State of Maine
Master Score Sheet

RFP# 202504053					
Assorted Actuarial Services and Fiscal Management Analytics and Reporting					
	Bidder Name:	**CBIZ Optumas, LLC**	**Deloitte Consulting LLP**	**Mercer Health & Benefits LLC**	**Milliman INC**
	Proposed Cost:	**$1,252,500.00**	**$4,856,000.00**	**$2,398,400.00**	**$4,710,000.00**
Scoring Sections	**Points Available**				
Section I: Preliminary Information	Pass/Fail	**Pass**	**Pass**	**Pass**	**Pass**
Section II: Organization Qualifications and Experience	25.00	**8.00**	**24.00**	**25.00**	**25.00**
Section III: Proposed Services	50.00	**15.00**	**43.00**	**46.00**	**37.00**
Section IV: Cost Proposal	25.00	**25.00**	**6.45**	**13.06**	**6.65**
TOTAL	**100.00**	**48.00**	**73.45**	**84.06**	**68.65**

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner

Maine Department of Health and Human Services
Division of Contract Management
11 State House Station
109 Capitol Street
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax: (207) 287-5031
TTY: Dial 711 (Maine Relay)

Award Justification Statement
RFP# 202504053
Assorted Actuarial Services and Fiscal Management Analytics and Reporting

I. Summary

Through RFP# 202504053, the Department sought proposals for Assorted Actuarial Services and Fiscal Management Analytics and Reporting. Four (4) Bidders responded to the RFP: CBIZ Optumas, LLC; Deloitte Consulting, LLP; Mercer Health & Benefits LLC; and Milliman Inc.

Through the evaluation process, Mercer Health & Benefits LLC received the highest score and was determined to provide the best value to the State of Maine.

II. Eligibility and Evaluation Process

An Evaluation Team, composed of five (5) State employees, verified the Bidders' eligibility requirements and applied the consensus method in scoring the Bidders' Qualifications & Experience and Proposed Services. Scores for the Cost Proposals were assigned using a mathematical formula.

III. Qualifications & Experience of Conditional Awardee

Mercer Health & Benefits LLC offered an accomplished, experience-laden portfolio demonstrating the ability to deliver the services required by the RFP and successfully perform under the prospective contract.

IV. Proposed Services by Conditional Awardee

Mercer Health & Benefits LLC provided a well-rounded response outlining an understanding of, and ability to meet, programmatic requirements of the RFP. Additionally, Mercer Health & Benefits LLC demonstrated the means and skills necessary to meet the RFP's performance requirements through its project teams' competencies, subject matter expertise, and background.

V. Cost Proposal

Mercer Health & Benefits LLC provided an initial-period-of-performance cost of $2,398,400.00.

VI. Conclusion

Out of 100 possible points, the Evaluation Team awarded Mercer Health & Benefits LLC a score of 84.06. The strength of Mercer Health & Benefits LLC's proposal outweighed the other Bidders through its qualifications and experience and the services and cost it proposed. The Evaluation Team determined that the proposal submitted by Mercer Health & Benefits LLC represents the best value to the State of Maine.

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Sep-12-2025

Via Electronic Mail: seth.adamson@optumas.com

CBIZ Optumas, LLC
Seth Adamson, ASA, MAAA, Managing Director
7400 East McDonald Drive, Suite 101
Scottsdale, AZ 85250

SUBJECT: Notice of Conditional Contract Award under RFP 202504053, Assorted Actuarial Services and Fiscal Management Analytics and Reporting

Dear Mr. Adamson,

This letter is in regard to the subject Request for Proposals (RFP), issued by the State of Maine Department of Health and Human Services, Office of MaineCare Services for Assorted Actuarial Services and Fiscal Management Analytics and Reporting. The Department has evaluated the proposals received using the evaluation criteria identified in the RFP, and the Department is hereby announcing its conditional contract award to the following bidder:

- Mercer Health & Benefits LLC

The bidder listed above received the evaluation team's highest ranking. The Department will be contacting the aforementioned bidder soon to negotiate a contract. As provided in the RFP, the Notice of Conditional Contract Award is subject to execution of a written contract and, as a result, this Notice does NOT constitute the formation of a contract between the Department and the apparent successful vendor. The vendor shall not acquire any legal or equitable rights relative to the contract services until a contract containing terms and conditions acceptable to the Department is executed. The Department further reserves the right to cancel this Notice of Conditional Contract Award at any time prior to the execution of a written contract.

As stated in the RFP, following announcement of this award decision, all submissions in response to the RFP are considered public records available for public inspection pursuant to the State of Maine Freedom of Access Act (FOAA). 1 M.R.S. §§ 401 et seq.; 5 M.R.S. § 1825-B (6).

This award decision is conditioned upon final approval by the State Procurement Review Committee and the successful negotiation of a contract.
Any person aggrieved by an award decision may request an appeal hearing. The request must be made to the Director of the Bureau of General Services, in writing, within 15 days of

notification of the contract award as provided in 5 M.R.S. § 1825-E (2) and the Rules of the Department of Administrative and Financial Services, Bureau of General Services, Office of State Procurement Services [formerly the Division of Purchases], Chapter 120, § (2) (2).

Thank you for your interest in doing business with the State of Maine.

Sincerely,

DocuSigned by:
3C31413C9F12439...
Michelle S. Probert
Director
Office of MaineCare Services

Signed by:
Debra Downer Grady
5DC6307B8558482...
Debra Downer Grady
Deputy Director for Competitive Procurement
Division of Contract Management

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Sep-12-2025

Via Electronic Mail: tfitzpatrick@deloitte.com

Deloitte Consulting LLP
Tim FitzPatrick
50 South 6th Street, Suite 2800
Hennepin, Minneapolis, MN 55402

SUBJECT: Notice of Conditional Contract Award under RFP 202504053, Assorted Actuarial Services and Fiscal Management Analytics and Reporting

Dear Mr. FitzPatrick,

This letter is in regard to the subject Request for Proposals (RFP), issued by the State of Maine Department of Health and Human Services, Office of MaineCare Services for Assorted Actuarial Services and Fiscal Management Analytics and Reporting. The Department has evaluated the proposals received using the evaluation criteria identified in the RFP, and the Department is hereby announcing its conditional contract award to the following bidder:

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Michelle S. Probert
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Signed by:
Debra Downer Grady
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Debra Downer Grady
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Sep-12-2025

Via Electronic Mail: sarah.yahna@mercer.com

Mercer Health & Benefits LLC
Sarah Yahna, Principal
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016

SUBJECT: Notice of Conditional Contract Award under RFP 202504053, Assorted Actuarial Services and Fiscal Management Analytics and Reporting

Dear Ms. Yahna,

This letter is in regard to the subject Request for Proposals (RFP), issued by the State of Maine Department of Health and Human Services, Office of MaineCare Services for Assorted Actuarial Services and Fiscal Management Analytics and Reporting. The Department has evaluated the proposals received using the evaluation criteria identified in the RFP, and the Department is hereby announcing its conditional contract award to the following bidder:

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Sep-12-2025

Via Electronic Mail: marlene.howard@milliman.com

Milliman, Inc.
Marlene Howard, FSA, MAAA, Principal & Consulting Actuary
10 W Market Street, Suite 1600
Indianapolis, IN 46204

SUBJECT: Notice of Conditional Contract Award under RFP 202504053, Assorted Actuarial Services and Fiscal Management Analytics and Reporting

Dear Ms. Howard,

This letter is in regard to the subject Request for Proposals (RFP), issued by the State of Maine Department of Health and Human Services, Office of MaineCare Services for Assorted Actuarial Services and Fiscal Management Analytics and Reporting. The Department has evaluated the proposals received using the evaluation criteria identified in the RFP, and the Department is hereby announcing its conditional contract award to the following bidder:

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Michelle S. Probert
Director
Office of MaineCare Services

Signed by:
Debra Downer Grady
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Debra Downer Grady
Deputy Director for Competitive Procurement
Division of Contract Management

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER: CBIZ Optumas, LLC
DATE: (Eligibility) June 30, 2025, August 21, 2025

SUMMARY PAGE

Department Name: Health and Human Services
Name of RFP Coordinator: Casandra Manson
Names of Evaluators: Roger Bondeson, Philip Dubois, Charyl Malik, Lauren Metayer, Jordan Rhodes

Pass/Fail Criteria	Pass	Fail
Section I. Preliminary Information (Eligibility)	**X**	
Scoring Sections	Points Available	Points Awarded
Section II. Organization Qualifications and Experience	**25.00**	**8.00**
Section III. Proposed Services	**50.00**	**15.00**
Section IV. Cost Proposal	**25.00**	**25.00**
Total Points	**100.00**	**48.00**

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER: CBIZ Optumas, LLC
DATE: (Eligibility) June 30, 2025, August 21, 2025

OVERVIEW OF SECTION I
Preliminary Information

Section I. Preliminary Information (Eligibility)

Evaluation Team Comments:

Demonstrated at least two (2) NET Services Rate Certifications, approved by CMS, in the past five (5) years and at least two (2) Upper Payment Limit (UPL) demonstrations, approved by CMS, in the past five (5) years.

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

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EVALUATION OF SECTION II
Organization Qualifications and Experience

	Points Available	Points Awarded
Section II. Organization Qualifications and Experience	**25.00**	**8.00**

Evaluation Team Comments:

Part IV. Section II. Organizational Qualification and Experience

1. Overview of the Organization

- Provided three (3) relevant project examples.
- A limited liability company, founded in 2006.
- Specializes in providing actuarial and consulting services to publicly sponsored health and welfare programs and state Medicaid programs.
- Has provided services to more than thirty (30) states over the last seventeen (17) years.
- Work to ensure transparency, accuracy, and collaboration in its services.
- Worked with multiple states, including Alabama, Colorado, Iowa, Kansas, Maryland, Nebraska, Ohio, and Oregon to provide analyses that support various fiscal forecast models.
  - Has experience developing fiscal forecast models across multiple states, but unclear if these are specific to Medicaid projections.
  - Highlighted evidence from Alabama but did not elaborate on the other states.
- States “actual data” are incorporated into their projection models. It is unclear what other types of data they would incorporate into the analysis.
- Asserts much of its FMA focused on developing budget forecasts to model disenrollments from the COVID19 Pandemic Public Health Emergency.
- Did not address service category and population type in the descriptions.
- Demonstrated some experience with setting rates where NET is a state plan service included as a benefit in managed care programs.
- Description of NET rate review work demonstrates no experience with standalone NET programs.
- Explained actuarial experience in value-based payment and Medicaid transformation programs in five (5) states including work on TCOC and shared savings.
- Work with North Dakota included the design of a password-protected, multi-factor authentication, protected portal for providers to access summarized, de-identified health care quality and outcomes data.

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

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• Cites twenty-five (25) years of experience in UPL demonstration calculations for nearly thirty (30) Medicaid agencies which contradicts their founded date of 2006. • Cites example working for the State in 2019 however, their work with Maine was deemed substandard with multiple errors, and in some instances was unusable, requiring rework from State staff.
2. Subcontractors
• Will not utilize subcontractors.
3. Project Team Organizational Chart
• Provided an organizational chart and outlined supplemental staff available across the firm as well. • Some team members will be splitting their time between multiple scopes of work.
4. Litigation
• Indicated none.
5. Financial Viability
• Provided three (3) years of audited financial statements.
6. Certificate of Insurance
• Provided a valid certificate of insurance.

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

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EVALUATION OF SECTION III
Proposed Services

	Points Available	Points Awarded
Section III. Proposed Services	**50.00**	**15.00**

Evaluation Team Comments:

Part IV, Section III Proposed Services

1. Services to be Provided

Part II

A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement

- Will provide at least one (1) certified actuary to sign off on NET rate certification reports.
- Currently employs eight (8) credentialed actuaries, four (4) of which have the FSA designation.
- Demonstrates ability to provide project planning and proposed and described a project plan which includes meeting cadence, program structure, methodology, deliverables and timing
- Agrees to utilize the MaineIT MoveIT SFTP for data transfer.
- Initial date request to include data dictionaries, enrollment data, NET encounter data, NET caseload data, broker contracts and financial records, and historical and projected program changes
- Proposes several methods of data review and validation, including control totals check, referential integrity check, review of data over time, review for denied, duplicate, reversed, or zero paid claims, and encounter to financial data comparison
- Proposes to summarize and document in Excel a question-based log identifying all potential data issues and gaps to be addressed by the Department before engaging the NET brokers. This same approach will then be used with the brokers to answer questions not answered by the Department
- Proposes the use of contract incentives with “teeth” to improve encounter data accuracy.
- Propose collaborating with stakeholders to improve encounter data by meetings to discuss and communications imploring the need for good data.
- Will distribute reports which describe resolutions to data problems.
- Will request data beginning January 2023, however, the RFP requirement is for data beginning January 2024.

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- Demonstrates knowledge of some common base data adjustments such as incurred but not reported estimates, encounter data underreporting/completion, identification of large claims impacts, and managed care plan aggregate or lump sum payments made outside of the claims system.
  - Identification of large claims impacts, and managed care plan aggregate or lump sum payments made outside of the claims system are not applicable to a PMPM full risk brokerage model for NET.
- Proposes use of a policy change document to track policy changes that may affect rate setting.
- Provided a description of policy changes that CBIZ Optumas has evaluated for Medicaid programs including legislative appropriations, acuity adjustments, and provider reimbursement changes.
  - Acuity adjustments are not applicable to a PMPM full risk NET brokerage model.
- Proposes to use a trend model that isolates both the utilization trend per 1,000 members and the unit cost trend.
- Proposes to proactively request trend estimates from the NET brokers at beginning or rate development work.
- Demonstrates knowledge of how to calculate administrative costs into PMPM rates.
- Demonstrates knowledge of establishing a profit / risk contingency to be incorporated into the rates – generally 1% to 3% is acceptable for CMS.
- Between rate cycles, will work with the Department to evaluate recent encounter and financial data, to stay on top of any policy changes, and to identify areas within the existing rate methodology that could be improved such as existing rate cohorts, regions, and administrative load assumptions.

B. Receipt and Management of Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables

- Provided background about their experience in receiving data, but did not specifically address claims and eligibility feeds, non-claims payment files, or other non-claims expenditure information for MaineCare Members.
- Proposes a pipe delimited data feed to limit potential data feed errors.
- Demonstrates ability to accept supplemental data files.
- Did not specifically reference AC population groups or AC eligible claims.

C. AC and PCPlus Data Analysis and Reporting

- Noted tracking legislative State and federal changes, but did not provide a direct reference to keeping up to date with Medicare developments.
- Provided the names of credentialed actuaries.
- It is unclear if the Bidder understands the requirements of receiving, organizing, and storing additional files, provided by the Department, necessary to produce

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deliverables, as the Bidder's response indicates providing AC and PCPlus files to the Department.

- Provided a basic review of the attribution process for AC Rosters but did not provide specific details including the lookback period, referencing the first step being recent PCPlus duration, and full-coverage MaineCare qualifications, which are specified in the methodology in **Appendix K**.
- Did not note the delivery of bi-annual pipe-delimited files as an additional task.
- Provided a basic review of the attribution process for PCPlus Rosters but did not provide specific details including the lookback period and full-coverage MaineCare qualifications or the inclusion of population group and risk score, which are specified in the methodology in **Appendix K**.
- Will fill out the TCOC template in the required timelines and will assist the Department in any updates to it in the future. However, did not provide details on how the TCOC calculations will be completed.
- Demonstrated ability to "developing and filling out report templates" but did not provide a description or detail how this is relevant to project work.
- Referenced the "annual TCOC" and "reconciliation TCOC" reports, rather than the annual projection and annual reconciliation.
- Cites two (2) TCOC deliverables, when in fact there are four (4).
- Provided minimal detail on producing comparisons between ACs, between ACs and Non-ACs, or other main drivers of performance.
- Did not provide details on potential formatting of presentations and the results of the analyses.
- TCOC report will be delivered as a .txt file however, it is only the data extracts that are to be delivered as .txt files.
- Proposes to use its incurred but not yet reported (IBNR) model to develop factors demonstrating knowledge of AC completion factors.
- Mapped out the typical process to assess program change impacts, but did not commit to participating in the annual deliberative process with the Department and claims-level adjustments.
- Will develop a methodology for each program change however, did not provide details on how these methodologies will be developed.
- Demonstrated experience in environmental scanning, model performance evaluation, and stakeholder feedback to identify opportunities for methodological or operational improvements.
- Proposes use of an online dashboard that providers can access to view their own performance, see how they compare against peers, and see gaps in care across quality measures.
- Proposes and describes a 5-step process for identifying outliers that includes a root cause analysis to determine what is driving the change. It is unclear what these "outliers" are since they are undefined.

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- Elements such as qualifying AC/PCPlus eligibility and change of member attribution between AC/PCPlus reporting periods were not included in the response to methodology documentation. The list of items provided in the documentation appeared minimal.

D. Fiscal Management Analytics (FMA)

- Proposes the development of a project plan that details timelines, data sources, projection methodology, and deliverable format before work begins.
- Proposes to evaluate the tradeoff between model complexity, interpretability, and accuracy via testing how models perform predicting historical data.
- Offers an infographic tool, at no additional cost, that would enable the Department to drill down into the data to determine the causes of deviations from projections.
- Did not outline factors/data elements to be used to develop a model for projecting MaineCare enrollment.
- Plan to collect data on demographic changes, economic factors, and potential State/federal policy changes and that staff will stay knowledgeable on changes to these factors, but did not provide details on how these will be incorporated into the modeling.
- Plans to utilize data visualization tools to show key reporting metrics across programs, category of service, providers, and regions, as well as incorporate infographics.
- Listed a number of performance metrics and definitions, but did not articulate why these are appropriate for the requested analysis and how these metrics will be useful in refining and finalizing projections specific to MaineCare.
- Forecasts will be for a two-year period, updated on a quarterly basis, and displayed by incurred and paid dates as required in the RFP.
- Demonstrated familiarity with non-claims and how to project them, including the need to be projected in multiple parts.
- It is unclear if the same modeling approach across both population-based and non-claims-based analysis will apply.
- Stated the overlap in non-claims to AC/PCPlus analysis and NET.
- Stated *"The result of this analysis will be projection cohorts that are fully or almost fully credible on an individual basis internally homogenous and heterogenous to other cohorts which will be granular enough to meet DHHS' needs when conducting analysis at the cohort level"* which is unclear and likely relevant to managed care states not fee for service states like Maine.
- Discussed risk groupings but it is unclear how this is relevant to Maine enrollment categories.
- Highlighted the importance of separation of populations by FMA.
- Proposes providing a table for the Department that shows coding logic of the cohorts, and a map of cohorts used in FMA to cohorts used in NET rate development and AC reports.
- Did not indicate categorizing services by the MaineCare Benefits Manual.

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- Discusses revisiting ratings cohorts but it is unclear why this is proposed as this is not relevant to the requirements of this section of the RFP.
- Proposes to conduct a review of historical data of State plan services to better understand proper service groupings.
- Did not clearly address the Microsoft Excel component of presenting projections. The response prioritized a discussion of their ability to deliver projections using data visualization tools like Tableau and PowerBI at an additional cost.
- Asserts skills and experience in presenting to state legislators, Medicaid Directors, and other non-actuarial senior managers.
- Provided some creative approaches to synergizing project work, such as leveraging AC attribution analysis in FMA analysis.
- Plans to use a centralized approach across the projects, having a single consultant doing the work across all three (3) projects
- Understood how combining these services will provide efficiencies, suggested combining the data validation process, aligning service and population categories where possible, leveraging similar projection methodologies and consistent assumptions, as well as creating one (1) dashboard to monitor all programs and unify presentation and exhibit design.

E. Upper Payment Limit (UPL)

- Demonstrates knowledge of CMS rules and guidance on developing UPLs.
- Asserts it has successfully undergone scrutiny of its UPL demonstrations via CMS and OIG audits. As there were no details included, it is unclear how OIG audit is relevant.
- Asserts being the only vendor with the capability to perform a Medicare RUG based nursing facility UPL demonstration which is not relevant.

F. Requirements Related to Receiving Confidential Data

- Did not provide details on implementing risk assessment and vulnerability scanning policies and procedures for collecting/receiving sensitive electronic information or complying with all State and Federal laws regarding the protection of confidential and/or sensitive information that is collected, received, or maintained or confidentiality requirements outlined in the State IT-Service Contract.

G. Project Management

- Plans to schedule a kick-off meeting at the start of each project to discuss major tasks and obligations.
- Utilizes several project management tools for creating a project plan, a question log, a status log, and meeting notes.
- Plans to staff these projects using a hub and spoke model. Cites interlinking project tasks, but does not specify focus on overlap across AC and FMA work.

H. Ad Hoc Work

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- Demonstrated ability to provide ad hoc work through its managed care program design, procurements, and compliance. However, managed care is not relevant to the requirements of this RFP.

I. Reports

- All reports will be included as deliverables in the project plan and monitored via the status log for timely delivery.
- Response lacked detail and did not specifically address how they will track and record data.
- Confirms reports will be delivered by specified dates.
- Proposes use of secure portals for transmission of reports that contain PHI/PII and via email for those reports that contain non-sensitive information, but response lacked details.

2. Staffing

- Staffing plan indicates that some team members will be splitting their time between multiple scopes of work.

3. Implementation - Work Plan

- Work plan was difficult to read in the format presented.
- Work plan does not reflect the four (4) TCOC report deliverables.
- Tasks were not concisely described.

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER: CBIZ Optumas, LLC
DATE: (Eligibility) June 30, 2025, August 21, 2025

EVALUATION OF SECTION IV
Cost Proposal

Lowest Submitted Cost Proposal	÷	Cost Proposal Being Scored	x	Score Weight	=	Score
$1,252,500.00	**÷**	**$1,252,500.00**	**x**	**25 points**	**=**	**25.00**

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER: Deloitte Consulting LLP
DATE: (Eligibility) June 30, 2025, Part IV, July 17-18, 2025, August 5, 2025

SUMMARY PAGE

Department Name: Health and Human Services
Name of RFP Coordinator: Casandra Manson
Names of Evaluators: Roger Bondeson, Philip Dubois, Charyl Malik, Lauren Metayer, Jordan Rhodes.

Pass/Fail Criteria	Pass	Fail
Section I. Preliminary Information (Eligibility)	**X**	
Scoring Sections	Points Available	Points Awarded
Section II. Organization Qualifications and Experience	**25.00**	**24.00**
Section III. Proposed Services	**50.00**	**43.00**
Section IV. Cost Proposal	**25.00**	**6.45**
Total Points	**100.00**	**73.45**

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER: Deloitte Consulting LLP
DATE: (Eligibility) June 30, 2025, Part IV, July 17-18, 2025, August 5, 2025

OVERVIEW OF SECTION I
Preliminary Information

Section I. Preliminary Information (Eligibility)

Evaluation Team Comments:

Demonstrated at least two (2) NET Services Rate Certifications, approved by CMS, in the past five (5) years and at least two (2) Upper Payment Limit (UPL) demonstrations, approved by CMS, in the past five (5) years.

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER: Deloitte Consulting LLP
DATE: (Eligibility) June 30, 2025, Part IV, July 17-18, 2025, August 5, 2025

EVALUATION OF SECTION II
Organization Qualifications and Experience

	Points Available	Points Awarded
Section II. Organization Qualifications and Experience	**25.00**	**24.00**

Evaluation Team Comments:

Part IV. Section II. Organizational Qualification and Experience

1. Overview of the Organization

- Provided three (3) relevant project examples demonstrating experience with other states on projects relating to the RFP requirements.
- Twenty (20) years of experience in providing consulting services to the State of Maine.
- Thirteen years of NET rate setting services to Maine with CMS approving all rate certifications submitted by this provider without need for any rate modifications.
- Projects in Maine include Child Support Enforcement, Accountable Communities, Behavioral Health, setting rates for NET and Durable Medical Equipment, assisting with Maine's Medicaid Information Technology Architecture (MITA) assessment, and annual analysis of Incurred but not Paid (IBNP) analysis for Maine's Department of Administrative and Financial Services.
- The Department has a positive working relationship with this provider.
- Indicates being one of the largest companies for providing actuarial services in the country.
- Received many awards for its work and organizational excellence.
- Utilizes the "no surprises" approach to its consulting work in that it engages stakeholders through the entire process of the project to advise every step of the way.
- Provider has experience from over 35 states and territories.
- Demonstrated experience working with the State as well as several other states to provide the services included in this RFP.
- Included "Serving Your Needs" quotes from members of their team to add personalization to the descriptions of the organization's qualifications and experience. Other summary boxes of key information such as "Project Spotlight", "Benefits to Maine", "Did you know?", "We Know Maine", etc. to bring attention to the experience and other information.
- Provided multiple Fiscal Management Experience.
- Services in Georgia including:
  - Designing 3 fiscal models, forecasting, expenditure tracking, and budget projections.

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  - Conducting analysis and developed fiscal notes for requests from the Georgia Assembly regarding Medicaid.
  - Building Tableau dashboards that tracked health plan financials, pharmacy claims data, fee for service data, and for comparing emerging trends to actual data.
- Services in New York include assisted the New York Division of Budget to better predict cost changes due to COVID-19 pandemic and to improved general budget forecasting.
- Developed a budget forecasting model for Texas Health and Human Services to better track Medicaid expenditures across 18 programs. Implemented a software solution for Texas that can forecast per-recipient expenditure using trending models.
- Worked with the Pennsylvania Department of Health to provide legislative analysis and determine the potential financial impact of implementing a healthcare cost growth benchmark.
- Has been setting PMPM rates in Maine since the inception of the brokerage model in 2013. Rate development work began before 2013 as the broker model was implemented in 2013. This work involves reviewing NET encounter claims, broker financial records and trip data, trends in transportation costs, data gap reconciliation, and obtaining CMS approval of rates annually.
- Created work plans for Georgia's NEMT program, develops annual rate ranges so the State can evaluate rates currently paid to the NEMT brokers, helped Georgia in evaluating proposals for its NEMT procurement process, created a data improvement plan, standardized certain broker reports and developed an evaluation model so the State can compare results across all brokers.
- Assisted New York in the transition from a fee for service NEMT program to a full risk broker model. Provided procurement support for selection of a vendor for the broker model implementation.
- Assisted Texas in transitioning from a fee for service model to a capitated (PMPM) reimbursement model. Assisted in program design, vendor procurement and securing a CMS 1915(b) waiver.
- Developed a readiness review process for Pennsylvania and assisted in multiple broker procurements. Developed an automated dashboard data testing tool to identify outliers and missing data to enhance data integrity.
- Experience examples from Maine and one other state were provided to include the initial design and build of the MaineCare AC program and implementation and continued work with the MassHealth ACO program.
- Demonstrated experience supporting value-based care assessment and implementation.
- Helped MassHealth develop its Accountable Care Organization program via a 1115 waiver.
- Provides continued support to MassHealth with its 17 ACOs.

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

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• Supports New York with analysis and modeling required for the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) UPL demonstration. • Supports Pennsylvania with Durable Medical Equipment (DME) and Clinic UPL demonstrations, including gathering and summarizing cost data, drafting the UPL guidance document, and assisting in communication with CMS to gain UPL approval. • Provided 15 years of consulting services in Texas for DSH (Disproportionate Share Hospital), UPL, and uncompensated care reimbursement programs. The company developed a model that incorporated DSH and UPL payment formulas to estimate the health reform impact on each component within the payment methodology by year. • Existing UPL and DSH methodology, performed an impact analysis of reforming inpatient UPL methodology, and delivered a recommendation to increase UPLs for the University of Virginia Medical Center and the Virginia Commonwealth University Health Systems.
2. Subcontractors
• Does not intend to use subcontractors.
3. Project Team Organizational Chart
• Provided an organizational chart with a clearly defined team and staff.
4. Litigation
• States no litigation reported related to Medicaid Actuarial Services.
5. Financial Viability
• Financial Statements were not audited or reviewed by a Certified Public Accountant. • Appears financially viable.
6. Certificate of Insurance
• Provided an expired COI.

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER: Deloitte Consulting LLP
DATE: (Eligibility) June 30, 2025, Part IV, July 17-18, 2025, August 5, 2025

EVALUATION OF SECTION III
Proposed Services

	Points Available	Points Awarded
Section III. Proposed Services	**50.00**	**43.00**

Evaluation Team Comments:

Part IV, Section III Proposed Services
1. Services to be Provided
Part II **A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement**
• Did not specifically address each of the requirements outlined in Project Planning. • Referred Part I, G. providing project management/plan and sample NET work plan describing specific deliverables and coordination with the Department sufficiently meeting the requirements. • Demonstrates a familiarity with MaineCare's available data sources, existing processes around sharing data, and features of the data. • Demonstrated ability to work with MaineCare data to identify different member population, regions, service types, and waiver participants in the various data sources. • Proposes to request most recent 3 years of NET encounter claims data on an incurred basis from MIHMS. • Once data is received will confirm the data has all the required fields and will warehouses the data and conducts additional validation. • Provided a detailed description on identifying eligible populations for MaineCare NET including use of procedure code modifiers. • Provided detail on assessing NET transportation type by region and acknowledges that in several areas of Maine there is no or very limited public transportation. Proposes to review other types of NET transportation such as wheelchair, bus, taxi, etc. • Proposes combining Waiver Services 18, 20, and 21 at the same rate due to the low population numbers using these services. • Provided a detailed description on how it will establish the number of rides, ride type, payments, and mileage traveled. • Proposes comparing encounter data with financial records to assess alignment and identify inconsistencies. • Proposes to make recommendations to the State to strengthen encounter data

reporting and quality.
- Proposes to compare encounter data with broker data for monthly totals, gross payments, rides, and miles. Will also review broker administrative costs and compare to previous years to look for significant changes.
- Proposes to adjust encounter data to address known issues such as reallocating trips provided by a broker outside of their region, incorporating costs for special rate trips not captured due to system limitations, and correcting for inconsistencies.
- Outlines approach to capturing demographic and geographic changes in interpreting trends in NET.
- Detailed an 8-step process in rate development that includes many factors:
  - Programmatic and policy changes (e.g. expansion and unwinding, mileage reimbursement increases, addition of adult dental).
  - Proposes to apply trend factors such as gas prices, CPI, labor costs, medical care costs, public transportation costs.
- The final certification report will attest that rates are developed in accordance with 42 CFR 438, CMS Rate Development Guide, and American Academy of Actuaries Standards of Practice (ASOP) Section 49 on managed care rate setting.

B. Receipt and Management of Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables

- Demonstrated ability to conduct data validations.
- Demonstrated familiarity with MaineCare and other state data files, validation and their details.

C. AC and PCPlus Data Analysis and Reporting

- Propose to use staff (former Medicaid Directors, senior industry advisors) as subject matter experts.
- Has a large reserve of existing health actuaries, some experienced in MaineCare's AC program.
- Demonstrated an understanding of the requirements around receiving and storing data files, highlighting important considerations for timelines, data quality, and potential data issues.
- Proposes use of Statistical Analysis Software (SAS), encrypted Structured Query Language (SQL) and Tableau for data analysis and to prepare executive data visualization dashboards.
- Plans to follow data quality standards of American Academy of Actuaries Standards of Practice (ASOP) Section 23.
- Demonstrated familiarity with the attribution model in Maine and an understanding of how important correct AC rosters are to the success of the program.

