insurance projections, to performance audits of Georgia's Community Service Boards.

Mr. Rehn has extensive experience supervising/managing multiple audit teams and projects concurrently. His ability to quickly grasp new concepts and incorporate/apply ever changing federal and state regulations and policies into the agreed upon procedures/audit steps sets him apart from the rest.

Certifications

Certified Public Accountant
Certified Fraud Examiner

Affiliations

Georgia Society of CPAs

Myers and Stauffer Client Experience

Georgia Department of Community Health (2005 – Present)
Benefits Testing
Scope of Work:

Myers and Stauffer assists the Georgia Department of Community Health to evaluate the accuracy of benefit payments made through the Medicaid program and Children's Health Insurance Program (CHIP).
Responsibilities:

- Supervises the Agreed-Upon Procedures project with the Georgia Department of Community Health to identify, quantify, and report on the calculated mispayment issues identified during our testing and re-repricing of claims paid through their Medicaid Management Information System.
- Meets quarterly with DCH management to provide updates on mispaid claims and/or policy issues identified that the Department should be made aware of.
- Responsible for preparing an annual report that estimates the financial liabilities and receivables as a result of the identified claim mispayments for each fiscal year.

Louisiana Department of Health (2015 – Present)
Managed Care Organization Medical Loss Ratio Audit
Scope of Work:
Myers and Stauffer provides services to the Louisiana Department of Health for medical loss ratio (MLR) reviews of managed care organizations.
Responsibilities:

- Supervised our examination procedures of the annual Medical Loss Ratio reports submitted by Louisiana managed care Responsible for ensuring that we communicate any findings to the Louisiana Department of Health and their managed care organizations, as well as issue the proper opinion in accordance with AICPA guidelines.
- Responsible for accurately recalculating and reporting the Medical Loss Ratio and rebates amounts due to the Louisiana Department of Health (when applicable).

Maine Department of Health and Human Services (2014 – 2015)
Non-Emergency Transportation Services
Scope of Work:
Provided professional assessment and recommendations regarding the use of non-emergency transportation services.
Responsibilities:

- Team leader responsible for the assessment and reporting on the new NET broker system Waiver Services implementation.
- Interviewed Broker personnel and observed Broker operations.
- Reviewed state/broker contracts for compliance issues, assessed member and provider satisfaction results, and analyzed monthly Broker reports filings.
- Offered recommendations to Brokers and MaineCare to help improve overall Waiver program oversight, accountability, and financial sustainability.

Mississippi Division of Medicaid (2015 – Present)
Outsourced Financial Reviews Mississippi Coordinated Access Network (MississippiCAN)
Scope of Work:
Myers and Stauffer assists the division in a wide-ranging assessment of the Coordinated Care Organizations' contract compliance. Under the contract, we perform encounter claim to cash

disbursement journal reconciliations to assess completeness; assess encounter claim accuracy under CMS EQR Protocol 4; review capitation payments for payment accuracy and potential duplicated capitation payments; provide examination services of Medical Loss Ratio report filings; perform other compliance testing of other monthly monitoring tools; and assisted with the development of a quality improvement strategy and evaluate options for other forms of directed payments.

Responsibilities:

- Supervising our Protocol 4 procedures of the Mississippi coordinated care organizations (CCO).
- Responsible for providing bi-monthly encounter to cash to disbursement journal reconciliation calculations and potential data issues to the Mississippi Division of Medicaid (DOM) and their coordinated care organizations (CCO) to be used as a contract monitoring and compliance tool of each CCOs' encounter data completeness.
- Supervising our examination procedures of the annual Medical Loss Ratio reports submitted by Mississippi managed care organizations to the Mississippi Division of Medicaid.
- Responsible for ensuring that we communicate any findings to the Mississippi Division of Medicaid and their managed care organizations, as well as issue the proper opinion in accordance with AICPA guidelines.
- Responsible for accurately recalculating and reporting the Medical Loss Ratio and rebates amounts due to the Mississippi Division of Medicaid (when applicable).
- Responsible for researching and providing assistance to the Mississippi Division of Medicaid (DOM) for special topics and suggestions for contract language improvements.

Work History

Myers and Stauffer LC (2010 – Present), Senior Manager
Georgia Department of Audits and Accounts (1996-2010), Manager

Reference	Address of Reference	Name of Contact	Contact Information
Mississippi	Mississippi Division of Medicaid 550 High Street, Suite 1000 Jackson, Mississippi 39201	Keith Heartsill, CPA, FHFMA, Healthcare Consultant	keith.heartsill@medicaid.ms.gov P: 601.359.3904
Georgia	Georgia Department of Community Health, Division of Medicaid 2 Peachtree St., 36th Floor Atlanta, Georgia 30303	Heather Bond, Assistant Chief, Medicaid Regulatory Services and Compliance	hbond@dch.ga.gov P: 404.657.1502
Georgia	Georgia Department of Human Services 2 Peachtree St., 36th Floor Atlanta, Georgia 30303	Gerlda Hines, CPA, Chief of Staff and Chief Financial Officer	Gerlda.hines@dhs.ga.gov P: 404.463.6060

Venesa Day, MPA

Ms. Day has more than 15 years' experience working in health care policy, including experience ensuring State and provider compliance with federal financial requirements. For Myers and Stauffer, she recently completed a project identifying and documenting potential fraud, waste, and abuse risks and vulnerabilities for several CMS alternative payment models, including CPC+, MSSP, CEC, and IAH. In addition, she worked with CMS program offices to identify potential mitigation strategies for risks and vulnerabilities. She also worked with the State of Vermont to develop its State Innovation Model (SIM) sustainability plan. As lead writer and researcher for the Vermont SIM sustainability plan, she completed research and analysis used to inform stakeholder inputs throughout the writing process, guided the State in identifying project requirements for sustainability, and facilitated the process by which the Vermont healthcare community gained consensus on SIM projects to sustain.

Currently, Ms. Day is working as an Innovation Agent with the State of New Hampshire DSRIP program. In this role, she is assisting the State in developing a statewide Learning Collaborative, as well as providing technical assistance in areas relevant to alternative payment models, behavioral and physical health integration, Substance Use Disorder, and Care Coordination.

Venesa Day, *MPA*

Senior Manager, Myers and Stauffer LC

EDUCATION

M.P.A., American University, 2003

B.A., Political Science, Morgan State University, 1999

EXPERIENCE

19 years professional experience

CORE COMPETENCIES

Medicaid institutional reimbursement policies

pay for performance and value-based purchasing policies

Myers and Stauffer Client Experience

New Hampshire Department of Health and Human Services (2017 – Present)
Delivery System Reform Incentive Program Learning Collaborative

Scope of Work:

Myers and Stauffer is providing professional services necessary to develop, operate and lead the Learning Collaborative – a required element of the Department of Health and Human Services' Building Capacity for Transformation, Section 1115 Medicaid Demonstration Waiver, #11-W-00301/1.

Responsibilities:

- Provided technical assistance and best practice research on a number of topics including incentives for MAT providers, Re-entry program principles, Critical Time Intervention principles and implementation, Behavioral/Physical Health Integration, Integrated care workforce position descriptions.
- Coordinated with the State, IDNs, and regional partners to deliver targeted Statewide and regional learning collaboratives tailored to meet the learning needs of the partners around integrated health and alternative payment models.
- Provided integration and process information to assist IDNs in meeting implementation goals.

Centers for Medicare & Medicaid Services (CMS) (2016 – 2017)
Center for Program Integrity (CPI) Medicare Access and CHIP Reauthorization Act (MACRA)
Scope of Work:
As a subcontractor to the RELI Group, the Myers and Stauffer team identified, studied and reported the risks and vulnerabilities of alternate payment models for CMS.
Responsibilities:

- Provided APM policy and process background to assist researchers in identifying potential vulnerabilities.
- Identified potential APM vulnerabilities within designated models.
- Provided support for the vulnerabilities identified, and I worked with CMS and the RELI partners to determine reasonable mitigation options.
- Coordinated and compiled research related to designated alternative payment models and worked with RELI and CMS to develop a narrative report outlining select APM risks, vulnerabilities, and potential mitigation options related to APM fraud, waste, and abuse.

Vermont Department of Vermont Health Access (2016 – 2017)
Vermont Health Care Innovation Project (VHCIP)/SIM Sustainability Plan
Scope of Work:
Myers and Stauffer supported the DVHA's efforts to conduct and facilitate stakeholder meetings, key informant interviews, and review projects and efforts implemented as part of the state's SIM project. We drafted the SIM Sustainability Plan to help the state identify innovation elements of SIM that should be continued after the end of the project. This work included a review of the operational and fiscal sustainability components.
Responsibilities:

- Compiled and coordinated industry research around sustainability and sustainability in health care programs.
- Develop a sustainability framework which ultimately became the outline and guide for the plan development.
- Compiled and coordinated research pertaining to Vermont Medicaid, SIM, ACOs, Programs, and Stakeholder organizations for inclusion and consideration in the sustainability plan.
- Conducted key informant interviews and convened stakeholder meetings to gather input on program sustainability.
- Outline State priorities and goals related to sustainability, as well as to manage stakeholder anxieties around broader system changes and the move to the Vermont All-payer model.
- Helped draft the SIMS sustainability plan according to CMS specifications. This included an initial draft, updates based on changes in policy and direction, as well as stakeholder feedback.
- Worked to ensure that the SIM sustainability plan incorporated concepts from related state projects – ensuring that the document minimized the continuance of silos detrimental to cross state efforts.
- Participated in stakeholder meetings as a facilitator, assisting the state and stakeholders in identifying the appropriate framework for sustainability.

Work History

Myers and Stauffer LC (2016 – Present), Senior Manager
Centers for Medicare & Medicaid Services, Center for Medicare (2015-2016), Acting Director Medicare Shared Savings Program (MSSP)
Centers for Medicare & Medicaid Services, Medicare and Medicaid Coordinated Care Office (2012 – 2015), Technical Director
Centers for Medicare & Medicaid Services, Centers for Medicaid and Children's Health Insurance Program (CHIP) Services, Financial Management Group (2001-2012), Technical Director

Presentations

"Medicare Access and CHIP Reauthorization Act (MACRA)," **MSLC** - Integrated Care Model Team, Indianapolis, IN, 2016.
"Medicare Access and CHIP Reauthorization Act (MACRA) - APM," **MSLC** - Atlanta RO, Atlanta, GA, 2016.
"Medicare Access and CHIP Reauthorization Act (MACRA) - MIPS," **MSLC** - Benefits/Program Integrity Team, Indianapolis, IN, 2016.
"Nevada Annual Training SAMHSA," Nevada State Staff, Reno, NV, 2017.
"Nevada Annual Training Health Homes for SMI," Nevada State Staff, Reno, NV, 2017.
"Plan Do Study Act, Info-Fresher," New Hampshire DSRIP IDN 2 All Partner Meeting, Concord, NH, 2017.
"Integrated Care Delivery 101," New Hampshire DSRIP Learning Collaborative, Concord, NH, 2017.

Reference	Address of Reference	Name of Contact	Contact Information
CMS	Centers for Medicare & Medicaid Services 7500 Security Boulevard Baltimore, Maryland 21244	Kristin Fan Director, Financial Management Group (FMG) Centers for Medicaid and CHIP Services (CMCS)	kristin.fan@CMS.hhs.gov P: 410-786-4581,
CMS	Centers for Medicare & Medicaid Services Atlanta Regional Office Atlanta Federal Center 61 Forsyth Street, SW, Suite 4T20 Atlanta, Georgia 30303	Heather Bond, Assistant Chief, Medicaid Regulatory Services and Compliance	Stanley.fields@cms.hhs.gov P: 502-223-5332,
CMS	Centers for Medicare & Medicaid Services Medicare – Medicaid Coordination Office 7500 Security Boulevard Baltimore, Maryland 21244	Stacey Lytle, Technical Director	Gerlda.hines@dhs.ga.gov P: 301-596-3754

Michael Johnson, CPA, CFE

Mr. Johnson, member with Myers and Stauffer, manages our Atlanta office. He has extensive experience working with state Medicaid clients on managed care initiatives and program integrity engagements, and currently serves as a partner-in-charge of our managed care engagement team.

During his career at Myers and Stauffer, Mr. Johnson has worked in all capacities on projects, including project director, project manager, and quality assurance. He provides high-level strategic input to assure successful completion of the project and the full satisfaction of the client.

Some of his accomplishments include the development of a strategy to reconcile MCO encounter claims back to financial records. With implementation of this strategy, the MCOs in several states have raised their completion rates and cleaned up erroneous encounters in the process. In addition, Mr. Johnson has worked with several states to implement many aspects of the recent CMS managed care regulation. This includes the development of a readiness review toolkit for health plans and conducting Medical Loss Ratio examinations.

Michael Johnson, *CPA, CFE*

Member, Myers and Stauffer LC

EDUCATION

B.B.A., Accounting, University of Georgia

1994

EXPERIENCE

24 years

professional experience

CORE COMPETENCIES

member and executive consultant for the firm

litigation consultation

MCO, encounter claims analysis, MLR, EHR, program integrity

provides high-level strategic input to state agency clients

Certifications

Certified Public Accountant
Certified Fraud Examiner

Affiliations

American Institute of Certified Public Accountants
Georgia Society of Certified Public Accountants
Association of Certified Fraud Examiners
National Healthcare Anti-Fraud Association

Myers and Stauffer Client Experience

Georgia Department of Community Health (2008 – Present)
Care Management Organization Compliance

Scope of Work:
Myers and Stauffer assists the Georgia Department of Community Health with providing oversight and monitoring of the Georgia Families Care Management Organizations (CMOs).

Responsibilities:

- Assisted the Department in the oversight of their managed care program.
- Validated encounter data.
- Conduct on-site reviews at CMOs addressing contract compliance.
- Conduct readiness reviews.

Georgia Department of Community Health (2008 – Present)
Benefits Testing
Scope of Work:
Myers and Stauffer assists the Georgia Department of Community Health to evaluate the accuracy of benefit payments made through the Medicaid program and Children's Health Insurance Program (CHIP).
Responsibilities:

- Oversee the work and delivery of the annual report detailing errors and issues with payments made by the Department.

Louisiana Department of Health (2015 – Present)
Managed Care Organization Oversight
Scope of Work:
Myers and Stauffer provides services to the Louisiana Department of Health for medical loss ratio (MLR) reviews of managed care organizations.
Responsibilities:

- Assisted the Department in the oversight of their managed care program.
- Validated encounter data.
- Conduct MLR examinations.

Maine Department of Health and Human Services (2014 – Present)
Audit Services for MaineCare MU Program
Scope of Work:
Myers and Stauffer provides professional audit services including the pre-payment review and post-payment audits of the registration, attestation, and payments made under the State's MaineCare Incentive Payment Program for Eligible Professionals and Eligible Hospitals under the federal Medicaid Meaningful Use Program since March 2014.
Responsibilities:

- Assisted the Department with their EHR incentive program.
- Directed a team that conducted the post-payment reviews of the incentive payments to ensure the payments were accurate, and in compliance with federal and state rules.

Mississippi Division of Medicaid (2015 – Present)
Outsourced Financial Reviews Mississippi Coordinated Access Network (MississippiCAN) and Health Information Technology/Health Information Exchange (HIT/HIE)
Scope of Work:
Myers and Stauffer assists the division in a wide-ranging assessment of the Coordinated Care Organizations' contract compliance. Under the contract, we perform encounter claim to cash disbursement journal reconciliations to assess completeness; assess encounter claim accuracy under CMS EQR Protocol 4; review capitation payments for payment accuracy and potential duplicated capitation payments; provide examination services of Medical Loss Ratio report filings; perform other compliance testing of other monthly monitoring tools; and assisted with the development of a quality improvement strategy and evaluate options for other forms of directed payments.
Responsibilities:

- Assisted the Department in the oversight of their managed care program.
- Conduct MLR examinations.

- Encounter Data Validation
- Review risk adjustment inputs.
- Assess compliance matters, including TPL, timely payment, denials, etc.

New Mexico Human Services Department (2015 – Present)
Medicaid Managed Care Compliance Reviews
Scope of Work:
Myers and Stauffer assists the department in assessing the compliance of the Medicaid MCOs with contract requirements.
Responsibilities:

- Assisted the Department in the oversight of their managed care program.
- Validated encounter data.
- Conduct on-site reviews at CMOs addressing contract compliance.

Work History

Myers and Stauffer LC (2008 – Present), Director, Member
Georgia Department of Audits and Accounts (1994-2008), Manager

Presentations

"Detecting Fraud, Abuse, and Errors in Fee-for-Service and Managed Care Programs," 25th Annual National Association of Medicaid Program Integrity Annual Conference.

"Identifying Improper Payments/Overpayments Using Data Mining," 27th Annual National Association of Medicaid Program Integrity Annual Conference.