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- Described the data required to collect and create an AC member attribution process, to determine member eligibility utilizing RAC codes, and assigning a member to an AC or a Non-AC comparison group.
- Plans to examine the utilization patterns of members by PCPlus, primary care services, and ER visits. After completing attribution will work to create rosters and deliver results to the Department.
- Propose to maintain methodology while identifying efficiency and improvements where possible.
- Demonstrated ability to create quarterly rosters and determine eligible members while maintaining alignment with AC attribution.
- Demonstrated familiarity with Maine AC TCOC calculations and report production.
- Proposed approach to TCOC report development includes:
  - Collaboration with the Department;
  - Presenting reports noting any material changes;
  - Identify drivers of change during each biannual and annual TCOC report;
  - Improve accuracy and efficiency of existing TCOC development process; and
  - Monitor program growth and changes and provide guidance from strategy to implementation.
- Demonstrated familiarity with Maine AC TCOC analyses and presentations while remaining open to determine potential reviews and adjustments.
- Proposes to provide OMS with a tool to review TCOC reports and will also perform an extensive quality review process at the end of each deliverable which will include an email and discussion as necessary summarizing key results and changes from prior report.
- Proposes to streamline AC Data Extracts by creating an automated process to complete these data extracts at the same time as the development of the TCOC report.
- Demonstrated a thorough understanding of the requirement around completion factors, and described an effective process for developing and applying completion factors.
- Demonstrated a thorough understanding of the requirements around policy change adjustments, including some examples for how to handle likely scenarios.
- Clearly described the approach to development of AC and PCPlus program methodology review and changes, including extensive testing and validation.
- Provided a planned approach on methodology documentation development.

D. Fiscal Management Analytics (FMA)

- Asserts experience with improving the budget projection process for other states.
- Plans to work to develop a comprehensive and streamlined projection model, however, the plan lacked details and did not clarify how they would integrate or non-integrate internal Department modeling.
- Proposed modeling multiple scenarios to assess a range of potential outcomes.

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- Plans to collaborate with the Department and stakeholders on non-claims payments to gather the necessary data, will trend and project them where appropriate similar to the claims projections.
- Did not provide a detailed approach to developing enrollment/population categories.
- Indicated the ability to create an enrollment crosswalk to crosswalk between FMA categories and AC and NET categories.
- Did not provide details concerning service category development and what the categories would be other than that they will tie to the AC categories and be able to crosswalk them as required.
- Demonstrated an understanding of how programs need to be aligned with what they are reporting and how groups are classified.
- Plans to work towards creating necessary crosswalks and assignment of subgroups to specific members.

E. Upper Payment Limit (UPL)

- Demonstrated an understanding of the various UPL demonstration methodologies, including discussion of important considerations for selecting a methodology.
- Provided various examples of centers/tools used to track changes in law, CMS requirements, and UPL demonstration methodology.
- Clear demonstration of data collection, review of viable UPL demonstration models/methodologies, preparation and submission to CMS, and addressing of issues and/or questions was provided.

F. Requirements Related to Receiving Confidential Data

- Acknowledged the requirement for insurance with a caveat that certain provisions should be modified or clarified. It is unclear which provisions should be modified or clarified and how that will impact compliance with MaineIT policies.

G. Project Management

- Committed to collaboration with the Department by remaining engaged and keeping the Department informed. This will include meeting preparation, facilitation, support, tracking, documentation, materials, and follow-up.
- Communication and resolution plans were defined and supported by a proposed suite of tools for project management including; Project Work Plan, Project Status Report, Risks, Actions, Issues, and Decisions (RAID) logs.

H. Ad Hoc Work

- Proposes to have a team that collaborates across rate setting and fiscal estimates that can pivot from an ongoing task to address a more urgent one such as budget estimates.
- Demonstrated ability to forecasting and one-time analyses projects such as primary care billing code evaluation, transitioning of reimbursement methodology and development of UPL models.

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• Plans to utilize resources to provide support, such as dashboards, predictive modeling, process integrations, and reporting solutions. • Cites flexibility and adaptability to incorporate regulatory changes to fiscal impact analysis.
I. Reports
• Met the requirements.
2. Staffing
• Met the requirements.
3. Implementation - Work Plan
• Provided a detailed breakdown of higher-level deliverables.

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

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RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER: Deloitte Consulting LLP
DATE: (Eligibility) June 30, 2025, Part IV, July 17-18, 2025, August 5, 2025

EVALUATION OF SECTION IV
Cost Proposal

Lowest Submitted Cost Proposal	÷	Cost Proposal Being Scored	x	Score Weight	=	Score
$1,252,500.00	**÷**	**$4,856,000.00**	**x**	**25 points**	**=**	**6.45**

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RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER: Mercer Health & Benefits LLC
DATE: (Eligibility) June 30, 2025, Part IV August 5, 2025

SUMMARY PAGE

Department Name: Health and Human Services
Name of RFP Coordinator: Casandra Manson
Names of Evaluators: Roger Bondeson, Philip Dubois, Charyl Malik, Lauren Metayer, Jordan Rhodes

Pass/Fail Criteria	Pass	Fail
Section I. Preliminary Information (Eligibility)	**X**	
Scoring Sections	Points Available	Points Awarded
Section II. Organization Qualifications and Experience	**25.00**	**25.00**
Section III. Proposed Services	**50.00**	**46.00**
Section IV. Cost Proposal	**25.00**	**13.06**
Total Points	**100.00**	**84.06**

STATE OF MAINE
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RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER: Mercer Health & Benefits LLC
DATE: (Eligibility) June 30, 2025, Part IV August 5, 2025

OVERVIEW OF SECTION I
Preliminary Information

Section I. Preliminary Information (Eligibility)

Evaluation Team Comments:

Demonstrated at least two (2) NET Services Rate Certifications, approved by CMS, in the past five (5) years and at least two (2) Upper Payment Limit (UPL) demonstrations, approved by CMS, in the past five (5) years.

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BIDDER: Mercer Health & Benefits LLC
DATE: (Eligibility) June 30, 2025, Part IV August 5, 2025

EVALUATION OF SECTION II
Organization Qualifications and Experience

	Points Available	Points Awarded
Section II. Organization Qualifications and Experience	**25.00**	**25.00**

Evaluation Team Comments:

Part IV. Section II. Organizational Qualification and Experience

1. Overview of the Organization

- Provided three (3) relevant project examples demonstrating experience with other states on projects relating to the RFP requirements.
- Became the first fully dedicated Medicaid actuarial consulting practice in the nation, in 1985.
- Client base includes active contracts with Medicaid and other health and human services programs in 30 states and U.S. territories.
- Provided organization visuals displaying successes and accomplishments.
- History of collaborative projects with Maine.
- The Department has a positive work history with this vendor.
- Cites several potential benefits to expanding a Mercer-Maine Partnership.
- Experience in creating and implanting standardized tools and reports to help project and monitor trends in utilization, enrollment, and costs across service categories and population groups, in more than twenty (20) states.
- Has partnered with Maine and two (2) other states regarding fiscal management and analytics.
- Provided data analysis and reporting for the MaineCare Accountable Communities program, including member rosters and total cost of care reports since 2018.
- Has a special workgroup that is focused on assessing the impact of federal policy changes on Medicaid.
- Worked with Delaware Medicaid to develop a suite of fiscal management tools, allowing for utilization trend tracking, enrollment projections, and analyzing costs.
- Supported Pennsylvania Medicaid in creating a standardized reporting framework integrating utilization, enrollment, and cost data.
- Works with MaineCare to provide some limited fiscal management support and actuarial consulting. This work is much more limited in scope than the RFP requires but the work has been good.
- Have provided continuous NET rate certifications for over ten (10) years.
- Has set NET rates for three (3) stand-alone programs and for eight (8) MCOs as part of the MCO rate.

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• Rate development adhered to CMS guidelines. • Worked with three (3) other states for payment reform efforts; Person-Centered Medical Home Plus, Primary care Reform Collaborative, and Primary Care Sub-Capitation Initiative.
2. Subcontractors
• Plans to partner with Sellers Dorsey as a subcontractor for the UPL scope of work citing experience in assisting clients with Medicaid managed care directed payments and FFS UPL programs. • Sellers Dorsey provided UPL services to Virginia in 2018-2019 to improve the UPL calculations related to managed care directed payments. • Sellers Dorsey developed and implemented a SNF UPL program for Bergen New Bridge Medical Center, working with the state of New Jersey. • Sellers Dorsey worked with Georgia on the FFS Physician UPL Program.
3. Project Team Organizational Chart
• Met the requirements.
4. Litigation
• States no litigation reported regarding their Government Human Services Consulting business.
5. Financial Viability
• Provided three (3) years of annual reports, including audited financial statements.
6. Certificate of Insurance
• Provided a valid COI.

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

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RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
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EVALUATION OF SECTION III
Proposed Services

	Points Available	Points Awarded
Section III. Proposed Services	**50.00**	**46.00**

Evaluation Team Comments:

Part IV, Section III Proposed Services
1. Services to be Provided
Part II **A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement**
• Proposes a team of three (3) credentialed actuaries belonging to the Fellows of the Society of Actuaries and the American Academy of Actuaries. • Proposes utilizing detailed agendas and data and decision trackers that document each analysis conducted or report developed and history of work product. • Plans to employ project management techniques and tools to create a project structure to match the preferences and processes of the Department. • Will provide draft documents and questions related to confirming rating approach in order to ensure the Department's expectations and desired outcomes are met. • Minimally responsive to discussing financial status of NET program and confirming rating approach. • Proposes to establish a common understanding of methodology and data specifications using a standard template for each broker. • Described the process to obtain data from the Department and NET brokers, identifying necessary fields and elements for the NET project, meeting with the Department and NET brokers to discuss the work and address questions, and gather and receive data for the project securely through MoveIT. Validation steps will also be provided for intake and loading of data. • Proposes to consider size and stability of each group because in some cases the small rate cells may not be considered credible. • Will develop methodologies, provide documentation and crosswalks, complete encounter data comparison to specifications, resolve missing data and facilitate discussions, prepare data for use in actuarial analysis and provide the Department with options and recommendations related to the data sources for capitation rate development. Required cohorts will be included. • Demonstrated ability to conduct data validation.

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- Proposes to validate NET broker costs by:
  - Broker interviews
  - Survey tools
  - Outlier identification
- Proposed Base Data Adjustments to be evaluated:
  - Incomplete data (e.g. not all costs included in the encounter data)
  - Unallowable costs
  - Midyear program changes
  - Incurred But Not Reported Claims (IBNR)
- Provided diagrams demonstrated helpful summaries for the actuarial rate-setting and peer review processes.
- Proposed to customize Maine's patterns (e.g. long-haul transport, seasonality, island transportation).
- Proposes to consider historical expenses, underwriting gain, taxes and fees to assess non-benefit load to the costs of delivering NET.
- Proposes to provide analyses of payment options including performance withholds.
- Proposes to use peer review to check work on development rates.
- Demonstrated an understanding of federal requirements and pointed out that there may be other ways/authorities to deliver the service than Maine is currently providing.
- Proposes to help with responding to CMS questions about rate setting methodology.

B. Receipt and Management of Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables

- Demonstrated familiarity with receipt and management of MaineCare data files used for this work, as well as secure file transfer systems; provided specific details regarding these files and familiar with the specific data elements contained in the files.
- Has HIPAA-compliant linkage and file intake process.
- Demonstrated ability to receive claims, non-claims, and other non-claims items.
- Has existing infrastructure to support Medicaid data, with more than 75 data analytics analysts and consultants who intake and analyze data for over 25 Medicaid programs.
- Plans to provide interim Data Management deliverables of Data Management and Documentation Plan, Received Data Summary, and Data Management Confirmation.
- Plans to implement a series of validation checks as part of their ongoing data management and quality assurance.
- Provided a structured approach to prepare and validate data, detailing a 7-step process including steps to conduct data validation and financial tie out, assign

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ACO Service Categories, identify final paid amounts, assign final Recipient Aid Category to each member, assign an AC population group for each member, identify AC eligible claims for fully eligible MaineCare members, and categorize AC services into Core, Optional, and Excluded.

- Proposes the use of an established algorithm to identify final claims payment amounts and describes how the algorithm works.

C. AC and PCPlus Data Analysis and Reporting

- Demonstrated familiarity with the AC and PCPlus data and its analysis and plan to use an experienced team including multiple AC/PCPlus subject matter experts with access to resources regarding federal policy and national trends, including other state Medicaid programs for continuity and consistency.
- Two (2) certified actuaries are part of the noted team for this work and have access to 75 credentialed health care actuaries, if needed.
- Provided details for the receipt, secure data transfer, documentation, organization, and storage of required AC and PCPlus files provided by the Department, specifically demonstrating familiarity with the data.
- Provided diagram was helpful in visualizing the attribution methodology, detailing the steps for determining eligible members, creation of the required roster versions, and production of the member comparison between rosters, demonstrating familiarity with the AC/PCPlus data.
- Provided detailed information regarding the process for determination of members eligible for PCPlus and attributable, as well as the process necessary to attribute the members to enrolled PCPlus locations and compare them to the previous attribution.
- Proposes to provide an additional report to include details on the number of members who are associated with each PCPlus provider.
- Demonstrated familiarity with the TCOC reports and templates.
- Provided diagrams demonstrating the methodology for the benchmark trend development, calculation of the benchmark TCOC PMPM, completion factors and claims cap factor, calculation of savings/loss which were helpful as summaries of the processes.
- Provided clear details of the TCOC and Savings/Loss Calculation Methodology, including the required steps of development of the annualized non-AC comparison group trends, establishing of the benchmark TCOC PMPM, actual TCOC PMPM (for base year and performance year), calculation of savings/loss, and production of required reports at the AC-level and provider-level.
- Provides details for AC TCOC summary analysis presentations.
- Proposes to make recommendations based on TCOC report findings for additional ad hoc analyses regarding specific areas of performance. It is unclear why this additional analysis is not included in the scope of work.

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- States *"may delve"* into the underlying root causes of performance trends to better understand factors but it is unclear why determining the root cause is not included in the scope of work.
- Commits to open lines of communication with the Department to meet the Department's needs and expectations.
- Plans to communicate TCOC results to ACs via email, PowerPoint, and Excel tools.
- Demonstrated familiarity with producing the required files contained in the AC data extracts package.
- Plans to apply completion factors as requested.
- Demonstrates understanding of importance of completion factors, relies on proprietary IBNR model that analyzes historical data. States that they plan to use actuarial judgement to reflect other adjustments.
- Describes the processes to coordinate with the Department and methodology to determine necessary AC policy change adjustments.
- Developed an empirical data-driven approach to employing policy adjustment factors.
- Proposes to apply the policy adjustment with the largest impact in total dollars when multiple policy adjustments apply to a single claim to avoid overstating the impact of overlapping changes.
- Ability to provide subject matter expertise in alternate payment models and dedication to assisting the Department in improvement and effectiveness of the AC/PCPlus methodologies.
- Demonstrated ability to implement other APMs, AC frameworks, with other states.

D. Fiscal Management Analytics (FMA)

- Demonstrates expertise and understanding of factors that could both impact and influence MaineCare enrollment trends, including Census and Maine State Economist demographic data, poverty and unemployment rates, and Maine government-issues reports.
- Proposed data sources and analyses indicate flexibility and adaptability in developing enrollment projections that are tailored to Maine.
- Described a trend development process which relies on qualitative and quantitative data, reflecting their expertise with projections.
- Demonstrates substantial understanding of processes and approaches to identifying non-claims-based payment categories and integrating these costs into future expenditures projections.
- Plans to collaborate with the Department at a kick-off meeting to develop non-claims items. Detailed the items they expect will be identified (based on the RFP) and demonstrated expertise in several of these payments.
- Will integrate these items into their overall fiscal management tool and provide quarterly updates.

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DATE: (Eligibility) June 30, 2025, Part IV August 5, 2025

- Proposes a structured approach to refining enrollment categories, including three (3) new population categories: CHIP population, dual eligible, and the LTC population.
- Demonstrates openness to adaptability in projecting enrollment, deep understanding of MaineCare population, and creativity in generating projections that will assist the Department.
- Demonstrated ability to crosswalk these categories to the AC and NET categories as requested.
- Proposes aggregating smaller service categories to improve statistical reliability of projections.
- Proposes to consider alignment with population categories, funding accounts, credibility, and alignment with other programs to determine optimal categories of services for FMA reporting.
- Agreed to develop service categories which link to each section of policy in coordination with the Department (as required in the RFP).
- Suggested working with the Department to ensure alignment with population categories and funding accounts.
- Suggested grouping some categories together which will likely be necessary, further indicating their expertise in this area.
- Proposes providing a template to the Department with a proposed layout and metrics for Department approval.
- Will provide projections by PMPM and enrollment as well as PMPM broken down by price and utilization components. It will do this on a paid and an incurred basis.
- Offers to design deliverables to cater to stakeholders' needs, in addition to the required departmental documents and format.
- Plans to include interactive dashboards available which may or may not be necessary.
- Highlights synergies and efficiencies among the various reporting work, including integrated data analysis and improved policy impact assessment.
- Proposes reviewing the existing 11 NET rate cohorts to determine if they can be collapsed or reorganized. Will review how the recommended NET rate cohorts map into existing FMA population groups.

E. Upper Payment Limit (UPL)

- Demonstrated an understanding that UPL demonstrations must follow 42 CFR 431.16.
- Plans to work with Sellers Dorsey to lead the UPL work.
- Other subject matter experts who have worked on UPLs for other states would be working with Sellers Dorsey.
- Plans to have Sellers Dorsey lead UPL activities and Mercer will manage and oversee the calculation of the UPL demonstration and other UPL-related services. It is unclear what the roles of Sellers Dorsey and Mercer would be.

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BIDDER: Mercer Health & Benefits LLC
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- Described meeting the specific requirements by obtaining data to support UPL analyses, identifying and outlining the UPL methodologies and reviewing with the Department including best practices and potential new financing mechanisms, and completing the UPL calculations using approved methodologies.
- Propose to monitor UPL issues raised by CMS in other states that could affect Maine.
- Propose to monitor changes in Medicare reimbursement policy and provide options to the Department to mitigate impact of the changes.
- Will collect the additional data as required in the RFP and review calculation options and collaborate on this with the Department where appropriate.
- Will prepare materials for submission to CMS and assist with any issues with CMS.

F. Requirements Related to Receiving Confidential Data

- Met the requirements.

G. Project Management

- Emphasizes continuous engagement with the Department to stay current on project plans.
- Described a detailed plan for project management, including periodic meetings, an ongoing project work plan, and decision and data trackers.
- Provided additional details related to agenda topics, status checks, documentation of key decisions, the use of trackers as part of their communication strategy, budget summary documentation, and the development of a portfolio dashboard document.
- Propose to use 1 senior project manager to oversee all work streams.
- Did not specifically address the minimum of 12 collaborative AC-work meetings per year in this section, but reflected later in the work plan.

H. Ad Hoc Work

- Described processing ad hoc data analyses and/or modification of report formats by providing defined process steps of preparing the budget estimate, then moving forward with the formal approval process, timeline development, integration into ad-hoc budget summary, and proactive suggestions.
- Described how to process ad-hoc work of forecasting revenues from the Medicaid Drug Rebate Program by comprehensive analysis, budget estimate development, collaboration with the Department, adaptability to changes, and documentation and approval.
- Demonstrated familiarity with the Department's data and programs enable staff to efficiently conduct analyses without a steep learning curve.

I. Reports

- Outlines comprehensive data management and recordkeeping processes.
- Detailed description provided for tracking and recording required reports by categorizing processes as project plan and feedback, routine communications, staggering deliverables, secure channels for PHI, deliverable format discussion,

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and use of templates. • Noted key benefits of their report submission process of security and compliance, tailored deliverable formats, template utilization, and structured feedback mechanism.
2. Staffing
• Subcontractor is integrated into the project team. Mercer maintains primary responsibility for the work delivered by the subcontractor. • Staffing plan includes some individuals with more expertise to spend less time on the project in year 2 than in year 1. Proposed staff have broad expertise and experience. • Time allocation was broken down for each of the two (2) first program years.
3. Implementation - Work Plan
• Tasks/Activities are labeled with RFP section references and specific lead name is noted for each Task/Activity. • Work plan includes very detailed broken-down steps for each Task/Activity and Deliverable, though this level of detail does create a very lengthy work plan. • Work plan is set up for Year 1, Year 2, and into the renewal period. • Did not include the tasks delegated to subcontractor within the work plan.

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

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BIDDER: Mercer Health & Benefits LLC
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EVALUATION OF SECTION IV
Cost Proposal

Lowest Submitted Cost Proposal	÷	Cost Proposal Being Scored	x	Score Weight	=	Score
$1,252,500.00	**÷**	**$2,398,400.00**	**x**	**25 points**	**=**	**13.06**

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BIDDER: Milliman Inc
DATE: (Eligibility) June 30, 2025, (Part IV) August 6, 2025

SUMMARY PAGE

Department Name: Health and Human Services
Name of RFP Coordinator: Casandra Manson
Names of Evaluators: Roger Bondeson, Philip Dubois, Charyl Malik, Lauren Metayer, Jordan Rhodes.

Pass/Fail Criteria	Pass	Fail
Section I. Preliminary Information (Eligibility)	**X**	
Scoring Sections	Points Available	Points Awarded
Section II. Organization Qualifications and Experience	**25.00**	**25.00**
Section III. Proposed Services	**50.00**	**37.00**
Section IV. Cost Proposal	**25.00**	**6.65**
Total Points	**100.00**	**68.65**

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OVERVIEW OF SECTION I
Preliminary Information

Section I. Preliminary Information (Eligibility)

Evaluation Team Comments:

Demonstrated at least two (2) NET Services Rate Certifications, approved by CMS, in the past five (5) years and at least two (2) Upper Payment Limit (UPL) demonstrations, approved by CMS, in the past five (5) years.

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TEAM CONSENSUS EVALUATION NOTES

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EVALUATION OF SECTION II
Organization Qualifications and Experience

	Points Available	Points Awarded
Section II. Organization Qualifications and Experience	**25.00**	**25.00**

Evaluation Team Comments:

Part IV. Section II. Organizational Qualification and Experience

1. Overview of the Organization

- Provided three (3) relevant project examples demonstrating experience with other states on projects relating to the RFP requirements.
- Have worked with over thirty (30) state health and human services agencies to advance sustainable healthcare reform within the past year.
- Reports key strengths of actuarial analysis, modern analytical approach, integrated multi-disciplinary team, and clear and effective communication.
- Team has over 1,300 credentialed actuaries, 140 of which are Medicaid focused.
- Key actuary staff for NET rate setting, FMA, AC and PCPlus are members of the Fellows of the Society of Actuaries.
- Health Information Trust Alliance (HITRUST) and Service Organization Controls (SOC) 2 certified.
- Extensive experience working with state Medicaid agencies.
- Have worked to develop standalone NET rates (7 states) and UPL demonstrations (7 states).
- Founded in 1947 and is one of the largest actuarial consulting firms worldwide.
- Experienced as an actuarial services vendor in nineteen (19) states, for fiscal management analytics and Alternative Payment Model (APM) support.
- Has experience developing tools for South Carolina and Mississippi to provide FMA services.
  - In South Carolina they developed an annual and mid-year budget forecast and created PMPM trends.
  - In Mississippi they developed expenditure projections for the Medicaid program for twelve (12) years.
- Reports more than three (3) decades of experience for state Medicaid agencies developing fiscal management analyses through the use of standard tools and reports as well as projecting and tracking trends.
- Prior engagements with multiple states to develop NET rates for both standalone NET programs and programs where NET is integrated into a managed care plan. Worked with Florida, Ohio, Idaho, Indiana, Kentucky, Arizona, and Hawaii.

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TEAM CONSENSUS EVALUATION NOTES

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• Has conducted NET rate certifications since 2020. • Supported the facilitation, design, implementation, management, and improvement of Rhode Island's Accountable Entities program. • Supported the facilitation, design, and implementation of Ohio's Patient-Centered Medical Home model and has continued to support the program for nine years providing quarterly dashboard reports, establishing TCOC adjustment factors, and validating shared savings calculations. • Supports Idaho on a quarterly basis by providing estimates of TCOC performance and calculates final settlement reports annually to document shared savings/(loss). • Has assisted four (4) state Medicaid agencies with UPL demonstrations in the past year. • Has worked with Washington since 1996 on UPL demonstrations.
2. Subcontractors
• Does not intend to utilize subcontractors.
3. Project Team Organizational Chart
• Met the requirement.
4. Litigation
• Provided ongoing litigation case. It appears unrelated to project work outlined in this RFP.
5. Financial Viability
• Provided three (3) years of audited financial statements.
6. Certificate of Insurance
• Provided Certificates of Liability Insurance which was current at the time of submission.

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

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EVALUATION OF SECTION III
Proposed Services

	Points Available	Points Awarded
Section III. Proposed Services	**50.00**	**37.00**

Evaluation Team Comments:

Part IV, Section III Proposed Services
1. Services to be Provided
Part II **A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement**
• Primary lead with 5 years of experience in NET capitation rate setting. • Has qualified Fellow of the Society of Actuaries employed with experience certifying rates in many other states. • Displayed a comprehensive understanding of project planning, financial status, and rating approaches associated with NET program analysis. • Proposed rating approach includes the creation of a rate methodology letter early in the project that will provide details on population and cohorts, covered services, regional rate structure, and grouping urban areas together. • Proposes utilization of the DRIVE (Dashboard for Research, Insight, and Validation of Experience) to assess and view program's financial performance. • Plans to meet with the Department to request data, receive claims data through a secure file transfer protocol, and store data in a location with encryption in place to protect Protected Health Information. • Plans to have the same staff receive all data related to this RFP. • Outlined a five-step process for monitoring broker encounter and financial data. This process included a DRIVE tool which it will use to monitor encounter data and create summaries and data comparisons. • Proposes to create distributions to observe who did not utilize NET services vs. members who do utilize NET to assist in the identification of regions or populations that may be underserved or over-utilizing services. • Proposes quality control checks when assessing encounter data such as unit cost outliers, utilization outliers, duplicate claims or members, consistency in reported experience, consistency in unit definitions, comparison of encounter data with financial data, and validation of caseload information with claims information. • Proposed conducting an annual survey of NET brokers in addition to collecting financial data from the broker. This survey would collect key information, such as

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incurred but not paid claims and can offer insights during the rate setting process.
- Proposes a 7-step process for completing NET capitation rates:
  - Claims completion
  - Program and policy adjustments
  - Non-State Plan Services (Maine NET is not via a state plan but via a 1915(b) waiver which was defined in the RFP.
  - Trend rate development
  - Quality and cost containment initiatives
  - Administration and other non-benefit costs
  - Other adjustments
- Will include a data book providing an overview of the rate development process meeting the requirements in CFR 438.7(e) as part of each rate certification package.
- Will remain engaged with CMS throughout the process and will participate in calls as needed and willing to discuss the rate-setting methodology with all stakeholders.

B. Receipt and Management of Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables

- Proposes to develop a combined data transfer process in compliance with MaineIT requirements across the NET, AC, PCPlus, FMA, and UPL workstreams to create efficiencies in the data collection process.
- Demonstrated ability to ingest, process, and validate claims and eligibility data and will adhere to Maine's OIT Access Control and Data Exchange policies.
- Proposes to provide the Department access to data via an online portal

C. AC and PCPlus Data Analysis and Reporting

- Demonstrated ability to assist Medicaid agencies in designing and implementing value-based payment initiatives.
- Actuary will be the AC Workstream Lead as well as employing more than 80 actuaries with experience supporting state Medicaid agencies who can provide expertise when needed.
- Propose the project team will have SMEs who monitor Medicare and other State Medicaid programs to keep abreast of payment reform efforts.
- Proposes use of a data template to increase efficiency and standardization of collecting AC and PCPlus information.
- No reference to full-coverage MaineCare members being a part of the defined eligible population.
- Lacks familiarity with the current methodology citing the use of Health Home methodology for AC attribution when it is no longer utilized since PCPlus began.
- Response does not reference various key elements of AC attribution such as data from the Muskie Crosswalk, tie-breaker logic for plurality of primary care, and the lookback period.

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

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- Explanation of AC roster comparison does not address members who changed PCP locations within an AC.
- Response does not reference full-coverage MaineCare eligibility being part of the PCPlus attribution process.
- Conflating claims associated with primary care services and "PCPlus services" and "PCPlus claims," suggests a lack of familiarity with program payment methodology.
- Cites 2 TCOC deliverables, when in fact there are four (4).
- Proposes to recalculate shared savings amounts for each AC using various combinations of optional service categories.
- Plans to present results in a dashboard that will be updated quarterly.
- Will schedule meetings with the Department to discuss results, aims to provide high-level insights into the types of services driving favorable or unfavorable experiences for the ACs.
- Will utilize a proprietary algorithm to identify claims as potentially avoidable to assess the efficiency of care.
- Though descriptions were provided on how analyses might occur and stated materials would be provided in a format facilitating seamless sharing with ACs, it didn’t clearly specify what that format would be (focus for this section was for presentations).
- Did not acknowledge the extract package will be delivered as .txt files.
- Did not provide an explanation of the list of claims excluded from the TCOC report being incorporated into the data extracts.
- Will incorporate AC data extracts into the same process to produce TCOC reports to avoid discrepancies.
- Proposes to use its “Robust Time-Series Analysis System” (RTS) to conduct incurred but not reported (IBNR) claims analysis.
- Plans to use the Muskie Crosswalk provided by the Department and will refine, if needed, these groupings so that completion patterns are consistent in each group.
- Did not acknowledge working with the Department annually in a deliberative process to review all changes to MaineCare regulations and other changes in the previous year.
- Provided a list of potential, relevant policy changes, and examples of applying related work.
- Demonstrated expertise on how to conduct adjustments and updates to provider reimbursement policies, population changes, and other program changes.
- Described several scenarios that might require adjustments to the data to reflect policy or program changes.
- Propose to develop an analytical approach to identify changes and their impacts and make recommendations for improvement to the Department but did not provide details on how they would accomplish that.
- Proposes to share national best practices to identify changes that could improve the program.

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- Demonstrated subject matter expertise in ACO programs and maintains connection to Medicaid, Medicare, and commercial ACO models.

D. Fiscal Management Analytics (FMA)

- Demonstrated ability to provide comprehensive fiscal and data analytics support.
- Proposed quarterly reports as required, providing additional detail for each deliverable which would be helpful such as calculating the State share of expenditures for specific deliverables. Will also be able to collaborate with the Department to provide other exhibits of interest and be available in Excel and dynamic dashboards.
- Provided an overview of the projection's methodology, which is based on an incurred basis and a population-based framework. This section demonstrated expertise in this area, and appropriately referenced other data sources that will inform their analysis.
- Stated that for policy changes they would provide a list to the department for review, and the Department would provide fiscal notes for each item.
- Stated that even though the projection model is based on incurred data, they would be able to project paid expenditures as well utilizing paid lag assumptions.
- Proposes to provide several exhibits on a longitudinal basis for FMA updates on enrollment, utilization, and expenditures.
- Cites a robust set of external data sources that could support enrollment and expenditures projections, including:
  - National Health Expenditure (NHE)
  - Bureau of Labor Statistics (BLS)
  - American Community Survey (ACS)
  - Congressional Budget Office (CBO)
  - Kaiser Family Foundation (KFF)
- Demonstrates understanding, including strengths and limitations, of analysis of variance techniques.
- Demonstrated expertise by providing an example table that stratifies by service category and showing variances by dollar and by percent over previous quarter.
- Proposes to include receivables related to Medicaid expenditures, such as pharmacy rebates, Third Party Liability (TPL) (outside of pay and chase), member cost share, estate recovery, and provider refunds and recoupments as offsets.
- Exhibits understanding of projections methodologies associated with non-claims-based payments.
- Demonstrated familiarity with non-claims data, suggested aligning projections with enrollment and reimbursement trend assumptions.
- Will collaborate with the Department to represent how these items are likely to grow in the future.
- Proposes consideration of several factors in determining which enrollment and population categories to be used in FMA and recommends a smaller number of population rollups or major population groups.

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- Proposed a sample population structure. While actual population categories may differ, sample structure exhibits understanding of MaineCare population groups and modelling considerations.
- Did not acknowledge a willingness to breakout projections by the sections of the MBM as required in the RFP.
- Will collaborate with the Department on service groupings and listed several items to be considered.
- Proposed customizing Excel exhibits as well as presentation decks, a report documenting key results, and supplementing Excel deliverables with more in-depth analysis of findings and access to the underlying data provided to staff at no additional fee.
- Plans to provide Dynamic Dashboards, in addition to the requested Excel deliverables.
- Proposes the possibility of mapping NET population cohorts to FMA population cohorts and provides an illustrative table to demonstrate this opportunity.
- Proposes further stratifying AC populations such as child population into CHIP and non-CHIP cohorts and non-ABD adults into expansion and non-expansion cohorts.
- Demonstrated a good understanding of how having one vendor provide all of this work would be beneficial to the Department.
- Outlines a broad set of synergies from alignment across topics, including data validation, assumption and projection alignment, and understanding of broad regulatory changes.

E. Upper Payment Limit (UPL)

- Demonstrated an understanding of important variables to consider in selecting a UPL methodology and approaches to calculate UPLs for inpatient and outpatient hospital services, nursing facility services, intermediate care facility services, clinics, and Psychiatric Residential Treatment Facility (PRTF) services.
- Demonstrated ability to calculate UPLs for fee for service Medicaid programs.
- Proposes and describes a 9-step process when calculating UPL demonstrations.
- Demonstrated ability to prepare UPL demonstrations and with handling all aspects of the UPL submission to CMS, including addressing questions from CMS.
- Proposes to utilize internal software to do full Medicare repricing of Medicaid claims data.
- Plans to review new UPL guidance issued by CMS and will proactively review the current UPL demonstrations in Maine to identify any areas of concern.
- Will review Medicare payment methodologies, relying on expert staff, to inform the Department of any changes.
- Will collect Medicaid utilization data, conduct the UPL calculation options, and prepare the materials for submittal to CMS.
- Demonstrated familiarity with the types of questions CMS asks in response to UPL demonstrations which may be helpful in the future.

F. Requirements Related to Receiving Confidential Data

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- Requests adjustment to ensure file ingestion in a secure staging environment (Sandbox API endpoints).

G. Project Management

- Will utilize a standard project management approach which includes an initiation and planning phase, a work phase, and a project completion phase. Each phase has several steps to ensure collaboration with the Department, sets expectations clearly, documents decisions, and provides timely materials.
- Project management approach demonstrated ability to work on long term and complex projects related to Medicaid.
- Propose to utilize a decision tracker and a data tracker detailing all the information that's needed to complete a project and provided an example of a data tracker.
- Notes record of consolidating parallel reporting structures, with example provided of work conducted for another state.
- Created a governance structure to eliminate duplication and maintain aligned assumptions, methods, and timelines.

H. Ad Hoc Work

- Proposes to use staffed subject matter experts in finance, policy, operations, clinical management, pharmacy, and data sciences to assist in ad hoc work requests when needed.
- Work that falls outside of the routine deliverables, a scope of work will be provided to the Department, prior to initiation, which includes a timeline, cost, workplan and approval by the Department.
- Prepared to assist the Department in unanticipated and unprecedented issues that may arise.
- Provided "Experience in Practice" examples of participation in actuarial consulting, pharmacy consulting, and financial consulting projects.
- Demonstrates significant understanding of ongoing policy initiatives in Maine, including TMaH and MaineMOM.
- Project team and Medicaid Pharmacy consultants (staff) are familiar with the proposed projects and provided detailed information related to the Medicaid Drug Rebate Program Revenue Forecasting work.

I. Reports

- Met the requirements.

2. Staffing

- Met the requirements.

3. Implementation - Work Plan

- Work plan did not include the TCOC biannual reports.

STATE OF MAINE
TEAM CONSENSUS EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER: Milliman Inc
DATE: (Eligibility) June 30, 2025, (Part IV) August 6, 2025

EVALUATION OF SECTION IV
Cost Proposal

Lowest Submitted Cost Proposal	÷	Cost Proposal Being Scored	x	Score Weight	=	Score
$1,252,500.00	**÷**	**$4,710,000.00**	**x**	**25 points**	**=**	**6.65**

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: CBIZ Optumas, LLC
DATE: 6/25/2025 (Eligibility Review): 7/22/2025 (Organizational Qualifications): 7/22/2025 - 7/25/2025 & 7/28/2025 (Scope of Services).
EVALUATOR NAME: Roger Bondeson
EVALUATOR DEPARTMENT: Department of Health and Human Services
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• CBIZ provided examples of two NET rate certifications for the Kansas Department of Health and Environment and two Upper Payment Limit demonstrations for MassHealth. CBIZ meets eligibility requirements.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• CBIZ completed and submitted all necessary forms for this section. The company was founded in 2006. In 2021, it acquired Schramm Health Partners, LLC out of Arizona. • CBIZ states that it not only provides analytics but takes the time to explain complex numbers and their implications to all stakeholders (P). • CBIZ has provided actuarial services to more than 30 states over 17 years.
2. Subcontractors
• No subcontractor(s)
3. Project Team Organizational Chart
• Identifies an overall project lead and key staff for NET, AC/PCPlus, FMA, and UPLs. Meets requirement.
4. Litigation
• No litigation noted.
5. Financial Viability
• Provided 3 years of financial statements – defer to scoring team's financial expert.
6. Certificate of Insurance
• Provided 4 certificates of insurance, Technology/Cyber, Errors and Omissions, Commercial General Liability (expired 9/30/25) and Crime.
Additional requirements from Appendix D.
• See above notes in #1.
• Provided fiscal management analytics for several states including Alabama, Colorado, Iowa, Kansas, Maryland, Nebraska, Ohio, and Oregon. • Asserts much of its FMA focused on developing budget forecasts to model disenrollments from the COVID19 Pandemic Public Health Emergency.

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

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DATE: 6/25/2025 (Eligibility Review): 7/22/2025 (Organizational Qualifications): 7/22/2025 - 7/25/2025 & 7/28/2025 (Scope of Services).
EVALUATOR NAME: Roger Bondeson
EVALUATOR DEPARTMENT: Department of Health and Human Services
****

• Described forecasting work in the state of Alabama demonstrating experience with FMA.
• Demonstrated some experience with setting rates where NET is a state plan service included as a benefit in managed care programs. • It has not certified rates for standalone NET programs. • Description of NET rate review work demonstrates minimal experience.
• Asserts development of value based payment experience in Colorado, Mississippi, North Dakota, Oregon, and Washington, with a focus of work description on North Dakota. • Provided consulting assistance for North Dakota's value based payment program from design, to implementation, and monitoring and reporting.
• Demonstrates good experience in preparing UPL demonstrations for several state Medicaid agencies including Maine (see Table 1, UPL Client Experience.

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. Meets requirements. • CBIZ will provide at least one certified actuary to sign off on NET rate certification reports. • Currently have 8 credentialed actuaries including 4 Fellows of the Society of Actuaries. 2. • Demonstrates project planning experience by proposing and describing a project plan to include: ➢ Meeting cadence ➢ Program structure ➢ Methodology ➢ Deliverables and timing
3. • Will use MaineIT MoveIT SFTP for data transfer. • Proposes initial date request to include: ➢ Data dictionaries ➢ Enrollment data ➢ NET encounter data

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

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EVALUATOR NAME: Roger Bondeson
EVALUATOR DEPARTMENT: Department of Health and Human Services
****

- NET caseload data
- Broker contracts and financial records
- Historical and projected program changes

- Proposes several methods of data review and validation:
  - Control totals check
  - Referential integrity check
  - Review of data over time
  - Review for denied, duplicate, reversed, or zero paid claims.
  - Encounter to Financial data comparison
- Proposes to summarize and document in Excel a question based log identifying all potential data issues and gaps to be addressed by the Department before engaging the NET brokers. This same approach will then be used with the brokers to answer questions not answered by the Department
- Proposes the use of contract incentives with “teeth” to improve encounter data accuracy.
- Propose collaborating with stakeholders to improve encounter data by:
  - Meetings to discus
  - Communications imploring the need for good data
  - Distribution of reports describing resolutions to data problems.

4.

- Demonstrates knowledge of some common base data adjustments such as incurred but not reported estimates, encounter data underreporting/completion, identification of large claims impacts, and managed care plan aggregate or lump sum payments made outside of the claims system (Yellow highlighted section not applicable to a PMPM full risk brokerage model for NET).
- Proposes use of a policy change document to track policy changes that may affect rate setting.
- Provided a description of policy changes that CBIZ Optumas has evaluated for Medicaid programs including legislative appropriations, acuity adjustments, and provider reimbursement changes (Yellow highlight not applicable to a PMPM full risk NET brokerage model).
- Proposes to use a trend model that isolates both the utilization trend per 1,000 members and the unit cost trend.

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EVALUATOR DEPARTMENT: Department of Health and Human Services
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- Proposes to proactively request trend estimates from the NET brokers at beginning or rate development work.
- Demonstrates knowledge of how to calculate administrative costs into PMPM rates.
- Demonstrates knowledge of establishing a profit / risk contingency to be incorporated into the rates – generally 1% to 3% is acceptable for CMS.
- Between rate cycles CBIZ proposes to work with the Department to evaluate recent encounter and financial data, to stay on top of any policy changes, and to identify areas within the existing rate methodology that could be improved such as existing rate cohorts, regions, and administrative load assumptions.

B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables

1.
   - Proposes a pipe delimited data feed to limit potential data feed errors.
   - Demonstrates ability to accept supplemental data files.
   - Doesn't address B.1.c – Other Non-Claims Expenditure Information.
2. Response to this section is minimal.

C. AC and PCPlus Data Analysis

1.
- Meets requirements on having at least one certified actuary, they have 8.

2. Meets requirements.
3. Didn't address 3 b iii 1 TCOC reports.
4. Meets requirements.
5. Meets requirements.
6. Response is minimal.
7. Meets requirements.
8.
   - Proposes to use its incurred but not yet reported (IBNR) model to develop factors under the following scenarios demonstrating knowledge of AC completion factors:
     - Averages of the most recent 12, 6, and 3 months
     - Using the middle of 10 of 12 months throwing out one high and one low value.

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- Using the middle of 8 of 12 months throwing out two high and two low values. CBIZ prefers this method to remove "noise" from the completion factor development.
- Proposes to exclude claims of 150k or more from IBNR analysis.

9.
- Demonstrates knowledge of developing and documenting methodologies to capture impact of program and/or policy changes.

10. Proposes use of an online dashboard that providers can access to view their own performance, see how they compare against peers, and see gaps in care across quality measures.
- Proposes an approach for evidence based recommendations to include environmental scanning, model performance evaluation, and stakeholder feedback to identify areas for improvement.
- To ensure financial sustainability, CBIZ proposes and describes a 5 step process for identifying outliers that includes a root cause analysis to determine what is driving the change.

11. Meets requirements.

D. Fiscal Management Analytics (FMA)

1.
- Proposes the development of a project plan that details timelines, data sources, projection methodology, and deliverable format before work begins.
- Describes a 6 step projection process that demonstrates expertise in FMA (p.37).
- Proposed approach to model selection is to use the model with the simplest solution requiring the least possible elements, Occam's Razor.
- CBIZ proposes to evaluate the tradeoff between model complexity, interpretability, and accuracy via testing how models perform predicting historical data.
- Demonstrates expertise in model evaluation by describing several techniques, page 42.
- Describes an infographic tool that would enable the Department to drill down into the data to determine the causes of deviations from projections. However, this would be an added cost to the proposal above and beyond what is needed (I).

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2.
- Demonstrates expertise in developing forecasting models for non-claims based expenditures.
- Proposes to work with the Department to determine desired deliverable format of projections and monitoring metrics.

3.
- Proposes that categories of aid be comprised of similar members and be different from all other rating categories.
- Provides a list of common elements that would differentiate between cohorts demonstrating knowledge of this task.
- Proposes providing a table for the Department that shows coding logic of the cohorts, and a map of cohorts used in FMA to cohorts used in NET rate development and AC reports.

4.
- Proposes to group each service by similar procedures but very different from all other service categories
- Demonstrates knowledge of creating and aligning rating cohorts for fiscal analysis.
- Proposes to conduct a review of historical data of state plan services to better understand proper service groupings.

5. Meets requirements.

6.
- Proposes use of Tableau and PowerBI at additional cost to the Department but not necessary to accomplish scope of work from this RFP. (I)
- Proposes to review prior or existing format as a starting point and then add refinements as necessary.
- Asserts skills and experience in presenting to state legislators, Medicaid Directors, and other non-actuarial senior managers.

Alignment Across Topics

- Proposes one consultant to do the necessary work across AC, NET, and FMA to increase alignment among these three programs.
- Proposes a pyramidal project that uses less data, models, and analysis at the top and then flows down to a much wider variety of reports and exhibits.

E. Upper Payment Limit (UPL)

1.
- Demonstrates knowledge of CMS rules and guidance on developing UPLs.

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- Asserts it has successfully undergone scrutiny of its UPL demonstrations via CMS and OIG audits.
- Demonstrates significant experience in developing UPLs for several states and program types.
- Proposes to follow the Department's established UPL methodologies and will consult with the Department on alternative methodologies.
- Proposes to collect additional data to develop UPLs including ownership type, hospital cost report data, public and private nursing facility data, and ICF\IID cost report data.
- Demonstrates knowledge of Maine's UPLs for inpatient and outpatient hospital services, nursing facilities, ICF/IDD, and clinic services.
- Provides a descriptive list of methodologies demonstrating significant knowledge of UPL methodologies.

2.

- Asserts that it is the only vendor with the capability to perform a Medicare RUG based nursing facility UPL demonstration (I).
- Proposes to utilize the expertise of staff that research changes in Medicare reimbursement and UPL requirements to inform the Department of any necessary changes it must make.

F. Requirements Related to Receiving Confidential Data

1. Meets requirements.
2. CBIZ states it complies with IT requirements in this section but doesn't state how they comply (e.g., a description of their in house policies)
3. Meets requirements.
4.Minimally response, no explanation on how CBIZ would comply.
5. Minimally responsive, provides no description on what they currently do to maintain confidentiality.
6.Meets requirements.

G. Project Management

1.

- Proposes an on-site kick off meeting to discuss major tasks and expectations.
- Proposes use of four project management tools including:
  - Project plan
  - Question log
  - Status log
  - Meeting notes

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- Proposes staffing projects using a hub and spoke model with a project director and an actuary as the hub and consultants and subject matter experts as the spokes.

2. Did not address.
3. Did not address.

H. Ad Hoc Work

1. Meets requirements.
2. Did not address.

I. Reports

1. Proposes that all of the reports will be included as deliverables in the project plan and monitored via the status log to ensure timely delivery.
2. Proposes use of secure portals for transmission of reports that contain PHI/PII and via email for those reports that contain non-sensitive information.

2. Staffing

a. Meets requirements
b. No subcontractors.
c. Meets requirements – staff is well qualified.

3. Implementation - Work Plan

a. Meets requirements.

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DATE: 6/26/2025 (eligibility), 7/23/2025 (Part IV), 8/18/2025 (Cost)
EVALUATOR NAME: Philip Dubois
EVALUATOR DEPARTMENT: DHHS, OMS
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Bidder meets the eligibility requirements and cited specific projects that satisfy these requirements.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• See Appendix D
2. Subcontractors
• The bidder indicated they will not utilize the services of a subcontractor in completing any of the required tasks.
3. Project Team Organizational Chart
• The bidder provided the required project team organizational chart. • The chart identifies that some team members will be splitting their time between multiple scopes of work.
4. Litigation
• The bidder indicated none.
5. Financial Viability
• The bidder provided three years of audited financial statements.
6. Certificate of Insurance
• The bidder provided the required certificate of insurance.
Additional requirements from Appendix D.
• The bidder has certified, reviewed, critiqued, and overseen the development of expenditure projection models, analytical calculations, actuarial analyses, actuarially sound rate ranges, and innovative program reforms in more than 30 states over the last 17 years.
• The bidder has experience in developing varying levels of fiscal forecast models in multiple (8) states.
• The bidder indicated that they have not certified stand-alone rates for NET services, but that they have certified rates in a number of states where NET is a state-plan service included as a benefit in the managed care program.
• The bidder has experience in value-based payment (VBP) and Medicaid transformation programs through their work in several states.

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- The bidder indicates that they have more than 25 years of experience in preparing UPL demonstrations for nearly 30 state Medicaid agencies.

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. The bidder indicated that they meet the requirement to have at least one certified actuary to sign off on the capitation rate certification letter. 2. The bidder met the requirements. 3. The bidder indicated that they would be requesting data beginning January 2023 – the RFP requirement was for data beginning January 2024. 4. N - The bidder's response lacked detail and did not specifically address the requirements of this RFP. The response was directed more towards a program where NET is a state-plan service included as a benefit in a managed care program.
B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables
1. N - The bidder's response lacked detail and did not specifically address the requirements of this RFP. 2. N – The bidder's response lacked detail and did not specifically address the requirements of this RFP.
C. AC and PCPlus Data Analysis
1. The bidder met the requirements. 2. It's not clear if the bidder actually understood the requirements of this section. 3. N – The bidder's response lacked detail and did not specifically address some of the requirements in this section. 4. N – The bidder's response lacked detail and did not specifically address some of the requirements in this section. 5. N – The bidder's response lacked detail and did not specifically address some of the requirements in this section. 6. The bidder did not address all requirements in this section (performance metrics). 7. The bidder met the requirements. 8. The bidder met the requirements. 9. The bidder met the requirements.

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10. The bidder met the requirements.
11. The bidder met the requirements.

D. Fiscal Management Analytics (FMA)

1. The bidder discussed some potential projection models and methods for selecting the best model.
   The bidder discussed presenting the results in a dashboard for an additional cost.
2. The bidder met the requirements.
3. The bidder met the requirements.
4. The bidder met the requirements.
5. The bidder met the requirements.
6. The bidder did not clearly address this RFP requirement. The bidder's response prioritized a discussion of their ability to deliver projections using data visualization tools like Tableau and PowerBI at an additional cost. The bidder's response did not mention the use of Microsoft Excel.

Alignment Across Topics

- The bidder met the requirements.

E. Upper Payment Limit (UPL)

1. The bidder met the requirements.
2. The bidder met the requirements.

F. Requirements Related to Receiving Confidential Data

1. The bidder met the requirements.
2. The bidder met the requirements.
3. The bidder met the requirements.
4. The bidder met the requirements.
5. The bidder met the requirements.
6. The bidder met the requirements.

G. Project Management

1. The bidder met the requirements.
2. The bidder did not address this requirement.
3. The bidder met the requirements.

H. Ad Hoc Work

1. The bidder met the requirements.
2. The bidder mentioned managed care program design, procurements and compliance as examples of ad hoc projects they are qualified for. Managed care is not relevant to the requirements of this RFP.

I. Reports

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1. The bidder's response lacked detail and did not specifically address how they will track and record data.
2. The bidder met the requirements.

2. Staffing

a. The bidder met the requirements.
b. The bidder indicated that they will not use subcontractors for this engagement.
c. The staffing plan indicates that some team members will be splitting their time between multiple scopes of work.

3. Implementation - Work Plan

a. The bidder provided a work plan in the form of a Gantt chart.

Part IV, Section IV. Cost Proposal

- Bidder changed the number of deliverables for C. viii – x from 3 to 8.

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EVALUATOR NAME: Charyl Malik
EVALUATOR DEPARTMENT: DHHS/OMS
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• 1. – N – Description of the NET Services Rate Certification project did not contain much detail. • 1. – P – Project used for this qualifier shows project dates were from 2009-2014 and 2016 to current date. • 1. – Q – Has the bidder conducted two NET Services Rate Certifications in the past 5 years? The language used in the descriptions seems unclear in answering this. • 2. – N - Description of the UPL demonstrations project did not contain much detail. • 2. – P – Bidder notes more than 25 years' experience for nearly 30 state Medicaid agencies in preparing UPL demonstrations outside of the primary project noted in Appendix C. A table of the additional demonstrations is included in documentation.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• Was founded in 2006 as an actuarial firm specializing in providing actuarial and consulting services to publicly sponsored health and welfare programs and state Medicaid programs. • Has provided services to more than 30 states over the last 17 years.
2. Subcontractors
• No subcontractors will be used.
3. Project Team Organizational Chart
• Meets requirement.
4. Litigation
• Noted no litigation.
5. Financial Viability
• Provided required certified financial statements and reports.
6. Certificate of Insurance
• Provided active Certificate of Insurance documents.
Additional requirements from Appendix D.
• Same information as found in overview.

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• Demonstrated experience in developing fiscal forecast models across eight states. • Explains experience working on enrollment projections following the PHE. • Stated they have supported more than 20 state Medicaid agencies in developing budget forecasts. • Didn't seem to get down to service category and population type levels in the descriptions.
• Repeated the first paragraph from the overview section. • Has experience with certification of rates in a number of states where NET is a state plan service included as a benefit in managed care. • Has performed rate review for multiple states for NET services.
• Explained actuarial experience in value-based payment and Medicaid transformation programs in five states including work on TCOC and shared savings. • Work with North Dakota included the design of a password-protected, multi-factor authentication, protected portal for providers to access summarized, de-identified health care quality and outcomes data.
• Has more than 25 years of experience preparing UPL demonstration calculations for nearly 30 state Medicaid agencies. • Provided a table of UPL client experience, detailing the many states worked with and each UPL project per state, which also includes Maine.

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. Bidder has eight credentialed actuaries and lists each of them. 2. Bidder's plan will start with a kickoff meeting to bring key people to the table and get everyone on the same page for data needs, timelines, content of deliverables, and current financial status of NET. Detailed their project plan areas of meeting cadence, program structure, methodology, as well as deliverables and timing. Methodology for the rate approach does include required decisions. 3. Described general methods of data review and validation, including control total checks; referential integrity checks; review of data over time; review data for denied, duplicate, reversed, or zero paid claims; and encounters to financial data

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comparison as well as additional review based on the findings of the initial validation process.
Described their two-pronged collaborative approach to resolution to data issues which includes

- First, summarizing and documenting potential data issues, anomalies, and gaps to develop questions regarding the drivers of each item to create a resolution strategy with the Department.
- Then, for data questions and issues not resolved with the Department, engage the NET brokers using a similar strategy.

Described their initial process for addressing encounter data issues including flag for consideration in other rate adjustments, requires supplemental data to develop adjustment, and full or partial data resubmission, with the goal to identify suggestions to help the Department get through root causes of encounter data issues.
Continued collaboration with the Department and NET brokers was stressed.
Required areas of this question seemed to be addressed in the response.

4. Commits to transparency by sharing all deliverables and methodologies with the Department and NET brokers, as approved.
Bidder described its process used within rate development, which includes base data overview, base data adjustments (IBNR estimates, encounter data underreporting/completion, identifying large claims impacts, managed care plan aggregate or lumpsum payments outside of claims), prospective program policy and contract changes, trend factor analysis, non-medical analysis, profit/risk contingency margin, actuarial certification and rate negotiations, and rate development cycle.
Will support the Department by meeting regularly and provide written answers to questions from CMS.

B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables

1. Bidder is accustomed to receiving claims feeds and eligibility files from 12 states as well as importing, validating, scrubbing, and warehousing the received data. Also accustomed to receiving various supplemental data files needing to be incorporated.
Recommends unique delimiter formatting, such as pipe delimited data feeds.
Explains they utilize an internal Secure Shell File Transfer Protocol site for data transfers which has protocols for multi-factor login, automatic purging of data after

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7 days and non-user access after 180 days, though they will use the most appropriate solution per the Department.
Maintains a data transfer log to ensure successful transfer of files.
2. Bidder documented their processes for data validation.
Noted their experience in identifying varying high levels of service categories.
No reference to population groups or AC eligible claims was made.

C. AC and PCPlus Data Analysis

1. Though they noted tracking legislative state and federal changes, there was no direct reference to keeping up to date with Medicare developments.
   States they have actuarial experience in rate setting, value-based payment and Medicaid transformation programs in five states.
   Listed the names of their credentialed actuaries.
2. Bidder noted they would provide the table files to the Department, but the files are delivered to the vendor from the Department.
3. Provided a basic review of the attribution process but did not provide specific details including the lookback period, referencing the first step being recent PCPlus attribution, minimum enrollment duration, and full-coverage MaineCare qualifications.
   Did not note the delivery of bi-annual pipe-delimited files as an additional task.
4. Provided a basic review of the attribution process but did not provide specific details including the lookback period and full-coverage MaineCare qualifications or the inclusion of population group and risk score.
5. Referenced the annual TCOC and reconciliation TCOC reports as two separate though they are the same, rather than the annual projection and annual reconciliation.
   Notes two TCOC deliverables, yet there are four – annual projection, annual reconciliation, and biannual reports, as clarified in Q&A #23.
   Very basic description with few details and though noted experience in developing and filling out report templates, did not expand on their experience with TCOC calculations.
6. Did not expand on potential formatting of presentations and the results of the analyses.
7. Notes that the TCOC report will be delivered as a txt file, but it is the data extracts that are to be delivered as txt files.
8. Meets requirement.
9. Though they did map out a description of their typical process to assess program change impacts, they didn't necessarily commit to the details of this

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section, such as the annual deliberative process with the Department and claims-level adjustments.

10. Plans to use experience in environmental scanning, model performance evaluation, and stakeholder feedback to identify opportunities for methodological or operational improvements.
Provides a visual of their five-step outlier process to ensure financial viability.

11. Elements such as qualifying AC/PCPlus eligibility and change of member attribution between AC/PCPlus reporting periods were not included – the included list of items in the documentation seemed minimal.

D. Fiscal Management Analytics (FMA)

1. Demonstrated experience with developing comprehensive, transparent projection models for Medicaid programs.
Provided an overview of the projection process, including understand goals and objectives, obtain accurate data, model selection, ensure process success and efficiency, incorporate changes, and provide necessary documentation.
Bidder states their "approach to model selection follows Occam's Razor; the simplest solution requiring the least possible elements is often the best and most appropriate."
Bidder's model evaluation would include techniques of performance metrics, residual analysis, sensitivity analysis, scenario testing, and comprehensive evaluation.
Bidder would use their data visualization tools to show key reporting metrics across programs, category of service, providers, and regions, as well as incorporate infographics.
Bidder will work collaboratively with the Department to compare actual experience with projections, evaluate recent encounter data submissions, and identify and suggest areas to be enhanced.
2. described their process outline as understand goals, objectives, and relevant program details, identify and collect data sources applicable to the desired projection elements, validate and review historical data, model selection and methodological approach, model validation and testing, develop projections for categories, provide documentation on projections and other key results, and retrospective analysis of actual experience to prior projections.
3. Provided their thoughts on methods to review for development of enrollment/population categories.
4. Described their thoughts on reviewing historical experience and analysis resulting in service categories for projections.

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5. Meets requirement.
6. Has experience with sophisticated data visualization tools to format projections for presentation, which allows for quick digestion of the data as well as drill down into supporting data. Is willing to provide the existing format while doing a collaborative evaluation with the Department to determine how best to improve the format and presentation.
Alignment Across Topics
• Plans to use a centralized approach across the projects, having one consultant doing the work across all three projects. • Described several potential synergies between FMA, AC, and NET tasks.
E. Upper Payment Limit (UPL)
1. Bidder demonstrated their understanding of a multiple UPL methodologies, including cost-based, prospective payment system, and payment-to-cost or payment-to-charge systems. Bidder is prepared to incorporate additional data elements into UPL demonstrations such as information regarding provider ownership types, hospital cost report data, private nursing facility minimum data set assessment information, public nursing facility Medicaid cost report information, IDF/IID Medicaid cost report data, and clinic cost reports. 2. Along with UPL calculations, the bidder will keep the Department updated on UPL issues raised by CMS, changes in Medicare reimbursement policy and UPL demonstration requirements, gather necessary data, model alternative methodologies, prepare materials for UPL submissions to CMS, and assist with correspondence with CMS.
F. Requirements Related to Receiving Confidential Data
1. Meets requirement. 2. Notes compliance. 3. Agrees with requirement. 4. Notes compliance. 5. Notes compliance. 6. Notes compliance and agrees with requirement.
G. Project Management
1. Meets requirements. 2. Ensures highly coordinated hub and spoke project management as well as open and timely communication 3. Meets requirements.

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H. Describe in detail how the Bidder will provide Ad Hoc Work
1. Meets requirement. 2. Meets requirement.
I. Reports
1. Though they describe the steps of sharing data/information, there isn't detail on how it will be tracked/recorded, for example the tools being used. 2. It is noted that they are equipped with a variety of tools to handle secure transmission of PHI and PII, but don't get into details.
2. Staffing
a. Though required data was provided, the paragraph format was b. No subcontractors will be used. c. Meets requirements.
3. Implementation - Work Plan
a. Work plan not reflecting four TCOC reports - annual projection, annual reconciliation, and biannual reports, as clarified in Q&A #23.