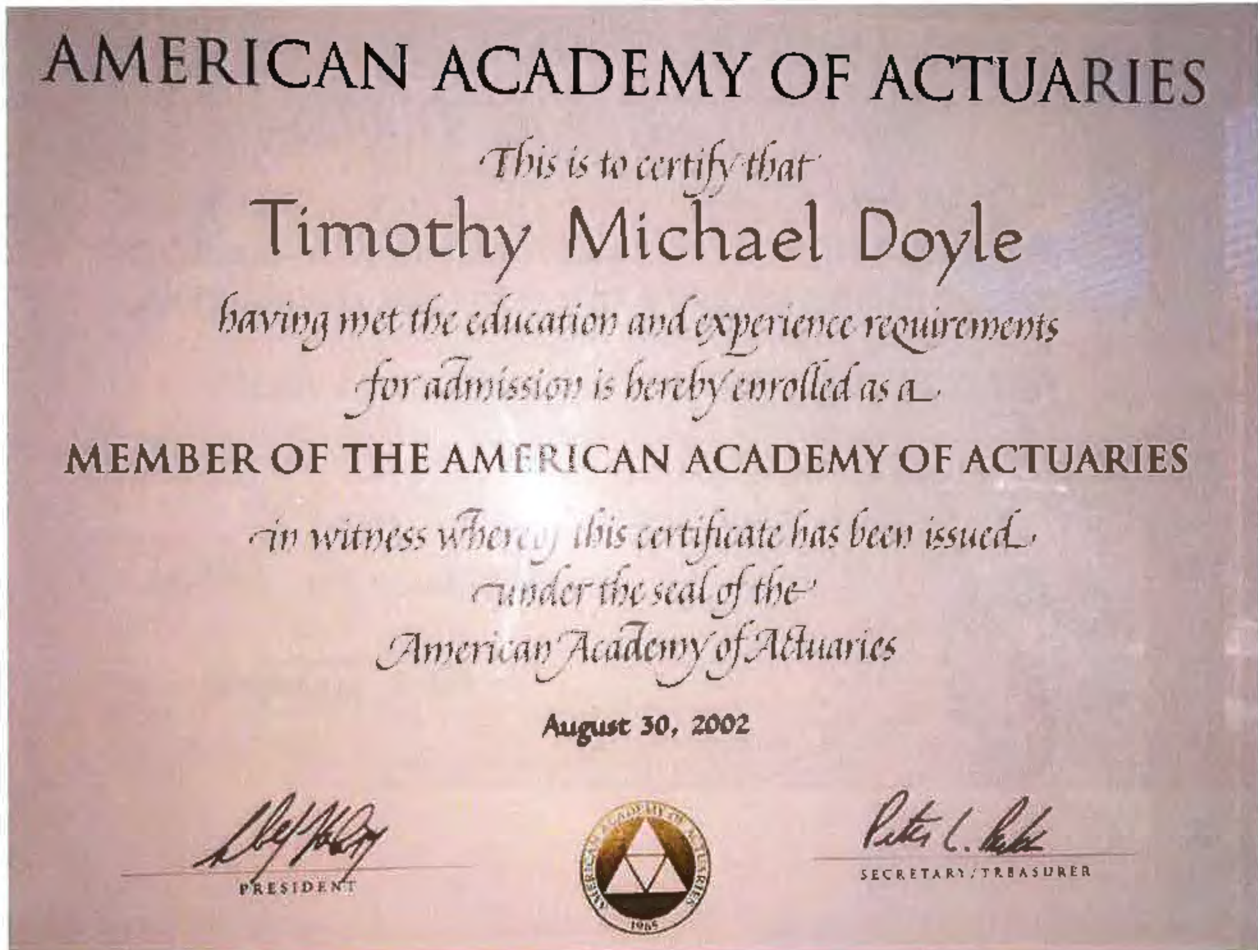
"Applying Recovery Audit Contractor (RAC) Concepts to Medicaid Managed Care," 28th Annual National Association of Medicaid Program Integrity Annual Conference.

"Medicaid Managed Care: Helpful Hints for Effective Monitoring and Ensuring Compliance," 29th Annual National Association of Medicaid Program Integrity Annual Conference.

Reference	Address of Reference	Name of Contact	Contact Information
Georgia	Georgia Department of Community Health 2 Peachtree St, 36th Floor, Atlanta, GA 30303	Lynnette Rhodes, JD Associate Chief, Medicaid Operations	lrhodes@dch.ga.gov P: 404.656.7513
Mississippi	Mississippi Division of Medicaid 550 High St, Suite 1000, Jackson, MS 39201	Phil Allen, CPA Chief Financial Officer	phillip.allen@medicaid.ms.gov P: 601.359.9561
Louisiana	Louisiana Department of Health Bienville Building 628 North 4th St Baton Rouge, LA 70802	Jen Steele, MPA Medicaid Director	Jen.steele@la.gov P: 337.354.5750

Appendix I(B) – Actuarial Credentials

Actuarial credentials for Tim, Barry, Zach, and Seth are provided below. Please note that one of our actuaries, Seth Adamson, received his designation in the past month, so his formal credentials are not yet available and have not been included in the response. In lieu of that, we have provided a screenshot of his Society of Actuary (SOA) directory listing from the SOA website.



AMERICAN ACADEMY OF ACTUARIES

This is to certify that

Timothy Michael Doyle

having met the education and experience requirements for admission is hereby enrolled as a

MEMBER OF THE AMERICAN ACADEMY OF ACTUARIES

in witness whereof this certificate has been issued under the seal of the American Academy of Actuaries

August 30, 2002

PRESIDENT

SECRETARY/TREASURER

SOCIETY OF ACTUARIES

SUCCESSOR TO THE ACTUARIAL SOCIETY OF AMERICA FOUNDED 1889
AND AMERICAN INSTITUTE OF ACTUARIES FOUNDED 1909

"THE WORK OF SCIENCE IS TO SUBSTITUTE FACTS FOR APPEARANCES AND DEMONSTRATIONS FOR IMPRESSIONS"
RUSKIN

THIS IS TO CERTIFY THAT

Timothy Michael Doyle

HAS SUCCESSFULLY COMPLETED THE EXAMINATIONS AND OTHER REQUIREMENTS AS PRESCRIBED BY THE BOARD OF GOVERNORS OF THE SOCIETY AND IS HEREBY ENROLLED AS A

FELLOW OF THE SOCIETY OF ACTUARIES

IN WITNESS WHEREOF THIS CERTIFICATE HAS BEEN ISSUED UNDER THE SEAL OF THE SOCIETY OF ACTUARIES AS OF THE *20th* DAY OF *May, 2005*

Stephen G. Kellison
PRESIDENT

SECRETARY

AMERICAN ACADEMY of ACTUARIES

This is to certify that

Barry Jordan Jr.

having met the admission requirements
for membership is hereby enrolled as a*

MEMBER OF THE AMERICAN ACADEMY of ACTUARIES

in witness whereof this certificate has been issued
under the seal of the
American Academy of Actuaries

January 13, 2016

PRESIDENT

SECRETARY-TREASURER

SOCIETY OF ACTUARIES

SUCCESSOR TO THE ACTUARIAL SOCIETY OF AMERICA FOUNDED [illegible]
AND AMERICAN INSTITUTE OF ACTUARIES FOUNDED [illegible]

"[illegible] SUBSTITUTE FACTS FOR APPEARANCES AND DEMONSTRATIONS FOR IMPRESSIONS"
[illegible]

THIS IS TO CERTIFY THAT

Barry Jordan

HAS SUCCESSFULLY COMPLETED THE EXAMINATIONS AND OTHER REQUIREMENTS AS PRESCRIBED BY THE BOARD OF DIRECTORS OF THE SOCIETY AND IS HEREBY ENROLLED AS AN

ASSOCIATE OF THE SOCIETY OF ACTUARIES

IN WITNESS WHEREOF THIS CERTIFICATE HAS BEEN ISSUED UNDER THE SEAL OF THE SOCIETY OF ACTUARIES ON 1st DAY OF December, 2015

President of Society of Actuaries

Secretary of Society of Actuaries

AMERICAN ACADEMY OF ACTUARIES

This is to certify that

Zach Aters

having met the education and experience requirements
for admission is hereby enrolled as a

MEMBER OF THE AMERICAN ACADEMY OF ACTUARIES

in witness whereof this certificate has been issued
under the seal of the
American Academy of Actuaries

July 30, 2009

PRESIDENT

SECRETARY/TREASURER

SOCIETY OF ACTUARIES

SUCCESSOR TO THE ACTUARIAL SOCIETY OF AMERICA FOUNDED 1889
AND AMERICAN INSTITUTE OF ACTUARIES FOUNDED 1909

"THE WORK OF SCIENCE IS TO SUBSTITUTE FACTS FOR APPEARANCES AND DEMONSTRATIONS FOR IMPRESSIONS."
RUSKIN

THIS IS TO CERTIFY THAT

Zachary Christian Aters

HAS SUCCESSFULLY COMPLETED THE EXAMINATIONS AND OTHER REQUIREMENTS AS PRESCRIBED BY THE BOARD OF DIRECTORS OF THE SOCIETY AND IS HEREBY ENROLLED AS AN

ASSOCIATE OF THE SOCIETY OF ACTUARIES

IN WITNESS WHEREOF THIS CERTIFICATE HAS BEEN ISSUED UNDER THE SEAL OF THE SOCIETY OF ACTUARIES AS OF THE *31st* DAY OF *July, 2009*

PRESIDENT

SECRETARY

SOCIETY OF ACTUARIES

SUCCESSOR TO THE ACTUARIAL SOCIETY OF AMERICA FOUNDED 1889
AND AMERICAN INSTITUTE OF ACTUARIES FOUNDED 1909

"THE WORK OF SCIENCE IS TO SUBSTITUTE FACTS FOR APPEARANCES AND DEMONSTRATIONS FOR IMPRESSIONS"
RUSKIN

THIS IS TO CERTIFY THAT

Seth Adamson

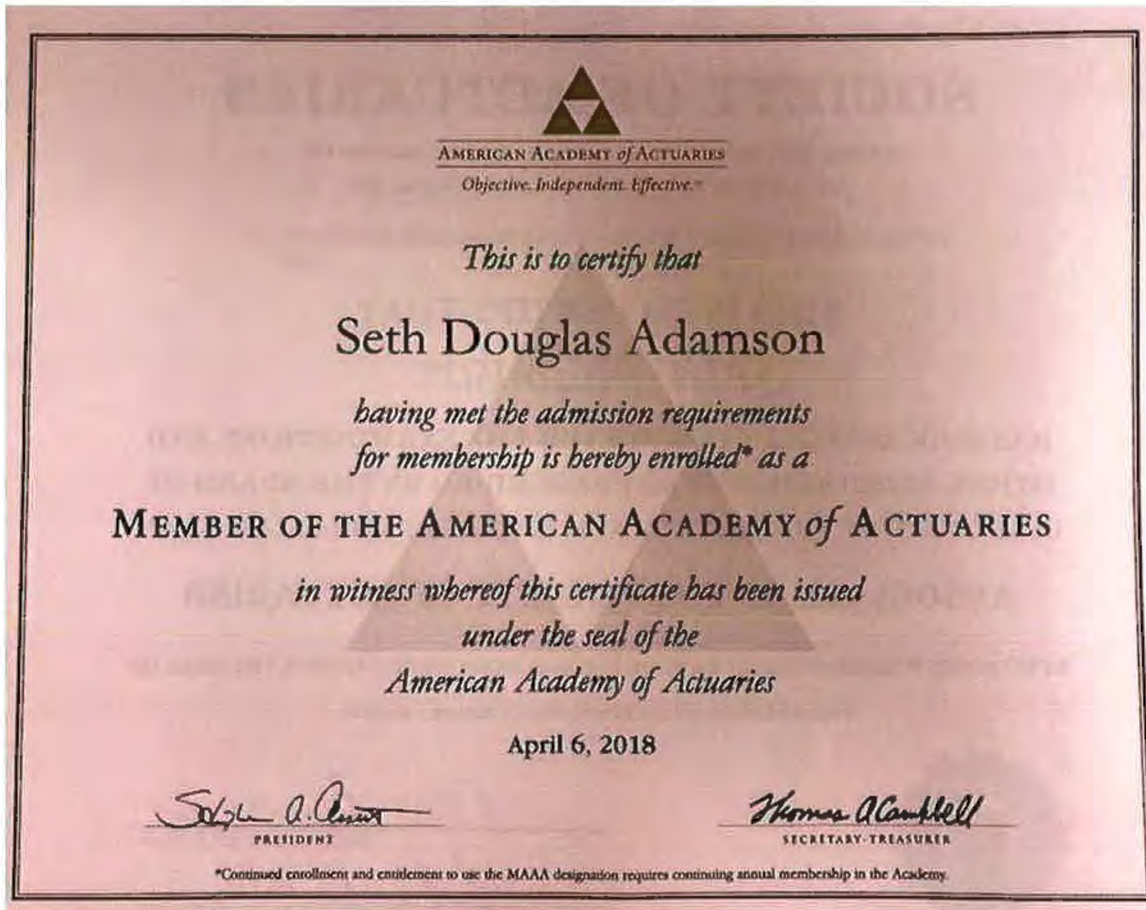
HAS SUCCESSFULLY COMPLETED THE EXAMINATIONS AND OTHER REQUIREMENTS AS PRESCRIBED BY THE BOARD OF DIRECTORS OF THE SOCIETY AND IS HEREBY ENROLLED AS AN

ASSOCIATE OF THE SOCIETY OF ACTUARIES

IN WITNESS WHEREOF THIS CERTIFICATE HAS BEEN ISSUED UNDER THE SEAL OF THE SOCIETY OF ACTUARIES ON March 1st, 2018

President of Society of Actuaries

Secretary of Society of Actuaries



AMERICAN ACADEMY *of* ACTUARIES

Objective. Independent. Effective.™

This is to certify that

Seth Douglas Adamson

having met the admission requirements
for membership is hereby enrolled as a*

MEMBER OF THE AMERICAN ACADEMY *of* ACTUARIES

in witness whereof this certificate has been issued
under the seal of the
American Academy of Actuaries

April 6, 2018

PRESIDENT

SECRETARY-TREASURER

*Continued enrollment and entitlement to use the MAAA designation requires continuing annual membership in the Academy.

Appendix II-Project Workplans

Appendix II – Project Workplans

Appendix II(A) – SOW 1 and SOW 2 Capitation Rate Setting and Rebasing Project Workplan

Item	Responsibility	Description	Due Date	Draft SFY20 Heritage Health Rate Setting Timelines							
				Nov 2018	Dec. 2019	Jan. 2019	Feb. 2019	Mar. 2019	Apr. 2019	May 2019	June 2019
Project Kickoff Meeting	All	Initial meeting to discuss project expectations and an overview of the timeline for capitation rate development.	11/1/2018								
Receive Encounter Data, Eligibility Data, and Financial Templates	State	State will provide an encounter and eligibility data extract and any supplemental information to be incorporated into the base data.	11/7/2018								
Final List of Policy Changes for SFY20 Rates	State	Provide final list of program/policy changes in effect for SFY20 contract period.	11/21/2018								
Data Validation	Optumas	Import eligibility and encounter data. Perform volume and validation checks to ensure that the data is complete.	11/23/2018								
Databook	Optumas	Provide databook to State.	11/30/2018								
MCO Touchpoint I	All	Discuss the summarized proposed base data and answer any questions on the data validation process.	12/7/2018								
Base Data Adjustments	Optumas	Account for any base data adjustments and provide summaries outlining the impact of each.	12/14/2018								
Risk Adjustment	Optumas	Conduct CDPS+RX risk score analysis. Analyze results and send summary for State to review.	12/21/2018								
Program/Policy Changes	Optumas	Incorporate any program/policy changes in to the rates and provide summaries outlining the impact of each.	12/21/2018								
MCO Touchpoint II	All	Review data adjustments: IBNR Risk Adjustment Program/policy changes	12/28/2018								
Trend	Optumas	Develop utilization and unit cost trends by COA and COS to trend base data to contract period.	1/3/2019								
Non-Medical Loading	Optumas	Develop admin, premium tax and HIPF non-medical loading percentages by COA.	1/4/2019								
HIPF	Optumas	Develop the estimated CY2020 HIPF.	1/4/2019								
MCO Touchpoint III	All	Review projection factors: Trend Non-medical load HIPF	1/8/2019								
Draft Rates to State for Feedback	Optumas	Provide draft rates to State for review.	1/10/2019								
State Provides Feedback on Rates	State	Provide feedback on rate setting policy decision and payment selection.	1/15/2019								
Final Rates	Optumas	Send final rates and rate ranges to State prior to presentation.	1/17/2019								
MCO Touchpoint IV	All	Present final rates.	1/22/2019								
Certification Letter	Optumas	Send certification letter to State.	1/29/2019								
Certification Letter	State	Send certification letter to CMS.	1/31/2019								
CMS Questions	Optumas	Respond to CMS questions regarding rates.	TBD								

Legend	
(blue)	State Responsibility
(red)	Optumas Responsibility
(yellow)	MCO Touchpoint

Please note: This is an example draft project plan timeline for capitation rate setting and capitation rebasing based on the process Optumas currently uses for the Heritage Health program. A final timeline and work plan will be developed upon discussion of the Department's goals and priorities for rate development. Rate development is shown on a Fiscal Year basis based on language in the RFP even though the Heritage Health contract is on a Calendar Year basis. Subsequent years would follow a similar timeline after adjusting for the Department's feedback.

Appendix II(B) – SOW 1 and SOW 2 MLTSS Capitation Rate Setting and Rebasing Project Workplan

				Draft SFY20 MLTSS Rate Setting Timelines							
Item	Responsibility	Description	Due Date	Nov 2018	Dec. 2019	Jan. 2019	Feb. 2019	Mar. 2019	Apr. 2019	May 2019	June 2019
Project Kickoff Meeting	All	Initial meeting to discuss project expectations and an overview of the timeline for capitation rate development.	11/1/2018								
Receive Encounter Data, Eligibility Data, and Financial Templates	State	State will provide an encounter and eligibility data extract and any supplemental information to be incorporated into the base data.	11/7/2018								
Final List of Policy Changes for SFY20 Rates	State	Provide final list of program/policy changes in effect for SFY20 contract period.	11/21/2018								
Data Validation	Optumas	Import eligibility and encounter data. Perform volume and validation checks to ensure that the data is complete.	11/23/2018								
LTSS Population and Service Analysis	Optumas	Analyze the distribution of service utilization within each LTSS cohort and perform durational checks to validate the Long Term Care or Waiver status of these populations. Analyze the mix of LTSS populations across the MCOs to determine if any additional adjustments are needed such as plan relativity factors when developing MCO-specific rates.	11/27/2018								
Databook	Optumas	Provide databook to State.	11/30/2018								
MCO Touchpoint I	All	Discuss the summarized proposed base data and answer any questions on the data validation process.	12/7/2018								
Base Data Adjustments	Optumas	Account for any base data adjustments and provide summaries outlining the impact of each.	12/14/2018								
Risk Adjustment	Optumas	Conduct CDPS+RX risk score analysis. Analyze results and send summary for State to review.	12/21/2018								
Program/Policy Changes	Optumas	Incorporate any program/policy changes in to the rates and provide summaries outlining the impact of each.	12/21/2018								
MCO Touchpoint II	All	Review data adjustments: IBNR Risk Adjustment Program/policy changes	12/28/2018								
Trend	Optumas	Develop utilization and unit cost trends by COA and COS to trend base data to contract period.	1/3/2019								
LTSS Nursing Facility/Waiver Blend Analysis	Optumas	Analyze the population distribution of Nursing Facility and Waiver members within the base data. Discuss any desired aspirational population mix assumptions with the Department prior to developing a blended LTSS rate.	1/3/2019								
Non-Medical Loading	Optumas	Develop admin, premium tax and HIPF non-medical loading percentages by COA.	1/4/2019								
HIPF	Optumas	Develop the estimated CY2020 HIPF.	1/4/2019								
MCO Touchpoint III	All	Review projection factors: Trend Non-medical load HIPF	1/8/2019								
Draft Rates to State for Feedback	Optumas	Provide draft rates to State for review.	1/10/2019								
State Provides Feedback on Rates	State	Provide feedback on rate setting policy decision and payment selection.	1/15/2019								
Final Rates	Optumas	Send final rates and rate ranges to State prior to presentation.	1/17/2019								
MCO Touchpoint IV	All	Present final rates.	1/22/2019								
Certification Letter	Optumas	Send certification letter to State.	1/29/2019								
Certification Letter	State	Send certification letter to CMS.	1/31/2019								
CMS Questions	Optumas	Respond to CMS questions regarding rates.	TBD								

	State Responsibility
	Optumas Responsibility
	MCO Touchpoint

Please note: This is an example draft project plan timeline for capitation rate setting and capitation rebasing that Optumas would use for the MLTSS program. A final timeline and work plan will be developed after discussing the Department's goals and priorities for rate development. Rate development has been shown on a Fiscal Year basis based on language in the RFP. Subsequent years would follow a similar timeline after adjusting for the Department's feedback.