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RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: CBIZ Optumas, LLC
DATE: 06/27/25
EVALUATOR NAME: Lauren Metayer
EVALUATOR DEPARTMENT: DHHS OMS
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Q- Has not certified stand-alone rates for NET services • P- Has certified rates in a number of states where NET is a state-plan service as part of the Managed Care program • Meets eligibility requirements

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• CBIZ is a limited liability company founded in 2006. They specialize in providing actuarial services to state Medicaid programs. Works to ensure transparency, accuracy, and collaboration in its services.
2. Subcontractors
• Will not utilize a subcontractor
3. Project Team Organizational Chart
• Provided organization chart as requested, outlined supplemental staff available across the firm as well
4. Litigation
• States no ongoing litigation
5. Financial Viability
• Provided last three years of financial statements
6. Certificate of Insurance
• Provided valid certificate of insurance
Additional requirements from Appendix D.
• Team has reviewed, critiqued, and overseen the development of projection models, and other analyses in more than 30 states over the last 17 years.
• Has worked with multiple states, including Alabama, Colorado, Iowa, Kansas, Maryland, Nebraska, Ohio, and Oregon to provide analyses that support various fiscal forecast models.
• Has not certified stand-alone rates for NET services, but have done so where NET is a state plan service included as a benefit in the managed care program. Optumas has been the actuary on record since 2016 in Kansas. Has also worked to perform rate reviews in multiple states.

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• Has assisted several states with VBP programs and Medicaid Transformation programs. This includes work in North Dakota
• Stated the team has over 25 years of experience in preparing UPLs (but wasn't the company founded in 2006?). Has conducted a UPL demonstration calculation for Maine.

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. Employs several Fellows of the Society of Actuaries (FSA), meets the requirement. Currently employs 8 credentialed actuaries, four of which have the FSA designation. 2. Optumas will follow a project plan with specified milestones and dates. The project plan will include frequent meetings on at least a weekly basis throughout the rate development cycle. It will also work with DHHS to develop a project structure and gain an understanding of the current financial status of Maines NET program. Has created a series of steps to create NET programs that are specific to each states needs and adhere to CMS guidelines. 3. Stated its first step in the rate development process will be to identify appropriate base data and fully understand the data sources being used and any modifications made to the data (a) Will submit a single request for data to avoid unnecessary work for the Department (b) Has experience utilizing the MoveIT platform in other states (c) Described steps it would take to review and validate the data, including control total checks, denied, duplicate or zero paid claims, and making financial data comparisons (f and h) Has a detailed coding logic to determine Categories of Service and Categories of Aid 4. Stated that Optumas shares all deliverables and methodologies with the Department and contracted NET brokers. Outlined its current process for rate development for Managed care programs. States it will provide ongoing support to DHHS and participate in calls with the Department and CMS. Stated that due to the additional detail it often includes in its rate certification letters it often results in fewer questions from CMS.

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****

B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables
1. Receives regular claims feeds and eligibility files from 12 states currently and is able to receive data required in this RFP. Meets requirement.
2. Described its process to load, process, warehouse, and reconcile data, including a last in chain logic for each claim. Meets requirements.
C. AC and PCPlus Data Analysis
1. Meets requirements, is the actuary of record in seven states and keeps up to date on the latest developments in the Medicaid Landscape and has eight credentialed actuaries. 2. Meets requirements, will receive all files provided by the Department and will move them to a secure network to produce monthly, quarterly, and bi-annual reports. 3. States how important member attribution is, demonstrating expertise in AC programs. Described how it would create AC rosters using final RAC identification and historical claims utilization. Doesn't specify that this uses the methodology in appendix K. 4. Will identify members eligible for PCPlus based on RAC identification and enrollment in MaineCare. Of those members, they will identify which members have PCP related claims and create a PCPlus Roster. Doesn't specify that this uses the methodology in appendix K ? 5. Stated it will fill out the TCOC template in the required timelines and will assist the Department in any updates to it in the future. Does not provide detail on how the TCOC calculations will be completed. 6. Meets requirements and will provide relevant presentations and reports, but provides little detail about how it would produce comparisons between ACs, between ACs and Non-ACs, or other main drivers of performance. 7. Stated it will provide .txt files and create an extract package. 8. Has an incurred but not reported model to develop completion factors, provides detail on different important items to consider includes several claims lag scenarios. 9. Described their typical process for policy adjustments, but did not state it would participate in the annual deliberative process to review all changes. 10. Stated its ability to make timely recommendations using the example of its work in North Dakota. Described a 5 step outlier process it uses to ensure financial viability of its program and make recommendations to the Department.

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11. Meets requirements

D. Fiscal Management Analytics (FMA)

1. Have developed a comprehensive and transparent projection model that is used in several Medicaid programs it has provided services to. Stated that we need an actuarial team skilled in all facets of Medicaid, not just Managed care rate development, which may demonstrate unfamiliarity with Maine (no managed care). Stated its forecasts will be for a two year period, updated on a quarterly basis, and displayed by incurred and paid dates as required in the RFP. Stated it would work with the department to create a projection model with an excel that would be provided to financial staff, which would be helpful. Suggested a deterministic model that adjusts the base data for known changes between the base and projection periods. Overall this was a thorough overview of its proposed model, demonstrated they would be capable of conducting this work.
2. Stated its approach to non-claims would follow a similar process to claims. Stated the overlap in non-claims to AC/PCPlus analysis and NET. Demonstrated familiarity with non-claims and how to project them, including that they need to be projected in multiple parts.
3. Seems to have COAs it uses regularly and typically suggests not to revise them. Stated it may consider separation of populations with different FMAP rates. Talks about risk groupings but it is unclear why in this section.
4. Did not state that it would work to categorize services by the MaineCare Benefits Manual. Discusses revisiting ratings cohorts but it is unclear why.
5. Agreed to the requirements in this section but provided little detail.
6. Meets requirements.

Alignment Across Topics

- Understood how combining these services under one bidder provides efficiencies, suggested combining the data validation process, aligning service and population categories where possible, leveraging similar projection methodologies and consistent assumptions, as well as creating one dashboard to monitor all programs and unify presentation and exhibit design.

E. Upper Payment Limit (UPL)

1. The bidder has developed a thorough understanding of Medicare reimbursement principles through various UPL system development projects. Experience with several other states has allowed Optumas to be familiar with many unique approaches to UPL demonstrations. Described its approach to calculations UPLs by required category. Meets requirements.

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2. Stated that it will keep the department updated on UPL issues raised by CMS through its work in other states (as questions come up in those demonstrations it will apply those lessons to Maine). Also agreed it will keep department updated on Medicare reimbursement policy and gather necessary data to complete the UPL calculations. Also stated that it will assist in correspondence with CMS. Meets requirements.

F. Requirements Related to Receiving Confidential Data

1. Meets requirements.
2. Meets requirements.
3. Meets requirements.
4. Meets requirements.
5. Meets requirements.
6. Meets requirements.

G. Project Management

1. Bidder will schedule a kick off meeting at the start of each project to discuss major tasks and obligations. Has several project management tools it has used for other clients including creating a project plan, a question log, a status log, and meeting notes. Will staff these projects using a hub and spoke model. Also noted it has taken over projects in other states several times and works to smoothly transition the work from previous consultants to them.
2. Did not specifically reference the overlapping nature of the AC and FMA programs, but the hub and spoke staffing model is intended to provide consistent staff across projects.
3. Did not specifically agree to attend at least 12 collaborative meetings per year.

H. Ad Hoc Work

1. Will respond to any ad-hoc request with a written estimate to document changes to the scope of work. Gave examples of work it could provide, which included a lot of work surrounding Managed care which is not relevant.
2. Stated expertise in forecasting revenues but did not provide significant detail.

I. Reports

1. Stated all reports listed in Table 5 will be included as Deliverables as part of the project plan. Utilizes a status log to ensure timely delivery of data as well as meeting notes from regular check ins. Meets requirements.
2. Flexible in the method of providing reports to DHHS but has a variety of tools to handle secure PHI and PII including secure portables and email deliverables where possible. Meets requirements.

2. Staffing

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a. Provided job descriptions and titles for all project staff.
b. Will not use subcontractors
c. Dan Skinner Senior Manager for both FMA and NET which could provide efficiencies but also is a significant amount of work for one person.

3. **Implementation - Work Plan**

a. Provided work plan as required

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BIDDER NAME: CBIZ Optumas, LLC
DATE: 8/20/2025
EVALUATOR NAME: Jordan Rhodes
EVALUATOR DEPARTMENT: DHHS - Commissioners Office
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• P – Meets eligibility requirements.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• Appendix D provided.
2. Subcontractors
• None.
3. Project Team Organizational Chart
• Provided.
4. Litigation
• None listed.
5. Financial Viability
• Financial statements provided.
6. Certificate of Insurance
• Meets requirements.
Additional requirements from Appendix D
• P – Worked on various analyses related to RFP across more than 30 states over the last 17 years. • Q – They note that "the success of any consulting engagement is determined by the strength of the client/consultant relationship, and that is an area where we excel when compared to our competitors." What evidence can they provide to support this claim?
• Q – They note experience developing fiscal forecast models across multiple states, but unclear if these are specific to Medicaid projections. They highlight evidence from Alabama, but do not elaborate on the other states, at least in this section. • Q – They note that "actual data" are incorporated into their projection models. It is unclear what other types of data they would incorporate into the analysis.
• Q – They note "Understanding billing and reimbursement guidelines for current state." What are they referring to by "current state?" • Q – Maine is highlighted in the provided map – it would be helpful to know in what capacity they have worked on Medicaid/NET-related projects with Maine.

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• P – notes experience working with North Dakota to design, implement, and monitor a value-based payment program.
• P – 25 years of experience in UPL demonstration calculations for nearly 30 Medicaid agencies, including Maine.

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. Meets requirement. 2. P – outlines clear and coherent process for completing NET rates. 3. P – experience working with a range of data sources that are related to project work, including MMIS encounter data and non-claims data. P – Outlines process for validating data, including identifying items to be "scrubbed." P – Provides detailed methodology for creating the base data for rate setting. 4. P – provides a detailed description of current process for rate development (for managed care program), including IBNR adjustments, policy and appropriations adjustments, and non-medical analysis.
B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables
1.P – developed processes through experience receiving regular claims feeds and eligibility files from 12 states (currently). P – Utilizes internal SSH SFTP site for all data transfers with multi-factor log. 2. Did not note identifying AC eligible claims for members who are fully MaineCare eligible.
C. AC and PCPlus Data Analysis
1. P – Team includes payment reform and Medicaid subject matter experts. Q – have supported numerous VBP models covering 16 million lives; specific to Medicaid? 2. State that they will meet the requirement. 3. P – experience using claims utilization to identify member attribution in other Medicaid programs. 4. State that they will identify historical utilization of PCP related claims. 5. Note that they have experience "developing and filling out report templates." No description provided, or relevancy to project work.

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6. Notes prior experience conducting similar work but does not provide details/examples.
7. State that they will meet the requirement.
8. P – notes that they will exclude claims above $150k in the IBNR analysis to ensure that these larger claims do not distort completion factor development.
9. P – experience with program changes and communicating to stakeholders.
   Q – note that they will develop a methodology for each program change; how will these methodologies be developed? How have they done so in prior/related work?
10. P – outlines a five-step outlier process to ensure financial viability, with the goal of identifying underlying causes that generate change and providing recommendations based on these findings.
11. Meets requirement.

D. Fiscal Management Analytics (FMA)

1.Notes experience with various modelling approaches and provides example modelling analysis corresponding to another state.
What factors/data elements would they use to develop a model for projecting MaineCare enrollment? Would they consider demographic changes, economic factors, or potential state/federal policy changes? They note that they will collect some of these data, and that staff will stay knowledgeable on changes to these factors, but they do not provide detail on how these will be incorporated into their modelling.
They list a number of performance metrics and their definitions, but do not articulate why these are appropriate for the requested analysis and how/why these metrics will be useful in refining and finalizing projections specific to MaineCare.
P – will model out scenario testing, such as economic downturns or public health emergencies.
2. Will they apply the same modelling approach across both the population-based and non-claims-based analysis?
P – details steps for projecting individual categories of non-claims-based payments.
3. P – highlights importance of separation of populations by FMAP.
This sentence does not make sense: “The result of this analysis will be projection cohorts that are fully or almost fully credible on an individual basis internally homogenous and heterogenous to other cohorts which will be granular enough to meet DHHS’ needs when conducting analysis at the cohort level.”
4.Outlines a hierarchy approach to developing categories of service.

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5.State that they will meet the requirement.
6.Did not confirm that projections will be presented in Excel.
Can provide a cost estimate for additional data tool.

Alignment Across Topics

- Notes some creative approaches to synergizing project work, such as leveraging AC attribution analysis in FMA analysis.

E. Upper Payment Limit (UPL)

1.Prior experience has helped them become familiar with several approaches to developing UPL analyses that are acceptable to CMS.
Outlines UPL work with a number of states.
Outlines various methodologies for different service categories.
2.State that they will meet the requirements, and provide evidence of understanding of working through CMS processes.

F. Requirements Related to Receiving Confidential Data

1. Meets requirement.
2. Meets requirement.
3. Meets requirement.
4. Meets requirement.
5. Meets requirement.
6. Meets requirement.

G. Project Management

1. Approach includes project plan, question log, status log, and meeting notes.
2.Notes interlinking project tasks but does not specify focus on overlap across AC and FMA work.
3. Meets requirement.

H. Ad Hoc Work

1.Meets requirement.
2.Meets requirement.

I. Reports

1.Brief description provided, highlighting data requests, status log, and meeting notes.
2.Confirms that reports will be delivered by specified dates.

2. Staffing

a. Attachment provides roles and responsibilities by position type.
b. No subcontractors.
c. Provided.

3. Implementation - Work Plan

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a. Monthly reporting plan provided.

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DATE: 6/25/2025 (Eligibility Review). 6/30/2025 (Sect. II, Organizational Qualifications and Experience). 7/1-7/3,2025 and 7/7/2025 (Sect. III, Proposed Services).
EVALUATOR NAME: Roger Bondeson
EVALUATOR DEPARTMENT: Department of Health and Human Services
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Deloitte provided examples of at least two NET rate certifications for Maine's Department of Health and Human Services and two Upper Payment Limit demonstrations for the Commonwealth of Pennsylvania. Deloitte meets eligibility requirements.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• Deloitte is one of the largest companies for providing actuarial services in the country and has 20 years of experience in providing consulting services to the State of Maine. Projects in Maine include Child Support Enforcement, Accountable Communities, Behavioral Health, setting rates for NET and Durable Medical Equipment, assisting with Maine's Medicaid Information Technology Architecture (MITA) assessment, and annual analysis of Incurred but not Paid (IBNP) analysis for Maine's Department of Administrative and Financial Services. (P) Deloitte has provided 13 years of NET rate setting services to Maine. Experience has been good to excellent. CMS has approved all rate certifications submitted by Deloitte without need for any rate modifications. (P) • Deloitte has received many awards for its work and organizational excellence (see page 8 Figure D-1). (P) • Deloitte uses the "no surprises" approach to its consulting work in that it engages stakeholders through the entire process of the project to advise every step of the way. (P)
2. Subcontractors
• Deloitte does not propose to use any subcontractors to perform the work detailed in the RFP.
3. Project Team Organizational Chart
• An organization chart was provided. Meets requirements.
4. Litigation
• Deloitte states it has no litigation history. Meets requirements.
5. Financial Viability
• Provided a financial statement. Defer to Financial expert for analysis.

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6. Certificate of Insurance

- Provided a current certificate of liability insurance – meets requirements

Additional requirements from Appendix D.

- See above notes – Organizational Overview.

a). Fiscal Management Experience

- For the State of Georgia Deloitte provided the following services:
  1. Designed 3 fiscal models, forecasting, expenditure tracking, and budget projections.
  2. Conducted analysis and developed fiscal notes for requests from the Georgia Assembly regarding Medicaid.
  3. Built Tableau dashboards that tracked health plan financials, pharmacy claims data, fee for service data, and for comparing emerging trends to actual data.
- For the State of New York, Deloitte assisted the New York Division of Budget to better predict cost changes due to COVID19 pandemic and to improved general budget forecasting.
- Deloitte developed a budget forecasting model for Texas Health and Human Services to better track Medicaid expenditures across 18 programs. Deloitte implemented a software solution for Texas that can forecast per-recipient expenditures using trending models.
- Worked with the Pennsylvania Department of Health to provide legislative analysis and determine the potential financial impact of implementing a healthcare cost growth benchmark.

(b) NET PMPM Rate Setting

- Deloitte has provided NET services in five states: Maine, New York, Georgia, Texas, and Pennsylvania.

Deloitte has been setting PMPM rates in Maine since the inception of the brokerage model in 2013. Rate development work began before 2011 as the broker model was implemented in 2013. This work involves reviewing NET encounter claims, broker financial records and trip data, trends in transportation costs, data gap reconciliation, and obtaining CMS approval of rates annually.

- Deloitte created work plans for Georgia's NEMT program, develops annual rate ranges so the State can evaluate rates currently paid to the NEMT brokers, helped Georgia in evaluating proposals for its NEMT procurement process, created a data improvement plan, standardized certain broker reports and

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developed an evaluation model so the State can compare results across all brokers. (P) • Deloitte assisted the State of New York in the transition from a fee for service NEMT program to a full risk broker model. (P) Deloitte also provided procurement support for selection of a vendor for the broker model implementation. • Assisted the State of Texas in transitioning from a fee for service model to a capitated (PMPM) reimbursement model. Assisted in program design, vendor procurement and securing a CMS 1915(b) waiver. (P) • Developed a readiness review process for the State of Pennsylvania and assisted in multiple broker procurements. Developed an automated dashboard data testing tool to identify outliers and missing data to enhance data integrity.
(c). Other State Medicaid Programs Payment Reform Efforts • Supported Maine's Accountable Communities Program in helping to build it from the ground up. • Helped MassHealth develop its Accountable Care Organization program via a 1115 waiver. Provides continued support to MassHealth with its 17 ACOs.
(d). Upper Payment Limit Demonstrations • Deloitte conducts analysis and modeling of UPLs for State of New York for Intermediate Care Facilities. It actively assists New York to achieve CMS approval of UPLs. • Deloitte has provided 15 years of consulting services in the State of Texas for DSH (Disproportionate Share Hospital), UPL, and uncompensated care reimbursement programs. The company developed a model that incorporated DSH and UPL payment formulas to estimate the health reform impact on each component within the payment methodology by year. • Analyzed existing UPL and DSH methodology, performed an impact analysis of reforming inpatient UPL methodology, and delivered a recommendation to increase UPLs for the University of Virginia Medical Center and the Virginia Commonwealth University Health Systems. • Demonstrates UPLs for Durable Medical Equipment for the Commonwealth of Pennsylvania. Assists with communications with CMS to gain UPL approvals. • Project examples were detailed and addressed the requirements.

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Part IV, Section III. Proposed Services

Part II

A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement

General: Deloitte states it will adhere to professional standards in Code of Professional Conduct, the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States and the Actuarial Standards of Practice (page 4). (P).

Deloitte's approach to quality management and improvement in client engagements includes the following components:

- Client expectations: Regular aligning of expectations with State leadership.
- Service Level Agreements: Adhering to standards in the SLA.
- Scope Management
- Cost Management: Well vetted project cost estimates including contingency funds.
- Teaming: Assigning appropriate staff to a project/program. (page 4). (P)

Deloitte conducts engagement reviews and periodic pulse checks to identify issues and seek early resolutions and for consistent evaluation. (page 4). (P).

A .NET Rate Setting

- Deloitte has provided consulting services for 18 state Medicaid NET programs.
- Deloitte has developed capitated rates for MCOs in 35 states.

1. Deloitte confirms is has one certified actuary for Maine NET rate setting and has three on staff.

2. NET Project Planning: References Section 1.G (see page 97).

- On page 97 Figure, G-2, Deloitte illustrates how it plans and tracks progress for NET PMPM rate setting. Deloitte proposes to set meeting agendas, facilitate meetings, document meeting outcomes and action items, and prepare and submit a project plan with dates and milestones.
- Deloitte provided three examples of conducting project management including the Oregon Health Authority, the Massachusetts Health and Human Services ACO, and the Ohio Department of Medicaid (ODM) Medicaid Advisory committee.
- Response to this requirement is detailed and thorough.

3a. NET Data Collection and Analysis

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****

- Proposes a kickoff meeting to identify program changes from previous year known issues from previous rate setting, procurement status, and any emerging topics. Meets requirements.

3b. Data Request and Review

- Deloitte proposes collecting the most recent encounter claims data, caseload information, contracts, OMS financial reports, NET Broker financial statements, Broker trip data, updated crosswalk information from the Department, and procedure code definitions.

3c. Secure File Transfer and NET Data Collection

- Proposes to establish a Secure File Transfer Protocol for the Department to use in sending encounter claims data.
- Proposes to request most recent 3 years of NET encounter claims data on an incurred basis from MIHMS.
- Deloitte proposes a detailed list of required fields for data submission.
- Once data is received, Deloitte proposes to confirm that the data has all the required fields, then it warehouses the data and conducts additional validation.
- Deloitte proposes to use NEMT enrollment/caseload data to assess MaineCare membership trends.
- Deloitte proposes a detailed list of cohort groupings for which rates will be established.
- Deloitte will compare overlapping years of data against what is received and warehoused in previous years and compare the data for consistency and verification of sample records against raw source files.
- Proposes to collect claims data in later months to better assess emerging trends in utilization.
- Proposes to collect broker financial statements and MaineCare financial reports to collect information on broker administrative costs and to provide comparison points to validate encounter data cost submissions.

3d. Data Usage

- Deloitte will request the most recent cohort methodology, unit methodology, crosswalks, and procedure code definitions to assign eligible populations and regions in the claims data.
- Detailed description of how Deloitte proposes to identify eligible populations for MaineCare NET including use of procedure code modifiers.
- Deloitte accounts for differences in transit regions for establishing rates for the broker assigned to the transit region(s).

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- Deloitte provides detail on how it proposes to assess NET transportation type by region and acknowledges that in several areas of Maine there is no or very limited public transportation. Deloitte proposes to review other types of NET transportation such as wheelchair, bus, taxi, etc.
- Deloitte proposes combining Waiver Services 18, 20, and 21 at the same rate due to the low population numbers using these services. Combining these three together provides sufficient information to establish a rate.
- Deloitte provides a detailed description on how it will establish the number of rides, ride type, payments, and mileage traveled.

3e. Review Encounter Data for Rate Certification

- Proposes to provide the state with control totals to confirm completeness and data integrity.
- Flag questionable values and compare current data to prior analysis.
- Identify any missing broker data and seek to get it from broker or make necessary adjustments to account for missing data.

3f. Department and NET Broker Collaboration

- Deloitte proposes to work with the Department and the NET brokers to resolve large variances or inconsistencies in submitted data.
- Proposes to facilitate meetings with NET brokers as necessary to resolve issues.
- Will recommend and implement practical steps to improve quality of data when material defects are identified.

3g. Review Encounter Data

- Proposes comparing encounter data with financial records to assess alignment and identify inconsistencies.
- Proposes to make recommendations to the State to strengthen encounter data reporting and quality.
- Deloitte adheres to Actuarial Standards of Practice #23 on Data Quality when developing per member per month rates.

3h. Data Credibility Assessment

- Will determine if encounter data is appropriate for assessing financial status of the NET program and for determining emerging experience.
- Will assess if the encounter data can be used as a base source for capitation rate development.

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- Proposes to compare encounter data with broker data for monthly totals, gross payments, rides, and miles. Will also review broker administrative costs and compare to previous years to look for significant changes.
- Proposes to adjust encounter data to address known issues such as reallocating trips provided by a broker outside of it's region, incorporating costs for special rate trips not captured due to system limitations, and correcting for inconsistencies.
- Will facilitate meetings with the Department and Brokers to address inconsistencies and will issue multiple rounds of questions to the brokers to resolve any data issues.
- Once differences between encounter and financial data are understood and resolved, Deloitte proposes to make recommendations to the Department on encounter data adjustments and will present these to the Department. Propose to discuss recommended adjustments to population cohorts if needed.

4. Rate Development and Certification

a.

- Will adhere to ASOP#23 and 42 CFR 438 in developing NET rates.
- Proposes to utilize the approach of setting a regional rate and differentiate by population cohort within the specified region.
- Details an 8 step process in rate development that includes many factors.
  - Programmatic and policy changes (e.g. expansion and unwinding, mileage reimbursement increases, addition of adult dental).
  - Proposes to apply trend factors such as gas prices, CPI, labor costs, medical care costs, public transportation costs.
- Proposes to develop rate ranges for Department review and decision.
- Proposes to develop supporting exhibits of rate development components and ranges.
- This response is very detailed and thorough (P).

4b. NET Capitation Rate Approach and Results

- Will provide a written certification report that supports the rates, including data utilized, assumptions, adjustments, and calculations.
- Proposes to provide a draft report for the Department to review and comment prior to final rate certification report.

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- The final certification report will attest that rates are developed in accordance with 42 CFR 438, CMS Rate Development Guide, and ASOP 49 on managed care rate setting.
- Proposed report contents are detailed on bottom of page 27 – top of page 28.
- Response to this section is detailed and thorough. (P).

4c-4d. Department, CMS, and NET Broker Engagement.

- Proposes to support the Department in responding to CMS questions about the rate certification report by providing additional rate development details, additional exhibits and calculations, answering CMS phone calls, and by providing formalized responses to CMS written questions.
- Proposes to support the Department when the NET brokers have questions about the rate setting process.

B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables

1.Claims, Eligibility, and Non-Claims Payment Data Intake

- Proposed scope includes processing initial and ongoing claims and eligibility feeds, incorporating non-claims payment files, and integrating additional non-claims expenditure information such as premium payments, shared savings, and incentive payments.
- Proposed validations to be conducted include:
  - Fully missing payments
  - Zero paid claims
  - Delayed submissions
  - Incomplete records
  - Third party coordination
  - Inconsistent coding
  - General outlier values
  - Claims not cross walked
  - Duplicate claims.
- Proposes the validation tool of comparing submissions to identify material changes to an overlapping time period or to an emerging time period. (P).

1a -1c. Initial Claims Feed Handling and Monthly File Handling

- Proposes to utilize an agreed upon solution to support AC/PCPlus, FMA, UPL analyses and deliverables:
  - Claims and eligibility feeds

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- Non-claims payments
- Other non-claims expenditures information

- Refers to Section F, Requirements to Receiving Confidential Data to describe security protocols for confidential and sensitive information.
  - Deloitte agrees to access PHI and PII data withing the State's secure systems.
  - Agrees to maintain insurance as required by MaineIT
  - Deloitte has with other states in this manner
  - Attests that it will comply with all state and federal laws regarding protection of confidential and/or sensitive data.
- Proposes to receive monthly files for medical, pharmacy, and dental claims, each including all claims and adjustments for the prior 36 months via an agreed upon data solution. Member eligibility files will be received quarterly.
- After each delivery of data, Deloitte proposes to compare overlapping periods with previous data feeds to confirm consistency and identify discrepancies.
- Deloitte proposed a detailed list of field types for non-claims payments and other non-claim expenditures.
- Deloitte provided an example of a Data Quality Dashboard used for the State of Georgia (P).

2a. Data Loading, Processing, Warehousing, and Reconciliation.

- Proposes to coordinate with key Department contacts to level set on where the data is currently, gain understanding of Department goals for the data, and to understand current documentation.
- Proposes to provide regular updates to the Department on data findings, discrepancies, and concerns.
- Proposes to provide technical assistance to support improvement on data quality.

2b. Assigning Service Categories, Aid Category, and Population Groups.

- Deloitte proposes use of certain groupings as detailed in Table B-1, page 35, to identify service categories. Meets requirements.

2c. Identifying Final Paid Amounts

- Proposes an outline of the data warehousing process to be used to identify final payment amounts and to identify resubmitted, adjusted, or voided claims and avoid duplicating claim lines (page 36). Meets requirements.

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2d. Recipient Aid Category

- Deloitte proposes to use the provided RAC list and documentation to confirm each member month is assigned a final RAC code.
- Proposes to disregard AC non-eligible RACs if the member has an AC eligible RACs.
- Proposes to use the RAC code hierarchy to determine final RAC when a member has multiple AC RACs in the same month.
- Presented the Georgia project as a "spotlight" to indicate that Deloitte has done similar work in the State of Georgia (page 37).

2e. AC Population Group

- Addressed by Deloitte – meets requirements

2f. Identifying AC Eligible Claims

- As part of its validation and reconciliation process, Deloitte proposes to conduct checks on eligible claims to identify and remove duplication or resolve missing data.

2g. AC Service Coordination

- Deloitte will work with the Department to get updated crosswalks for core/optional/excluded, cost grouping and pharmacy indicators. These will be mapped onto medical and dental data tables.
- Proposes to update crosswalk as policy changes warrant.

C. AC and PCPlus Data Analysis

1. Employee and/or Subcontract to Perform AC and PCPlus Data Analysis and Reporting.
   a. Deloitte staff include former Medicaid Directors and other longstanding industry advisors as subject matter experts that keep abreast of federal policy changes, CMS guidance, and emerging best practices.
   b. Deloitte Actuaries: Deloitte has over 160 health actuaries on staff, some of whom have worked on ACO projects for Rhode Island, MA, Kentucky, and Minnesota. Deloitte actuaries also helped to design Maine's ACO program.
2. Receive, Organize, and Store Additional Files Provided by the Department, Necessary to Provide Deliverables.

2a.-2b. AC and PCPlus Data Analysis and Reporting

- Proposes to develop a data collection plan with the Department.
- Proposes to work with the Department and its data vendors to collect all data based on agreed upon timelines and will perform data warehousing and validation upon receipt of data.

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- Propose use of secure FTP, encrypted Structured Query Language (SQL) server, and a managed analytics platform that enables secure intake of Department files.
- Proposes use of Statistical Analysis Software (SAS) and Tableau for data analysis and to prepare executive data visualization dashboards.
- Deloitte's proposed approach to receive, store an organize files for the AC program is described in Table C-1, pages 43 and 44. Approach is detailed and thorough.
- Deloitte's proposed approach to receive, store, and organize PCPlus program data is described in Table C-2, page 44. Approach is detailed and thorough.
- Deloitte proposes a two week period per quarter from receipt of clean claims data to warehouse and validate the data.
- Proposed data validation checks include:
  - Missing value tests
  - Consistent format for same field across records
  - Large population shifts compared to prior data feeds
  - Member age consistent with eligibility date
  - Review consistency with financial summaries provided by the Department
  - Compare sample records to raw source files.

3. AC Rosters

a. AC Member Attribution Process

- Deloitte proposes to collect the following data to produce attribution rosters:
  - Most recent eligibility data
  - Most recent medical claims data
  - Most recent AC practice/provider list
  - Most recent ACO service category crosswalk
  - Most recent RAC code list
- Proposes a two-step attribution methodology process (pages 47 and 48). The process is detailed and thorough.

3b. – 3c. Create Member Rosters

- Response meets requirements.

4. PCPlus Rosters

- Propose to maintain current methodology but inject efficiency and improvements where possible.

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- Proposes to provide insight and analysis to support Department's goals for the program.

4a. Member Attribution

- Proposes to collect eligibility data, medical claims data, NPI+3 crosswalk, primary care claims, crosswalk, and RAC code list.
- Proposes a three step process for attribution:
  - Eligibility
  - Identify PCP claims
  - Attribute members to PCPlus service locations.