Appendix II(C) – SOW 3 1915(b) Waiver Project Workplan

Item	Responsibility	Description	Due Date	Draft SFY20 1915(b) Waiver Timeline						
				Dec. 2019	Jan. 2019	Feb. 2019	Mar. 2019	Apr. 2019	May 2019	June 2019
Project Kickoff Meeting	State/Optumas	Initial meeting to discuss project expectations and an overview of the timeline for the 1915(b) project.	12/3/2018							
Waiver Design Documents	State/Optumas	Optumas will provide documentation illustrating our understanding of the Waiver design. The State will provide any available waiver submission/proposal documents.	12/5/2018							
Receive Encounter Data, Eligibility Data, and Financial Templates	State	State will provide an encounter and eligibility data extract and any supplemental information to be incorporated into the Waiver base data.	12/7/2018							
Final List of Policy Changes for SFY20 Rates	State	Provide final list of program/policy changes in effect for SFY20 contract period.	12/13/2018							
Data Validation	Optumas	Import eligibility and encounter data. Perform volume and validation checks on monthly enrollment and expenditures to ensure that the data is complete and any gaps are addressed.	12/20/2018							
Databook	Optumas	Provide databook after working with the State to identify the appropriate population Medicaid Eligibility Groups (MEGs) and Categories of Service (COS) applicable to the Waiver template.	12/20/2018							
Base Data Adjustments	Optumas	Account for any base data adjustments, such as IBNR, and provide summaries outlining the impact of each.	12/27/2018							
Program/Policy Changes	Optumas	Incorporate any retrospective or prospective program/policy changes that will impact the Waiver base data and provide summaries outlining the impact of each.	12/27/2018							
Regional Analysis	Optumas	Conduct a regional analysis to better understand the differences in risk for the different areas within the State.	1/3/2019							
Trend	Optumas	Develop MEG-specific utilization and unit cost trends by all MEG and COS combinations to trend base data to projection period.	1/3/2019							
Managed Care Savings Estimates	Optumas	Determine reasonable Managed Care Savings estimates for Waiver program (if applicable).	1/10/2019							
Non-Medical Loading	Optumas	Apply appropriate Non-Medical expenditures to the Waiver spend based on review of CMS 64 reports and other documents detailing state administrative spend.	1/17/2019							
Populate Waiver Model Pre-Printed Template Data	Optumas	Insert source data into internal (i.e. for DHHS and Optumas only) 'Data Documentation' Excel tabs. This includes incorporating recently-developed capitation rates as appropriate.	1/24/2019							
Populate Waiver Model Pre-Printed Template Assumptions	Optumas	Insert assumptions into internal (i.e. for DHHS and Optumas only) created 'Assumptions' Excel tab.	1/31/2019							
Create Draft Cost-Effectiveness Tables	Optumas	Vary assumptions to determine key factors in setting an achievable cost-effectiveness threshold.	2/7/2019							
State Provides Feedback on Waiver	State	Provide feedback on populated Waiver templates.	2/14/2019							
Finalize Cost-Effectiveness Demonstration	Optumas	Present Waiver Pre-Print showing that the waiver is cost effective for the current period and projected to remain cost effective over the waiver extension period.	2/21/2019							
Methodology Presentation	Optumas	Create a presentation for the State describing the methodology used for Waiver cost-effectiveness development.	2/21/2019							
Waiver Submission	State	State submits 1915(b) Waiver to CMS.	2/28/2019							
CMS Questions	Optumas	Provide support to the State in all negotiations with CMS and respond to any CMS questions.	TBD							

(blue)	State Responsibility
(orange)	Optumas Responsibility

Please note: This is an example draft project plan timeline for a 1915(b) Waiver submission based on the process Optumas currently uses for the Department's 1915(b) waiver. A final timeline and work plan will be developed after discussing the Department's goals and priorities for the Waiver submission. Subsequent years would follow a similar timeline after adjusting for the Department's feedback.

Appendix II(D) – SOW 4 PACE Rate Setting Project Workplan

Item	Responsibility	Description	Due Date	Draft SFY20 PACE UPL Development Timeline					
				Jan. 2019	Feb. 2019	Mar. 2019	Apr. 2019	May 2019	June 2019
Project Kickoff Meeting	State/Optumas	Initial meeting to discuss project expectations and an overview of the timeline for UPL and PACE rate development.	2/4/2019						
Receive FFS Data, Eligibility Data, and Supplemental CMS-64 Forms	State	State will provide FFS and eligibility data extracts and any supplemental information to be incorporated into the base data.	2/8/2019						
Final List of Policy Changes for SFY20 Rates	State	Provide final list of program/policy changes in effect for SFY20 contract period.	2/15/2019						
Data Validation	Optumas	Import eligibility and encounter data. Perform volume and validation checks to ensure that the data is complete and any gaps are identified and addressed.	2/22/2019						
Databook	Optumas	Provide databook to State for the appropriate PACE-like Waiver and Nursing Facility populations age 55+ that will comprise the base data for the UPL.	2/26/2019						
Base Data Adjustments	Optumas	Account for any base data adjustments, such as IBNR, and provide summaries outlining the impact of each.	3/1/2019						
Program/Policy Changes	Optumas	Incorporate any retrospective or prospective program/policy changes in to the UPL development and provide summaries outlining the impact of each.	3/4/2019						
Trend	Optumas	Develop utilization and unit cost trends by COA and COS to trend base data to contract period.	3/6/2019						
Regional Factor and NF/Waiver Mix Analysis	Optumas	Develop a regional factor and Nursing Facility/Waiver distribution mix analysis to calculate a blended rate.	3/8/2019						
Non-Medical Loading	Optumas	Develop UPL administrative load from the CMS-64 Forms to reflect State administration costs under FFS, consistent with the PACE UPL checklist.	3/11/2019						
Draft UPL to State for Feedback	Optumas	Provide draft UPL to State for review.	3/13/2019						
State Provides Feedback on Rates	State	Provide feedback on rate setting policy decision and final payment selection below the UPL.	3/18/2019						
Final Rates	Optumas	Send final rates to State and supporting exhibits	3/22/2019						
Methodology Letter	Optumas	Send UPL Methodology letter to State.	3/27/2019						
Methodology Letter	State	Send UPL Methodology letter to CMS.	3/29/2019						
CMS Questions	Optumas	Respond to CMS questions regarding rates.	TBD						

	State Responsibility
	Optumas Responsibility

Please note: This is an example project plan timeline for PACE UPL development based on the process Optumas currently uses for the Department's PACE rate development. A final timeline and work plan will be developed after discussing the Department's goals and priorities regarding PACE UPL development. Subsequent years would follow a similar timeline after adjusting for feedback from the Department.

Appendix II(E) – SOW 5 1115 Waiver Project Workplan

Item	Responsibility	Description	Due Date	Draft SFY20 1115 Waiver Timeline						
				Dec. 2019	Jan. 2019	Feb. 2019	Mar. 2019	Apr. 2019	May 2019	June 2019
Project Kickoff Meeting	State/Optumas	Initial meeting to discuss project background and an overview of the timeline for the 1115 project.	12/3/2018							
Waiver Design Documents	State/Optumas	Optumas will provide documentation illustrating our understanding of the Waiver design. The State will provide any available waiver submission/proposal documents, such as draft STCs.	12/5/2018							
Receive Encounter Data, Eligibility Data, and Financial Templates	State	State will provide an encounter and eligibility data extract and any supplemental information to be incorporated into the Waiver model.	12/7/2018							
Final List of Policy Changes for SFY20 Rates	State	Provide final list of program/policy changes in effect for SFY20 contract period.	12/13/2018							
Review Waiver Standard Terms and Conditions (STCs)	State/Optumas	Coordinate with the State to review/develop any required quarterly or annual monitor reporting per the Waiver STCs.	12/13/2018							
Data Validation	Optumas	Import eligibility and encounter data. Perform volume and validation checks on monthly enrollment and expenditures to ensure that the data is complete and any gaps are addressed.	12/20/2018							
Databook	Optumas	Provide databook summaries after working with the State to identify the appropriate population and services applicable to the 1115 Waiver.	12/20/2018							
Base Data Adjustments	Optumas	Account for any base data adjustments, such as IBNR, and provide summaries outlining the impact of each.	12/27/2018							
Program/Policy Changes	Optumas	Incorporate any retrospective or prospective program/policy changes that will impact the Waiver populations or services and provide summaries outlining the impact of each.	12/27/2018							
Trend	Optumas	Develop MEG-specific utilization and unit cost trends by all MEG and COS combinations to trend base data to projection period.	1/3/2019							
Non-Medical Loading	Optumas	Perform an administrative analysis that includes reviewing reported financials to assist in developing a reasonable non medical load for the Waiver projections.	1/17/2019							
Populate 1115 Waiver Templates	Optumas	Insert all source data and assumptions into CMS Waiver Templates providing supporting narrative as indicated.	1/24/2019							
Draft Budget Neutrality Calculation	Optumas	Conduct analysis demonstrating the budget neutrality of the Waiver service exception.	2/7/2019							
State Provides Feedback on Waiver	State	Provide feedback on populated Waiver templates.	2/14/2019							
Finalize Budget Neutrality Calculation	Optumas	Finalize budget neutrality analysis incorporating any State feedback.	2/21/2019							
Methodology Presentation	Optumas	Create a presentation for the State describing the methodology used for Waiver projections and budget neutrality calculations.	2/21/2019							
Waiver Submission	State	State submits 1115 Waiver to CMS.	2/28/2019							
CMS Questions	Optumas	Provide support to the State in all negotiations with CMS and respond to any CMS questions.	TBD							

	State Responsibility
	Optumas Responsibility

Please note: This is an example draft project plan timeline for 1115 Waiver submission based on the process Optumas currently uses for the Department's 1115 waiver. A final timeline and work plan will be developed after discussing the Department's goals and priorities for the Waiver submission. Subsequent years would follow a similar timeline after adjusting for the Department's feedback.

Appendix II(F) – SOW 6 and SOW 7 Dental Capitation Rate Setting and Rebasing Project Workplan

				Draft SFY20 Dental Rate Setting Timelines							
Item	Responsibility	Description	Due Date	Nov 2018	Dec. 2019	Jan. 2019	Feb. 2019	Mar. 2019	Apr. 2019	May 2019	June 2019
Project Kickoff Meeting	All	Initial meeting to discuss project expectations and an overview of the timeline for capitation rate development.	11/1/2018								
Receive Encounter Data, Eligibility Data, and Financial Templates	State	State will provide an encounter and eligibility data extract and any supplemental information to be incorporated into the base data.	11/7/2018								
Final List of Policy Changes for SFY20 Rates	State	Provide final list of program/policy changes in effect for SFY20 contract period.	11/21/2018								
Data Validation	Optumas	Import eligibility and encounter data. Perform volume and validation checks to ensure that the data is complete.	11/23/2018								
Databook	Optumas	Provide databook to State.	11/30/2018								
DBM Touchpoint I	All	Discuss the summarized proposed base data, financial template comparisons, and answer any questions on the data.	12/7/2018								
Base Data Adjustments	Optumas	Account for any base data adjustments and provide summaries outlining the impact of each.	12/14/2018								
Program/Policy Changes	Optumas	Incorporate any program/policy changes into the rates and provide summaries outlining the impact of each.	12/21/2018								
DBM Touchpoint II	All	Review data adjustments: IBNR Program/policy changes	12/28/2018								
Trend	Optumas	Develop utilization and unit cost trends by COA and COS to trend base data to contract period.	1/3/2019								
Non-Medical Loading	Optumas	Develop admin, premium tax and HIPF non-medical loading percentages by COA.	1/4/2019								
HIPF	Optumas	Develop the estimated CY2020 HIPF.	1/4/2019								
DBM Touchpoint III	All	Review projection factors: Trend Non-medical load HIPF	1/8/2019								
Draft Rates to State for Feedback	Optumas	Provide draft rates to State for review.	1/10/2019								
State Provides Feedback on Rates	State	Provide feedback on rate setting policy decision and payment selection.	1/15/2019								
Final Rates	Optumas	Send final rates and rate ranges to State prior to presentation.	1/17/2019								
DBM Touchpoint IV	All	Present final rates.	1/22/2019								
Certification Letter	Optumas	Send certification letter to State.	1/29/2019								
Certification Letter	State	Send certification letter to CMS.	1/31/2019								
CMS Questions	Optumas	Respond to CMS questions regarding rates.	TBD								

Legend	
(blue)	State Responsibility
(red)	Optumas Responsibility
(yellow)	DBM Touchpoint

Please note: This is an example draft project plan timeline for capitation rate setting and capitation rebasing based on the process Optumas currently uses for the Dental Benefits Managed Care program. A final timeline and work plan will be developed after discussing the Department's goals and priorities for rate development. Rate development is shown on a Fiscal Year basis consistent with current Nebraska DBM contracts and language in the RFP. Subsequent years would follow a similar timeline after adjusting for the Department's

Appendix II(G) – SOW 8 Special Projects Project Workplan

				Draft SFY20 Special Projects PROMETHEUS Timeline					
Item	Responsibility	Description	Due Date	Jan. 2019	Feb. 2019	Mar. 2019	Apr. 2019	May 2019	June 2019
Project Kickoff Meeting	All	Initial meeting to discuss project expectations and PROMETHEUS Analytics timeline with State and MCOs.	1/3/2019						
Receive Encounter Data and Eligibility Data	State	State will provide an encounter and eligibility data extract and any supplemental information to be incorporated into PROMETHEUS.	1/9/2019						
Data Prep and Validation	Optumas	Prepare data to match the format required to run through PROMETHEUS episode of care grouper.	1/23/2019						
Run PROMETHEUS	Optumas	Run Nebraska Medicaid data through PROMETHEUS and review output data and summaries.	2/13/2019						
Data Sharing 1	Optumas	Share Report Episode Detail files	2/20/2019						
Data Sharing 2	Optumas	Share provider-level summaries: 1) Total Episode Dollars by Provider 2) Total PAC Dollars by Provider 3) Share info. from #1/2, for top 5 episodes *Each of the above will likely require thresholds of Episode dollars for particular providers	2/27/2019						
MCO Touchpoint I	All	Touch-point for questions stemming from shared data/discussion around additional output data that may be shared with MCOs.	3/6/2019						
MCO Touchpoint II	All	Discuss draft methodology Optumas will use to convert PACs to an efficiency adjustment for managed care rates focusing on key episodes of interest.	3/13/2019						
Finalize PAC Efficiency Adjustment	Optumas	Develop additional data models and summaries to convert PACs to a final efficiency adjustment for managed care rates for key episodes and populations, taking into consideration State and MCO feedback.	3/18/2019						
Incorporate PROMETHEUS Adjustment Within Managed Care Rate Development	Optumas	Incorporate efficiency adjustment within managed care rate development.	3/20/2019						
MCO Touchpoint III	All	Discuss in more detail (including additional data and summaries) the final methodology and impact of converting PACs to an efficiency adjustment for managed care rates. Answer any follow-up questions from State and MCOs.	3/27/2019						
Methodology Narrative	Optumas	Develop methodology narrative to outline process for converting PACs to an efficiency adjustment to the managed care rates. This narrative will be inserted within the rate certification letter.	3/31/2019						

	State Responsibility
	Optumas Responsibility
	MCO Touchpoint

Please note: This is an example draft project plan for the PROMETHEUS Analytics special project. A final timeline and work plan will be developed after discussing the Department's goals and priorities regarding PROMETHEUS. Other special projects would follow a similar timeline based on direction from the Department.

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Appendix III – Banking Reference

North Valley Business Banking

MAC S4104-012
2123 W. Happy Valley Road
Phoenix, AZ 85085
623 587-3720
623 587-3724 Fax

Wells Fargo Bank, N.A.

May 16, 2018

Schramm Health Partners, LLC
7400 E. McDonald Drive, Suite #101
Scottsdale, AZ 85250

RE: Schramm Health Partners, LLC

To Whom It May Concern:

Please accept this letter as confirmation of the Business Banking relationship with Schramm Health Partners, LLC DBA Optumas.

Optumas has been a high value client at Wells Fargo Bank for approximately 4 years. Optumas maintains their Business Deposit Accounts with average yearly balances of approximately $1,600,000.

Optumas also maintains a revolving Line of Credit, multiple Business Credit Card accounts - which are always paid in full each month, and a Building Term loan.
All credit obligations with Wells Fargo Bank are all paid as agreed and managed very responsibly.

Wells Fargo considers Optumas a very high value client and appreciates the continued banking relationship.

If any further verification is required, please do not hesitate to contact me directly at my contact information below.

Sincerely,

Brian Kallemeyn
Vice President
Senior Business Relationship Manager
Brian.kallemeyn@wellsfargo.com
623-587-3736

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Appendix IV-Example of Key Deliverables

Appendix IV – Example of Key Deliverables

Appendix IV(A) – Sample Questions Log

Nebraska Questions and Clarifications Log

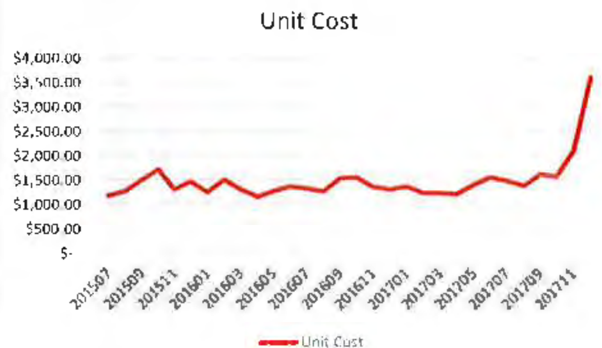
Drug Questions
Elig Questions
Facility Questions
Professional Questions
All Files
Gray shading denotes that the issue has been resolved

Ques. No.	Issue	Optumas Comments/Statements	Date Asked	Nebraska Response	Optumas Follow-up	Date Asked
1.0	Drug Header Fields	What are the valid values for the CAP_PAY_IND field and the CAT_SVC_CD field? What does each value mean?	15-Oct-2013	Y, N or ~ - Yes, No or missing; An indicator for capitation payment.		
2.0	Drug Control Totals	Optumas successfully matched total dollars for the CHG_ALLOW_DTL_AMT in the detail files with the Truven figures provided. However, for the 2007 header file, Optumas was unable to match total dollars for the CHG_ALLOW_HDR_AMT with the Truven figures. The file Optumas received is roughly $2 million less than the Truven control totals. How should we interpret this difference?	15-Oct-2013	Please provide the numbers in question so that we can investigate.	Optumas calculated a total CHG_ALLOW_HDR_AMT on the header file of $158,306,187.37 in 2007. The Truven figures suggest that the total CHG_ALLOW_HDR_AMT in 2007 should be $160,318,262.47. How should we interpret the $2 million difference?	31-Oct-2013
3.0	Eligibility Spans	When validating the eligibility files, Optumas noticed that eligibility spans consistently start on the first day of the month and end on the last day of the month, resulting in only whole member months. Can you confirm that partial member months are not valid in your program?	15-Oct-2013			
4.0	Facility Financial Fields	How do the financial fields relate between the Header and Detail files? Is it more appropriate to use the Detail or Header financial fields for facility claims?	15-Oct-2013		Optumas is still uncertain as to which financial fields we should rely on. We have proceeded with using the financial fields from the detail files.	31-Oct-2013
5.0	Facility Header Fields	What are the valid values for the CAP_PAY_IND field, the CAP_SVC_IND field, the DRG_PEER_GROUP field, the TYPE_OF_BILL_CD field, and the CAT_SVC_CD field? What does each value mean?	15-Oct-2013	See attachment "Data Dictionary for Optumas"		
6.0	Professional Detail Fields	What are the valid values for the CAP_PAY_IND field, the SEQUENCE_NBR_ID, and the CAP_SVC_IND field? What does each value mean?	15-Oct-2013	sequence_nbr_id: The sequence number of the claim line.	What is the relationship between the 'CAP_SVC_IND' and 'CAP_PAY_IND' fields?	31-Oct-2013
7.0	Professional and Facility Financial Fields	How does the DISALLOW_AMT relate to the CLAIM_BILLED_DTL_AMT? For example, we noticed that some claims have the same value for these two financial fields, and all other financial fields are 0. Are these denied claims? Additionally, is there a field in the data that tells us if a claim is denied?	31-Oct-2013			

Appendix IV(B) – Data Validation Summaries

COS: IP

MOE	Paid	Allowed	Units	Unit Cost
201507	$ 1,823,076	$ 1,834,808	1,572	$ 1,167.18
201508	$ 1,854,471	$ 1,865,725	1,475	$ 1,264.90
201509	$ 1,715,019	$ 1,724,009	1,157	$ 1,490.07
201510	$ 2,404,602	$ 2,417,133	1,426	$ 1,695.04
201511	$ 1,722,468	$ 1,732,127	1,327	$ 1,305.30
201512	$ 1,596,214	$ 1,603,989	1,108	$ 1,447.64
201601	$ 2,281,518	$ 2,297,758	1,855	$ 1,238.68
201602	$ 1,862,279	$ 1,871,759	1,253	$ 1,493.82
201603	$ 2,180,223	$ 2,192,233	1,693	$ 1,294.88
201604	$ 1,744,620	$ 1,755,530	1,519	$ 1,155.71
201605	$ 2,110,174	$ 2,121,545	1,673	$ 1,268.11
201606	$ 1,951,454	$ 1,961,271	1,445	$ 1,357.28
201607	$ 1,712,050	$ 1,721,370	1,300	$ 1,324.13
201608	$ 1,938,821	$ 1,949,371	1,537	$ 1,268.30
201609	$ 1,870,100	$ 1,878,540	1,226	$ 1,532.25
201610	$ 1,962,499	$ 1,973,222	1,274	$ 1,548.84
201611	$ 1,845,514	$ 1,854,214	1,367	$ 1,356.41
201612	$ 1,450,263	$ 1,458,163	1,127	$ 1,293.84
201701	$ 2,245,038	$ 2,256,938	1,652	$ 1,366.19
201702	$ 1,828,494	$ 1,838,934	1,502	$ 1,224.32
201703	$ 2,190,425	$ 2,203,445	1,797	$ 1,226.18
201704	$ 1,527,891	$ 1,535,939	1,276	$ 1,203.71
201705	$ 1,928,413	$ 1,936,913	1,392	$ 1,391.46
201706	$ 1,665,951	$ 1,672,111	1,073	$ 1,558.35
201707	$ 2,267,201	$ 2,277,571	1,540	$ 1,478.94
201708	$ 2,086,165	$ 2,094,789	1,513	$ 1,384.53
201709	$ 1,885,572	$ 1,892,282	1,183	$ 1,599.56
201710	$ 1,836,306	$ 1,843,777	1,174	$ 1,570.51
201711	$ 1,373,023	$ 1,377,723	659	$ 2,090.63
201712	$ 10,768	$ 10,798	3	$ 3,599.20



Appendix IV(C) – Sample MCO Financial Comparison Summary

MCO #1

	FY15 Financials					
	FY15 Q3					
COA	**MMs**	**Raw Dollars**	**IBNR**	**SubCap**	**Incentive/Provider**	**PMPM**
AABD 00-20 M&F	3,522	$ 2,024,381	$ 53,369	$ 8,888	$ 16,669	$ 597.19
AABD 21+ M&F	12,304	$ 8,964,342	$ 253,926	$ 31,050	$ 112,963	$ 760.91
AABD 21+ WWC	-	$ -	$ -	$ -	$ -	$ -
CHIP M&F	29,454	$ 2,160,882	$ 36,923	$ 74,327	$ 41,908	$ 78.57
Family Under 1 M&F	10,219	$ 2,906,636	$ 72,155	$ 25,789	$ 41,115	$ 298.03
Family 01-05 M&F	32,268	$ 5,227,161	$ 176,228	$ 81,429	$ 69,616	$ 172.14
Family 06-20 F	28,084	$ 1,867,798	$ 30,503	$ 70,871	$ 33,933	$ 71.33
Family 06-20 M	26,731	$ 1,556,993	$ 27,764	$ 67,457	$ 29,710	$ 62.92
Family 21+ M&F	23,007	$ 5,080,269	$ 86,376	$ 58,059	$ 78,473	$ 230.50
Foster Care M&F	3,635	$ 591,883	$ 12,781	$ 9,174	$ 9,058	$ 171.35
Katie Beckett 00-18 M&F	21	$ 242,079	$ 3,708	$ 53	$ 180	$ 11,715.24
Maternity	744	$ 4,688,717	$ 142,084	$ -	$ 71,372	$ 6,588.94
Total	**169,245**	**$ 35,311,140**	**$ 895,817**	**$ 427,098**	**$ 504,998**	**$ 219.44**

	FY15 Encounters					
	FY15 Q3					
COA	**MMs**	**Raw Dollars**	**IBNR**	**SubCap**	**Incentive/Provider**	**PMPM**
AABD 00-20 M&F	3,701	$ 2,038,245	$ 455	$ 8,888	$ 16,669	$ 557.76
AABD 21+ M&F	12,946	$ 9,467,923	$ 2,534	$ 31,050	$ 112,963	$ 742.66
AABD 21+ M&F-WWC	-	$ -	$ -	$ -	$ -	$ -
CHIP M&F	30,948	$ 2,158,614	$ 874	$ 74,327	$ 41,908	$ 73.53
Family Under 1 M&F	11,200	$ 4,000,243	$ 1,034	$ 25,789	$ 41,115	$ 363.23
Family 01-05 M&F	33,983	$ 3,754,632	$ 1,325	$ 81,429	$ 69,616	$ 114.97
Family 06-20 F	29,685	$ 1,893,827	$ 810	$ 70,871	$ 33,933	$ 67.36
Family 06-20 M	28,310	$ 1,585,861	$ 673	$ 67,457	$ 29,710	$ 59.47
Family 21+ M&F	24,250	$ 5,114,496	$ 1,901	$ 58,059	$ 78,473	$ 216.62
Foster Care M&F	3,859	$ 672,386	$ 186	$ 9,174	$ 9,058	$ 179.01
Katie Beckett 00-18 M&F	22	$ 249,544	$ 3	$ 53	$ 180	$ 11,353.64
Maternity	706	$ 4,564,695	$ 1,174	$ -	$ 71,372	$ 6,568.33
Total	**178,904**	**$ 35,500,467**	**$ 10,967**	**$ 427,098**	**$ 504,998**	**$ 203.70**

	Financials Minus Encounters					
	FY15 Q3					
COA	**MMs**	**Raw Dollars**	**IBNR**	**SubCap**	**Incentive/Provider**	**PMPM**
AABD 00-20 M&F	(179)	$ (13,864)	$ 52,914	$ -	$ -	$ 39.43
AABD 21+ M&F	(642)	$ (503,582)	$ 251,393	$ -	$ -	$ 18.25
AABD 21+ M&F-WWC	-	$ -	$ -	$ -	$ -	$ -
CHIP M&F	(1,494)	$ 2,268	$ 36,049	$ -	$ -	$ 5.03
Family Under 1 M&F	(981)	$ (1,093,608)	$ 71,121	$ -	$ -	$ (65.20)
Family 01-05 M&F	(1,715)	$ 1,472,529	$ 174,903	$ -	$ -	$ 57.17
Family 06-20 F	(1,601)	$ (26,029)	$ 29,694	$ -	$ -	$ 3.97
Family 06-20 M	(1,579)	$ (28,869)	$ 27,091	$ -	$ -	$ 3.45
Family 21+ M&F	(1,243)	$ (34,227)	$ 84,475	$ -	$ -	$ 13.89
Foster Care M&F	(224)	$ (80,503)	$ 12,595	$ -	$ -	$ (7.66)
Katie Beckett 00-18 M&F	(1)	$ (7,465)	$ 3,705	$ -	$ -	$ 361.60
Maternity	38	$ 124,022	$ 140,910	$ -	$ -	$ 20.61
Total	**(9,659)**	**$ (189,328)**	**$ 884,851**	**$ -**	**$ -**	**$ 15.74**

Appendix IV(D) – Sample Base Data Summary

Rating Region	COA	CY15 Base Data					
		MMs	Dollars	Units	Util/1000	Unit Cost	PMPM
1	AABD 00-20 M&F	37,398	$ 34,797,880	171,345	54,980	$ 203	$ 930.47
1	AABD 21+ M&F	114,625	$164,623,199	1,130,496	118,351	$ 146	$ 1,436.19
1	AABD 21+ M&F-WWC	1,071	$ 2,309,063	9,303	104,235	$ 248	$ 2,155.99
1	CHIP M&F	294,289	$ 39,098,200	362,378	14,776	$ 108	$ 132.86
1	Family Under 1 M&F	115,578	$ 68,143,920	260,995	27,098	$ 261	$ 589.59
1	Family 01-05 M&F	348,695	$ 40,582,645	432,504	14,884	$ 94	$ 116.38
1	Family 06-20 F	316,941	$ 41,209,601	401,231	15,191	$ 103	$ 130.02
1	Family 06 20 M	305,121	$ 42,736,539	415,705	16,349	$ 103	$ 140.06
1	Family 21+ M&F	243,769	$ 77,283,707	658,010	32,392	$ 117	$ 317.04
1	Foster Care M&F	87,154	$ 33,862,601	317,130	43,665	$ 107	$ 388.54
1	Healthy Dual	192,034	$ 51,846,190	1,085,135	67,809	$ 48	$ 269.98
1	Dual LTC	58,136	$ 12,739,018	326,157	67,323	$ 39	$ 219.12
1	Non-Dual LTC	5,615	$ 15,168,032	112,860	241,197	$ 134	$ 2,701.34
1	Dual Waiver	50,539	$ 12,995,912	358,677	85,164	$ 36	$ 257.15
1	Non-Dual Waiver	29,012	$ 38,189,108	314,432	130,056	$ 121	$ 1,316.32
1	Katie Beckett 00-18 M&F	438	$ 5,493,559	15,002	411,014	$ 366	$12,542.37
1	599 CHIP - Cohort	6,673	$ 1,973,730	26,740	48,086	$ 74	$ 295.78
1	599 CHIP - Supplemental	1,242	$ 5,646,418	5,983	57,807	$ 944	$ 4,546.23
1	Maternity	6,893	$ 48,444,932	196,362	341,846	$ 247	$ 7,028.13
Total	Total	2,207,088	$737,144,254	6,600,445	35,887	$ 112	$ 333.99
2	AABD 00-20 M&F	10,072	$ 9,821,262	52,732	62,826	$ 186	$ 975.11
2	AABD 21+ M&F	29,102	$ 42,070,233	307,683	126,871	$ 137	$ 1,445.61
2	AABD 21+ M&F-WWC	424	$ 1,223,455	4,946	139,981	$ 247	$ 2,885.51
2	CHIP M&F	98,037	$ 13,109,275	122,600	15,007	$ 107	$ 133.72
2	Family Under 1 M&F	35,493	$ 18,643,411	77,941	26,351	$ 239	$ 525.27
2	Family 01-05 M&F	99,060	$ 11,610,282	119,678	14,498	$ 97	$ 117.20
2	Family 06-20 F	92,674	$ 12,820,210	129,279	16,740	$ 99	$ 138.34
2	Family 06-20 M	89,148	$ 14,515,742	121,127	16,305	$ 120	$ 162.83
2	Family 21+ M&F	69,277	$ 26,137,176	205,434	35,585	$ 127	$ 377.29
2	Foster Care M&F	22,663	$ 8,491,959	67,023	35,489	$ 127	$ 374.71
2	Healthy Dual	64,467	$ 15,084,681	329,391	61,313	$ 46	$ 233.99
2	Dual LTC	22,665	$ 4,036,475	119,077	63,045	$ 34	$ 178.09
2	Non-Dual LTC	1,918	$ 3,231,331	31,499	197,074	$ 103	$ 1,684.74
2	Dual Waiver	23,031	$ 5,379,214	151,751	79,068	$ 35	$ 233.56
2	Non-Dual Waiver	6,721	$ 8,465,023	75,793	135,325	$ 112	$ 1,259.49
2	Katie Beckett 00 18 M&F						
2	599 CHIP - Cohort						
2	599 CHIP - Supplemental						
2	Maternity	2,206	$ 15,537,576	63,243	344,024	$ 246	$ 7,043.33
Total	Total	664,752	$210,177,303	1,979,197	35,728	$ 106	$ 316.17

Appendix IV(E) – Sample Policy Changes Log

Color Key
MLTSS
PH and MLTSS
BH and MLTSS
PH, BH, and MLTSS

No.	Program Change	Effective Date	Impact	Description of Program Change	Populations Affected	Services Affected
12-59	Aged and Disabled Medicaid Waiver Assisted Living Rates	1/1/2013	1.54%	The Medicaid portion of the Waiver assisted living rates will increase by 1.54%	All populations	NF and Waiver
12-62	New Dental Procedure Code	1/1/2013	TBD	Effective January 1, 2013 The American Dental Association procedure codes D1203 (topical application of fluoride-child) and D1204 (topical application of fluoride-adult) will become obsolete. The new procedure code that replaces D1203 and D1204 is D1208 (topical application of fluoride).	All populations	Dental Services
12-63	Enhanced Primary Care Rates	1/1/2013	TBD	Effective January 1, 2013, certain physicians who provide eligible primary care services to Medicaid clients are eligible to be paid the Medicare rates in effect in calendar years (CY) 2013 and 2014 instead of their usual state-established Medicaid rates.	All populations	Physician Services
12-64	Base Rates for Levels 101-105	1/1/2013	NF: Rural- $72.43 Urban - $81.60 Hospice: Rural - $68.81 Urban - $77.52	Base rates of Levels 101, 102, 103, 104, and 105 for NF and hospice providers will increase.	All populations	NF and Hospice
13-05	Medicaid Swing Bed Per Diem Rate	1/1/2013		Medicaid per diem rate for SNF care in hospital swing beds will be increased to $159.57	All populations	SNF
13-22	Psychiatric diagnostic evaluation daily limit	1/1/2013	TBD	Providers may only report psychiatric diagnostic evaluation CPT codes 90791 or 90792 once per day for the same patient	All populations	Behavioral Health Services
13-38	BH E/M Services in a NF or PRTC	1/1/2013		Updates/Fee Schedule As a result of the 2013 CPT code changes, the pharmacological management CPT code 90862 was made obsolete. See table in attachment.	All populations	BH E/M Services in a NF or PRTC
13-12	Prenatal Visit CPT Codes	4/1/2013	59400 U1 - $1,420.30 59510 U1 - $1,772.30 59610 U1 - $1,695.90	CMS has directed the State to reimburse 599CHIP prenatal visits and delivery services under a bundled rate methodology.	599CHIP	Delivery (prenatal and event) services
13-24	Coverage of Makena	4/1/2013	TBD	The brand name Makena will be covered by Nebraska Medicaid as a physician administered injectable medication beginning with date of service April 1, 2013. New Code: J1725	All populations	Physician Administered Injectable Medication
13-39	Updated Fee Schedules	7/1/2013	2.25%	Updated Provider Fee Schedules	All populations	All services

Appendix IV(F) – Sample Prevalence Report

COA:	CHIP M&F
CDPS Aid Category:	AC
Rating Region:	1
Study Period:	CY16
Snapshot Month:	4/17
MCO:	Regional

Demographic Weights			
Demo Category	Weight	Scored Members	Unscored Members
Under Age 1	-0.01400	1,185	308
Age 1-4	-0.07240	3,181	381
Age 5-14 Male	-0.08207	7,112	652
Age 5-14 Female	-0.09487	6,693	672
Age 15-24 Male	0.00000	2,020	247
Age 15-24 Female	0.31739	2,057	226
Total		22,248	2,486