4b. PCPlus Roster Deliverables

- Proposes delivering to the Department each quarter at the member level using the provided template.
- Lists out the required fields.
- Proposes to compare every roster to the previous quarter's roster minus those where a manual attribution was necessary.
- Meets RFP requirements.

5. AC TCOC Reports
   - Deloitte recognizes that the development of benchmark and performance TCOC amounts, and AC savings is not simply a calculation exercise. It is an ongoing process involving data analysis, reporting, actuarial rate calculations, development of assumptions, evaluation of AC's and their reported data.
   - Deloitte's proposed approach to TCOC report development includes the following:
     - Collaboration with the Department;
     - Presenting reports noting any material changes;
     - Identify drivers of change during each biannual and annual TCOC report;
     - Improve accuracy and efficiency of existing TCOC development process; and
     - Monitor program growth and changes and provide guidance from strategy to implementation.

5a. Reporting and Projections

- Proposed approaches to produce TCOC reports include:
  - Data collection

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- Benchmark TCOC and Actual TCOC calculation (details a 6 step process for this task.
- Risk adjustment
- Claim caps
- Performance year member months reweight
- Savings calculation

- Response to this section is detailed and thorough (P)

6. AC TCOC Summary Analysis Presentation

6a. TCOC Program Component Analysis

- Proposes a four step process
  - Collect data
  - Determine thresholds
  - Summarize results
  - Interpret results

6b. Shareable Materials Presentation

- Proposes to provide OMS with a tool to review TCOC reports and will also perform an extensive quality review process at the end of each deliverable which will include an email and discussion as necessary summarizing key results and changes from prior report.

7. AC Data Extracts

7a. TCOC Report

- Deloitte proposes to streamline this task by creating an automated process to complete these data extracts at the same time as the development of the TCOC report.

8. AC Completion Factors

- Proposes to analyze historical spending and claims completion patterns to develop and apply completion factor estimates by service category.

8a. Annual Completion Factor Analysis

- Proposes a 4 step process to include:
  - Summarize Medicaid paid amounts
  - Make appropriate adjustments
  - Develop completion factors
  - Apply completion factors to claims data

9. AC Policy Change Adjustment

- 9a. Proposes to develop a methodology to account for the impact of state policy changes to normalize the data.

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- Proposes and describes a 4 step policy change process
  - Data collection and preparation
  - Perform data checks and determine methodology
  - Calculate and apply policy adjustment factors
  - Use policy adjusted claims methodology for other analyses.
    Deloitte will provide documentation of adjustment methodology for each policy change.

10. Initiative Monitoring and Maintenance
    - Proposed approach includes:
      - Reviewing new APMs used by other payors
      - Identify benefits that could be derived from alternative payment models
      - Ongoing reviews of TCOC and benchmark cost drivers
      - Provide suggestions for adjustments

10a. – 10.b Methodology Change Review and Solution
- Deloitte's proposed approach includes:
  - Data driven analysis
  - Customized methodology development
  - Rigorous testing and validation
  - Methodology alignment

11. Methodology Documentation
    - Proposes to incorporate best practices and innovative solutions that have yielded successful outcomes.

D. Fiscal Management Analytics (FMA)

1a -1c. Development and Subsequent Projections
- Asserts that it has improved budget projection process for Texas and Georgia.
- Provided a detailed description of its proposed approach to include:
  - Data collection and adjustments to include a transition plan, proposed quality checks and data adjustment techniques.
  - Completion for Claims and Enrollment using a proprietary process to adjust data and to reflect claims that have been incurred but not reported (IBNR).
  - A 3 step process for developing projection and trend analysis
    - Model Specification
    - Model Selection

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- Model Application and Trending ➢ Monitoring and Model Updates
2. Non-Claims Based Inclusion Approach 2a.-2h. Non-Claims Expenditure Projection Approach Deloitte proposes a 4 task approach to include: • Data collection and adjustments. Proposes to collaborate with Maine stakeholders to determine source data for each non-claims based payment type. Proposes to evaluate historical trend rates for each non-claim based payment type. • Projection and Trend Analysis. Deloitte proposes to use a similar approach as described in Fiscal Management and Analytics Approach process 1a – 1c. • Program and Legislative Changes. Proposes to use the following four task approach: ➢ Scenario analysis ➢ Dynamic adjustments ➢ Detailed breakdown ➢ Stakeholder collaboration • Monitoring and model updates.
3.Enrollment and Category Development • Proposes to use existing NET and AC categories as a starting point and then assess whether these categories are sufficient. (I) (interesting) 3a. Population Specific Claim Guidance • Deloitte proposes to conduct hierarchical modeling that will organize claims data into a tree chart and break down into various levels as forecasts are made for each level across different cohorts. 3b. Enrollment Category Crosswalk • Deloitte asserts that it is already familiar with Maine's existing AC cohorts and proposes to develop a crosswalk with new FMA categories generated from hierarchical modeling.
4. Service Category Development • Deloitte proposes to evaluate historical expenditures, enrollment, and utilization to evaluate where services align closely to group into one category service.
5. FMA Reports • Proposes to leverage Microsoft Excel to create various tables and visualizations that convey PMPM and enrollment projections.
6. Excel Projections

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- 6a. – 6b. Proposes to deliver a dynamic Excel presentation featuring visuals that illustrate projections by service category and aggregate levels.

6c – 6d. Use of Microsoft Excel and Other Tools

- Deloitte proposes it can use PowerPoint, Excel, and Tableau for data visualization including geographic visuals.

Alignment Across Topics

- Proposes to use existing NET and AC categories to create FMA enrollment and population groups mappable to NET, AC, PCPlus, and Health Homes groups.
- Proposed 4 principals for group creation:
  - Mutually exclusive and collectively exhaustive – each member should only belong to one group and every member must be in a group.
  - Utilizes hierarchical modeling
  - Clinical and programmatic relevance
  - Administrative feasibility
- Described and proposed a mapping logic that includes 4 tasks.
- Identified 3 mapping considerations
- Proposes to achieve synergies between tasks by utilizing NET data to develop sustainable, equitable, and data driven Medicaid rates.
- Provided a detailed description of how it proposes to achieve synergies for actuarial support.

E. Upper Payment Limit (UPL)

1a. Claims, Non-Claims, Payment, Eligibility and RAC files.

- Deloitte described in detail how it proposes to collect claims data, non-claims payment data, eligibility information, RAC files, and other data such as state plan payment methodologies, Medicare payment data, per diem rates, etc.

1b. Maximizing Room Under the UPL

- Deloitte describes and proposes a 7 step process to prepare and submit the annual UPL demonstrations to CMS (see Table E-1, page 82). These proposed steps include:
  - Establish a timeline
  - Client data request
  - Download CMS data
  - Calculate the UPL
  - Sharing results

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- Narrative to accompany the UPL data submission
- Responding to CMS questions

- Deloitte proposes to maximize the Medicare and Medicaid rate differential by reviewing the Department's current UPL demonstration methodology and provide solutions to increase the UPL gap while staying complaint with CMS requirements. Deloitte proposes 5 possible strategies that could yield a higher UPL (see page 83).

1c. Demonstration Methodologies for each Service.

- Provided a table (E-2, pages 83 and 84) that detailed demonstration type, data needed and considerations to use when choosing a methodology.
- Provided a table (E-3, page 84) that outlined methodology options by service type.

2. UPL Demonstration Related Services

2a.-2b. Notify the Department of UPL Issues

- Proposes to utilize the following to stay abreast of CMS/Medicare changes:
  - Health Care Strategy and Regulatory Implementation Services
  - RegExplorer
  - Deloitte Center for Government Insights
  - Deloitte Center for Health Solutions
  - Medicaid and Medicare Advantage Regulatory Teams
- Proposes to provide status updates on pending regulatory changes by scheduling ad hoc meetings to review Deloitte's proposed solutions to the pending regulatory changes.

2c. Collect Medicaid Statistics and Resident Assessment Information.

- Proposes to capture key information including Medicaid payments, total Medicaid revenue, contractual allowances, utilization statistics such as patient days and occupancy rates.
- Deloitte proposes to develop a crosswalk classifying facilities as privately owned, non-state government owned, or state owned and to analyze how ownership type impacts reimbursement and service delivery.

2d. Alternative UPL Demonstrations

- Proposes to prepare side by side comparison summaries of all viable UPL demonstration methodologies to highlight UPL room, compliance, data requirements, and alignment with Department goals.
- Proposes to document the regulatory basis for each methodology, identify risks and uncertainties, and provide guidance on how to address them.

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2e.-2f. Submissions to CMS and Subsequent Questions.

- Deloitte proposes to provide a comprehensive package that will include everything the Department needs for submission to CMS. The package will include the following:
  - UPL Demonstration Narrative
  - Responses to Supplemental Guidance Questions
  - Supporting Rate Documentation

F. Requirements Related to Receiving Confidential Data

Deloitte asserts compliance with MaineIT requirements (see table F-1, page 90).

1. Insurance: Deloitte acknowledges MaineIT insurance requirements – Deloitte suggests it will seek to modify or clarify certain provisions.

2. Sensitive Electronic Information: Deloitte proposes to access PHI and PII data within the State's secure system to complete the scope of work in this RFP.

- Proposes to access PHI and PII directly within the State's secure system to complete the scope of work from this RFP.
- Proposes to provide a Confidential Information Management Plan (CIMP) for every project and the CIMP will be developed collaboratively with MaineIT policies.

2a.-2f. Risk Assessment Maine IT Policies

- Deloitte states it is in compliance with MaineIT Risk Assessment Policies and Procedures (see Table F-2, page 91 and 92).

3. MaineIT Policies and Compliance

- Deloitte agrees to confirm annually with MaineIT on compliance.

4. State and Federal Laws

- Deloitte states that it will comply with all state and federal laws.

5. Confidentiality

- Deloitte acknowledges MaineIT's request to comply with all confidentiality requirements in MaineIT Rider B-IT, Section 30. Deloitte states it will want t modify and clarify certain provisions in this agreement.

6. Application Assumption
Deloitte agrees.

G. Project Management

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1. Project Structure and Planning
   - Deloitte illustrates project management experience in Table G-1.

1a. Status Update Meetings with the Department.
- Deloitte proposes the following for meetings on projects:
  - Agenda Development
  - Facilitation and Coordination
  - Follow up Action Steps (will document)
  - Status Tracking (provided an example used for Maine NET rate setting work, Figure G-2, page 97)

1b. Documentation of Notes, Deliverables, and Trackers
- Proposes to document actions, issues, risks, dependencies, and decisions.
- Proposed tools for project management include Project Work Plan, Project Status Report, Risks, Actions, Issues, and Decisions (RAID) logs.
- Provided a detailed table of project deliverables (Table G-2, pages 98 and 99.

1c. Communicating Issues and Resolutions
- Deloitte proposes a proactive approach to identification, assessment, and mitigation of potential project issues and risks.

2. AC and FMA Project Management
- Meets requirements.

3. Meets requirements.

H. Ad Hoc Work

1.Provide Ad Hoc Analyses and Modification of Reports
- Proposes to have a team that collaborates across rate setting and fiscal estimates that can pivot from an ongoing task to address a more urgent one such as budget estimates.

1a. Provide a Written Request. Meets requirements.
1b. Document and Agree Upon Scope: Meets requirements.

2. Ad HOC Work

2a. Forecasting Revenues
- Proposes scaling up its team to respond to forecasting and other fiscal requests within 24 to 72 hours to support the State.

2b. One-Time Analyses
- Deloitte proposes to use AI, cloud-hosted solutions, and data analytics to navigate complex regulatory environments and achieve sustainable improvements.

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I. Reports
1. Meets requirements 2. Meets requirements
2. Staffing
a. Meets requirements b. Meets requirements No subcontractors c. Meets requirements Proposed staff is qualified and experienced to do the work.
3. Implementation - Work Plan
a. Meets requirements.

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DATE: 6/26/2025 (eligibility), 7/3/2025 (Part IV), 8/18/2025 (Cost)
EVALUATOR NAME: Philip Dubois
EVALUATOR DEPARTMENT: DHHS, OMS
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Bidder meets the eligibility requirements and cited specific projects that satisfy these requirements.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• See Appendix D
2. Subcontractors
• The bidder does not intend to use subcontractors.
3. Project Team Organizational Chart
• The bidder provided the project team organizational chart.
4. Litigation
• The bidder indicated that they have not been subject to any litigation related to Medicaid actuarial services during the past five years.
5. Financial Viability
• The bidder did not provide three years of audited or reviewed financial statements.
6. Certificate of Insurance
• The bidder provided a certificate of insurance however the policies expired on 6/1/2025.
Additional requirements from Appendix D.
• P – The bidder's team of practitioners have state health program experience from over 35 states and territories. • P – Bidder has experience working on a variety of projects for MaineCare over the course of two decades.
• The bidder worked with Georgia to design fiscal models for improving forecasting accuracy, simplifying expenditure tracking, and improving budget projections. • The bidder worked with New York to anticipate the impacts of the COVID-19 pandemic on service utilization and cost. • I - The bidder worked with Texas Health and Human Services to develop and implement a solution that forecast per-recipient expenditures.
• P – Bidder has developed MaineCare Non-Emergency Transportation (NET) rates over the past 13 years.

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

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EVALUATOR NAME: Philip Dubois
EVALUATOR DEPARTMENT: DHHS, OMS
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- The bidder currently works with Georgia annually to help the state evaluate rates paid to NEMT brokers by using broker financial reporting and encounter data.
- The bidder supported Texas in transitioning the NEMT program from a fee-for-service (FFS) model to a fully capitated reimbursement model.

- P – Bidder supported Maine DHHS with a feasibility study, design, and implementation of the MaineCare Accountable Communities program.
- The bidder worked with MassHealth to implement an accountable care organization program. As part of this work, the bidder managed attribution, member enrollment, and continuity of care processes.

- The bidder supports the State of New York with analysis and modeling required for the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) UPL demonstration.
- The bidder supports Pennsylvania with Durable Medical Equipment (DME) and Clinic UPL demonstrations, including gathering and summarizing cost data, drafting the UPL guidance document, and assisting in communication with CMS to gain UPL approval.

Part IV, Section III. Proposed Services

Part II

A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement

1. The bidder confirms that they will have at least one actuary to perform the independent annual development and certification of NET service reimbursement.
2. The bidder met the requirements based on the response in section G.
3. The bidder's response to this section demonstrates a familiarity with MaineCare's available data sources, existing processes around sharing data, and features of the data.
    a. P – The bidder has experience working with MaineCare data to identify different member population, regions, service types, and waiver participants in the various data sources.
    b. P – As the existing vendor for this work, this bidder is familiar with some of the data issues or challenges that are likely to occur.
4. The bidder provided a step-by-step walkthrough of the rate development and certification process.

B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

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EVALUATOR DEPARTMENT: DHHS, OMS
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1. The bidder demonstrated understanding of how data would be received and provided examples for how some data would be handled.
2. The bidder met the requirements.

C. AC and PCPlus Data Analysis

1. P – The bidder supported MaineCare in developing and implementing the Accountable Communities program.
2. P – The bidder demonstrated an understanding of the requirements around receiving and storing data files, highlighting important considerations for timelines, data quality, and potential data issues.
3. P – The bidder demonstrated a thorough understand of the requirements around AC Rosters, citing previous experience working with MaineCare to build the original attribution algorithm.
4. Q – It's unclear if the bidder understood the existing process for attribution, particularly the step for identifying PCP claims.
5. The bidder met the requirements.
6. The bidder met the requirements.
7. The bidder met the requirements.
8. The bidder demonstrated a thorough understanding of the requirement around completion factors, and described an effective process for developing and applying completion factors.
9. The bidder demonstrated a thorough understanding of the requirements around policy change adjustments, including some examples for how to handle likely scenarios.
10. The bidder met the requirements.
11. The bidder met the requirements.

D. Fiscal Management Analytics (FMA)

1. P - The bidder demonstrated understanding of this requirement, providing an overview of potential forecasting models and detailed discussion of the process for model selection and application.
2. The bidder demonstrated understanding of the unique challenges associated with forming projections related to non-claims payments, highlighting the importance of allowing for real-time adjustments to assumptions and inputs.
3. The bidder met the requirements.
4. The bidder met the requirements.
5. The bidder met the requirements.
6. The bidder met the requirements.

Alignment Across Topics

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

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- P – The bidder demonstrated understanding of the requirement and the significance of synergies between FMA, AC, and NET analysis and reporting, while acknowledging some of the challenges.

E. Upper Payment Limit (UPL)

1. The bidder demonstrated an understanding of the various UPL demonstration methodologies, including discussion of important considerations for selecting a methodology.
2. The bidder met the requirements.

F. Requirements Related to Receiving Confidential Data

1. The bidder acknowledged the requirement for insurance with a caveat that certain provisions should be modified or clarified.
2. The bidder demonstrated an understanding of the importance of protecting confidential data and cited current work with Maine on various scopes of work that include the use of data.
3. The bidder met the requirements.
4. The bidder met the requirements.
5. The bidder acknowledged this requirement with a caveat that the bidder thinks certain provisions should be modified or clarified.
6. The bidder met the requirements.

G. Project Management

1. The bidder provided a details into the bidder's approach to project management.
2. The bidder met the requirements.
3. The bidder met the requirements.

H. Ad Hoc Work

1. The bidder met the requirements.
2. The bidder met the requirements.

I. Reports

1. The bidder demonstrated understanding of this requirement and provided details into how the bidder would track and record all data necessary for completing required reports.
2. The bidder demonstrated understanding of the requirement to submit required reports within established timelines and provided a draft project schedule in the form of a Gantt chart.

2. Staffing

a. The bidder met the requirements.
b. The bidder indicated that subcontractors will not be used.
c. The bidder met the requirements.

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

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EVALUATOR DEPARTMENT: DHHS, OMS
****

3. Implementation - Work Plan
a. The bidder provided a detailed work plan in the form of a Gantt chart.

Part IV, Section IV. Cost Proposal
• Bidder changed the number of deliverables for C. viii – x from 3 to 8.

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: Deloitte Consulting LLP
DATE: 6/27/2025 (Eligibility), 7/15/2025 & 7/16/2025 (Remaining review)
EVALUATOR NAME: Charyl Malik
EVALUATOR DEPARTMENT: DHHS/OMS
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Met requirements • 1. – P – Bidder has provided over 14 years of NET rate certifications, including the full past 5 years. The work being provided in this project was clearly defined, including techniques utilized and key impacts. • 1. – P – Bidder has provided clear descriptions of 4 other projects outside of the one defined in the noted Appendix C project, for NET rate certifications. • 2. – P – has provided 9 years of UPL demonstrations and continues to do so. The project elements of the project are explained, also including key impacts. • 2. – P – Bidder has provided clear descriptions of 3 other projects outside of the one defined in the noted Appendix C project, for UPL demonstrations.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
•
2. Subcontractors
• No subcontractors will be used by this bidder for this contract.
3. Project Team Organizational Chart
• Meets requirements. • P – organizational chart notes the position for each team member, which assists in aligning staff/positions with deliverables in the work plan.
4. Litigation
• There is no litigation reported for this section by this bidder.
5. Financial Viability
• To my knowledge, the attached financial viability documentation meets the requirement.
6. Certificate of Insurance
• To my knowledge, the attached Certificate of Liability Insurance documentation meets the requirement.
Additional requirements from Appendix D.
• Meets requirements. Bidder provides general and specific relevant qualifications for work required, including its work with Maine. • I – Bidder added “Serving Your Needs” quotes in various areas of the proposal from members of their team to add personalization to the descriptions of the

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organization's qualifications and experience. Other summary boxes of key information such as "Project Spotlight", "Benefits to Maine", "Did you know?", "We Know Maine", etc. to bring attention to the experience and other information. • I – Bidder notes that their team brings experience from over 35 states and territories.
• Meets requirements. Bidder provided fiscal management analytics experience of working with four other states.
• Meets requirements. Bidder has provided over 14 years of NET rate certifications, including the full past 5 years. NET experience for Maine and 4 other states was provided.
• Meets requirements. Experience examples from Maine and one other state were provided, to include the initial design and build of the MaineCare AC program and implementation and continued work with the MassHealth ACO program. They also have experience supporting value-based care assessment and implementation.
• Meets requirements. Bidder has provided 9 years of UPL demonstrations and continues to do so. UPL experience with 4 other states was provided. .

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. Meets requirement – has multiple qualified actuaries. 2. Meets requirements – project management/plan and sample NET work plan describe specific deliverables and coordination with the Department. 3. Meets requirements. Supported by the NET work plan. Bidder explains familiarity with Maine NET history, data, processes as well as experience in meeting detailed requirements. Also, detailed descriptions were provided for the various steps of data collection, data usage, review of data for rate recertification, Department/NET broker collaboration, and review and assessment of encounter and financial data. Importance of data discussion and collaboration with the Department on data adjustments was also stressed. 4. Meets requirements. Bidder provided detailed descriptions of how they would meet requirements, while referencing their experience with Maine NET analyses, rate development, rate certification, and stakeholder engagement.

STATE OF MAINE
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EVALUATOR DEPARTMENT: DHHS/OMS
****

B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables
1. Meets requirements. 2. Meets requirements. P – bidder displayed/explained its familiarity with various MaineCare data files and their details.
C. AC and PCPlus Data Analysis
1. a. Meets the requirement. b. Meets the requirement - bidder has over 160 health actuaries, many who have worked with the Department for the past 20 years, including for the original development of MaineCare's AC program. 2. Meets the requirements - bidder provided understanding and approach for the various files used to produce deliverables. P - Bidder is familiar with State data files utilized for deliverables 3. Meets requirements. Bidder describes familiarity with the AC attribution data and processes and a clear understanding of the required deliverables. Supported by the work plan. 4. Meets requirements. Bidder describes familiarity with data being used for PCPlus and the alignment with AC attribution. Supported by the work plan. 5. Meets requirements. Bidder describes familiarity with Maine AC TCOC calculations and report production. 6. Meets requirements. Bidder describes familiarity with Maine AC TCOC analyses and presentations while remaining open to determine potential reviews and adjustments. 7. Meets requirements. Bidder describes familiarity with Maine AC Data Extracts creation, review and preparation for delivery to the ACs. 8. Meets requirements. Bidder describes familiarity with Maine AC Completion Factors. 9. Meets requirements. Bidder clearly describes processes to be used for AC Policy Change Adjustments. 10. Meets requirements. Bidder clearly describes their approach in development of AC and PCPlus program methodology review and changes, including extensive testing and validation. 11. Meets requirements. Bidder has a planned approach on methodology documentation development.
D. Fiscal Management Analytics (FMA)

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EVALUATOR DEPARTMENT: DHHS/OMS
****

1. Meets requirements. Bidder explained, in detail, the processes involved in their development of quarterly enrollment, utilization, and expenditure projections. Supported by deliverables in the work plan.
2. Meets requirements. Bidder verifies experience aggregating claims and non-claims payments for fiscal reporting. They then proceed with explaining the evaluation, model development, and stakeholder engagement related to non-claims payments.
3. Meets requirements. Bidder explains processes to be followed to develop enrollment/population categories and work towards program alignment.
4. Meets requirements. Bidder explains how they will work toward development of service categories and crosswalk FMA and AC categories.
5. Bidder verifies reporting will be developed to meet the noted projection breakdowns.
6. Bidder verifies projections will be presented in the required format, with granular and aggregate levels and likely additional applications will be utilized, if appropriate to meet stakeholder needs.

Alignment Across Topics

- Meets requirements. Supported by work plan.

E. Upper Payment Limit (UPL)

1. Meets requirements. Bidder explained their detailed approach for UPL calculation demonstrations. The proposal also included methodology options with considerations.

2. Meets requirements. Bidder provided various examples of centers/tools used to track changes in law, CMS requirements, and UPL demonstration methodology. Clear demonstration of data collection, review of viable UPL demonstration models/methodologies, preparation and submission to CMS, and addressing of issues and/or questions was provided.

F. Requirements Related to Receiving Confidential Data

1. Meets requirement. Bidder acknowledges required insurance shall be maintained.
2. Meets requirement – bidder states they will (at a minimum) align with the noted MaineIT policies standards for risk assessment and vulnerability scanning policies and procedures for collecting/receiving sensitive electronic information.
3. Meets requirement, as bidder will comply.
4. Meets requirement, as bidder will comply.
5. Bidde acknowledges State's request to comply, though recommends modification or clarification for this work.

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6. Meets requirement, as bidder agrees with the application consumption statement.

G. Project Management

1. Meets requirements. Bidder notes its commitment to collaboration with the Department by remaining engaged and keeping the Department informed. This will include meeting preparation, facilitation, support, tracking, documentation, materials, and follow-up. Communication and resolution plans were defined, to be supported by a suite of tools.

Supported by detailed deliverables in the work plan for NET, AC, PCPlus, and FMA

I – Bidder provided an example of their rate setting NET status tracker

2. Meets requirements. Supported by coordinated deliverables in work plan.
3. Meets requirements. Supported by deliverables in work plan.

H. Ad Hoc Work

1. Meets requirements.
2. Meets requirements. Bidder provided examples of experience in forecasting and one-time analyses projects such as primary care billing code evaluation, transitioning of reimbursement methodology, regulatory change impact assessment, and development of UPL models. Bidder also noted resources that will provide support to this work such as dashboards, predictive modeling, process integrations, and reporting solutions.

I. Reports

1. Meets requirements. Bidder clearly defines methodology and components of how they will track and record data/information. Supported by work plan.
2. Meets requirements. Details of implementation are specified in work plan implementation and is supported by the work plan itself.

2. Staffing

a. Meets requirements.
b. No subcontractors or consultants are expected to be used for this contract.
c. Meets requirements.
P – Bidder has experience working with State of Maine on Accountable Communities and Non-Emergency Transportation.

3. Implementation - Work Plan

a. Meets requirements.
P – Very detailed breakdowns of higher-level deliverables.

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: Deloitte Consulting LLP
DATE: 06/27/25
EVALUATOR NAME: Lauren Metayer
EVALUATOR DEPARTMENT: DHHS OMS
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Meets eligibility requirements

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• Deloitte has worked with the state of Maine for more than 20 years. States that it has a proven track record of delivering projects on time within budget for clients across Maine • Has team members who were Medicaid directors and CMS regulators • Has worked with Maine before, familiar with our program, has direct NET experience with Maine • Has worked with several other states for Financial Management
2. Subcontractors
• Not planning to use subcontractors at this time.
3. Project Team Organizational Chart
• Clearly defined team with leads in different areas and a lot of support staff
4. Litigation
• No litigation
5. Financial Viability
• Provided their revenues and liabilities but state that the information is not intended to present financial position. • Not really concerned given total net revenues reported
6. Certificate of Insurance
• Provided certificate of liability insurance
Additional requirements from Appendix D.
• Deloitte has experience working with Maine as well as several other states to provide the services included in this RFP. See above section for overview.
• Currently works with Georgia, New York, Texas, and Pennsylvania to provide FMA • States that it has experience projecting utilization, enrollment, price/cost, and breaking these out by population and service category.
• Currently partners with the state of Maine on NET for over 13 years

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DATE: 06/27/25
EVALUATOR NAME: Lauren Metayer
EVALUATOR DEPARTMENT: DHHS OMS
****

• Has a lot of experience with Managed Care rate development in addition to Fee for service states • Has worked with Maine, Georgia, New York, Texas, and Pennsylvania on NET • Has an established data intake and review processes to develop rates
• Worked with Maine to set up AC, staff includes other state Medicaid directors familiar with reform efforts • Has also worked with Massachusetts to implement accountable care organization program
• Has worked with other states before to support UPL demonstrations including New York, Texas, Virginia, and Pennsylvania.

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. Deloitte has at least one certified actuary as required in the RFP
2. References other sections for the intended approach and project structure
3. States it will have a project kick off meeting to review any modifications to the data and help align the Department, Deloitte, and the Brokers. Will then request the data, has 13 years of experience working with MaineCare on NET. Will then use the MoveIt FTP to transfer data to Deloitte's FTP, provided detail of the data it would request. Met requirements of this section.
4. Outlined an eight step process for developing capitation rate ranges for the NET program (page 22). Met requirements.
B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables
1.Would like to receive monthly claims and eligibility files as well as non-claims payment files. Deloitte can validate the data and has experience doing this. Deloitte will support the Department to incorporate services paid on a non-claims basis into the monthly claims feed, create crosswalks to assign field types.
2. Deloitte has a structured process to approach data preparation for claims and eligibility files and is able to validate, assign appropriate AC categories, identify final claims amounts, assign AC RAC codes, AC population groups, AC eligible claims, and categorizing AC categories.
C. AC and PCPlus Data Analysis

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EVALUATOR NAME: Lauren Metayer
EVALUATOR DEPARTMENT: DHHS OMS
****

1. Deloitte has many actuaries available for this work and that were involved in the MaineCare AC program in its initial stages. Meets the requirements.
2. Deloitte would receive files from DHHS, then validate them. They will work within agreed upon timelines. They have a secure FTP, an encrypted SQL server, and a Managed Analytics platform to securely analyze, intake, and utilize the files provided. Bidder thoroughly described timelines and steps it takes to ensure data quality.
3. The Bidder is familiar with the attribution model in Maine and understands how important correct AC rosters are to the success of the program. Deloitte described the data it needed to collect to create an AC member attribution process, the process to determine a members eligibility utilizing RAC codes, and then assigning a member to an AC or a Non-AC comparison group. They would also examine the utilization patterns of members by PCPlus, primary care services, and ER visits. After completing attribution, the bidder would work to create rosters and deliver results to the department. Bidder seems very capable of doing this work and has detailed background and expertise.
4. Bidder will determine which members are eligible for PCPlus and create quarterly rosters. Will identify PCP claims through a review of the members eligibility, then a claims review process, and then work to attribute members from this information. Met requirements.
5. Create TCOC report which includes several different components, like policy adjustments and risk adjustments (page 54), as well as completion factors.
6. Deloitte will provide a TCOC report that includes projections, and then present this information to the Department and to ACs. Meets requirements of this section.
7. Deloitte will also provide an extract package of the TCOC report
8. Deloitte will complete annual completion factor analysis using a four step process of summarizing Medical Paid Amounts, making appropriate adjustments, developing completion factors, and then applying those factors to claims data (table on page 60).
9. Deloitte will adjust for federal and state policies, with input from the department. Agreed to participate in annual process. Stated it will also consult with subject matter advisors who have policy knowledge as part of this process.
10. They will monitor and maintain the data, will make timely methodological adjustments and operational changes based on subject matter expertise
11. They will document all details and changes, met requirements.

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D. Fiscal Management Analytics (FMA)
1. Year 1, Deloitte will work to develop a comprehensive and streamlined projection model that accounts for enrollment, utilization data and expenditure data (including non-claims payments). They first collect data, then use a process to account for claims that are incurred but not yet reported (completion ratios), then they will project and do a trend analysis, then accounting for program and legislative changes, and then monitoring the model. Trend options offered include simple averages to trend functions in excel. More complex options like univariate time series may be considered.
2. Deloitte will collaborate with the department on non-claims payments to gather the necessary data, will trend and project them where appropriate similar to the claims projections.
3. Will develop enrollment/population categories. Willing to work with the department to identify claims for each population, and is able to create an enrollment crosswalk to crosswalk between FMA categories and AC and NET categories.
4. Service category development- not a lot of detail here but that they will tie to the AC categories and be able to crosswalk them as required. Does not specifically say they will tie to the MaineCare Benefits Manual.
5. Deloitte will develop reports of both the enrollment and pmpm projections Will include the information in Microsoft excel, which is what many in the department will be familiar with.
6. Stated that they will meet the requirements of this sections of presenting projections in excel.
<u>Alignment Across Topics</u>
• Seems to understand that these programs need to be aligned with what they are reporting and how groups are classified • Will work to create necessary crosswalks and assignment of subgroups to specific members
E. Upper Payment Limit (UPL)
1. First they will gather all relevant data (Claims, non-claims, eligibility, and RAC files. They then create crosswalks to link Medicaid provider IDs to their Medicare provider IDs to build a detailed Medicaid claims database that aligns closely with Medicare. They then create a tailored UPL calculation for each required service, this is a seven part process (page 82). Stated they will work

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EVALUATOR DEPARTMENT: DHHS OMS
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with DHHS to understand current methodologies and inform the department with any UPL issues
2. Deloitte can also determine if there may be alternative approaches to better fit current UPL demonstrations. Deloitte will provide the Department a package that we can then give to CMS. This package will include detailed explanations to minimize potential questions from CMS. Meet requirements.
F. Requirements Related to Receiving Confidential Data
1. Deloitte confirms and acknowledges receiving the Requirements Related to Receiving Confidential Data,
2. Works with Maine on other projects, is very familiar with requirements, and knows how to sucre and collect sensitive data
3. Deloitte will comply with Maine IT Policies
4. Deloitte will comply with all state and federal laws that are applicable
5. Deloitte will comply with confidentially requirements that the state requests
6. Deloitte acknowledges that the state does not consume any bidder application and the bidder does not consume the state
G. Project Management
1. Deloitte has experience managing projects in multiple states. The frequency of the touchpoints will be determined in alignment with the State's desired processes and Deloitte will remain flexible to accommodate accordingly. Meetings will track progress towards goals, escalate issues, inform about adjustments to the project plan as necessary.
2. Will use Microsoft teams and other collaboration tools to collaborate where appropriate across AC and FMA. Create regularly updated status trackers visible to all workstreams.
3. Deloitte will attend at least 12 AC collaborative meetings each year
H. Ad Hoc Work
1. Meets requirements and will provide estimate and scope for ad hoc work.
2. Deloitte has experience supporting several state Medicaid programs with ad hoc work forecasting revenues and one-time analyses. Has experience forecasting drug rebates in Georgia.
I. Reports
1. States that they will track, develop, and record the required reports in Table 5. Deloitte has a documentation and tracking process that it uses to manage and organize any interaction with the state. Meets requirements.

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****

2. States that they will submit required reports in Table 6 to the department on an as agreed upon timely basis, meets requirements.
2. Staffing
a. All staff seems well qualified, and minimum requirements listed for each role. I- most qualified people don't spend a lot of time on the project, even of this size?
b. No subcontractors
c. Has set staff already to fill each role in the staffing plan
3. Implementation - Work Plan
a. Work plans seem feasible, well laid out and detailed.

STATE OF MAINE
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RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: Deloitte Consulting LLP
DATE: 7/16/2025
EVALUATOR NAME: Jordan Rhodes
EVALUATOR DEPARTMENT: DHHS -Commissioner's Office
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• P – meets eligibility requirements.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• P – previous experience working with the state of Maine. • P – experience with other states working on projects similar to those outlined in RFP.
2. Subcontractors
• They do not intend to use subcontractors.
3. Project Team Organizational Chart
• P – project team has diverse experiences working with state Medicaid agencies.
4. Litigation
• None listed.
5. Financial Viability
• P – positive working capital and current ratio > 1.
6. Certificate of Insurance
• Q – policy expired, although perhaps this occurred after proposal submission?
Additional requirements from Appendix D.
• Exhibits familiarity with Maine, and highlights over 20 years of experience. • Highlights knowledge and understanding of Maine demographics, service needs, and geography.
• **a.** Provides example FMA work corresponding to 4 states, exhibiting comprehensive understanding of forecasting approaches.
• **b.** Describes a range of experiences working on states' NET program initiatives, including for Maine. • Highlights impact of current work on continued improvements to data reporting process and data quality.
• **c.** Experience working on payment reform efforts for Maine through the Accountable Communities model, as well as supporting another state in implementation of ACO program.
• **d.** Provides experience assisting four states with UPL demonstration.

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: Deloitte Consulting LLP
DATE: 7/16/2025
EVALUATOR NAME: Jordan Rhodes
EVALUATOR DEPARTMENT: DHHS -Commissioner's Office
****

- Descriptions highlight bidder's broad understanding of UPL demonstration methodologies and expertise in conducting impact analysis.

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. P – confirms at least one certified actuary will perform this work. 2. Q – did not follow the referenced section numbers in section 2a. 3. P – detailed description of data collection and processes. 4. P – outlines approach to capturing demographic and geographic changes in interpreting trends in NET.
B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables
1. I – frequent reference to comparing encounter data to financial data.
2. P – experience receiving and managing data files in prior work with state of Maine Medicaid program.
C. AC and PCPlus Data Analysis
1. P – direct experience working on Maine's AC program and working on ACO programs with other states. 2. P – prior experience with Department will enhance ability to assess credibility of data. 3. P – familiarity with attribution model from prior experience. 4. P – detailed description of approach. 5. Q – will individual members exceeded the threshold be listed, or will the numbers be listed in aggregate? 6. P – description meets requirements. 7. P – requested package will meet requirements. 8. P – established methodology for generating completion factors. 9. P – will provide detailed documentation of adjustments. 10. P – substantial experience with data-driven practices. 11. P – will leverage experiences with other state clients to incorporate best practices.
D. Fiscal Management Analytics (FMA)

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

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RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: Deloitte Consulting LLP
DATE: 7/16/2025
EVALUATOR NAME: Jordan Rhodes
EVALUATOR DEPARTMENT: DHHS -Commissioner's Office
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1. Q – How will they determine which aspects of internal modelling to carry forward?
2. P – proposes modelling multiple scenarios to assess a range of potential outcomes.
3. I – will apply the same population categories as those used in the AC program.
4. P – will account for anticipated utilization increases across service categories.
5. P – will use Excel enabling widespread use throughout the Department.
6. P – Flexibility in presenting projections across different software.

Alignment Across Topics

- I – will create FMA population groups to be mappable to NET, AC, PCPlus, and Health Home.

E. Upper Payment Limit (UPL)

1. P – provides detailed approach and methodology.
2. P – detailed overview provided.

F. Requirements Related to Receiving Confidential Data

1. P – will satisfy insurance requirements.
2. Q – what provisions should be modified?
2. P – demonstrated experience and commitment to receiving and maintaining sensitive data.
3. P – will maintain compliance with MaineIT policies.
4. P – will comply with all State and Federal laws.
5. Q – what provisions require modification?
6. P – confirmed.

G. Project Management

1. P – proposed process is organized and emphasizes communication.
2. Q – will the AC and FMA teams involve overlapping team members, or be limited to coordination across teams?
3. P – committed to attending required number of meetings.

H. Ad Hoc Work

1. P – notes the ability to address urgent client needs.
2. P – notes flexibility and adaptability to incorporate regulatory changes to fiscal impact analysis.

I. Reports

1. P – Experience working with Maine's data sources.
2. P – emphasizes quality assurance in the lead-up to report distribution.

2. Staffing

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a. P – Proposed team members have extensive experience conducting similar work.
b. No expectation of subcontractors or consultants.
c. Q – will technical analyst I be required for this work, or would responsibilities under this project more align with a business analyst II?

3. **Implementation - Work Plan**

a. P – structured and detailed work plan provided.

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

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DATE: 6/25/2025 (Eligibility Review) 7/7/2025 (Sect. II, Organizational Qualifications and Experience) 7/7-7/10, 2025 (Sect. III Proposed Services)
EVALUATOR NAME: Roger Bondeson
EVALUATOR DEPARTMENT: DHHS-Office of MaineCare Services
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Mercer provided examples of two NET rate certifications for the Missouri HealthNet Division and the Department of Mental Health. Mercer conducted at least two Upper Payment Limit demonstrations for the Commonwealth of Pennsylvania. Mercer meets eligibility requirements.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• Asserts that in 1985, the company became the first fully dedicated Medicaid actuarial consulting practice in the nation. • Has been under contract with OMS since 2018 for Accountable Communities Program data analysis and reporting. Also provides services for Maine Primary Care Plus and CCBHC programs. • Provides consulting services for programs in 30 states and US Territories.
2. Subcontractors
• Proposes to subcontract with Sellers Dorsey for UPL calculations.
3. Project Team Organizational Chart
• A chart was provided – meets requirements.
4. Litigation
• Mercer does not have any current litigation – meets requirements.
5. Financial Viability
• Provided 3 years of audited financial statements. Defer to Financial expert reviewer for analysis.
6. Certificate of Insurance
• Insurance certificate provided. Meets requirements.
Additional requirements from Appendix D.
• See #1 above.
Experience in development of: • Tacking dashboards including interactive dashboards that deliver real time insights into service utilization patters • Enrollment projection models • Cost projections • Cost analysis reports

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Fiscal Management experience includes: (P)

- Maine Accountable Communities Program data analysis, total cost of care reporting. Provided MaineCare budget estimates.
- Delaware Medicaid: fiscal management to track utilization, project enrollment changes, and analyze costs.
- Pennsylvania: MCO rate development.

- Has set NET rates for 3 stand alone programs and for 8 MCOs as part of the MCO rate.

Oklahoma: Set PMPM rates from 2014 – 2023. (P) The 2023 rate setting included:

- Collection of encounter data and broker financial reports
- Base data adjustments as encounter data underreported expenditures
- Population groups PMPM
- Programmatic changes and adjustments
- Trend analysis.

Mercer states that rate development adhered to CMS guidelines but does not state that rates were reviewed and approved by CMS (Q). Note: It may be that the model used by Oklahoma did not require CMS review and approval, but we don't know.
Virginia:

- Collected encounter data and non-encounter data.
- Analysis of historical data.
- Cost projections
- Trend analysis
- Final PMPM rate development

Mercer does not indicate if the Virginia rate setting work involved review and approval by CMS. Again, the model used in the state of Virginia may not need rate setting oversight by CMS.

Mercer provided two examples of providing other Medicaid programs, one for Connecticut and one for Delaware.
Connecticut Person Centered Medical Home Plus services provided include:

- Program design.
- Stakeholder engagement.
- Legislative testimony support.
- Development of RFPs.
- Provision of ongoing support.

Delaware Primary Care Reform Collaborative services provided include:

- Supporting the effort
- Helping to draft legislative bill language

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• Designed a concept model
• Developed an all-payer benchmark including:
  ➢ Facilitated coordination amount state agencies
  ➢ Led stakeholder meetings with external parties including healthcare providers and insurance companies
  ➢ Provides ongoing support in quality measure expertise, measure specifications documentation, training, and data analytics support and validation. (P)

• Provided three examples of UPL demonstrations by Sellers Dorsey; Virginia, New Jersey, and Georgia.
• Services provided for Virginia included:
  ➢ Improved UPLs for hospital rates
  ➢ Assisted in preparation of state plan amendments and MCO preprint applications for CMS approval.
• Services provided to New Jersey included:
  ➢ Successful CMS approval of UPLs for the Bergen New Bridge Medical Center (BNBMC) on 3/31/2021.
  ➢ Collaboration with State of New Jersey and BNBMC officials to gather essential census and payer data.
  ➢ Assisted to secure legislative authority for BNBMC to receive additional payments.
  ➢ Developed all required documents including state plan amendments, intergovernmental transfer agreements, and drafted language for New Jersey's MCO contracts. (P)
• Services provided to Georgia include:
  ➢ Improved UPL payments for primary care practitioners.
  ➢ Received CMS approval of UPLs on 12/31/2021.

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. Proposes a team of three credentialed actuaries belonging to the Fellows of thee Society of Actuaries and the American Academy of Actuaries. Meets requirements.
2. Project Planning

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- Mercer proposes utilizing detailed agendas and Data and decision trackers that document each analysis conducted or report developed and history of work product.

2ai -2aii Developing a Project Plan and Structure

- Mercer proposes to schedule a kickoff meeting to set expectations and goals.
- Proposes to create a project schedule including development of a project work plan, a communication plan, and support tools.
- Will refine tasks and timelines as needed.

2.a.iii Financial Status and Contractual / Programmatic Changes

- Proposes to lead discussions with the Department and NET Brokers about the financial status of the program.

2.a. iv. Confirming Rating Approach

- Mercer's response to Project Planning is minimally responsive.

3. Data Collection, Analysis, Gap Analysis/Rectification and Preparation.
3a. Meeting with the Department. Response meets requirements.
3b. Data Request and Review

- Proposes to collect claims, eligibility, enrollment and financial data.
- Proposes to establish a common understanding of methodology and data specifications using a standard template for each broker (P).

3c. Gather NET Data

- Mercer states that it already collects and receives claims, enrollment, and eligibility data via Maine's MoveIt protocol and proposes use of the same for NET data collection.
- Proposes a 3 step preliminary data validation process:
  - Data dictionaries and file layout
  - Control totals and verification
  - Field checks for consistency
- Proposed data security protocols include:
  - Cybersecurity standards in ISO/IEC 27001 and NIST SP 800-53
  - Usage of encryption and transmission methods
  - Restricting access to PHI to specific team members
  - Access to stored data controlled by setting permissions
  - Back up process for disaster recovery and business continuity
- Mercer did not specifically address items 3ci, ii, iii, iv, or v.(N).

3d.i Waiver Eligible Participants and Claims

- Proposes to consider size and stability of each group because in some cases the small rate cells may not be considered credible.

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- Anticipates assigning rate cells via eligibility code crosswalks.
- Proposes to use county to region crosswalks to assign regions to the data

3.d.ii NET Rides and Service Details.

- Mercer proposes to identify payment fields that accurately represent the amount paid to the providers by the NET brokers.

3.d.iii Description of Population, Eligibility, and Benefit Changes

- Meets requirements.

3d. iv Methodology to Correct Data Issus

- Proposes to validate current crosswalks and procedure code definitions.
- Mercer proposes to develop a plan to improve underlying data including a list of outstanding issues for the Department and NET brokers to address.

3d.v. Updated Crosswalk and Procedure Codes.

- Proposes to gather and maintain documentation on any additional crosswalks necessary to apply appropriate identifiers to the encounter data.

3e. Encounter Data Comparison to Specifications

- Proposes a detailed validation process to include the following (page 14):
  - Missing fields
  - Missing NET Brokers
  - Referential integrity
  - Lag Triangles
  - Frequency report
  - Valid values
  - Date distribution
  - Numerical distribution
  - Duplicates

3f – 3g. Resolve Missing Data and Facilitate Discussions

- Proposes to identify and summarize data gaps, data issues, and questions and share with the Department and NET brokers.
- Proposes to validate NET broker costs by:
  - Broker interviews
  - Survey tools
  - Outlier identification

3h. Preparing Data for use in Actuarial Analysis

- Proposes several steps to review and validate encounter and financial data.
  - Verify proper fields are included and control totals match.
  - Create validation reports to identify illogical or missing data and numerical values.

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- Summarizing encounter data volumes by month, region, and/or NET broker to identify incomplete data or data anomalies.
- Identifying NET services and eligible populations using Dept. information.
- Comparing encounter and enrollment data to NET broker financial data.
- Reviewing with previous submissions used in rate development
- Checking for consistency among NET brokers.

4. Rate Development and Certification

4a. Develop Capitation Rates –

- Proposed Base Data Adjustments to be evaluated include (see Figure 1, page 18).
  - Incomplete data (e.g. not all costs included in the encounter data)
  - Unallowable costs
  - Midyear program changes
  - Incurred But Not Reported Claims (IBNR)
- Proposed Assessment of Trends to include
  - National studies
  - Technology trends
  - Medicare trends
  - Maine public transit trends from MDOT
  - Trends in neighboring states
  - National economic indicators.
- Proposes to customize Maine's patterns (e.g. long haul transport, seasonality, island transportation).
- Non-Benefit Load: Proposes to consider historical expenses, underwriting gain, taxes and fees to assess non-benefit load to the costs of delivering NET.
- Proposes to provide analyses of payment options including performance withholds.
- Proposes to use peer review to check work on development rates (see Figure 2 on page 22).

4b. NET Rate Certification

- Proposes to adhere to 42 CFR 438.4 and the Actuarial Standards of Practice.

4c. Engagement with CMS

- Proposes to help with responding to CMS questions about rate setting methodology.
- Mercer asserts that all rates developed by the company on behalf of Medicaid clients have been approved by CMS.

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4c.-4d. NET Broker and Other Stakeholder Agreement

- Mercer proposes the following communication mechanisms in response to this item.
  - Actuarial memoranda to allow NET brokers to review rate development before submission to CMS.
  - Written responses to NET broker questions
  - Webinars with NET brokers to describe rate development process and to answer questions.
- Mercer proposes the following enhanced communication mechanisms.
  - Regular updates
  - Live virtual stakeholder sessions
  - Feedback mechanisms to allow stakeholders to voice concerns and ask questions.
- Response to section #4 is thorough and detailed. (P)

B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables

- Mercer proposes to use it's existing approach to receiving and managing MaineCare data files for AC/PCPLus, FMA, and UPLs.
- Proposes to provide interim deliverables
  - Data management and documentation plan
  - Received data summary
  - Data management confirmation

1a -1b Receiving Claims and Eligibility Feeds

- Proposes the following:
  - Initial Data Load – anticipates receiving claims and eligibility data through December 30, 2025 as part of the scope of the existing contract with the Department.
  - Receipt of ongoing monthly files
  - Receipt of non-claims payment (PMPM) data for:
    - ✓ Opioid Health Homes
    - ✓ Behavioral Health Homes
    - ✓ Community Care Team

1c. Receiving Other Non-Claims Expenditure Information

- Mercer proposes to collect the following additional non-claims payment information:
  - Medicare premium payments

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- Medicare Part D claw back
- NET contracts
- AC shared savings payments
- Pharmacy Incentive Payments
- Private Health Insurance Premium (PHIP) payments
- Supplemental payments

2. Load, Process, Warehouse, and Reconcile Data

- Proposes and describes a 7 step data preparation process (see pages 27 -31). This is a thorough and detailed response (P).
- Mercer proposes use of an established algorithm to identify final claims payment amounts and describes how the algorithm works (see page 30).
- Mercer proposes the following: Once it assigns monthly population groups to each individual, an annual group is assigned based on the most recent population group assignment (e.g. 10 months as a child and 2 months as an adult, the individual is assigned to the adult category for the period). Q Is this ok?

C. AC and PCPlus Data Analysis

1. 1a Subject Matter Experts
    - Proposes to use the existing team to continue the AC and PCPlus data analysis and reporting work.

1b. Proposes two certified actuaries, both currently working on Maine programs.

2. Receive, Organize and Store Additional Files
    - File receipt via secure data transfer using GlobalScape
    - Data organization and storage using version control and data integrity checks.

2a. AC Program Files

- Proposes to gather the following information:
    - Updated list of providers, practices, and emergency departments
    - Updated physicians file
    - Most recent PCPlus attribution file
    - Risk scores
    - Crosswalk file to map claims to AC categories

2b. PCPlus Program Files

- Mercer proposes to collect the following information:
    - PCPlus provider data files for purposes of PCPlus attribution
    - Crosswalk for National Provider Identifier +3
    - Crosswalk to identify primary care claims.

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2a.vi – 2b.iv Additional Files and Flexibility

- Proposes use of collaborative file management and a flexible data management system that allows for new file types.

3. AC Rosters

3a. AC Attribution Methodology

- Proposes use of an algorithm to evaluate whether individuals are attributable to the AC program.
- Proposes the following steps for attribution methodology (see Figure 3, p.35).
  - Eligibility review
  - Utilization requirement
  - Determining AC and non-AC members
  - Assigning members to ACs or non-AC comparison groups.

3b.-3c. Response meets requirements

4. PCPlus Rosters

4a. Attribution Methodology

Proposed process steps

- Data collection
  - Claims
  - Eligibility
  - RAC
  - Muskie Crosswalk
- Determine eligibility
- Conduct pre-attribution analyses
- Execute the attribution process
- Generate final attribution process

4b. Rosters and Reports

- Proposes to create a quarterly report to include:
  - Member ID
  - Demographic and attribution data
  - Provider identification
  - Risk score
  - Service information
  - Hierarchy and attribution logic
- Proposes to create a comparison report to include:
  - Member ID
  - Current and prior NPI and SL indicators
  - Member attribution status

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- Proposes to provide an additional report not required by the RFP to include details on number of members who are associated with each PCPlus provider.

5. AC TCOC Reports

- Mercer states it will produce 4 TCOC reports each year
  - Annual reconciliation
  - Annual projection
  - Two biannual interim reports
- Proposes a and describes a 4 step TCOC savings/loss calculation methodology (pages 43-46). This response is detailed and thorough (P).

5aiii. Report Exhibits

- Proposes to produce AC-level workbooks with all required exhibits.
- Proposes to create organization specific reports with all required exhibits.

6. AC TCOC Summary Analysis

6a. Analysis of Results for each TCOC reporting period.

- Proposes to present a thorough comparison of TCOC results between current TCOC reports and the previous period chosen by OMS via a PowerPoint presentation to include:
  - Main drivers of performance
  - Comparative analysis
  - Detailed explanation of findings

6b. Presentation of Results for ACs

- Mercer proposes to communicate TCOC results to ACs via email, PowerPoint, and Excel tools.

7. AC Data Extracts

7a. Extract Package Creation

- Mercer proposes to create an extract package of .txt files containing the following information:
  - Base year member list
  - Excluded claims
  - Included claims
  - Performance year member list.

8. AC Completion Factors

8a. Completion Factor Methodology

- Mercer proposes to use its proprietary IBNR model to analyze historical expenditure data.

8ai. Calculation Frequency

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- Mercer proposes to calculate new completion factors once per year for 9 consolidated service categories.

9. AC Policy Change Adjustments

9a. Identification of Potential Policy Changes

- Mercer proposes the following considerations for its methodology in determining whether a policy change may require an adjustment in the TCOC calculations:
  - Negligible impact
  - Consistent material impact
  - Significant impact.

9ai. Calculation Methodology for Policy Adjustment

- Mercer proposes (and describes) using one of the 3 following methodologies:
  - Empirical
  - Fee schedule
  - Claims-based adjustments
- Examples of when Mercer would conduct policy change assessments
  - Non-index adjustments
  - Benchmark changes
  - Percentage adjustments

9aii. Apply Claims-Level Adjustments

- Mercer proposes to apply the policy adjustment with the largest impact in total dollars when multiple policy adjustments apply to a single claim to avoid overstating the impact of overlapping changes. (P)

9aiii. Documentation

- Proposes providing a list of adjustments to the Department, to get the Department's review and confirmation, prior to submitting deliverables.
- Proposes to provide the Department with a chart that summarizes all the adjustments made for TCOC calculations Chart will include:
  - Services impacted by chapter and section of MaineCare BM.
  - Description of the adjustment.
  - Adjustment calculation methodology
  - Notes specific to each adjustment
  - Total dollars in base year claims before and after adjustment is applied.

10. Initiative Monitoring and Maintenance

10.a Expertise in Alternative Payment Models.

- Mercer proposes to monitor developments in other Medicaid programs to share lessons learned and best practices with the Department.

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10b. Identifying Needed Changes

- Mercer proposes several approaches to identifying and assessing the potential for needed changes.
  - Benchmark against best practices
  - Evaluate current technology
  - Data monitoring
  - Threshold establishment
  - Data analysis
  - Contextual evaluation.

11. Methodology Documentation

11a. Updating Methodology Documentation

- Mercer states that its documentation will include:
  - Annual PC program attribution and reporting methodology
  - Annual PCPlus attribution methodology
  - Annual AC program performance year policy adjustment methodology.
- Propose that these documents will include:
  - Detailed descriptions
  - Process diagrams

11b. Ensuring Data Dictionaries and Validation Elements

- Proposes data dictionaries for each AC to include:
  - Field definitions
  - Data types and formats

D. Fiscal Management Analytics (FMA)

1. Fiscal Management Analysis

- Mercer proposes and describes in detail, a 6 step process to develop reporting and projection deliverables.
  - Step 1, define deliverable goals and parameters
  - Step 2, Incorporate required elements
  - Step 3, Summarize historical data
  - Step 4, Compare prior projections to actual experience
  - Step 5, Project future enrollment
  - Step 6, Project future utilization cost
- Mercer proposes use of the following for developing trend projections;
  - Federal reports
  - Market experience
  - Benefit specific market trends
  - Industry trends.

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INDIVIDUAL EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Asst. Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: Mercer Health & Benefits LLC
DATE: 6/25/2025 (Eligibility Review) 7/7/2025 (Sect. II, Organizational Qualifications and Experience) 7/7-7/10, 2025 (Sect. III Proposed Services)
EVALUATOR NAME: Roger Bondeson
EVALUATOR DEPARTMENT: DHHS-Office of MaineCare Services
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- Proposes use of a 5 step process to evaluate program and policy changes.
  - Review policy change
  - Identify policy specifications
  - Validate and review data
  - Calculating financial impact
  - Apply policy adjustment factor to the projection

2. Develop an Approach to Include Non-Claims based Expenditure in projections.

2a. – 2h. Identify and Analyze Non-Claims Based Expenditures.

- As part of the initial FMA kickoff meeting, Mercer proposes to develop a list of all non-claims based expenditures for the Department to review and approve.

3. Develop Enrollment/Population Categories

- Mercer recommends retaining the following population categories for FMA;
  - Medicaid expansion
  - Aged and disabled
  - Traditional adults
  - Traditional children
  - State only
  - Limited and other.
- Mercer proposes the Department consider additional population groups:
  - CHIP
  - Dual eligible
  - Long term care

3b. Crosswalk to AC and NET Populations

- Proposes to establish a crosswalk between FMA populations and current AC and NET population groups.

4. Develop Service Categories

4b. Proposed Service Categories

- Mercer proposes to consider the following factors to determine optimal categories of services for FMA reporting:
  - Alignment with population categories
  - Funding accounts
  - Credibility
  - Alignment with other programs

5. Ensure FMA Reports show projections by PMPM and enrollment and then by PMPM by price vs. utilization components.

- Mercer proposes to provide a template to the Department with a proposed layout and metrics for Department approval.

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6. Present projections in Excel.
- Agrees to use Excel in presenting to the Department.
- Proposes to use dashboard, charts, graphs, and tables for other stakeholders.

Alignment Across Topics

- Mercer proposes reviewing the existing 11 NET rate cohorts to determine if they can be collapsed or reorganized. Then it will review how the recommended NET rate cohorts map into existing FMA population groups.
- Proposes to analyze whether the participants in the AC and PCPlus programs warrant a separate population break-out within their existing categories.
- Mercer proposes that the Department consider separate reports and projections for the various health home program participants.
- Mercer's vision of synergies includes:
  - Integrated data analysis
  - Enhanced reporting capabilities
  - Improved policy impact assessments
  - Streamlined process
  - Project management to understand a change in one program may affect another.

E. Upper Payment Limit (UPL)

1.a -1c. Mercer proposes a 3 step approach for calculating UPLs:
- Obtain data to support UPL analyses
- Identify and outline the UPL methodology options for each service.
- Complete UPL calculations using approved methodologies.

2. UPL Demonstration Related Services
- Proposes to monitor UPL issues raised by CMS in other states that could affect Maine.
- Proposes to monitor changes in Medicare reimbursement policy and provide options to the Department to mitigate impact of the changes.
- Additional data to collect includes Medicaid payment and utilization statistics and resident assessment information at the individual provider level.
- Mercer states that it will provide guidance to the Department when evaluating alternative calculation options to determine the best methodology for each demonstration.
- Sellers Dorsey and Mercer will assist the Department in preparing all materials required for CMS for annual UPL demonstrations including:
  - UPL Guidance Document

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- Supporting Rate Documentation
- CMS Required Templates
- Will assist the Department in responding to CMS questions.

F. Requirements Related to Receiving Confidential Data

1. Mercer states it has an insurance policy that meets or exceeds MaineIT requirements.
2. Mercer's framework, policies, and procedures for collection and receipt of sensitive electronic information significantly aligns with MaineIT requirements.
3. Mercer will confirm in July of each year, compliance with MaineIT requirements.
4. Mercer confirms it will comply with all state and federal laws.
5. Confirms it will comply with all MaineIT confidentiality requirements.
6. Acknowledged

G. Project Management

1. Proposes to conduct weekly meetings
   - Proposed project management tools include:
     - Agenda and Status Updates
       - Documentation of action items and follow ups
       - Project workplan
       - Data and Decision documentation and tracker
2. Consistency Across Work Streams
   - Propose to use one senior project manager to oversee all work streams.
   - Proposes a budget summary document for the following purposes:
     - Comprehensive budget tracking
     - Ad hoc activity prioritization
     - Base scope of work monitoring
     - Alignment and transparency
     - Ease of access.
   - Proposes development of a comprehensive portfolio dashboard.
3. Attend at least 12 Meetings with the Department and ACs
   - Mercer did not address this requirement. (N)

H. Ad Hoc Work

1. Mercer proposes the following process for ad hoc work requests:
   - Preparation of a budget for the ad hoc request
   - Formal approval by the Department
   - Timeline development
   - Integration into ad hoc budget summary
   - Pro-active suggestions.

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2. One Time Analysis
    - Mercer asserts that it has extensive familiarity with the Department's data and programs, enabling staff to quickly and efficiently conduct analyses without a steep learning curve.

I. Reports

1. Meets requirements
2. Meets requirements

2. Staffing

a. Meets requirements
b. Submitted a completed Appendix E Subcontractor form for Sellers Dorsey, meets requirements
c. Meets requirements

Proposed staff is qualified and experienced to accomplish the work.

3. Implementation - Work Plan

a. Meets requirements

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BIDDER NAME: Mercer Health & Benefits LLC
DATE: 6/26/2025 (eligibility), 7/9/2025 (Part IV), 8/18/2025 (Cost)
EVALUATOR NAME: Philip Dubois
EVALUATOR DEPARTMENT: DHHS, OMS
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Bidder meets the eligibility requirements and cited specific projects that satisfy these requirements.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• See Appendix D.
2. Subcontractors
• The bidder indicated that they are partnering with a subcontractor for the UPL scope of work.
3. Project Team Organizational Chart
• The bidder provided the project team organizational chart.
4. Litigation
• The bidder indicated that there have been no legal proceedings filed against them in the last five years.
5. Financial Viability
• The bidder provided three years of annual reports, including audited financial statements.
6. Certificate of Insurance
• The bidder provided the required certificates of insurance.
Additional requirements from Appendix D.
• P - Since 2018, the bidder has provided data analysis and reporting for the MaineCare Accountable Communities program, including member rosters and total cost of care reports. • The bidder is also currently supporting MaineCare's Primary Care Plus (PCPlus) program, with attribution, fiscal management support, actuarial consulting, and other ad hoc activities. • The bidder worked to develop a prospective payment system (PPS) for MaineCare's new Certified Community Behavioral Health (CCBHC) program.
• The bidder has worked with Delaware Medicaid to develop a suite of fiscal management tools, allowing for utilization trend tracking, enrollment projections, and analyzing costs. • The bidder has supported Pennsylvania Medicaid in creating a standardized reporting framework integrating utilization, enrollment, and cost data.