Score Calculation	
Score Type	Value
Demo Score, Scored Members	(0.037)
Disease Score, Scored Members	1.097
Total Score, Scored Members	1.061
Demo Score, Unscored Members	(0.031)
Disease Score, Unscored Members	1.097
Total Score, Unscored Members	1.066
Total Raw Risk Score	1.061
Credibility	100%
Region Raw Risk Score	1.061
Credibility Adjusted Score	1.061
Normalized Risk Score	1.000
Final, 50% Phase-in Score	**1.000**

Disease Weights		
Disease Category	Weight	Scored Members
AIDS, high	7.38449	2
Cancer, high	7.89288	11
Cancer, low	1.44934	3
Cancer, medium	1.66703	5
Cancer, very high	19.97167	1
Cardiovascular, extra low	1.06402	58
Cardiovascular, low	1.06402	221
Cardiovascular, medium	1.87669	62
Cerebrovascular, low	1.70465	479
CNS, high	14.57699	3
CNS, low	1.21223	270
CNS, medium	3.90798	35
DD, low	2.66254	48
Diabetes, type 2 low	1.28959	68
Eye, very low	0.49497	95
Genital, extra low	0.36859	112
Gastro, high	17.82758	31
Gastro, low	0.47159	640
Gastro, medium	1.69968	47
Hematological, extra high	39.67883	3
Hematological, low	0.53920	34
Hematological, medium	1.06295	75
Hematological, very high	3.14010	9
HIV, medium	1.23039	1
Infectious, high	7.38449	5
Infectious, low	0.15844	125
Infectious, medium	1.23039	22
Metabolic, high	4.46729	73
Metabolic, medium	1.76520	67
Metabolic, very low	1.17967	327
Psychiatric, high	6.09640	2
Psychiatric, low	0.98791	599
Psychiatric, medium	3.99746	208
Psychiatric, medium low	1.60402	1,963
Pulmonary, high	7.58002	19
Pulmonary, low	0.40551	2,052
Pulmonary, medium	1.49942	59
Renal, low	0.77195	245
Renal, medium	2.19631	7
Renal, very high	7.13112	22
Skeletal, low	0.37118	487
Skeletal, medium	0.77670	206
Skeletal, very low	0.19444	250
Skin, high	4.79502	5
Skin, low	0.77504	7
Skin, very low	0.14212	782
Substance abuse, low	1.02806	26
Substance abuse, very low	0.77072	26
Pharmacy-only: Anti coagulants	1.87669	3
Pharmacy-only: Cardiac	1.06402	370
Pharmacy-only: Psychosis/Bipolar/ Depression	0.98791	159
Pharmacy-only: Diabetes	1.28959	56
Pharmacy-only: Hepatitis	1.23039	1
Pharmacy-only: Infections, high	7.38449	5
Pharmacy-only: Inflammatory /Autoimmune	0.19444	18
Pharmacy-only: Malignancies	1.66703	16
Pharmacy-only: Multiple Sclerosis / Paralysis	3.90798	5
Pharmacy-only: Parkinsons / Tremor	1.21223	6
Pharmacy-only: Seizure disorders	1.21223	90
Pharmacy-only: Tuberculosis	0.40551	6
No Disease	0.57163	14,679
Disease Intercept	0.57163	7,569

Appendix IV(G) – Sample Meeting Minutes Log

[Meeting Title]
Meeting Minutes

[Client Logo Goes Here]

Subject	*[Enter Meeting Subject]*	Date	*[enter meeting date]*
Facilitator	*[enter facilitator]*	Time	*[enter meeting time]*
Location	*[enter location or conference call info]*	Scribe	*[enter scribe's name]*
Attendees	*[enter attendee list]*		
	[continue attendee list if required]		

Key Points Discussed		
No.	**Topic**	**Highlights**
1.	*[enter discussion topics in chronological order as they happened during meeting]*	*[enter key points from discussion.]*
2.		
3.		
4.		
5.		

Action Plan			
No.	**Action Item(s)**	**Owner**	**Target Date**
1.	*[enter action items that resulted from the meeting]*	*[enter the person responsible for seeing the action item to completion]*	*[enter target date for completion of action item]*
2.			
3.			
4.			
5.			

Page 1 of 1

Optumas
7400 E. McDonald Drive Suite 101
Scottsdale, AZ 85250

480.588.2499 (office)
480.315.1795 (fax)

www.**Optumas**.com

Response to the
Nebraska State Purchasing Bureau

Solicitation Number RFP 5868 Z1
Medicaid Managed Care Actuarial and Consulting Services

Cost Proposal

Original

Submitted by:
Optumas
7400 E. McDonald Drive Suite 101
Scottsdale, AZ 85250

Response to the
Nebraska State Purchasing Bureau

Solicitation Number RFP 5868 Z1
Medicaid Managed Care Actuarial and Consulting Services

Cost Proposal

Original

Submitted by:
Optumas
7400 E. McDonald Drive Suite 101
Scottsdale, AZ 85250

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Transmittal Letter

Transmittal Letter

July 10, 2018

Ms. Nancy Storant and Ms. Teresa Fleming
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

Subject: Request for Proposal (RFP #5868 Z1) — Medicaid Managed Care Actuarial and Consulting Services for Nebraska Medicaid

Dear Ms. Storant and Ms. Fleming:

Per Section VII of the RFP, we have provided a Cost Proposal using the State's Cost Sheet in accordance with Section I Submission of Proposal.

The Cost Proposal presents the total fixed price to perform all the requirements of the RFP. We understand that the State reserves the right to review all aspects of cost for reasonableness and to request clarification of any proposal where the cost component shows significant and unsupported deviation from industry standards or in areas where detailed pricing is required.

Prices quoted in the Cost Proposal are net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the RFP. We understand that no additional charges will be allowed for packing, packages, or partial delivery costs and that when an arithmetic error has been made in the extended total, the unit price will govern.

I, Steven P. Schramm, will be the **Optumas** team contact person regarding this RFP and I am the person authorized to bind **Optumas** to all statements, including services and prices, contained in the proposal and any RFP addenda. My contact information is noted below.

Sincerely,

By: ______________________ Date: July 10, 2018

Steven P. Schramm
Managing Director
Schramm Health Partners, LLC dba **Optumas**
7400 East McDonald Drive, Suite #101
Scottsdale, AZ 85250
480.588.2493 (Direct)
480.315.1795 (Fax)
602.625.6155 (Cell)
Email: Steve.Schramm@Optumas.com
Website: www.Optumas.com

Section VII. Cost Proposal Requirements

Section VII. Cost Proposal Requirements

Within this section of our RFP response we provide the Cost Proposal references in "VII. Cost Proposal Requirements" on page 34 of the RFP.

Attachment A – Cost Proposal

Please see the following pages for the Cost Proposal provided using the State's Cost Sheet

Attachment A:
Cost Proposal

Attachment A
Cost Proposal
Request for Proposal Number 5868 Z1

Bidder is to complete and return this form with their Bid Submission.

Bidder is to provide a cost for each SOW and for each plan year shown with an "X".

BIDDER NAME: **Schramm Health Partners, LLC dba Optumas**

	Plan Year									
DESCRIPTION	January 2019 – December 2019		January 2020 – December 2020		January 2021 – December 2021		January 2022 – December 2022		January 2023 – December 2023	
SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination	x	$70,000	x	$70,000	x	$70,700	x	$70,700	x	$70,700
Rate Data analysis and Manipulation	x	$60,000	x	$60,000	x	$60,600	x	$60,600	x	$60,600
Interim Reporting and other Deliverables for Rate Setting Functions	x	$60,000	x	$60,000	x	$60,600	x	$60,600	x	$60,600
Capitation Rate Updates - Two (2) or more times per year	EA	$45,000	EA	$45,000	EA	$45,450	EA	$45,450	EA	$45,450
Capitation Rate Finalization	x	$45,000	x	$45,000	x	$45,450	x	$45,450	x	$45,450
SOW 2 – Capitation Rate Rebasing – One (1) time for contract duration	$150,000									
SOW 3 - 1915(b) Waiver	x	$35,000	x	$35,000	x	$35,350	x	$35,350	x	$35,350
SOW 4 - PACE	x	$30,000	x	$30,000	x	$30,300	x	$30,300	x	$30,300
SOW 5 – 1115 Waiver	x	$50,000	x	$50,000	x	$50,500	x	$50,500	x	$50,500
SOW 6- Dental Rate Setting	x	$12,500	x	$12,500	x	$12,625	x	$12,625	x	$12,625
Rate Data Analysis and Manipulation	x	$10,000	x	$10,000	x	$10,100	x	$10,100	x	$10,100
Interim Reporting and Other Deliverables for Rate Setting Functions	x	$10,000	x	$10,000	x	$10,100	x	$10,100	x	$10,100
Capitation Rate Updates - Two (2) or more times per year	EA	$20,000	EA	$20,000	EA	$20,200	EA	$20,200	EA	$20,200
Dental Capitation Rate Finalization	x	$10,000	x	$10,000	x	$10,100	x	$10,100	x	$10,100
SOW 7- Dental Rebasing– One (1) time for contract duration	$30,000									

Please Note:

SOW 1 and **SOW 2** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan.
SOW 3 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period.
SOW 4 Upper payment limits for PACE
SOW 5 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period
SOW 6 and **SOW 7** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan.

OPTIONAL RENEWALS

DESCRIPTION	First Optional Renewal Period – Year One		First Optional Renewal Period – Year Two	
	January 2024 – December 2024		January 2025 – December 2025	
SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination	x	$71,407	x	$71,407
Rate Data analysis and Manipulation	x	$60,600	x	$60,600
Interim Reporting and other Deliverables for Rate Setting Functions	x	$61,206	x	$61,206
Capitation Rate Updates – Two (2) or more times per year	EA	$61,206	EA	$61,206
Capitation Rate Finalization	x	$45,905	x	$45,905
SOW 2 – Capitation Rate Rebasing – One (1) time for contract duration	$153,015			
SOW 3 - 1915(b) Waiver	x	$35,704	x	$35,704
SOW 4 - PACE	x	$30,603	x	$30,603
SOW 5 – 1115 Waiver	x	$51,005	x	$51,005
SOW 6- Dental Rate Setting	x	$12,751	x	$12,751
Rate Data Analysis and Manipulation	x	$10,201	x	$10,201
Interim Reporting and Other Deliverables for Rate Setting Functions	x	$10,201	x	$10,201
Capitation Rate Updates - Two (2) or more times per year	EA	$20,402	EA	$20,402
Dental Capitation Rate Finalization	x	$10,201	x	$10,201
SOW 7- Dental Rebasing– One (1) time for contract duration	$30,603			

Please Note:

SOW 1 and **SOW 2** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan.
SOW 3 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period.
SOW 4 Upper payment limits for PACE
SOW 5 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period
SOW 6 and **SOW 7** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan

BIDDER NAME: **Schramm Health Partners, LLC dba Optumas**

DESCRIPTION	Second Optional Renewal Period – Year One January 2026 – December 2026		Second Optional Renewal Period – Year Two January 2027 – December 2027	
SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination	x	$72,121	x	$72,121
Rate Data analysis and Manipulation	x	$60,600	x	$60,600
Interim Reporting and other Deliverables for Rate Setting Functions	x	$61,818	x	$61,818
Capitation Rate Updates – Two (2) or more times per year	EA	$61,818	EA	$61,818
Capitation Rate Finalization	x	$46,364	x	$46,364
SOW 2 – Capitation Rate Rebasing – One (1) time for contract duration	$154,545			
SOW 3 - 1915(b) Waiver	x	$36,061	x	$36,061
SOW 4 - PACE	x	$30,909	x	$30,909
SOW 5 – 1115 Waiver	x	$51,515	x	$51,515
SOW 6- Dental Rate Setting	x	$12,879	x	$12,879
Rate Data Analysis and Manipulation	x	$10,303	x	$10,303
Interim Reporting and Other Deliverables for Rate Setting Functions	x	$10,303	x	$10,303
Capitation Rate Updates - Two (2) or more times per year	EA	$20,606	EA	$20,606
Dental Capitation Rate Finalization	x	$10,303	x	$10,303
SOW 7- Dental Rebasing– One (1) time for contract duration	$30,909			

Please Note:

SOW 1 and **SOW 2** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan.
SOW 3 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period.
SOW 4 Upper payment limits for PACE
SOW 5 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period
SOW 6 and **SOW 7** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan

BIDDER NAME: **Schramm Health Partners, LLC dba Optumas**

DESCRIPTION	Third Optional Renewal Period – Year One		Third Optional Renewal Period – Year Two	
	January 2028 – December 2028		January 2029 – December 2029	
SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination	x	$72,842	x	$72,842
Rate Data analysis and Manipulation	x	$60,600	x	$60,600
Interim Reporting and other Deliverables for Rate Setting Functions	x	$62,436	x	$62,436
Capitation Rate Updates – Two (2) or more times per year	EA	$62,436	EA	$62,436
Capitation Rate Finalization	x	$46,827	x	$46,827
SOW 2 – Capitation Rate Rebasing – One (1) time for contract duration	$156,091			
SOW 3 - 1915(b) Waiver	x	$36,421	x	$36,421
SOW 4 - PACE	x	$31,218	x	$31,218
SOW 5 – 1115 Waiver	x	$52,030	x	$52,030
SOW 6- Dental Rate Setting	x	$13,008	x	$13,008
Rate Data Analysis and Manipulation	x	$10,406	x	$10,406
Interim Reporting and Other Deliverables for Rate Setting Functions	x	$10,406	x	$10,406
Capitation Rate Updates - Two (2) or more times per year	EA	$20,812	EA	$20,812
Dental Capitation Rate Finalization	x	$10,406	x	$10,406
SOW 7- Dental Rebasing– One (1) time for contract duration	$31,218			

Please Note:

SOW 1 and **SOW 2** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan.
SOW 3 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period.
SOW 4 Upper payment limits for PACE
SOW 5 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period
SOW 6 and **SOW 7** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan

BIDDER NAME: **Schramm Health Partners, LLC dba Optumas**

OPTIONAL SERVICES

Bidder Name: Schramm Health Partners, LLC dba Optumas

Provide the hourly rate for additional consulting services for new Statements of Work. There is no guarantee regarding the number of hours that will be used.

Also for **SOW 8;** Statement of Work for Special Work Projects to be determined and based upon the staffing and hourly rates provided below

The bidder must list each role/title and provide an hourly rate. These rates are fixed for the initial term of the contract. At renewal time, rates may increase by no more than 5% with supporting justification for any increase.

POSITION ROLE/TITLE	UOM	Rate
Lead Strategist	HR	$205
Principal/Project Manager	HR	$205
Lead Actuary	HR	$205
Actuarial Consultant	HR	$205
Actuarial Analyst	HR	$205
Informatics Analyst	HR	$205
	HR	$

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
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

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,	Page 25 and Page	Section V Part C contains a list of items in a-j related to	The bidder should respond to each item in Section V.C.6.a-j

	Part A.3	33	“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?	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 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?	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: 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. Is SOW 2 limited to <u>only</u> 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?	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. 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 Question #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	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.

			State expects of the Actuary/Vendor?	
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?	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.
			Has Nebraska completed the stakeholder process for the 1115 SUD waiver?	
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 only 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	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.

			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?	
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 amendments typically occur on an annual basis?	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: • 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? c. Will the State obtain the appropriate licenses for the risk adjustment software (if applicable)?	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. 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?	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.
			d. Does the State anticipate the data to include protected health information (PHI) and/or personally identifiable information (PII)?	Yes
			e. What frequency will the data be provided to the vendor?	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 Submission	27	Does the state have a target timeline/roadmap for submitting the 1115 application and implementing the waiver upon subsequent approval?	Please see response to question #23.
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	The dental managed care entity is contractually required to provide accurate, valid

			expectations of the credibility of the data being utilized for the upcoming rate development processes?	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 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?	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.

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

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

ADDENDUM FOUR
REVISED SCHEDULE OF EVENTS

Date: July 17, 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
6.	Evaluation period	~~July 13, 2018 Through July 20, 2018~~ **July 17, 2018 Through July 24, 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

ADDENDUM FIVE
REVISED SCHEDULE OF EVENTS

Date: July 19, 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
6.	Evaluation period	~~July 13, 2018~~ ~~Through~~ ~~July 20, 2018~~ ~~**July 17, 2018**~~ ~~**Through**~~ ~~**July 24, 2018**~~ **July 17, 2018** **Through** **July 27, 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~~ **August 20, 2018**
9.	Contract finalization period	~~August 1, 2018~~ ~~Through~~ ~~August 31, 2018~~ **August 20, 2018** **Through** **September 28, 2018**
10.	Contract award	~~September 1, 2018~~ **October 1, 2018**
11.	Contractor start date	~~September 1, 2018~~ **October 1, 2018**

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

State of Nebraska State Purchasing Bureau
REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES

RETURN TO:
Name: State Purchasing Bureau
Address: 1526 K Street, Suite 130
City/State/Zip: Lincoln, NE 68508
Phone:402-471-6500

SOLICITATION NUMBER	RELEASE DATE
RFP 5868 Z1	June 12, 2018
OPENING DATE AND TIME	**PROCUREMENT CONTACT**
July 11, 2018 2:00 p.m. Central Time	Nancy Storant/Teresa Fleming

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska (State), Department of Administrative Services (DAS), Materiel Division, State Purchasing Bureau (SPB), is issuing this Request for Proposal (RFP) Number 5868 Z1 for the purpose of selecting a qualified Bidder to provide Medicaid Managed Care Actuarial And Consulting Services. A more detailed description can be found in Section VI. The resulting contract may not be an exclusive contract as the State reserves the right to contract for the same or similar services from other sources now or in the future.

The term of the contract will be five (5) years commencing upon execution of the contract by the State and the Bidder (Parties)/notice to proceed. The Contract includes the option to renew for three (3) additional two (2) year periods upon mutual agreement of the Parties. The State reserves the right to extend the period of this contract beyond the termination date when mutually agreeable to the Parties.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR PROPOSAL CAN BE FOUND ON THE INTERNET AT: **http://das.nebraska.gov/materiel/purchasing.html**.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. § 84-602.04, State contracts in effect as of January 1, 2014, and contracts entered into thereafter, must be posted to a public website. The resulting contract, the RFP, and the successful bidder's proposal or response will be posted to a public website managed by DAS, which can be found at http://statecontracts.nebraska.gov.

In addition and in furtherance of the State's public records Statute (Neb. Rev. Stat. § 84-712 et seq.), all proposals or responses received regarding this RFP will be posted to the State Purchasing Bureau public website.