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• P - The bidder worked with Oklahoma Health Care Authority in their rate development process from 2014 through 2023. The NET broker is paid on a PMPM basis. • The bidder is current contracted to develop NET capitation rates for Virginia. • The bidder has developed capitation rate ranges in Missouri since 2015.
• The bidder assisted Connecticut in the design and implementation of a Person-Centered Medical Home initiative, a shared savings model targeting practice improvement, physical and behavioral health integration, and care coordination. • The bidder worked with Massachusetts on a program aimed at transitioning payments to primary care providers from fee-for-service (FFS) to a prospective global per member per month (PMPM) payment structure.
• The bidder's subcontractor worked with Virginia to evaluate and optimize hospital UPL calculations. • The bidder's subcontractor also has experience with UPL reporting in New Jersey and Georgia.

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. The bidder indicated that they would have three actuaries assigned to this scope of work. 2. The bidder indicated that they would schedule a kick-off meeting to discuss the project plan and their proposed work plan. • The bidder offered to lead discussion with the Department and NET brokers about the financial status of the Maine NET program. 3. P - The bidder currently receives data from the Department, so they are familiar with the process. They also discussed some important considerations for reviewing and validating the data. • The bidder thoroughly discussed methodologies for identifying populations and updating documentation for issues identified or changes to crosswalks used in the rate setting exercise. • P – The bidder discussed a very detailed process and methods for validating data, including identifying historical utilization and cost patterns. 4. P – The bidder described a thorough process for rate development and agreed to present the rates in the two reports specified in the RFP requirements.

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EVALUATOR DEPARTMENT: DHHS, OMS
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a. The bidder indicated that they would develop the NET capitation rate certification in accordance with applicable actuarial standards and document the rate development process for CMS.

5. The bidder indicated that they would have three actuaries assigned to this scope of work.
6. The bidder indicated that they would schedule a kick-off meeting to discuss the project plan and their proposed work plan.

- The bidder offered to lead discussion with the Department and NET brokers about the financial status of the Maine NET program.

7. P - The bidder currently receives data from the Department, so they are familiar with the process. They also discussed some important considerations for reviewing and validating the data.
    - The bidder thoroughly discussed methodologies for identifying populations and updating documentation for issues identified or changes to crosswalks used in the rate setting exercise.
    - P – The bidder discussed a very detailed process and methods for validating data, including identifying historical utilization and cost patterns.
8. P – The bidder described a thorough process for rate development and agreed to present the rates in the two reports specified in the RFP requirements.
    a. The bidder indicated that they would develop the NET capitation rate certification in accordance with applicable actuarial standards and document the rate development process for CMS.

B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables

1. P – As a current vendor for MaineCare, the bidder cites their experience with MaineCare data, understanding program data, efficiently receiving and validating claims, eligibility, and other non-claims data.
    a. P – The bidder is already in receipt of the claims and eligibility data covering the AC Base Year.
    b. P – The bidder also demonstrated their experience working with the Department's non-claims payment files.
2. P – As a current vendor with MaineCare, the bidder is already experienced with assigning detailed Accountable Care Organization (ACO) service categories using MaineCare data.
   P - As a current vendor with MaineCare, the bidder is already experienced with assigning Recipient Aid Category (RAC) codes and Accountable Communities population groups to members.

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****

C. AC and PCPlus Data Analysis

1. The bidder is proposing to use the same team of subject matter experts currently doing this work for MaineCare, including two certified actuaries.
2. P – The bidder cited their experience currently doing the activities included in this requirement.
3. P – As the incumbent for this scope of work, the bidder described in detail the work that they currently do to attribute members and develop the AC roster file.
4. P – As the incumbent for this scope of work, the bidder described in detail the work that they currently do to attribute members and develop the PCPlus roster file.
5. P – The bidder discussed in detail their methods for preparing the AC Total Cost of Care (TCOC) reports. The bidder discussed how they handle the reporting for the one AC that has chosen to be accountable for optional services.
6. The bidder met the requirements.
7. The bidder met the requirements.
8. The bidder met the requirements.
9. P – The bidder discussed how policy changes are reviewed with the Department and provided their criteria for determining if a policy change should results in an adjustment to the TCOC calculation.
10. The bidder met the requirements.
11. The bidder met the requirements.

D. Fiscal Management Analytics (FMA)

1. The bidder met the requirements.
1. The bidder discussed their approach to this requirement, including methods for associating payments with individuals, population groups, and/or service categories.
2. The bidder agreed to discuss reporting structure in a kick-off meeting, and also recommended some population categories for reporting.
4. The bidder met the requirements.
5. The bidder met the requirements.
6. The bidder met the requirements.

Alignment Across Topics

- The bidder discussed some important considerations for developing a mapping of FMA enrollment/population groups to NET, AC, PCPlus, and Health Home population groups.

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- P – The bidder identified some benefits and synergies that can be created between FMA, AC, and NET, including improved policy impact assessment and streamlined processes.

E. Upper Payment Limit (UPL)

1. The bidder met the requirements.
2. The bidder met the requirements.

F. Requirements Related to Receiving Confidential Data

1. The bidder met the requirements.
2. The bidder met the requirements.
3. The bidder met the requirements.
4. The bidder met the requirements.
5. The bidder met the requirements.
6. The bidder met the requirements.

G. Project Management

1. The bidder described a detailed plan for project management, including periodic meetings, an ongoing project work plan, and decision and data trackers.
2. The bidder described an arrangement where a senior project manager will oversee all work streams. For the UPL work stream, collaboration with the subcontractor will be managed by a UPL project lead.
3. The bidder did not specifically address this requirement.

H. Ad Hoc Work

1. The bidder met the requirements.
2. The bidder met the requirements.

I. Reports

1. The bidder described an approach using data management files, detailed record keeping, and ad hoc file tracking to meet this requirement.
2. The bidder described an approach relying on the project plan and management tools, routine communications, and staggering draft deliverables.

2. Staffing

a. The bidder met the requirements.
b. The subcontractor is integrated into the project team. The bidder maintains primary responsibility for the work delivered by the subcontractor.
c. The bidder met the requirements.

3. Implementation - Work Plan

a. P – The bidder provided a detailed work plan in the form of a Gantt chart.

Part IV, Section IV. Cost Proposal

- Bidder changed the number of deliverables for C. viii – x from 3 to 8.

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DATE: 6/27/2025 (Eligibility), 7/17/2025, 8/1/2025, & 8/3/2025 (Remaining review)
EVALUATOR NAME: Charyl Malik
EVALUATOR DEPARTMENT: DHHS/OMS
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Met requirements • 1. – P – The project has been providing continuous NET rate certifications for over 10 years. The most recent example of work within the project was defined with specific key steps used in the development. Bidder expanded their description to include several other projects they are working on in conjunction with the noted project. • 1. - P - Bidder also provided information regarding two other projects with states other than that noted in the project reflected in Appendix C for NET rate certification, ending in 2023. • 2. – P – The project has been providing continuous UPL demonstrations since 2009. The project description was clearly defined, including specific tasks • 2. – P - Bidder also provided information regarding three other projects with states other than that noted in the project reflected in Appendix C for UPL demonstrations. • 2. – I – Bidder noted the generation of nearly $2 billion in new federal Medicaid funds annually.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• I – in 1985, bidder became the first fully dedicated Medicaid actuarial consulting practice in the nation. • Client base includes active contracts with Medicaid and other health and human services programs in 30 states and US territories. • Provides organization visuals displaying successes/ accomplishments. • Has a history of collaborative projects with Maine. • Notes several potential benefits to expanding a Mercer-Maine Partnership.
2. Subcontractors
• Bidder has provided information regarding its subcontractor/consultant for UPL work, including valuation, compliance, and Medicaid rate-setting methodologies. The subcontractor/consultant has assisted states and provider associations with CMS-compliant UPL program design and implementation.
3. Project Team Organizational Chart
• Meets requirements.

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4. Litigation
• Bidder noted no legal proceedings filed against regarding their Government Human Services Consulting business.
5. Financial Viability
• Bidder provided the most recent five years of revenue history, with attached annual report and attached the most recent three years of Financial Statements audited or reviewed by a Certified Public Accountant.
6. Certificate of Insurance
• Bidder provided a current Certificate of Liability, as well as a current Certificate of Insurance.
Additional requirements from Appendix D.
• Client base includes active contracts with Medicaid and other health and human services programs in 30 states and US territories. • Provides organization visuals displaying successes/ accomplishments. • Has a history of collaborative projects with Maine. • Notes several potential benefits to expanding a Mercer-Maine Partnership.
• Have experience in creating and implanting standardized tools and reports to help project and monitor trends in utilization, enrollment, and costs across service categories and population groups, in more than 20 states. • Has partnered with Maine and two other states regarding fiscal management and analytics.
• The project noted has been providing continuous NET rate certifications for over 10 years. The most recent example of work within the project was defined with specific key steps used in the development. Bidder expanded their description to include several other projects they are working on in conjunction with the noted project. • Bidder also provided information regarding two other projects with states other than that noted in the project reflected in Appendix C for NET rate certification, ending in 2023.
• Bidder has worked with three other states for payment reform efforts, as described in their proposal – Person-Centered Medical Home Plus, Primary care Reform Collaborative, and Primary Care Sub-capitation Initiative.
• The project noted has been providing continuous UPL demonstrations since 2009. • Bidder also provided information regarding three other projects with states other than that noted in the project reflected in Appendix C for UPL demonstrations.

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- I – Bidder noted the generation of nearly $2 billion in new federal Medicaid funds annually.

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. Meets requirement. Bidder proposes team of 3 qualified actuaries for development and certification of NET services reimbursement. Bidder follows with description of each actuary's experience, with the minimum experience being over 10 years. 2. Bidder has plan for creation of project plan / structure, communication plan, meeting timelines, review structure, and support tools. Supported by and aligned with work plan. Use of tools such as agendas informing immediate, near-term and longer-term topics, as well as data/decision trackers, documentation of key considerations for decision topics and tracking of interim decisions and relevant discussions, and is open to working closely with the Department to finetune tools to meet the needs of the projects and deliverables. Has a plan to lead discussions about the financial status of Maine NET program, as required. Describes methods of preparation for rating approach development, including examples of items to potentially address, but refers to section 4 for the rating approach description. 3. Bidder stresses their experience with Maine and other state Medicaid data collection, processing, and validation. They are committed to collaboration with the Department to discuss and assess changes to the encounter data since the previous rate calculations as well as advising the Department on rate development implications of the modifications. They described their process to obtain data from the Department and NET brokers, identify necessary fields and elements for the NET project, meet with the Department and NET brokers to discuss the work and address questions, and gather and receive data for the project securely through MoveIT. Validation steps will also be provided for intake and loading of data. As required, bidder will develop methodologies, provide documentation and crosswalks, complete encounter data comparison to specifications, resolve missing data and facilitate discussions, prepare data for use in actuarial analysis and provide the Department with options and recommendations related to the

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data sources for capitation rate development. They verify that the required cohorts will be included. 4. Added figures in this section were helpful as summaries for the actuarial rate-setting and peer review processes. Bidder detailed processes for capitation development, capitation rate certification, engagement with CMS, and stakeholder engagement, to include enhanced communication strategies.
B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables
1. Bidder states familiarity with receipt and management of MaineCare data files used for this work, as well as secure file transfer systems, and provided specific details regarding these files. They are also familiar with the specific data elements contained in the files. Has existing infrastructure to support Medicaid data, has more than 75 data analytics analysts and consultants who intake and analyze data for over 25 Medicaid programs, and has an existing HIPAA-compliant linkage and file intake process. Plans to provide interim Data Management deliverables of Data Management and Documentation Plan, Received Data Summary, and Data Management Confirmation. States they will implement a series of validation checks as part of their ongoing data management and quality assurance. 2. Bidder detailed their key-step approach to ensure the data is ready for analysis. Included clear description of their steps to conduct data validation and financial tie out, assign ACO Service Categories, identify final paid amounts, assign final Recipient Aid Category to each member, assign an AC population group for each member, identify AC eligible claims for fully eligible MaineCare members, and categorize AC services into Core, Optional, and Excluded
C. AC and PCPlus Data Analysis
1. Bidder described their familiarity with the AC and PCPlus data and its analysis and would use its existing team to maintain continuity and consistency. Team consists of multiple AC/PCPlus subject matter experts with access to resources regarding federal policy and national trends, including other state Medicaid programs. Two certified actuaries are part of the noted team for this work and have access to 75 credentialed health care actuaries, if needed.

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2. Bidder provided details for the receipt, secure data transfer, documentation, organization, and storage of required AC and PCPlus files provided by the Department. Specifics display their familiarity with the data.
3. The figure contained in this section is helpful in visualizing the attribution methodology. The detailed steps of determination of eligible members, creation of the required roster versions, and production of the member comparison between rosters displayed their familiarity with the AC/PCPlus data.
4. Bidder provided detailed information regarding their determination of members eligible for PCPlus and attributable, as well as the process necessary to attribute the members to enrolled PCPlus locations and compare them to the previous attribution.
5. Inclusion of the figures of the methodology for the benchmark trend development, calculation of the benchmark TCOC PMPM, completion factors and claims cap factor, calculation of savings/loss were helpful as summaries of the processes.
   Clear descriptions of the TCOC and Savings/Loss Calculation Methodology, including the required steps of development of the annualized non-AC comparison group trends, establishing of the benchmark TCOC PMPM, actual TCOC PMPM (for base year and performance year), calculation of savings/loss, and production of required reports at the AC-level and provider-level.
   Bidder notes their familiarity with a recent change to the AC comparison group composition.
6. Bidder provides details regarding the required deliverables for AC TCOC summary analysis presentations.
   Adds that they can make recommendations based on TCOC report findings for additional ad hoc analyses regarding specific areas of performance.
   Commits to open lines of communication with the Department to meet the Department's needs and expectations.
7. Bidder verifies familiarity with producing the required files contained in the AC data extracts package.
8. Bidder describes their completion factors development process.
   To note, the bidder uses their proprietary Incurred But Not Reported (IBNR) model to analyze historical expenditure data.
9. Bidder clearly describes processes to coordinate with the Department and methodology to determine necessary AC policy change adjustments.

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10. Bidder expresses their expertise in alternate payment models and dedication to assisting the Department in improvement and effectiveness of the AC/PCPlus methodologies.
11. Submission meets requirements.

D. Fiscal Management Analytics (FMA)

1. Bidder expresses familiarity with quarterly FMA projections reporting. They propose expanding the analytic modeling to establish more detailed projections. Provided an overview of reporting and projection deliverables with required components.
2. Bidder describes their approach to identify and analyze non-claims-based expenditures including those required. The process will include a comprehensive data request, integration into historical reporting and projections, and quarterly updates.
3. Bidder provides information related to several existing familiar enrollment/population categories, while discussing the consideration of expansion to potential new population categories.
There is agreement to the crosswalk to AC an NET population categories, with the future alignment with AC.
4. Bidder agrees to the development of service categories appropriate for projections, including those provided by the Department related to the MaineCare Benefits manual. They will work with the Department to determine optimal categorization considering alignment with population categories, funding accounts, credibility of reporting and projections, and alignment with other programs.
5. Bidder's proposal is in alignment with these requirements.
6. Bidder is in agreement with the required projections presentation Excel format. Sample of dashboards was added to this section, displaying a helpful visual of potential future reports.
Explains capability of building interactive data visualization tools / dashboards. They have developed such dashboards using analytics data software.
Commits to working with the Department to evaluate the structure of the reporting templates to support needs.

Alignment Across Topics

- Bidder described their approaches on FMA enrollment/population groups and mapping the population groups to NET, AC, PCPlus and HH, while noting their familiarity with this work at MaineCare. They also described their vision of synergies between FMA, AC, and NET analyses and reporting including

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INDIVIDUAL EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: Mercer Health & Benefits LLC
DATE: 6/27/2025 (Eligibility), 7/17/2025, 8/1/2025, & 8/3/2025 (Remaining review)
EVALUATOR NAME: Charyl Malik
EVALUATOR DEPARTMENT: DHHS/OMS
****

integrated data analysis, enhanced reporting, improved policy impact assessment, streamlined processes, and project management.

E. Upper Payment Limit (UPL)

1. Bidder described how they would meet the specific requirements by obtaining data to support UPL analyses, identifying and outlining the UPL methodologies and reviewing with the Department including best practices and potential new financing mechanisms, and completing the UPL calculations using approved methodologies.
2. Bidder described the role of the subcontractor as providing ongoing support related to UPL demonstrations. They described how they would meet each requirement of this UPL demonstration related services area.

F. Requirements Related to Receiving Confidential Data

1. Bidder verifies current coverage.
2. Bidder meets requirements.
3. Bidder confirms compliance.
4. Bidder confirms compliance.
5. Bidder confirms compliance.
6. Bidder simply stated “Acknowledged”, rather than noting the statement they are acknowledging.

G. Project Management

1. Bidder described its methods for project structure and planning through agenda and status updates, action items and follow-ups, their project work plan, and data and decision documentation. They proceeded to provide additional details related to agenda topics, status checks, documentation of key decisions, the use of trackers as part of their communication strategy, budget summary documentation, and the development of a portfolio dashboard document. Supported by work plan.
2. Bidder described their structured approach for oversight and consistency between work streams. Supported by work plan.
3. Bidder did not specifically address the minimum of 12 collaborative AC-work meetings per year in this section, but they were reflected in the work plan.

H. Ad Hoc Work

1. Bidder described how they would process ad hoc data analyses and/or modification of report formats by providing defined process steps of preparing the budget estimate, then moving forward with the formal approval process, timeline development, integration into ad-hoc budget summary, and proactive suggestions.

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

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2. Bidder described how they would process ad-hoc work of forecasting revenues from the Medicaid Drug Rebate Program by comprehensive analysis, budget estimate development, collaboration with the Department, adaptability to changes, and documentation and approval. They also noted that their familiarity with Maine's data and programs, along with their positive history of analytics deliverables, leads them to provide valuable one-time analyses.

I. Reports

1. Bidder described how they will track and record required reports by categorizing processes as data management files, detailed recordkeeping, ad hoc file tracking, ad hoc file tracking, internal accessibility, continuous updates, and data and decision trackers.
2. Bidder described how they will track and record required reports by categorizing processes as project plan and feedback, routine communications, staggering deliverables, secure channels for PHI, deliverable format discussion, and use of templates. They also noted key benefits of their report submission process of security and compliance, tailored deliverable formats, template utilization, and structured feedback mechanism.

2. Staffing

a. Meets requirement. Clear position titles, job descriptions and minimum qualifications.
b. Bidder will be using subcontracts and note how subcontractors would be integrated into the team/work, as well as their management, oversight, and quality assurance.
c. Bidder meets requirements by providing the staffing plan as requested, also including qualifications and background for each staff member. Time allocation was broken down for each of the two first program years.

3. Implementation - Work Plan

a. Meets requirement.

Task/Activities are labeled with RFP section references and specific lead name is noted for each Task/Activity. Work plan includes very detailed broken-down steps for each Task/Activity and Deliverable, though this level of detail does create a very lengthy work plan. Work plan is set up for Year 1, Year 2, and into the Renewal period.

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INDIVIDUAL EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: Mercer Health & Benefits LLC
DATE: 06/27/25
EVALUATOR NAME: Lauren Metayer
EVALUATOR DEPARTMENT: DHHS OMS
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Meets eligibility requirements • Q- would collaborate with sellers Dorsey on UPL

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• Mercer provides consulting and actuarial services to several states across the US • Has a large team of over 500 professionals nationwide • Mercer has a working relationship with the state of Maine and MaineCare currently including work on the AC program, fiscal management analytics support, and actuarial consulting. • Mercer provided the required examples of working with other states including Pennsylvania, Delaware, Maine, and Oklahoma among others • Good experience working with Mercer currently
2. Subcontractors
• Mercer intends to use Sellers Dorsey as a subcontractor for the UPL work • Sellers Dorsey has experience in assisting clients with Medicaid managed care directed payments and FFS UPL programs. • Does not appear to use a subcontractor for other areas of the RFP
3. Project Team Organizational Chart
• Provided a project team organizational chart
4. Litigation
• Stated there have been no legal proceedings filed against Mercer regarding their government human services consulting business • Q: Made the above statement, but then said any litigation they are involved in will not be material? • Disclosed legal proceedings pertaining to Mercer and its affiliates at a link
5. Financial Viability
• Provided audited report and company is financially viable, provided 2024, 2023, and 2022 reports.
6. Certificate of Insurance

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• Mercer is covered under a comprehensive insurance program under its parent company March & McLennan Companies. • Provided certificate of liability insurance in effect through 9/30/2025
Additional requirements from Appendix D.
• Mercer became a dedicated Medicaid actuarial consulting practice in 1985, and in 1992 became officially designated as a Government Human Services Consulting group. • Mercer offers broad experience working with several states, including Maine. Also includes a special workgroup that is focused on assessing the impact of federal policy changes on Medicaid. • Began working with Maine in 2018 on the AC program and their work has expanded to also include PCPlus, fiscal management support, CCBHC, and PCPlus Phase II. • Client base includes active contracts with 30 different states and US territories
• Mercer currently works with MaineCare to provide some limited fiscal management support and actuarial consulting. This work is much more limited in scope than the RFP requires but the work has been good to excellent. • Provides FMA to clients in more than 20 states that includes utilization tracking, enrollment projections, cost projections, and cost analysis reports. • State examples Mercer works with not including Maine are Delaware, and Pennsylvania. With both states they developed tools to track utilization, enrolment, and cost trends.
• Mercer has supported three states with standalone NET programs and eight states with transportation services included within their managed care programs • States include Oklahoma, Missouri, and Virginia, among others
• In addition to working with Maine, Mercer works with Connecticut on the design and implementation of the PCMH+ initiative, as well as Delaware on a Primary Care Reform Collaborative.
• Mercer will subcontract with Sellers Dorsey on UPL but Mercer will have a project lead to oversee the work. • Sellers Dorsey provided UPL services to Virginia in 2018-2019 to improve the UPL calculations related to managed care directed payments • Sellers Dorsey developed and implemented a SNF UPL program for Bergen New Bridge Medical Center, working with the state of New Jersey. • Sellers Dorsey worked with Georgia on the FFS Physician UPL Program

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Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1.Proposing a team of three actuaries who have the highest professional FSA designation. Meets requirement 2. Will employ project management techniques and tools to create a project structure, already works with Maine on other projects and have customized their project management tools to match department preferences and processes. Provided draft documents and questions it will work on with the department to ensure the departments needs are met. 3. Provided thorough process for each step in this request, shows expertise in their responses of defining the service type, identifying the waiver eligible participants, and categorizing the NET rides. Also showed expertise in data validating and discussing the data with brokers as well as the department to make necessary adjustments. 4. Demonstrated an understanding of federal requirements surrounding this program and pointed out there may be other ways/authorities to deliver the service than Maine is currently providing. Provided an overview for how they would develop capitated rates, including adjustments to the date and stated their ability to review Maine's data with insights gained from their experience in other states. Stated that they will deliver rates as requested in two separate reports. Demonstrated an understanding of the rate certification process, experience with CMS approval process. Mercer has a strong relationship with CMS and is willing to engage with CMS in this process. Cited 42 CFR 438.4, demonstrating their understanding of the Rate Certification process. Met qualifications.
B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables
1. Mercer is able to receive and manage data files sent to them. They have the current infrastructure in place through working with Maine and other states to do this. Has a HIPAA-compliant linkage and file intake process. Able to receive claims, non-claims, and other non-claims items. 2. Has a structured approach to prepare and validate data, detailed a 7 step process that it would use which follows the requirements of the RFP request. Meets requirements.
C. AC and PCPlus Data Analysis

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1. Mercer has several subject matter experts and actuaries to perform the analysis and reporting. Have access to the resources and expertise of more than 500 of Mercer's Government colleagues. Have experience with the Maine AC and PC Plus programs as well as other state Medicaid programs and national trends.
2. Has an implemented program established to meet the requirements of this section, developed the approach to ensure data is accurate and ready for analysis. Would be able to provide the requested files, maintains open lines of communication with the department to collaborate on additional files, has an adaptable system to incorporate new file types.
3. Uses an algorithm to attribute members to the AC program, demonstrated an understanding of the process and expertise. Explained how it would deal with interplay of PCPlus. Discussed what it will include on its roster reports which met the requirements of the RFP.
4. Would rely on an already established process for determining a members eligibility for PCPlus. Detailed a 5 step process to identify PCPlus attribution, in alignment with appendix K. Would create the quarterly rosters on the required timelines.
5. States that they will provide four TCOC reports each year, an annual reconciliation report, and annual projection report, and two biannual interim reports. Will be provided in excel and in the required templates. Stated how they would calculated TCOC and demonstrated an understanding of Maine's current methodologies, a willingness to collaborate with the Department.
6. Will provide the required reports, has experience completing this report for Maine currently. Aims to deliver relevant insights along with the reports, which would help to pass the information on to decision makers. Made suggestions for best ways to provide reports to ACs, including multiple formats and methods of communication.
7. Met requirements and would create extracts as requested.
8. Would apply completion factors as requested. Demonstrates understanding of importance of completion factors, relies on proprietary IBNR model that analyzes historical data. States that they use actuarial judgement to reflect other adjustments.
9. Would make the required policy adjustments, demonstrated an understanding of how other programs run by the department may have an impact on the TCOC data and the trends seen in the data.
10. Met requirements, has expertise in this program and has several subject matter experts with extensive knowledge of the program to help monitor the

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program, investigate issues, and make recommendations for corrections. Has experience working with implementing other APMs, AC frameworks, with more than 10 states in the last 5 years.
11. Stated that they would update documentation of methodologies used, documentation they detailed including matches requirements of the RFP.
D. Fiscal Management Analytics (FMA)
1. Demonstrated the ability to produce the required reports in this section during the timelines required. Provided some backup to how they would produce each report, including potential date sources used. They also described a trend development process which relies on qualitative and quantitative data, reflecting their expertise with projections and ability to provide analysis to the department above what we can currently do. 2. Will collaborate with the department at a kick-off meeting to develop non-claims items. Mercer detailed the items they expect will be identified (based on the RFP) and demonstrated their current expertise in several of these payments (for example calling out the $30M supplemental payment to NFs). Will integrate these items into their overall fiscal management tool and provide quarterly updates. 3. Stated their current work with the department on population groups, suggested adding a few other groups include the CHIP population, dual eligibles, and the LTC population. These are good suggestions, especially in the context of financial management. Stated their ability to crosswalk these categories to the AC and NET categories as requested.
4. Agreed to develop service categories which tie to section of policy in coordination with the department (as required in the RFP). Mercer also suggested working with the department to ensure alignment with population categories and funding accounts. They also suggested grouping some categories together which will likely be necessary, further indicating their expertise in this area.
5. Mercer indicated that it would be able to provide projections by PMPM and enrollment as well as PMPM broken down by price and utilization components. It will do this on a paid and an incurred basis.
6. Proposed several dashboard summaries to provide the data as well as other visualizations. Stated that excel will be the primary tool for data reporting which is good since most people use excel. Has interactive dashboards available which may or may not be necessary.
Alignment Across Topics

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

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- Detailed how It will create the FMA groups that map to NET, AC, PCPlus and Health Home population groups. Indicated that it would like to create crosswalks where possible between the groups and data. Indicated an understanding of where these programs overlap and where efficiencies are possible.

E. Upper Payment Limit (UPL)

1. Indicated that UPL demonstrations must be in compliance with 42 CFR 431.16, demonstrating their familiarity and expertise. Will work with Sellers Dorsey to lead the UPL work. There are also subject matter experts at Mercer who have worked on UPLs for other states that would be working with Sellers Dorsey. Mercer plans to have Sellers Dorsey lead UPL activities and Mercer will manage and oversee the calculation of the UPL demonstration and other UPL-related services (not sure exactly what this means).
2. Sellers Dosey and Mercer work together on UPLs for several other states, has a well established process. Are able to monitor issues from CMS and Medicare Reimbursement Policies. Also indicated that it can collect the additional data as required in the RFP, will review calculation options and collaborate on this with the department where appropriate. Will prepare materials for submission to CMS and assist with any issues with CMS.

F. Requirements Related to Receiving Confidential Data

1. Has a comprehensive insurance program under its parent company which meet or exceed the requirements outlined in the RFP
2. Meets requirments
3. Stated that they will confirm compliance each July
4. Stated that they will comply with all state and federal laws
5. Will comply with all confidentiality requirements
6. Agrees with this requirment

G. Project Management

1. Will plan to have weekly meetings, and will provide agendas, status updates, action items and follow ups, work plans, documentation of decisions. Listed several other document tools it uses to assist in this process including a summary budget document tool for budget management. Details of this section demonstrate an ability and expertise to go beyond requirements of RFP.
2. Mercer has a process in place which includes a project manager overseeing all work streams to ensure consistency across all projects.
3. Didn't specially state 12 meetings per year but the meetings detailed likely would amount to more than this, meeting or exceeding requirement.

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H. Ad Hoc Work
1. Process to provide ad-hoc work was described clearly. Specified that they will provide budget estimates for the work requested (but shouldn't ad hoc work already be "paid for" as part of this RFP?) 2. Stated hey are comfortable forecasting revenues and have expertise for other one time analyses as needs arise.
I. Reports
1. Detailed a comprehensive process for completing the reports listed in Table 5. 2. Detailed a plan to complete Table 6, which also included staggering deliverables to account for sufficient time for department to review, this is helpful as the staff for these programs overlaps.
2. Staffing
a. Referred to attachment 7, which included the required relevant information. b. Has a history of integrating subcontractors into project team, able to collaborate effectively. Monitors subcontractors work for quality and only selects subcontractors it has a longstanding relationship with. c. Provided this information in attachment 8 as required. Some individuals with more expertise to spend less time on the project in year 1 than in year 2. Proposed staff have broad expertise and experience.
3. Implementation - Work Plan
a. Work plan was realistic, begins October 2025 and covers two years. Detailed list of tasks, but does not include what it will delegate to sellers Dorsey in the work plan.