These postings will include the entire proposal or response. Bidders must request that proprietary information be excluded from the posting. The bidder must identify the proprietary information, mark the proprietary information according to state law, and submit the proprietary information in a separate container or envelope marked conspicuously in black ink with the words "PROPRIETARY INFORMATION". The bidder must submit a detailed written document showing that the release of the proprietary information would give a business advantage to named business competitor(s) and explain how the named business competitor(s) will gain an actual business advantage by disclosure of information. The mere assertion that information is proprietary or that a speculative business advantage might be gained is not sufficient. (See Attorney General Opinion No. 92068, April 27, 1992) THE BIDDER MAY NOT ASSERT THAT THE ENTIRE PROPOSAL IS PROPRIETARY. COST PROPOSALS WILL NOT BE CONSIDERED PROPRIETARY AND ARE A PUBLIC RECORD IN THE STATE OF NEBRASKA. The State will then determine, in its discretion, if the interests served by nondisclosure outweighs any public purpose served by disclosure. (See Neb. Rev. Stat. § 84-712.05(3)) The Bidder will be notified of the agency's decision. Absent a State determination that information is proprietary, the State will consider all information a public record subject to release regardless of any assertion that the information is proprietary.

If the agency determines it is required to release proprietary information, the bidder will be informed. It will be the bidder's responsibility to defend the bidder's asserted interest in non-disclosure.

To facilitate such public postings, with the exception of proprietary information, the State of Nebraska reserves a royalty-free, nonexclusive, and irrevocable right to copy, reproduce, publish, post to a website, or otherwise use any contract, proposal, or response to this RFP for any purpose, and to authorize others to use the documents. Any individual or entity awarded a contract, or who submits a proposal or response to this RFP, specifically waives any copyright or other protection the contract, proposal, or response to the RFP may have; and, acknowledges that they have the ability and authority to enter into such waiver. This reservation and waiver is a prerequisite for submitting a proposal or response to this RFP, and award of a contract. Failure to agree to the reservation and waiver will result in the proposal or response to the RFP being found non-responsive and rejected.

Any entity awarded a contract or submitting a proposal or response to the RFP agrees not to sue, file a claim, or make a demand of any kind, and will indemnify and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses, sustained or asserted against the State, arising out of, resulting from, or attributable to the posting of the contract or the proposals and responses to the RFP, awards, and other documents.

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GLOSSARY OF TERMS

Acceptance Test Procedure: Benchmarks and other performance criteria, developed by the State of Nebraska or other sources of testing standards, for measuring the effectiveness of products or services and the means used for testing such performance.

Addendum: Something to be added or deleted to an existing document; a supplement.

After Receipt of Order (ARO): After Receipt of Order

Agency: Any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any other office or agency established by the Constitution of Nebraska.

Agent/Representative: A person authorized to act on behalf of another.

Amend: To alter or change by adding, subtracting, or substituting.

Amendment: A written correction or alteration to a document.

Appropriation: Legislative authorization to expend public funds for a specific purpose. Money set apart for a specific use.

Award: All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the RFP. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

Best and Final Offer (BAFO): In a competitive bid, the final offer submitted which contains the bidder's (vendor's) most favorable terms for price.

Bid/Proposal: The offer submitted by a vendor in a response to a written solicitation.

Bid Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the vendor will not withdraw the bid.

Bidder: A vendor who submits an offer bid in response to a written solicitation.

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity.

Business Day: Any weekday, except State-recognized holidays.

Calendar Day: Every day shown on the calendar including Saturdays, Sundays, and State/Federal holidays.

Cancellation: To call off or revoke a purchase order without expectation of conducting or performing it at a later time.

Central Processing Unit (CPU): Any computer or computer system that is used by the State to store, process, or retrieve data or perform other functions using Operating Systems and applications software.

Change Order: Document that provides amendments to an executed purchase order or contract.

Collusion: An agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful, or unlawful purpose.

Commodities: Any equipment, material, supply or goods; anything movable or tangible that is provided or sold.

Commodities Description: Detailed descriptions of the items to be purchased; may include information necessary to obtain the desired quality, type, color, size, shape, or special characteristics necessary to perform the work intended to produce the desired results.

Competition: The effort or action of two or more commercial interests to obtain the same business from third parties.

Confidential Information: Unless otherwise defined below, "Confidential Information" shall also mean proprietary trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In

accordance with Nebraska Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Contract: An agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law; the writing that sets forth such an agreement.

Contract Administration: The management of the contract which includes and is not limited to; contract signing, contract amendments and any necessary legal actions.

Contract Award: Occurs upon execution of the State document titled "Service Contract Award" by the proper authority.

Contract Management: The management of day to day activities at the agency which includes and is not limited to ensuring deliverables are received, specifications are met, handling meetings and making payments to the Contractor.

Contract Period: The duration of the contract.

Contractor: Any individual or entity having a contract to furnish commodities or services.

Cooperative Purchasing: The combining of requirements of two or more political entities to obtain advantages of volume purchases, reduction in administrative expenses or other public benefits.

Copyright: A property right in an original work of authorship fixed in any tangible medium of expression, giving the holder the exclusive right to reproduce, adapt and distribute the work.

Critical Program Error: Any Program Error, whether or not known to the State, which prohibits or significantly impairs use of the Licensed Software as set forth in the documentation and intended in the contract.

Customer Service: The process of ensuring customer satisfaction by providing assistance and advice on those products or services provided by the Contractor.

Default: The omission or failure to perform a contractual duty.

Deviation: Any proposed change(s) or alteration(s) to either the terms and conditions or deliverables within the scope of the written solicitation or contract.

Evaluation: The process of examining an offer after opening to determine the vendor's responsibility, responsiveness to requirements, and to ascertain other characteristics of the offer that relate to determination of the successful award.

Evaluation Committee: Committee(s) appointed by the requesting agency that advises and assists the procuring office in the evaluation of bids/proposals (offers made in response to written solicitations).

Extension: Continuance of a contract for a specified duration upon the agreement of the parties beyond the original Contract Period. Not to be confused with "Renewal Period".

Free on Board (F.O.B.) Destination: The delivery charges are included in the quoted price and prepaid by the vendor. Vendor is responsible for all claims associated with damages during delivery of product.

Free on Board (F.O.B.) Point of Origin: The delivery charges are not included in the quoted price and are the responsibility of the agency. Agency is responsible for all claims associated with damages during delivery of product.

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of another state, government, or country.

Installation Date: The date when the procedures described in "Installation by Contractor", and "Installation by State", as found in the RFP, or contract, are completed.

Interested Party: A person, acting in their personal capacity, or an entity entering into a contract or other agreement creating a legal interest therein.

Late Bid/Proposal: An offer received after the Opening Date and Time.

Licensed Software Documentation: The user manuals and any other materials in any form or medium customarily provided by the Contractor to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently.

Mandatory/Must: Required, compulsory, or obligatory.

May: Discretionary, permitted; used to express possibility.

Module (see System): A collection of routines and data structures that perform a specific function of software.

Must: See Mandatory/ Must and Shall/Will/Must.

National Institute for Governmental Purchasing (NIGP): National Institute of Governmental Purchasing – Source used for assignment of universal commodity codes to goods and services.

Open Market Purchase: Authorization may be given to an agency to purchase items above direct purchase authority due to the unique nature, price, quantity, location of the using agency, or time limitations by the AS Materiel Division, State Purchasing Bureau.

Opening Date and Time: Specified date and time for the public opening of received, labeled, and sealed formal proposals.

Operating System: The control program in a computer that provides the interface to the computer hardware and peripheral devices, and the usage and allocation of memory resources, processor resources, input/output resources, and security resources.

Outsourcing: The contracting out of a business process which an organization may have previously performed internally or has a new need for, to an independent organization from which the process is purchased back.

Payroll & Financial Center (PFC): Electronic procurement system of record.

Performance Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the Contractor fulfills any and all obligations under the contract.

Platform: A specific hardware and Operating System combination that is different from other hardware and Operating System combinations to the extent that a different version of the Licensed Software product is required to execute properly in the environment established by such hardware and Operating System combination.

Point of Contact (POC): The person designated to receive communications and to communicate.

Pre-Bid/Pre-Proposal Conference: A meeting scheduled for the purpose of clarifying a written solicitation and related expectations.

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption.

Program Error: Code in Licensed Software which produces unintended results or actions, or which produces results or actions other than those described in the specifications. A program error includes, without limitation, any Critical Program Error.

Program Set: The group of programs and products, including the Licensed Software specified in the RFP, plus any additional programs and products licensed by the State under the contract for use by the State.

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and services to be provided under the contract.

Proposal: See Bid/Proposal.

Proprietary Information: Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serves no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific named competitor(s) advantaged by release of the information and the demonstrated advantage the named competitor(s) would gain by the release of information.

Protest/Grievance: A complaint about a governmental action or decision related to a RFP or resultant contract, brought by a vendor who has timely submitted a bid response in connection with the award in question, to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Public Proposal Opening: The process of opening correctly submitted offers at the time and place specified in the written solicitation and in the presence of anyone who wished to attend.

Recommended Hardware Configuration: The data processing hardware (including all terminals, auxiliary storage, communication, and other peripheral devices) to the extent utilized by the State as recommended by the Contractor.

Release Date: The date of public release of the written solicitation to seek offers.

Renewal Period: Optional contract periods subsequent to the original Contract Period for a specified duration with previously agreed to terms and conditions. Not to be confused with Extension.

Request for Information (RFI): A general invitation to vendors requesting information for a potential future solicitation. The RFI is typically used as a research and information gathering tool for preparation of a solicitation.

Request for Proposal (RFP): A written solicitation utilized for obtaining competitive offers.

Responsible Bidder: A bidder who has the capability in all respects to perform fully and lawfully all requirements with integrity and reliability to assure good faith performance.

Responsive Bidder: A bidder who has submitted a bid which conforms to all requirements of the solicitation document.

Shall/Will/Must: An order/command; mandatory.

Should: Expected; suggested, but not necessarily mandatory.

Software License: Legal instrument with or without printed material that governs the use or redistribution of licensed software.

Sole Source – Commodity: When an item is available from only one source due to the unique nature of the requirement, its supplier, or market conditions.

Sole Source – Services: A service of such a unique nature that the vendor selected is clearly and justifiably the only practical source to provide the service. Determination that the vendor selected is justifiably the sole source is based on either the uniqueness of the service or sole availability at the location required.

Specifications: The detailed statement, especially of the measurements, quality, materials, and functional characteristics, or other items to be provided under a contract.

Statutory: These clauses are controlled by state law and are not subject to negotiation.

Subcontractor: Individual or entity with whom the contractor enters a contract to perform a portion of the work awarded to the contractor.

System (see Module): Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the Contractor as functioning or being capable of functioning, as an entity.

Termination: Occurs when either Party, pursuant to a power created by agreement or law, puts an end to the contract prior to the stated expiration date. All obligations which are still executory on both sides are discharged but any right based on prior breach or performance survives.

Third Party: Any person or entity, including but not limited to fiduciaries, shareholders, owners, officers, managers, employees, legally disinterested persons, and sub-contractors or agents, and their employees. It shall not include any entity or person who is an interested Party to the contract or agreement.

Trade Secret: Information, including, but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. §87-502(4)).

Trademark: A word, phrase, logo, or other graphic symbol used by a manufacturer or vendor to distinguish its product from those of others, registered with the U.S. Patent and Trademark Office.

Upgrade: Any change that improves or alters the basic function of a product or service.

Vendor: An individual or entity lawfully conducting business in the State of Nebraska, or licensed to do so, who seeks to provide goods or services under the terms of a written solicitation.

Vendor Performance Report: A report issued to the Contractor by State Purchasing Bureau when products or services delivered or performed fail to meet the terms of the purchase order, contract, and/or specifications, as reported to State Purchasing Bureau by the agency. The State Purchasing Bureau shall contact the Contractor regarding any such report. The vendor performance report will become a part of the permanent record for the Contractor. The State may require vendor to cure. Two such reports may be cause for immediate termination.

Will: See Shall/Will/Must.

Work Day: See Business Day.

I. PROCUREMENT PROCEDURE

A. GENERAL INFORMATION

The RFP is designed to solicit proposals from qualified Bidders who will be responsible for providing Medicaid Managed Care Actuarial and Consulting Services at a competitive and reasonable cost.

Proposals shall conform to all instructions, conditions, and requirements included in the RFP. Prospective bidders are expected to carefully examine all documents, schedules, and requirements in this RFP, and respond to each requirement in the format prescribed. Proposals may be found non-responsive if they do not conform to the RFP.

B. PROCURING OFFICE AND COMMUNICATION WITH STATE STAFF AND EVALUATORS

Procurement responsibilities related to this RFP reside with the State Purchasing Bureau. The point of contact (POC) for the procurement is as follows:

Name: Nancy Storant/Teresa Fleming
Agency: State Purchasing Bureau
Address: 1526 K Street, Suite 130
Lincoln, NE 68508
Telephone: 402-471-6500

E-Mail: as.materielpurchasing@nebraska.gov

From the date the RFP is issued until the Intent to Award is issued, communication from the Bidder is limited to the POC listed above. After the Intent to Award is issued, the Bidder may communicate with individuals the State has designated as responsible for negotiating the contract on behalf of the State. No member of the State Government, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this RFP. The POC will issue any clarifications or opinions regarding this RFP in writing. Only the buyer can modify the RFP, answer questions, render opinions, and only the SPB or awarding agency can award a contract. Bidders shall not have any communication with, or attempt to communicate or influence any evaluator involved in this RFP.

The following exceptions to these restrictions are permitted:

1. Contact made pursuant to pre-existing contracts or obligations;
2. Contact required by the schedule of events or an event scheduled later by the RFP POC; and
3. Contact required for negotiation and execution of the final contract.

The State reserves the right to reject a bidder's proposal, withdraw an Intent to Award, or terminate a contract if the State determines there has been a violation of these procurement procedures.

C. SCHEDULE OF EVENTS

The State expects to adhere to the procurement schedule shown below, but all dates are approximate and subject to change

ACTIVITY		DATE/TIME
1.	Release RFP	June 12, 2018
2.	Last day to submit written questions	June 20, 2018
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
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
10.	Contract award	September 1, 2018
11.	Contractor start date	September 1, 2018

D. WRITTEN QUESTIONS AND ANSWERS

Questions regarding the meaning or interpretation of any RFP provision must be submitted in writing to the State Purchasing Bureau and clearly marked "RFP Number 5868 Z1; Medicaid Managed Care Actuarial and Consulting Services Questions". The POC is not obligated to respond to questions that are received late per the Schedule of Events.

Bidders should present, as questions, any assumptions upon which the Bidder's proposal is or might be developed. Proposals will be evaluated without consideration of any known or unknown assumptions of a bidder. The contract will not incorporate any known or unknown assumptions of a bidder.

It is preferred that questions be sent via e-mail to as.materielpurchasing@nebraska.gov, but may be delivered by hand or by U.S. Mail. It is recommended that Bidders submit questions using the following format.

RFP Section Reference	RFP Page Number	Question

Written answers will be posted at http://das.nebraska.gov/materiel/purchasing.html per the Schedule of Events.

E. RECYCLING (§81-15,159(d)(2)

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use. Preference will also be given to purchases of corn-based biodegradable plastics and road deicers if available and suitable. No preference shall be given if such preference would result in the purchase of products, materials, or supplies that are of inadequate quality or of substantially higher cost.

F. PRICES

All prices, costs, and terms and conditions submitted in the proposal shall remain fixed and valid commencing on the opening date of the proposal until the contract terminates or expires.

G. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS (Statutory)

All bidders must be authorized to transact business in the State of Nebraska and comply with all Nebraska Secretary of State Registration requirements. The bidder who is the recipient of an Intent to Award will be required to certify that it has complied and produce a true and exact copy of its current (within ninety (90) calendar days of

the intent to award) Certificate or Letter of Good Standing, or in the case of a sole proprietorship, provide written documentation of sole proprietorship and complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html. This must be accomplished prior to execution of the contract.

H. ETHICS IN PUBLIC CONTRACTING

The State reserves the right to reject bids, withdraw an intent to award or award, or terminate a contract if a bidder commits or has committed ethical violations, which include, but are not limited to:

1. Offering or giving, directly or indirectly, a bribe, fee, commission, compensation, gift, gratuity, or anything of value to any person or entity in an attempt to influence the bidding process;
2. Utilize the services of lobbyists, attorneys, political activists, or consultants to influence or subvert the bidding process;
3. Being considered for, presently being, or becoming debarred, suspended, ineligible, or excluded from contracting with any state or federal entity:
4. Submitting a proposal on behalf of another Party or entity; and
5. Collude with any person or entity to influence the bidding process, submit sham proposals, preclude bidding, fix pricing or costs, create an unfair advantage, subvert the bid, or prejudice the State.

The Bidder shall include this clause in any subcontract entered into for the exclusive purpose of performing this contract.

Bidder shall have an affirmative duty to report any violations of this clause by the Bidder throughout the bidding process, and throughout the term of this contract for the successful Bidder and their subcontractors.

I. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

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

J. SUBMISSION OF PROPOSALS

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. The Bidder is solely responsible for any variance between the copies submitted. Proposal responses should include the completed Form A, “Bidder Contact Sheet”. Proposals must reference the RFP number and be sent to the specified address. Please note that the address label should appear as specified in Section I B. on the face of each container or bidder’s bid response packet. If a recipient phone number is required for delivery purposes, 402-471-6500 should be used. The RFP number should be included in all correspondence.

Emphasis should be concentrated on conformance to the RFP instructions, responsiveness to requirements, completeness, and clarity of content. If the bidder’s proposal is presented in such a fashion that makes evaluation difficult or overly time consuming the State reserves the right to reject the proposal as non-conforming.

By signing the “Request for Proposal for Contractual Services” form, the bidder guarantees compliance with the provisions stated in this RFP.

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

The Technical and Cost Proposals should be packaged separately (loose-leaf binders are preferred) on standard 8 ½” by 11” paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½” by 11” format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables should be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text. The Technical Proposal should not contain any reference to dollar amounts. However, information such as data concerning labor hours and categories, materials, subcontracts and so forth, shall be considered in the Technical Proposal so that the bidder’s understanding of the scope of work may be evaluated. The Technical Proposal shall disclose the bidder’s technical approach in as much detail as possible, including, but not limited to, the information required by the Technical Proposal instructions.

K. BID PREPARATION COSTS

The State shall not incur any liability for any costs incurred by Bidders in replying to this RFP, including any activity related to bidding on this RFP.

L. FAILURE TO COMPLY WITH REQUEST FOR PROPOSAL

Violation of the terms and conditions contained in this RFP or any resultant contract, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's proposal;
2. Withdrawal of the Intent to Award;
3. Withdrawal of the Award;
4. Termination of the resulting contract;
5. Legal action; and
6. Suspension of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation, such period to be within the sole discretion of the State.

M. BID CORRECTIONS

A bidder may correct a mistake in a bid prior to the time of opening by giving written notice to the State of intent to withdraw the bid for modification or to withdraw the bid completely. Changes in a bid after opening are acceptable only if the change is made to correct a minor error that does not affect price, quantity, quality, delivery, or contractual conditions. In case of a mathematical error in extension of price, unit price shall govern.

N. LATE PROPOSALS

Proposals received after the time and date of the proposal opening will be considered late proposals. Late proposals will be returned unopened, if requested by the bidder and at bidder's expense. The State is not responsible for proposals that are late or lost regardless of cause or fault.

O. PROPOSAL OPENING

The opening of proposals will be public and the bidders will be announced. Proposals **WILL NOT** be available for viewing by those present at the proposal opening. Vendors may contact the State to schedule an appointment for viewing proposals after the Intent to Award has been posted to the website. Once proposals are opened, they become the property of the State of Nebraska and will not be returned.

P. REQUEST FOR PROPOSAL/PROPOSAL REQUIREMENTS

The proposals will first be examined to determine if all requirements listed below have been addressed and whether further evaluation is warranted. Proposals not meeting the requirements may be rejected as non-responsive. The requirements are:

1. Original Request for Proposal for Contractual Services form signed using an indelible method;
2. Clarity and responsiveness of the proposal;
3. Completed Corporate Overview;
4. Completed Sections II through VI;
5. Completed Technical Approach; and
6. Completed State Cost Proposal Template.

Q. EVALUATION COMMITTEE

Proposals are evaluated by members of an Evaluation Committee(s). The Evaluation Committee(s) will consist of individuals selected at the discretion of the State. Names of the members of the Evaluation Committee(s) will not be published prior to the intent to award.

Any contact, attempted contact, or attempt to influence an evaluator that is involved with this RFP may result in the rejection of this proposal and further administrative actions.

R. EVALUATION OF PROPOSALS

All proposals that are responsive to the RFP will be evaluated. Each evaluation category will have a maximum point potential. The State will conduct a fair, impartial, and comprehensive evaluation of all proposals in accordance with the criteria set forth below. Areas that will be addressed and scored during the evaluation include:

1. Corporate Overview should include but is not limited to:
- **a.** the ability, capacity, and skill of the bidder to deliver and implement the system or project that meets the requirements of the RFP;
- **b.** the character, integrity, reputation, judgment, experience, and efficiency of the bidder;
- **c.** whether the bidder can perform the contract within the specified time frame;
- **d.** the quality of bidder performance on prior contracts;
- **e.** such other information that may be secured and that has a bearing on the decision to award the contract;

2. Technical Approach; and,
3. Cost Proposal.

Neb. Rev. Stat. §73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible bidder, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident bidder, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection and (ii) the management and daily business operations of the business are controlled by one or more persons described in subdivision(a) of this subsection. Any contract entered into without compliance with this section shall be null and void.

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a proposal in accordance with Neb. Rev. Stat. §73-107 and has so indicated on the RFP cover page under "Bidder must complete the following" requesting priority/preference to be considered in the award of this contract, the following will need to be submitted by the vendor within ten (10) business days of request:

1. Documentation from the United States Armed Forces confirming service;
2. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions);
3. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and
4. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the bidder from consideration of the preference.

Evaluation criteria weighting will be released with the RFP.

S. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The State may determine after the completion of the Technical and Cost Proposal evaluation that oral interviews/presentations and/or demonstrations are required. Every bidder may not be given an opportunity to interview/present and/or give demonstrations; the State reserves the right, in its discretion, to select only the top scoring bidders to present/give oral interviews. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical and Cost Proposals. The presentation process will allow the bidders to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Bidders' key personnel, identified in their proposal, may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Only representatives of the State and the presenting bidder will be permitted to attend the oral interviews/presentations and/or demonstrations. A written copy or summary of the presentation, and demonstrative information (such as briefing charts, et cetera) may be offered by the bidder, but the State reserves the right to refuse or not consider the offered materials. Bidders shall not be allowed to alter or amend their proposals.

Once the oral interviews/presentations and/or demonstrations have been completed, the State reserves the right to make an award without any further discussion with the bidders regarding the proposals received.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

T. BEST AND FINAL OFFER

If best and final offers (BAFO) are requested by the State and submitted by the bidder, they will be evaluated (using the stated BAFO criteria), scored, and ranked by the Evaluation Committee. The State reserves the right to conduct more than one Best and Final Offer. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

U. REFERENCE AND CREDIT CHECKS

The State reserves the right to conduct and consider reference and credit checks. The State reserves the right to use third parties to conduct reference and credit checks. By submitting a proposal in response to this RFP, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients. Reference and credit checks may be grounds to reject a proposal, withdraw an intent to award, or rescind the award of a contract.

V. AWARD

The State reserves the right to evaluate proposals and award contract(s) in a manner utilizing criteria selected at the State's discretion and in the State's best interest. After evaluation of the proposals, or at any point in the RFP process, the State of Nebraska may take one or more of the following actions:

1. Amend the RFP;
2. Extend the time of or establish a new proposal opening time;
3. Waive deviations or errors in the State's RFP process and in bidder proposals that are not material, do not compromise the RFP process or a bidder's proposal, and do not improve a bidder's competitive position;
4. Accept or reject a portion of or all of a proposal;
5. Accept or reject all proposals;
6. Withdraw the RFP;
7. Elect to rebid the RFP;
8. Award single lines or multiple lines to one or more bidders; or,
9. Award one or more all-inclusive contracts.

The RFP does not commit the State to award a contract. Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Grievance and protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

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

II. TERMS AND CONDITIONS

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.

A. GENERAL

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

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:

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)

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:

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:

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:

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:

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 excess cost occasioned thereby.

The State's failure to make payment shall not be a breach, and the Contractor shall retain all available statutory remedies and protections.

H. NON-WAIVER OF BREACH

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

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:

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:

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

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole

cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. PERSONNEL

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

4. SELF-INSURANCE

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

5. 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:

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:

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:

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:

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:

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)

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)

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:

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, 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:

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:

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;
2. Transfer ownership and title to all completed or partially completed deliverables to 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.

III. CONTRACTOR DUTIES

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

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

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:

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)

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:

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:

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:

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

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. 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.

G. INSURANCE REQUIREMENTS

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

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.

1. WORKERS' COMPENSATION INSURANCE

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter**. 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.

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

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

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

3. EVIDENCE OF COVERAGE

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.

4. DEVIATIONS

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:

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:

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:

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:

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:

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)

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:

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:

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.

IV. PAYMENT

A. PROHIBITION AGAINST ADVANCE PAYMENT (Statutory)

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

B. TAXES (Statutory)

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:

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:

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:

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)

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:

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:

The State shall have the right to audit the Contractor's performance of this contract upon a 30 days' written notice. Contractor shall 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.

V. PROJECT DESCRIPTION AND SCOPE OF WORK

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

A. PROJECT OVERVIEW

This is a Request for Proposal (RFP) to engage the services of an Actuarial and Consulting Services firm to provide methods for and calculation of capitation rates for Medicaid Managed Care initiatives and other services that may be necessary to be provided by an actuary. These methods must be actuarially sound, acceptable to the Centers for Medicare and Medicaid Services (CMS) and readily replicated.

B. PROJECT ENVIRONMENT

The State of Nebraska, Department of Health and Human Services ("Department") by virtue of Nebraska Title 42 of the Code of Federal Regulation (CFR), Part 438 Managed Care; Title 471, Nebraska Administrative Code (NAC) "Nebraska Medical Assistance Program Services"; and Title 482, Nebraska Administrative Code "Nebraska Medicaid Managed Care", is authorized to provide Medicaid Managed Care Services.

Nebraska is currently using, or may use, the following systems to deliver managed care services:

1. MANAGED CARE ORGANIZATION (MCO)

Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or Health Insuring Organization (HIO). Comprehensive means that the contractor is at risk for services in the Basics Benefits package in compliance as set forth in the contract terms.

2. PREPAID INPATIENT HEALTH PLAN (PIHP)

Provides services to enrollees on the basis of capitation payments and is responsible to provide, arrange for or otherwise provide inpatient hospital services to its enrollees

3. PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY

Provides comprehensive coordinated long term services and supports specifically to Medicaid and Medicare enrollees.

4. LONG-TERM CARE MANAGED CARE (Optional)

The Department is developing the Long-Term Care Managed Care program that will provide long term services and supports in the home/community setting or nursing facility to Nebraska Medicaid enrollees. The Long-Term Care managed care initiative is expected to manage physical and Behavioral health services, as well as long-term care services, required by the client. Dental services may be excluded from the Managed Long-Term Care capitated rate.

Managed populations will include persons who receive nursing facility services, Aged & Disabled Medicaid waiver services under 1915 (c) of the Social Security Act, Traumatic Brain Injury Medicaid waiver services under 1915 (c) of the Social Security Act, and home and community-based services under the Nebraska Medicaid State Plan. Populations served under this program will not include persons who receive intermediate care facility for developmental disabilities (ICF/DD) services and developmental disability services related to the 1915 (c) Medicaid waiver services.

Current 1915 (c) waivers expected to be included in Managed Long-Term Care (identified as # 0187 and # 40199) may be found at:
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=nebraska

The Nebraska Medicaid State Plan may be found at:
http://dhhs.ne.gov/medicaid/Pages/med_xixstateplan.aspx

Nebraska Medicaid regulations may be found at:
http://dhhs.ne.gov/medicaid/Pages/med_regs.aspx

It is expected that some long-term care managed care recipients will be dually eligible for Medicare and Medicaid. However, Nebraska is not proposing to CMS a state demonstration to integrate care for dual eligible individuals at this time. It is expected that some long-term care managed care recipients will be covered by a third party health insurance plan in addition to Medicaid. It is expected that long-term care managed care recipients will represent all age categories.

The above expectations and populations for long-term care management are subject to change prior to implementation. It is possible that other additional populations or programs may be added before the end of the contract term.

Nebraska Medicaid currently provides health care coverage for approximately 239,087 individuals each month. Approximately 226,835 of these individuals are enrolled in physical managed care.

C. SCOPE OF WORK (SOW)

Each SOW Project itemized in this Section is presented with the minimum requirements to be performed. The bidder is to provide enough detail in narrative form in its response to allow the Evaluation Committee to score the bidder's approach to each requirement.

Bidders are to provide the following information on **each** service proposed if it applies:

a. Process, staffing, and timeframe
b. Methodology for performing the service;
c. Prior experience performing this service for other states or companies of similar size and Medicaid Managed Care enrollment numbers to the State of Nebraska. This includes:
d. Successes achieved, in regards to prior experiences listed above;
e. Description of challenges present with rate-setting and how bidder addresses each challenge;
f. Number of years performing the service;
g. Any requirements to be provided by the Department;
h. An estimated timeline for completion of services;
i. All costs proposed must be inclusive of all out-of-pocket and any miscellaneous expenses; and
j. All analysis, findings and/or recommendations are to be in line with current statutory/actuary as it applies to each SOW defined below.

D. SOW 1 – CAPITATION RATE SETTING

The purpose of this SOW is to secure Actuarial and Consulting Services to set a rate range of high/target/low full risk capitation rates based on factual data and trends in pricing and certified as such by the actuary for the Medicaid Managed Care program.

The capitation rate setting activity can be expected to occur each state fiscal year and may be additionally required due to changes resulting in Federal and/or State requirements, program changes or changes in coverage.

Activities related to capitation rate setting include but are not limited to:

a. Capitation Rate Methodology Development and Determination:
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;
c. Develop a risk adjustment methodology; and
d. Develop a range of rates that are actuarially sound.

1. Rate Data Analysis and Manipulation:

a. Analyze the financial statement data of managed care plans with focus on relevant issues affecting capitation rate development;
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;
c. Analyze medical and pharmacy service utilization and cost profile patterns by category of service for all Managed Care cohorts;
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; and
e. Analyze inflation, economic, and health related trends;

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

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;
b. Provide documents and data, as directed by Department staff, to discuss at these meetings;
c. Provide project management staff and project/timeline updates for all tasks associated with the capitation rate setting process;
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;

- **e.** Work collaboratively with Department staff and other Department vendors to improve the accuracy and efficiency of capitation rate development methodologies;
- **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;
- **g.** Develop work plans for rates to be determined including milestones for completion;
- **h.** Meet work plan milestones and timelines as agreed upon with the Department,
- **i.** Provide staff training in methodologies used to develop rates; and
- **j.** Develop or assist in development of rate methodology for any new program(s) that may be implemented during the contract period;

3. Capitation Rate Finalization:

- **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;
- **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;
- **c.** Provide actuarial certification as to the soundness of the rates along with all associated exhibits supporting the development of capitation rates
- **d.** Provide necessary certification to meet the requirements of the CMS rate setting consultation guide;
- **e.** Prepare all presentation material, attend and participate in MCO meetings as requested to promote approved recommendations.
- **f.** Attend, participate, and provide support in the Department's rate setting discussions and meetings with CMS.
- **g.** Submit final rates and final rate exhibits 150 days or 5 months prior to their effective date.

E. SOW 2 – CAPITATION RATE REBASING

The SOW is to secure Actuarial and Consulting Services to rebase full risk capitation rates for the Medicaid Managed Care program. The rebasing process includes analysis of updated data and adjustment to trends. The rebasing activity will occur at least once annually.

Activities related to capitation rate rebasing include but are not limited to:

- **a.** Analyze different types of rate methodologies and models used by governmental and commercial entities upon request;
- **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;
- **c.** Analyze rate cell alternatives for identification of various groupings for the population (e.g. age, gender, eligibility);
- **d.** Assess compliance of rate methodologies and applications with Federal and State laws, rules, and regulations regarding reimbursement and budget-related issues;
- **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;
- **f.** Provide an actuarial certification as to the soundness of the rates the contractor develops; and
- **g.** Prepare all presentation material, and attend and participate in with MCO meetings as requested to promote approved recommendations.

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.
- **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.

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.

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;

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;

f. Develop dashboard reporting with benchmark comparisons by category of service for the Managed Care programs;

g. Analyze the accuracy of MCO premiums based on overall MCO financial performance, retrospectively;

h. Provide on-site plan audit reviews as necessary including but not limited to financial, clinical and operational assessment;

i. Track and analyze financial impacts of populations transitioning from service based payments programs to Managed Care;

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.

F. SOW 3 - 1915(b) WAIVER

The contractor will assist with current and new programs developed and operating under the 1915(b) Waiver, waiver renewals, and waiver amendments. The 1915(b) Waiver is renewed every two (2) years and must be amended with any program changes affecting the managed care program.

This activity would include documentation and spread sheets for cost effectiveness and completion of relative narrative portions of the waiver renewal or amendment applications in accordance with CMS requirements. Documentation, spreadsheets, and narrative portions of waiver renewal or amendment applications as stated above to be delivered six (6) months prior to renewal date for applicable waivers. Bidder should include details of experience in the preparation of 1915(b) waivers.

Contractor will submit exhibits related to 1915(b) waiver 120 days or 4 months prior to their effective date.

Based on program changes, it may be necessary to repeat this process.

G. SOW 4 – PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) RATE SETTING

The contractor shall, upon the Department's request, calculate a PACE capitation rate for a fee-for-service equivalent. The rate is designed to result in cost savings relative to expenditures that would otherwise be paid for a comparable nursing facility eligible population not enrolled under the PACE program. Written reports providing detail of determining the capitation rate and recommendation of the Upper Payment Limit rate to be proposed to PACE providers by region will be required with this activity.

Proposals should include details of experience in the calculation of (PACE) capitation rates.

H. SOW 5 – 1115 WAIVER DEVELOPMENT AND SUBMISSION

The contractor will assist with current and new programs developed and operating under the 1115 demonstrations, 1115 renewals, and/or amendments. The 1115 waiver is for, but not limited to, the delivery of the opioid use disorder and substance use disorder (OUD/SUD) services.

The contractor shall assist the Department in the design and submission of 1115 demonstrations that meet the criteria of CMS' OUD/SUD initiative. The 1115 demonstration application must also meet 42 CFR 431.412 requirements.

I. SOW 6– DENTAL CAPITATION RATE SETTING

The purpose of this SOW is to secure Actuarial and Consulting Services to set a rate range of high/mid/low full risk capitation rates based on factual data and trends in pricing and certified as such by the actuary for the Dental Benefits Managed Care program.

The capitation rate setting activity can be expected to occur each state fiscal year and may be additionally required due to changes resulting in Federal and/or State requirements, program changes or changes in coverage.

Activities related to capitation rate setting include but are not limited to:

a. Capitation Rate Methodology Development and Determination:
b. Develop Dental Benefit Manager (DBM) cohorts and capitation rates, using a variety of parameters, including but not limited to, recipients' age, gender, category of eligibility, and geographic location;
c. Develop a risk adjustment methodology; and
d. Develop a range of rates that are actuarially sound.

1. Rate Data Analysis and Manipulation:

a. Analyze the financial statement data of managed care entity with focus on relevant issues affecting capitation rate development;
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;
c. Analyze dental service utilization and cost profile patterns by category of service for all DBM rating cohorts;
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; and
e. Analyze inflation, economic, and health related trends;

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

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;
b. Provide documents and data, as directed by Department staff, to discuss at these meetings;
c. Provide project management staff and project/timeline updates for all tasks associated with the capitation rate setting process;
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;
e. Work collaboratively with Department staff and other Department vendors to improve the accuracy and efficiency of capitation rate development methodologies;
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;
g. Develop work plans for rates to be determined including milestones for completion;
h. Meet work plan milestones and timelines as agreed upon with the Department,
i. Provide staff training in methodologies used to develop rates; and
j. Develop or assist in development of rate methodology for any new program(s) that may be implemented during the contract period;

3. Dental Capitation Rate Finalization:

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;
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;
c. Provide actuarial certification as to the soundness of the rates along with all associated exhibits supporting the development of capitation rates
d. Provide necessary certification to meet the requirements of the CMS rate setting consultation guide;
e. Prepare all presentation material, attend and participate in DBM meetings as requested to promote approved recommendations.
f. Attend, participate, and provide support in the Department's rate setting discussions and meetings with CMS.
g. Submit final rates and final rate exhibits 150 days or 5 months prior to their effective date.

J. SOW 7 –DENTAL CAPITATION RATE REBASING

The SOW is to secure Actuarial and Consulting Services to rebase full risk capitation rates for the Dental Benefit Managed Care program. The rebasing process includes analysis of updated data and adjustment to trends. The rebasing activity will occur at least once per contract period.

Activities related to capitation rate rebasing include but are not limited to:

- **a.** Analyze different types of rate methodologies and models used by governmental and commercial entities upon request;
- **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/mid/low full risk capitation rates;
- **c.** Analyze rate cell alternatives for identification of various groupings for the population (e.g. age, gender, eligibility);
- **d.** Assess compliance of rate methodologies and applications with Federal and State laws, rules, and regulations regarding reimbursement and budget-related issues;
- **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;
- **f.** Provide an actuarial certification as to the soundness of the rates the contractor develops; and
- **g.** Prepare all presentation material, and attend and participate in DBM meetings as requested to promote approved recommendations.

K. SOW 8- SPECIAL PROJECTS (Optional)

The Department may request the contractor, subject to mutual agreement by both parties, to engage in special consulting projects related to Medicaid.

The bidder should provide the hourly rate for each Staff position used to complete special consulting projects. Please identify any additional Staff titles and their appropriate rates, which bidder believes may be used to complete said projects.

A project plan will be prepared for each project, which may include, but is not limited to, project identification number, project statement, deliverables, milestones, due date(s), and projected hours. Should the Department and the contractor agree to changes in the project plan, the original hours may be adjusted during the execution of the project. The amount paid to contractor will be based on the lower of the actual billed hours or the hours specified in contractor's most recently approved project plan, multiplied by the applicable hourly billable rate(s), as submitted. The Department is interested in proposals that provide well-organized, comprehensive, and technically sound business solutions.

Special Project activities may include but are not limited to:

- **a.** Contractor will provide the Department with financial analysis and actuarial consultation to assist the Department in the Request for Proposal process as the Department implements new managed care programs;
- **b.** Provide detailed analysis and develop recommendations for potential modifications, improvements or enhancements to existing managed care plans and programs, in compliance with current State statute and Federal requirements;
- **c.** Participate in the annual review of performance evaluations of managed care plans and provide analysis and recommendations; and
- **d.** Managed Care encounter validation activities.

The specific Scope of Work listed above is not intended to be all-inclusive and will be determined at the sole discretion of the Department, based on projected needs. Contractor will be required to provide an hourly rate per specific position.

All special consulting project costs must be based upon the hourly rates.

VI. PROPOSAL INSTRUCTIONS

This section documents the requirements that should be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

A. PROPOSAL SUBMISSION

1. 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 VI must be completed and returned with the proposal response.

2. CORPORATE OVERVIEW (Delete Corporative Overview if Cost Only)

The Corporate Overview section of the Technical Proposal should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

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

b. FINANCIAL STATEMENTS

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

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

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

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

c. CHANGE OF OWNERSHIP

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

d. OFFICE LOCATION

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

e. RELATIONSHIPS WITH THE STATE

The bidder should describe any dealings with the State over the previous ten (10) years. If the organization, its predecessor, or any Party named in the bidder's proposal response has contracted with the State, the bidder should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any Party named in the bidder's proposal response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

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

g. CONTRACT PERFORMANCE

If the bidder or any proposed Subcontractor has had a contract terminated for default during the past ten (10) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past ten (10) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past ten (10) years, so declare.

If at any time during the past ten (10) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

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

The bidder should address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this RFP. These descriptions should include:

- **a)** The time period of the project;
- **b)** The scheduled and actual completion dates;
- **c)** The Contractor's responsibilities;
- **d)** Each project description should identify whether the work was performed as the prime Contractor or as a Subcontractor. If a bidder performed as the prime Contractor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.
- **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
- **f)** Provide detailed experience with Prepaid Inpatient Health Plan (PIPHP)

g) Provide detailed experience with All-Inclusive Care for the Elderly Program..

h) Provide detailed experience with Long-Term care Managed Care Program.

i) Experience in evaluating plan encounter data including what tools have been used to assess the completeness and accuracy of the data.

j) Experience of staff assigned for providing technical assistance regarding these techniques. Include a description of the technique(s) used, applicable Medicaid populations and an assessment of the effectiveness of the risk adjusted methodology.

k) Provide information shown below for a minimum of three (3) current or former clients that can provide references for activities related to risk adjusted rate setting techniques. This should include references for work performed by a subcontractor for this task if applicable.

1). Name and telephone number of contact

2). Organization name and address

3). Description of services performed

4). Dates when services were performed

5). Staff assigned to this proposal, who worked on the referenced project, including a description of their role on the referenced project.

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

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

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder should present a detailed description of its proposed approach to the management of the project.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this RFP. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

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

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

j. PROJECT PLANNING AND MANAGEMENT

The bidder shall provide a single Principal that will be in charge of all Scope of Work (SOW) projects proposed and accepted. The Principal must actively participate in all daily, weekly, and / or monthly deliverables in conjunction with all SOW projects performed by the contractor. 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 and a minimum of five (5) years consulting experience in governmental managed care programs and must have worked with entities of the size of Nebraska's Medicaid Program. The Department reserves the right to have complete approval rights to the Principal assigned. Changes in the assigned Principal must be approved by the Department.

Each Scope of Work (SOW) project may require a Consultant or Analyst to perform the work required. All SOW project work products performed by a Consultant or Analyst are to be coordinated through the Principal. 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.

k. SUBCONTRACTORS

If the bidder intends to Subcontract any part of its performance hereunder, the bidder should provide:

iv. name, address, and telephone number of the Subcontractor(s);
v. specific tasks for each Subcontractor(s);
vi. percentage of performance hours intended for each Subcontract; and
vii. total percentage of Subcontractor(s) performance hours.

3. TECHNICAL APPROACH

The technical approach section of the Technical Proposal should consist of the following subsections:

a. Understanding of the project requirements;
b. Proposed development approach;
c. Technical considerations;
d. Detailed project work plan; and
e. Deliverables and due dates.

VII. COST PROPOSAL REQUIREMENTS

This section describes the requirements to be addressed by bidders in preparing the State's Cost Sheet. The bidder must use the State's Cost Sheet. The bidder should submit the State's Cost Sheet in accordance with Section I Submission of Proposal.

THE STATE'S COST SHEET AND ANY OTHER COST DOCUMENT SUBMITTED WITH THE PROPOSAL SHALL NOT BE CONSIDERED CONFIDENTIAL OR PROPRIETARY AND IS CONSIDERED A PUBLIC RECORD IN THE STATE OF NEBRASKA AND WILL BE POSTED TO A PUBLIC WEBSITE.

A. COST SHEET

This summary shall present the total fixed price to perform all of the requirements of the RFP.

The State reserves the right to review all aspects of cost for reasonableness and to request clarification of any proposal where the cost component shows significant and unsupported deviation from industry standards or in areas where detailed pricing is required.

B. PRICES

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the RFP. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

Form A
Bidder Contact Sheet
Request for Proposal Number 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:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

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:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

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.

_____ 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:	
COMPLETE ADDRESS:	
TELEPHONE NUMBER:	
FAX NUMBER:	
DATE:	
SIGNATURE:	
TYPED NAME & TITLE OF SIGNER:	

Attachment A
Cost Proposal
Request for Proposal Number 5868 Z1

Bidder is to complete and return this form with their Bid Submission.

Bidder is to provide a cost for each SOW and for each plan year shown with an “X”.

BIDDER NAME: ____

	Plan Year									
DESCRIPTION	January 2019 – December 2019		January 2020 – December 2020		January 2021 – December 2021		January 2022 – December 2022		January 2023 – December 2023	
SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination	x	$	x	$	x	$	x	$	x	$
Rate Data analysis and Manipulation	x	$	x	$	x	$	x	$	x	$
Interim Reporting and other Deliverables for Rate Setting Functions	x	$	x	$	x	$	x	$	x	$
Capitation Rate Updates - Two (2) or more times per year	EA	$	EA	$	EA	$	EA	$	EA	$
Capitation Rate Finalization	x	$	x	$	x	$	x	$	x	$
SOW 2 – Capitation Rate Rebasing – One (1) time for contract duration	$									
SOW 3 - 1915(b) Waiver	x	$	x	$	x	$	x	$	x	$
SOW 4 - PACE	x	$	x	$	x	$	x	$	x	$
SOW 5 – 1115 Waiver	x	$	x	$	x	$	x	$	x	$
SOW 6- Dental Rate Setting	x	$	x	$	x	$	x	$	x	$
Rate Data Analysis and Manipulation	x	$	x	$	x	$	x	$	x	$
Interim Reporting and Other Deliverables for Rate Setting Functions	x	$	x	$	x	$	x	$	x	$
Capitation Rate Updates - Two (2) or more times per year	EA	$	EA	$	EA	$	EA	$	EA	$
Dental Capitation Rate Finalization	x	$	x	$	x	$	x	$	x	$
SOW 7- Dental Rebasing– One (1) time for contract duration	$									

Please Note:

SOW 1 and **SOW 2** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan.
SOW 3 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period.
SOW 4 Upper payment limits for PACE
SOW 5 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period
SOW 6 and **SOW 7** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan.

OPTIONAL RENEWALS

DESCRIPTION	First Optional Renewal Period – Year One January 2024 – December 2024		First Optional Renewal Period – Year Two January 2025 – December 2025	
SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination	x	$	x	$
Rate Data analysis and Manipulation	x	$	x	$
Interim Reporting and other Deliverables for Rate Setting Functions	x	$	x	$
Capitation Rate Updates – Two (2) or more times per year	EA	$	EA	$
Capitation Rate Finalization	x	$	x	$
SOW 2 – Capitation Rate Rebasing – One (1) time for contract duration	$			
SOW 3 - 1915(b) Waiver	x	$	x	$
SOW 4 - PACE	x	$	x	$
SOW 5 – 1115 Waiver	x	$	x	$
SOW 6- Dental Rate Setting	x	$	x	$
Rate Data Analysis and Manipulation	x	$	x	$
Interim Reporting and Other Deliverables for Rate Setting Functions	x	$	x	$
Capitation Rate Updates - Two (2) or more times per year	EA	$	EA	$
Dental Capitation Rate Finalization	x	$	x	$
SOW 7- Dental Rebasing– One (1) time for contract duration	$			

Please Note:

SOW 1 and **SOW 2** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan.
SOW 3 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period.
SOW 4 Upper payment limits for PACE
SOW 5 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period
SOW 6 and **SOW 7** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan

BIDDER NAME: ____

DESCRIPTION	Second Optional Renewal Period – Year One		Second Optional Renewal Period – Year Two	
	January 2026 – December 2026		January 2027 – December 2027	
SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination	x	$	x	$
Rate Data analysis and Manipulation	x	$	x	$
Interim Reporting and other Deliverables for Rate Setting Functions	x	$	x	$
Capitation Rate Updates – Two (2) or more times per year	EA	$	EA	$
Capitation Rate Finalization	x	$	x	$
SOW 2 – Capitation Rate Rebasing – One (1) time for contract duration	$			
SOW 3 - 1915(b) Waiver	x	$	x	$
SOW 4 - PACE	x	$	x	$
SOW 5 – 1115 Waiver	x	$	x	$
SOW 6- Dental Rate Setting	x	$	x	$
Rate Data Analysis and Manipulation	x	$	x	$
Interim Reporting and Other Deliverables for Rate Setting Functions	x	$	x	$
Capitation Rate Updates - Two (2) or more times per year	EA	$	EA	$
Dental Capitation Rate Finalization	x	$	x	$
SOW 7- Dental Rebasing– One (1) time for contract duration	$			

Please Note:

SOW 1 and **SOW 2** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan.
SOW 3 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period.
SOW 4 Upper payment limits for PACE
SOW 5 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period
SOW 6 and **SOW 7** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan

BIDDER NAME: ____

DESCRIPTION		Third Optional Renewal Period – Year One January 2028 – December 2028		Third Optional Renewal Period – Year Two January 2029 – December 2029
SOW 1 – Annual Capitation Rate Setting Capitation Rate Methodology Development Determination	x	$	x	$
Rate Data analysis and Manipulation	x	$	x	$
Interim Reporting and other Deliverables for Rate Setting Functions	x	$	x	$
Capitation Rate Updates – Two (2) or more times per year	EA	$	EA	$
Capitation Rate Finalization	x	$	x	$
SOW 2 – Capitation Rate Rebasing – One (1) time for contract duration	$			
SOW 3 - 1915(b) Waiver	x	$	x	$
SOW 4 - PACE	x	$	x	$
SOW 5 – 1115 Waiver	x	$	x	$
SOW 6- Dental Rate Setting	x	$	x	$
Rate Data Analysis and Manipulation	x	$	x	$
Interim Reporting and Other Deliverables for Rate Setting Functions	x	$	x	$
Capitation Rate Updates - Two (2) or more times per year	EA	$	EA	$
Dental Capitation Rate Finalization	x	$	x	$
SOW 7- Dental Rebasing– One (1) time for contract duration	$			

Please Note:

SOW 1 and **SOW 2** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan.
SOW 3 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period.
SOW 4 Upper payment limits for PACE
SOW 5 is a Statement of Work project in the Plan Year shown in which the deliverables will impact the next Waiver Period
SOW 6 and **SOW 7** are Statement of Work projects in the Plan Year shown in which the deliverable will impact the next Year Plan

BIDDER NAME: ____

OPTIONAL SERVICES

Bidder Name: ____

Provide the hourly rate for additional consulting services for new Statements of Work. There is no guarantee regarding the number of hours that will be used.

Also for **SOW 8;** Statement of Work for Special Work Projects to be determined and based upon the staffing and hourly rates provided below

The bidder must list each role/title and provide an hourly rate. These rates are fixed for the initial term of the contract. At renewal time, rates may increase by no more than 5% with supporting justification for any increase.

POSITION ROLE/TITLE	UOM	Rate
	HR	$
	HR	$
	HR	$
	HR	$
	HR	$
	HR	$
	HR	$

ATTACHMENT B

DHHS HIPAA BUSINESS ASSOCIATE AGREEMENT PROVISIONS
SERVICES CONTRACTS

1. BUSINESS ASSOCIATE. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR § 160.103, and in reference to the party in this contract, shall mean Contractor.

2. COVERED ENTITY. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103, and in reference to the party to this contract, shall mean DHHS.

3. HIPAA RULES. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

4. OTHER TERMS. The following terms shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

5. THE CONTRACTOR shall do the following:
   - 5.1. Not use or disclose Protected Health Information other than as permitted or required by this contract or as required by law. Contractor may use Protected Health Information for the purposes of managing its internal business processes relating to its functions and performance under this contract. Use or disclosure must be consistent with DHHS' minimum necessary policies and procedures.
   - 5.2. Implement and maintain appropriate administrative, physical, and technical safeguards to prevent access to and the unauthorized use and disclosure of Protected Health Information. Comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information, to prevent use or disclosure of Protected Health Information other than as provided for in this contract and assess potential risks and vulnerabilities to the individual health data in its care and custody and develop, implement, and maintain reasonable security measures.
   - 5.3. To the extent Contractor is to carry out one or more of the DHHS' obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to DHHS in the performance of such obligations. Contractor may not use or disclosure Protected Health Information in a manner that would violate Subpart E of 45 CFR Part 164 if done by DHHS.
   - 5.4. In accordance with 45 CFR §§ 164.502(E)(1)(ii) and 164.308(b)(2), if applicable, ensure that any agents and subcontractors that create, receive, maintain, or transmit Protected Health Information received from DHHS, or created by or received from the Contractor on behalf of DHHS, agree in writing to the same restrictions, conditions, and requirements relating to the confidentiality, care, custody, and minimum use of Protected Health Information that apply to the Contractor with respect to such information.
   - 5.5. Obtain reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware that the confidentiality of the information has been breached.
   - 5.6. Within fifteen (15) days:
     - 5.6.1. Make available Protected Health Information to DHHS as necessary to satisfy DHHS' obligations under 45 CFR § 164.524;
     - 5.6.2. Make any amendment(s) to Protected Health Information as directed or agreed to by DHHS pursuant to 45 CFR § 164.526, or take other measures as necessary to satisfy DHHS' obligations under 45 CFR § 164.526;
     - 5.6.3. Maintain and make available the information required to provide an accounting of disclosures to DHHS as necessary to satisfy DHHS' obligations under 45 CFR § 164.528.
   - 5.7. Make its internal practices, books, and records relating to the use and disclosure of Protected

Heath Information received from, or created or received by the Contractor on behalf of the DHHS available to the Secretary for purposes of determining compliance with the HIPAA rules. Contractor shall provide DHHS with copies of the information it has made available to the Secretary.

5.8. Report to DHHS within fifteen (15) days, any unauthorized use or disclosure of Protected Health Information made in violation of this contract, or the HIPAA rules, including any security incident that may put electronic Protected Health Information at risk. Contractor shall, as instructed by DHHS, take immediate steps to mitigate any harmful effect of such unauthorized disclosure of Protected Health Information pursuant to the conditions of this contract through the preparation and completion of a written Corrective Action Plan subject to the review and approval by DHHS. The Contractor shall report any breach to the individuals affected and to the Secretary as required by the HIPAA rules.

6. TERMINATION.

6.1. DHHS may immediately terminate this contract and any and all associated contracts if DHHS determines that the Contractor has violated a material term of this contract.

6.2. Within thirty (30) days of expiration or termination of this contract, or as agreed, unless Contractor requests and DHHS authorizes a longer period of time, Contractor shall return or at the written direction of DHHS destroy all Protected Health Information received from DHHS (or created or received by Contractor on behalf of DHHS) that Contractor still maintains in any form and retain no copies of such Protected Health Information. Contractor shall provide a written certification to DHHS that all such Protected Health Information has been returned or destroyed (if so instructed), whichever is deemed appropriate. If such return or destruction is determined by the DHHS be infeasible, Contractor shall use such Protected Health Information only for purposes that makes such return or destruction infeasible and the provisions of this contract shall survive with respect to such Protected Health Information.

6.3. The obligations of the Contractor under the Termination Section shall survive the termination of this contract.