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RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: Mercer Health & Benefits LLC
DATE: 8/04/2025
EVALUATOR NAME: Jordan Rhodes
EVALUATOR DEPARTMENT: DHHS Commissioner's Office
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• P – meets eligibility requirements.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• P – highlights experience and knowledge from prior work with the state of Maine. • I – notes challenges associated with a large rural population. • I – 3rd project listed corresponds to subcontractor.
2. Subcontractors
• Yes, they plan to work with Sellers Dorsey.
3. Project Team Organizational Chart
• Provided.
4. Litigation
• None filed against Mercer regarding Government Human Services Consulting business.
5. Financial Viability
• N – No information on expenses or balance sheet provided.
6. Certificate of Insurance
• Provided.
Additional requirements from Appendix D.
• P – experience working with the state of Maine in various capacities related to the MaineCare program.
• Q – notes experience aiding the state in projecting budget estimates for MaineCare. Curious as to what work this refers to?
• P – conducted detailed trend analysis for Virginia, which included analysis of external factors, such as trends in gasoline prices.
• P – experience conducting VBP and APM work in FFS environment.
• Q – does Mercer have prior experience working with Sellers Dorsey?

Part IV, Section III. Proposed Services
Part II

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DATE: 8/04/2025
EVALUATOR NAME: Jordan Rhodes
EVALUATOR DEPARTMENT: DHHS Commissioner's Office
****

A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement

1. P – plans to employ 3, all with extensive experience.
2. P – emphasizes both meeting project needs and staying within budget.
3. P – outlines extensive approach to data security.
4. P – notes the potential for small size rate cells and stability issues, and plan to offer solutions.
5. P – will take extensive steps to validate encounter and financial data.
4. P – plans to adapt trend methodology to account for patterns unique to Maine, such as seasonality and geography.

B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables

1. P – prior experience working with the state of Maine and receiving sensitive health data files.
2. P – robust data validation techniques, involving examination of frequency reporting, missing values, and distribution analysis.

C. AC and PCPlus Data Analysis

1. P – proposes to use existing team to maintain continuity.
2. P – has already established processes for the requirements.
3. P – presents significant understanding of AC attribution methodology and logic.
4. P – has established a methodology and processes for PCPlus attribution and generating corresponding reports.
5. P – prior experience and familiarity with the TCOC reports and templates.
6. Q – notes that they "may delve" into the underlying cause of performance trends to better understand factors. What would warrant a more thorough analysis of these trends?
7. Satisfies requirement.
8. Q – rely on actuarial judgement to assess whether observed changed reflect actual change or statistical noise. Isn't the IBNR methodology designed to prevent statistical fluctuation that impacts projected claims run out?
9. P – has developed an empirical data-driven approach to employing policy adjustment factors.
10. P – offers examples of prior recommendations for methodological and operational changes.
11. Current approach satisfies requirement.

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D. Fiscal Management Analytics (FMA)
1.P – demonstrates expertise and understanding of factors that could both impact and influence MaineCare enrollment trends, including Census and Maine State Economist demographic data, poverty and unemployment rates, and Maine government-issues reports. P – proposed data sources and analyses indicate flexibility and adaptability in developing enrollment projections that are tailored to Maine. 2. P – demonstrates substantial understanding of processes and approaches to identifying non-claims-based payment categories and integrating these costs into future expenditures projections. 3. P – proposes a structured approach to refining enrollment categories, including new 3 new population categories. Demonstrates openness to adaptability in projecting enrollment, deep understanding of MaineCare population, and creativity in generating projections that will assist the Department. 4.P – proposes aggregating smaller service categories to improve statistical reliability of projections. 5. Satisfies requirement. 6.P – offers to design deliverables to cater to stakeholder needs, in addition to the required departmental documents and format.
<u>Alignment Across Topics</u>
• P – highlights synergies and efficiencies among the various reporting work, including integrated data analysis and improved policy impact assessment.
E. Upper Payment Limit (UPL)
1. P – will work with the Department to provide potential new financing mechanisms based on UPL room and Departmental needs. 2. Q – in what capacity will Mercer support the Sellers Dorsey team in conducting UPL demonstration efforts? 3. Q – have Mercer and Sellers Dorsey worked together in the past in assisting other states? (Notes work "alongside several states…").
F. Requirements Related to Receiving Confidential Data
1. Satisfies requirement. 2. Satisfies requirement. 3. Satisfies requirement. 4. Satisfies requirement. 5. Satisfies requirement. 6. Satisfies requirement.

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****

G. Project Management
1. P – Emphasizes continuous engagement with the Department to stay current on project plans. 2. P – single project manager will oversee all work streams, ensuring coordinating across the AC and FMA project work. 3. P – proposes weekly meetings to coordinate AC and FMA work and is willing to be on-site at least once per year.
H. Ad Hoc Work
1. P – outlines structured approach. 2. P – familiarity with MaineCare data will facilitate ad hoc analyses efficiently.
I. Reports
1. P – outlines comprehensive data management and recordkeeping processes. 2. P – outlines
1. **Staffing**
a. P – Staff data analytic staff have extensive experience with statistical programming software used by the Department (SAS and SQL). b. P – maintains responsibility for all work conducted by subcontractor. c. P – projects leads have extensive experience.
2. **Implementation - Work Plan**
a. Provided, meets requirements.

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RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: Milliman Inc
DATE: 6/25/25 (Eligibility Review): 7/15/2025 (Overview of Organization): 7/15/25-7/21/25, (Scope of Services)
EVALUATOR NAME: Roger Bondeson
EVALUATOR DEPARTMENT: Department of Health and Human Services
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Milliman provided examples of two NET rate certifications for the Kentucky NEMT Program and conducted at least two Upper Payment Limit demonstrations for the Washington State Health Care Authority. Milliman meets eligibility requirements.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• Milliman has provided NET rate certification and UPL demonstrations in 7 states. • Provides actuarial services in 19 states. • Founded in 1947. • 1,300 credentialed actuaries, 140 of which are Medicaid focused. • Key actuary staff for NET rate setting, FMA, AC and PCPlus are members of the Fellows of the Society of Actuaries. • Health Information Trust Alliance (HITRUST) and Service Organization Controls (SOC) 2 certified.
2. Subcontractors
• Milliman proposes no subcontractors.
3. Project Team Organizational Chart
• One was provided – meets requirements
4. Litigation
• One pending court case was described – meets requirements – no concerns
5. Financial Viability
• Defer to scoring team financial expert
6. Certificate of Insurance
• Insurance certificates were provided – meets requirements.
Additional requirements from Appendix D.
• See above notes.
• Three decades of experience in using MMIS eligibility, fee for service claims, and encounter claims to develop reliable fiscal management intelligence for state Medicaid agencies.

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EVALUATOR NAME: Roger Bondeson
EVALUATOR DEPARTMENT: Department of Health and Human Services
****

• FMA services range from financial forecasting and monitoring to supporting states in evaluating program impacts.
• Standard tools and reporting approach include:
  ➢ Preparation of historical data including rigorous data validation and quality checks.
  ➢ Summarization and stratification by service category and/or population
  ➢ Develop reports using automated processes
  ➢ Proposes to illustrate data in table and graphical format
  ➢ Pharmacy module provides detail by brand, generic, and specialty status, patent expirations, and pipeline therapies.
• Milliman provides annual and mid-year budget forecasting services for South Carolina Health and Human Services.
• Provided 12 years of expenditure projections for Mississippi Division of Medicaid.

• Experienced in setting NET rates for standalone programs and those integrated into Managed Care Organizations. • Provides rate setting for 7 stand-alone programs, Florida, Idaho, Ohio, Indianna, Kentucky, Arizona, and Hawaii.

• Supported 12 states with alternative payment methodologies.
• Supported the design, implementation, management, and improvement of Rhode Island's Accountable Entities program.
  ➢ Redesigned the total cost of care (TCOC) target-setting methodology to ensure alignment between the MCO capitation rate setting and the shared savings calculations.
• Designed and implemented the Ohio Comprehensive Primary Care program.
  ➢ Provides dashboard reports
  ➢ Provided TCOC adjustment factors for each provider
  ➢ Validated shared savings calculations
• Provided analytical and strategic support for Idaho's Healthy Value Connections Program.

• Assists several states with UPL demonstrations for CMS approval. • Provided examples of UPL work for four states, Florida, Nebraska, Washington, and Wisconsin.
Part IV, Section III. Proposed Services
Part II

STATE OF MAINE
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EVALUATOR NAME: Roger Bondeson
EVALUATOR DEPARTMENT: Department of Health and Human Services
****

A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. • Milliman proposes to utilize a Fellow of the Society of Actuaries person with 5 years of NET rate setting experience as the lead for Maine. • Both assigned actuaries meet the qualifications of the American Academy of Actuaries and adhere to the standards of the Actuarial Standards Board. (P)
2. • Proposes a 3 core phase approach to project management (see Section G, page 84): ➢ Initiation and Planning ➢ Work Phase ➢ Projection Completion Phase • 2ai -2aii: Proposes a kickoff meeting to identify project goals, key stakeholders, deliverables, and any additional information. • Proposes to develop a project management plan including scheduling regular status updates. • 2aiii: Proposes utilization of the DRIVE (Dashboard for Research, Insight, and Validation of Experience) to assess and view program's financial performance. • 2aiv: Proposed rating approach includes the creation of a rate methodology letter early in the project that will provide details on the following: ➢ Population and Cohorts ➢ Covered services ➢ Regional rate structure ✓ Proposes grouping urban areas together
3. Data Collection 3a-3b • Proposes access to all available and necessary historical data, information, and documentation. • Proposes to review encounter data using the data dictionary provided by the Department. 3c. Gathering NET Data • Proposes use of a secure file transfer protocol to receive encounter, caseload, and financial data.

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

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BIDDER NAME: Milliman Inc
DATE: 6/25/25 (Eligibility Review): 7/15/2025 (Overview of Organization): 7/15/25-7/21/25, (Scope of Services)
EVALUATOR NAME: Roger Bondeson
EVALUATOR DEPARTMENT: Department of Health and Human Services
****

- Proposes to gather data from January 1, 2024, through the current period and to gather the prior three years of data to provide better support for trend and credibility analysis.
- Proposes to engage in initial data validation to ensure received record counts match figures provided by the Department.
- Proposes to use the same data engineers for NET, FMA, AC and PCPlus to create efficiencies in the data collection process.
- Proposes to identify contract terms that may drive broker expenses to ensure rates reflect true cost of program administration.
- Milliman proposes using a standard data collection template and an annual survey to collect all NET relevant expenses, including IBNR costs.

3d. Methodologies, Population, Region, and Service Type

- Milliman proposes to summarize historical NET experience by population, region, service type, and waiver eligibility within actuarial cost models.
- Milliman proposes to create distributions to observe who did not utilize NET services vs. members who do utilize NET to assist in the identification of regions or populations that may be underserved or over-utilizing services. (P)

3diii-3dv Data Changes/Issues and Updating Crosswalks

- Proposes to conduct a comprehensive review via the kickoff meeting and subsequent regular meetings to confirm all relevant changes are understood and documented.

3e-3g Encounter Data

- Proposes quality control checks when assessing encounter data such as:
  - Unit cost outliers
  - Utilization outliers
  - Duplicate claims or members
  - Consistency in reported experience
  - Consistency in unit definitions
  - Comparison of encounter data with financial data
  - Validation of caseload information with claims information
- Proposes and describes a 5 step process to monitor broker encounter and financial data.
  - Develop/update data template for NET brokers
  - Review and evaluate data templates
  - Develop detailed observations
  - Share DRIVE and observations with the Department

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- Receive and respond to broker feedback on observations

3h Data Credibility

- Milliman proposes and describes the creation of a base data book via a 4 step process:
  - Select
  - Summarize
  - Adjust
  - Report
- Response to this section is detailed and thorough.

4. Rate Development and Certification

4a.

- Milliman proposes a 7 step process for completing NET capitation rates
  - Claims completion
  - Program and policy adjustments
  - Non-State Plan Services (Note: Maine NET is not via a state plan but via a 1915(b) waiver – see definitions in RFP
  - Trend rate development
  - Quality and cost containment initiatives
  - Administration and other non-benefit costs
  - Other adjustments

4b. Rate Reports

- Asserts the company will adhere to ASOP 23 (data quality) and ASOP 41 (communications).
- Proposes a data book to show how rates were calculated with the following exhibits:
  - Base data
  - Adjustments
  - Trend
  - Non-benefit component
  - Rate change summary
  - Estimated fiscal impact

4c – 4d Discussions with CMS, Brokers, and the Department

- Proposes to participate in calls and meetings with CMS to provide further analysis, explanations, and recommendations as necessary.
- Proposes to engage brokers by:
  - Rate methodology presentation
  - Answering broker questions on the methodology presentation

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➢ Draft rate presentation ➢ Answering questions on the draft rate presentation
B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables
1. 1ai- Receipt of initial claims and eligibility data. • Milliman proposes to develop a combined data transfer process in compliance with MaineIT requirements across the NET, AC, PCPlus, FMA, and UPL workstreams to create efficiencies in the data collection process. • Proposes to schedule automated retrievals using Gainwell SFTP credentials with all data encrypted in transit. • 1b. Non-claims: Milliman proposes a secure retrieval of supplemental PMPM payment files via authenticated SFTP or application programming interface (API) processing each cycle's data in accordance with Maine IT data exchange policy. 1c Receipt of non-claims expenditures information. • Proposes to retrieve other non-claims expenditures e.g., Medicare premiums, NET contracts, shared savings, etc., in accordance with MaineIT SFTP guidelines.
2. Load, process, warehouse, and reconcile data. • Propose to utilize its flexible and automated data pipeline to load, process, warehouse, and validate the data. • Provided a detailed description of a 6 step process on how the company anticipates customizing the data management process for the Department. • Proposes to provide the Department access to data via an online portal.
C. AC and PCPlus Data Analysis
1. • Proposes that the project team will have SMEs who monitor Medicare and other State Medicaid programs to keep abreast of payment reform efforts. • Employs 80 Medicaid focused actuaries and policy, management, and pharmacy consults that can provide expertise when needed.
2. • Proposes use of a data template to increase efficiency and standardization of collecting AC and PCPlus information. • Provided lists of AC and PCPlus files it anticipates receiving from the Department demonstrating a good understanding of the work involved.

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3. • Proposes to work with the Department to develop easily understood data summaries.
4. Meets requirements.
5. • Proposes and provides a detailed description of a 3 step process to develop retrospective Non-AC comparison group trends to include: ➢ Cohort identification ➢ Claims identification ➢ Trend calculation • Proposes that each TCOC report receive a quality assurance check to include: ➢ Financial tie-outs to MaineCare financial reports ➢ Consistency checks ➢ Peer actuarial review of all calculations and adjustments ➢ Comparisons to prior reports to identify outliers and explanations of variances. ➢ Review of non-AC comparison group trends.
6. • Proposes use of a proprietary algorithm to identify claims that may be avoidable. • Asserts it found errors in another vendor's calculations that prevented a state from overpaying shared savings of over $100 million. • Proposes publishing a quarterly web based "RShiny" dashboard for the Department and AC organizations. • Proposes collaborating with the Department to identify areas of alignment across AC and PCPlus reporting to the FMA framework.
7. • Will incorporate AC data extracts into the same process to produce TCOC reports to avoid discrepancies.
8. • Milliman proposes to use its "Robust Time-Series Analysis System (RTS) to conduct incurred but not reported (IBNR) claims analysis. • Will use the Muskie crosswalk provided by the Department and will refine, if needed, these groupings so that completion patterns are consistent in each group.

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9.
- Provided a list of policy changes for which Milliman has experience in modeling demonstrating expertise in adjusting for policy changes (p.52).
    - Demonstrated expertise of how it will conduct adjustments and updates to provider reimbursement policies, population changes, and other program changes.

10.
- Proposes to develop an analytical approach to identify changes and their impacts and make recommendations for improvement to the Department.
- Proposes to share national best practices to identify changes that could improve the program.

11. Meets requirements.

D. Fiscal Management Analytics (FMA)

1.
- Proposes to provide several exhibits on a longitudinal basis for FMA updates on enrollment, utilization, and expenditures (page 58).
- Proposes a review of several broader historical and projected data sources to assist with trend analysis. (page 60).
- For enrollment, Milliman proposes to stratify data by population group and for utilization and reimbursement, it proposes to stratify data by service category or budget account.
- Demonstrated expertise by providing an example table that stratifies by service category and showing variances by dollar and by percent over previous quarter (page 61).

2.
- Milliman proposes to include receivables related to Medicaid expenditures, such as pharmacy rebates, TPL (outside of pay and chase), member cost share, estate recovery, and provider refunds and recoupments as offsets.

3.
- Proposes consideration of several factors in determining which enrollment and population categories to be used in FMA and recommends a smaller number of population rollups or major population groups.

4. Response is a repeat of section #3.
5. Meets requirements.

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6. Proposes to allow Department staff access to its internal dashboard at no additional cost.

Alignment Across Topics

- Proposes the possibility of mapping NET population cohorts to FMA population cohorts and provides an illustrative table to demonstrate this opportunity.
- Proposes further stratifying AC populations such as child population into CHIP and non-CHIP cohorts and non-ABD adults into expansion and non-expansion cohorts.

E. Upper Payment Limit (UPL)

1.
   - Demonstrated experience in calculating UPLs for fee for serve Medicaid programs in Florida, Nebraska, Washington, Wisconsin, and Wyoming.
   - Proposes and describes an 8 step process when calculating UPL demonstrations (page 73).
   - Demonstrates knowledge of different ways to calculate UPLs for inpatient and outpatient hospital services, nursing facility services, intermediate care facility services, clinics, and Psychiatric Residential Treatment Facility services.

2.
   - Milliman proposes to utilize internal software to do full Medicare repricing of Medicaid claims data.
   - Proposes to use the CMS Healthcare Cost Report Information System (HCRIS) to extract and review Medicare cost data for use in UPL calculations.

F. Requirements Related to Receiving Confidential Data

1. Attests to having insurance as required by MaineIT.
2. Will abide by MaineIT policy.
3. Will abide by MaineIT policy.
4. Will abide by MaineIT policy.
5. Will abide by MaineIT policy.
6. Asserts HITRUST CSF certification, SOC 2, Type II attestation, and use of FedRamp certified AWS and Azure clouds.

G. Project Management

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1.
- Proposes and describes 3 core phases to project management.
  - Initiation and planning phase
  - Work phase
  - Project completion phase.
- Proposes to use a decision tracker and a data tracker detailing all the information Milliman needs to complete a project and provided an example of a data tracker.

2. & 3. Meets requirements.

H. Ad Hoc Work

1.
- Proposes to use on staff subject matter experts in finance, policy, operations, clinical management, pharmacy, and data sciences to assist in ad hoc work requests when needed.

2.
- Demonstrates knowledge and experience in drug rebate forecasting.
- Acknowledges that Maine is one of 15 CMS funded states for the Transforming Maternal Health Model grant. Asserts it successfully assisted the state of Illinois with its application for this grant and the resulting programs.
- Provided and described examples of ad hoc work in Hawaii, Kentucky, and Indiana for VBP, Pharmacy, and financial consulting, respectively.

I. Reports

1.
- Proposes use of a data tracker for each file type and will maintain a file layout or file description.
- For each data file received, Milliman will perform an analysis to identify data issues and recommend mitigation steps.

2. Meets requirements.

2. Staffing

a. Project leads identified – meets requirements.
b. No subcontractors
c. Meets requirements

3. Implementation - Work Plan

a. Meets requirements.

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RFP TITLE: Assort. Actuarial Services and Fiscal Management Analytics & Reporting
BIDDER NAME: Milliman Inc
DATE: 6/27/2025 (eligibility), 7/15/2025 (Part IV), 8/18/2025 (Cost)
EVALUATOR NAME: Philip Dubois
EVALUATOR DEPARTMENT: DHHS, OMS
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Bidder meets the eligibility requirements and cited specific projects that satisfy these requirements.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• See Appendix D
2. Subcontractors
• The bidder does not intend to use subcontractors.
3. Project Team Organizational Chart
• The bidder provided the project team organizational chart.
4. Litigation
• The bidder disclosed current litigation.
5. Financial Viability
• The bidder provided three years of audited financial statements.
6. Certificate of Insurance
• The bidder provided certificates of insurance however the policies expired on 6/30/2025.
Additional requirements from Appendix D.
• P – Over the past five years, the bidder has conducted NET rate certifications in seven states and UPL demonstrations approved by CMS in seven states. • P – In the past year, the bidder has worked in over 30 state health and human services agencies to advance sustainable healthcare reform.
• P – The bidder has over three decades of experience using Medicaid Management Information System (MMIS) eligibility, fee-for-service claims, and encounter claims to develop fiscal management intelligence for state Medicaid agencies. • P – The bidder works with South Carolina Medicaid to develop annual and mid-year budget forecasts by analyzing program and policy impacts, utilization changes, and enrollment and PMPM trends. • P – The bidder has supported Mississippi Medicaid for 12 years – projecting Medicaid expenditures stratified into enrollment trends, utilization trends, unit cost trends, program change impacts, and other expenditure impacts.
• P – The bidder has conducted a rate certification for Kentucky's NET program each year since 2021.

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• The bidder cites experience in six other states setting standalone NET rates.
• The bidder supported the facilitation, design, implementation, management, and improvement of Rhode Island's Accountable Entities program. • The bidder supported the facilitation, design, and implementation of Ohio's Patient-Centered Medical Home model and has continued to support the program for nine years providing quarterly dashboard reports, establishing TCOC adjustment factors, and validating shared savings calculations. • The bidder supports Idaho on a quarterly basis by providing estimates of TCOC performance and calculates final settlement reports annually to document shared savings/(loss).
• In the past year, the bidder has assisted four state Medicaid agencies with UPL demonstrations. • P – The bidder has worked with Washington since 1996 on UPL demonstrations.

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. The bidder would assign multiple actuaries to this scope of work. 2. The bidder met the requirements. 3. The bidder is proposing to conduct an annual survey to NET brokers to get a better understanding of the operational characteristics unique to each broker. a. The bidder indicated that they will use collected data to create base data summaries structured as an actuarial cost model to analyze eligible populations, regions, and service types. b. The bidder will create a dynamic reporting tool to use for encounter monitoring, identify high-level issues, drill into service level drivers, and visualize data over time across various dimensions. c. The bidder provided a detailed description of how data validation would be performed. 4. The bidder provided details for the rate development and certification process. a. Q – The bidder mentions managed care several times throughout this section. It's unclear if they understand the RFP requirements.
B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables

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1. The bidder met the requirements.
2. The bidder described in detail how they would load, process, warehouse, and reconcile data.

C. AC and PCPlus Data Analysis

1. P - The bidder's project team has experience working on similar programs in other states.
2. The bidder met the requirements.
3. The bidder demonstrated an understanding of the requirements for attributing members and developing roster files.
4. The bidder met the requirements.
5. The bidder demonstrated an understanding of this requirement, and discussed important considerations for quality assurance and stakeholder support.
6. P – The bidder described in detail their approach to meeting this requirement, including providing a web-based dashboard to present the TCOC summary analysis.
    a. In addition to the dashboard, the bidder agreed to provide comprehensive and actionable explanations of key findings for each TCOC report.
7. The bidder met the requirements.
8. P – The bidder described their process for developing claims completion factors including methods to ensure that completion patterns are consistent across service categories.
9. P – The bidder demonstrated their understand of this requirement along with their relevant experience in doing this work. They described several scenarios that might require adjustments to the data to reflect policy or program changes.
10. The bidder has been involved in Accountable Care Organization programs since 2011, supporting both payers and provider organizations.
11. The bidder met the requirements.

D. Fiscal Management Analytics (FMA)

1. P – The bidder described how they would develop quarterly projections and highlighted important considerations and variables that may impact projections.
2. The bidder described in detail how non-claims expenditures would be factored into projections.
3. The bidder met the requirements.
4. The bidder met the requirements.
5. The bidder is proposing to host the FMA data in a standard online dashboard product that they have developed and use in other states.
6. The bidder met the requirements.

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****

Alignment Across Topics
• The bidder met the requirements.
E. Upper Payment Limit (UPL)
1. P - The bidder demonstrated an understanding of some important variables to consider in selecting a UPL methodology. 2. P – The bidder demonstrated that they have experience preparing UPL demonstrations and with handling all aspects of the UPL submission to CMS, including addressing questions from CMS.
F. Requirements Related to Receiving Confidential Data
1. The bidder met the requirements. 2. The bidder met the requirements. 3. The bidder met the requirements. 4. The bidder met the requirements. 5. The bidder met the requirements. 6. The bidder met the requirements.
G. Project Management
1. The bidder met the requirements.
2. P – The bidder described their methods for managing deliverables and organizing decisions and data trackers and provided an example of their data tracker.
3. The bidder met the requirements.
H. Ad Hoc Work
1. The bidder met the requirements. 2. The bidder met the requirements.
I. Reports
1. P – The bidder described in detail how they would use their data tracker file to track and record all data necessary to complete reports.
2. The bidder indicated they will utilize the project plan to ensure that they submit all required reports to the Department within established timelines.
2. Staffing
a. The bidder met the requirements. b. The bidder indicated they will not be using any subcontractors for this engagement. c. The bidder provided a staffing plan with position titles and time allocations for each scope of work.
3. Implementation - Work Plan
a. The bidder provided a work plan in the form of a Gantt chart.

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Part IV, Section IV. Cost Proposal
• Bidder changed the number of deliverables for C. viii – x from 3 to 8.

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BIDDER NAME: Milliman, Inc
DATE: 6/27/2025 (Eligibility), 8/3/2025, 8/4/2025, & 8/5/2025 (Remaining review)
EVALUATOR NAME: Charyl Malik
EVALUATOR DEPARTMENT: DHHS/OMS
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Met requirements • 1. – Bidder has conducted NET rate certifications since 2020. • 1. – P – Description of the primary project clearly defines the elements involved. Bidder notes 6 additional states with which they are also involved in NET certification projects. • 2. – P – Bidder has conducted UPL demonstrations since 2019, which was an expansion of their work with this state since 1996. They have offered a clear general description of their UPL work. • 2. – P - Bidder notes involvement with 4 additional states for UPL demonstrations.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• Experienced as actuarial services vendor in 19 states, for fiscal management analytics and APM support. • In the past year, they have worked with over 30 state health and human services agencies to advance sustainable healthcare reform. • Reports key strengths of actuarial analysis, modern analytical approach, integrated multi-disciplinary team, and clear and effective communication.
2. Subcontractors
• No subcontractors will be used.
3. Project Team Organizational Chart
• Meets requirements, including both corporate structure and project team for Maine.
4. Litigation
• Reported one pending litigation case with no amount listed in the initial filing. • It is noted that they are unable to provide specific details about settled cases as settled cases are subject to confidentiality agreements.
5. Financial Viability
• Provided the five most recent years' audited consolidated financial statements.
6. Certificate of Insurance
• Provided Certificates of Liability Insurance, though they are end dated for 6/30/2025.

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Additional requirements from Appendix D.
• Qualifications and history information found in the overview area.
• Reports more than three decades of experience for state Medicaid agencies developing fiscal management analyses through the use of standard tools and reports as well as projecting and tracking trends. • Describes experience with two states on similar scopes of work to the RFP.
• Bidder has conducted NET rate certifications since 2020. • Description of the primary project clearly defines the elements involved. Bidder notes 6 additional states with which they are also involved in NET certification projects.
• Work on strategies to improve healthcare delivery and reducing costs spans 12 states. • Describes work with three states comparable to the payment reform work in this RFP.
• Bidder has conducted UPL demonstrations since 2019, which was an expansion of their work with this state since 1996. They have offered a clear general description of their UPL work. • Bidder notes involvement with 4 additional states for UPL demonstrations.

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. Two actuaries, both with experience developing NET capitation rates with multiple states, would be working on the development and certification of NET service reimbursement. 2. Bidder will implement their project management and client communication process for the Maine NET rates setting development, which includes steps of project plan and structure, financial monitoring, and a rating approach including all required cohorts, covered services, and regional rate structure. 3. Bidder will participate in a meeting with the Department and submit data requests, securely gather NET program data, develop methodology to identify eligible populations, regions, and service types, develop methodology to identify claims and vital claim elements, provide descriptions of data changes/issues and updating crosswalks, review encounter data, and discuss and resolve issues with the Department. The detailed descriptions of all deliverables in this section meet the requirements.

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4. Bidder will develop two rate development and certification reports by developing capitation by rate, cohort, region, and population, using a seven step process; developing NET capitation rate certification reports; and participating in discussions with CMS, NET brokers, and the Department while assisting in responding to questions and participating in CMS and/or NET broker calls.
B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables
1. Bidder described how they would receive and manage data files for AC/PCPlus, FMA, and UPL deliverables and noted their data engineers' proficiency with data file formats. 2. Though bidder did provide descriptions of processes to be covered for this section of loading, processing, warehousing, and reconciling of data, not all details noted in the requirements were fully covered, such as noting resubmitted, adjusted, and voided claims in 2.c. or details in 2.b.i. – ACO Category, ACO cost grouping, allocation provider type, and detailed claims.
C. AC and PCPlus Data Analysis
1. It seems #1 bullet for this section was removed, though the proper text remained. Provided examples of four states for which they assisted Medicaid agencies in designing and implementing value-based payment initiatives. Grid of states assisted with various projects was provided for a quick overview. Bidder has actuary who would be the AC Workstream Lead. They employ more than 80 actuaries with experience supporting state Medicaid agencies.
2. It seems a #2 bullet was added to the bottom of table 3. Meets requirements.
3. The 3.c. bullet label was removed. No reference to full-coverage MaineCare members being a part of the defined eligible population. Unsure why previous use of Health Home methodology for AC attribution was referenced when it is no longer used since PCPlus began. Didn't reference various key elements of AC attribution such as data from the Muskie crosswalk, tie-breaker logic for plurality of primary care, and the lookback period. Explanation of AC roster comparison doesn't note members who changed PCP locations within an AC.
4. There is no reference to full-coverage MaineCare eligibility being part of the PCPlus attribution process. Concerned by the reference to "PCPlus services" and "PCPlus claims" terminology used, yet no reference to the data review being a review of primary care claims for attribution. Referred to deliverables described in an attachment, rather than specifically naming them as well as

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criteria and methodology found in an appendix, rather than naming/describing them.
5. Bidder notes there are two TCOC deliverables, yet there are four – annual projection, annual reconciliation, and biannual reports, as clarified in Q&A #23. Reporting areas of this section were addressed otherwise.
6. Q - I'm not clear on the description of the full-year projections based on partial-year experience noted for interim reports. A screenshot of a potential AC dashboard was provided, allowing users to stratify, filter and aggregate data. Though descriptions were provided on how analyses might occur and it was stated that materials would be provided in a format facilitating seamless sharing with ACs, it didn't clearly specify what that format would be (focus for this section was for presentations).
7. There was no explanation of the list of claims excluded from the TCOC report being incorporated into the data extracts.
8. Meets requirements.
9. Bidder is experienced in various policy change models. Bidder describes updates to provider reimbursement policies, population changes, and other program changes as potential adjustments to consider. Unable to find reference to annual participation in a deliberative review process with the Department to review MaineCare regulation changes and other changes in the previous year that could skew the comparison of Base Year and Reporting Period spending in this section.
10. Bidder notes involvement in ACO programs since 2011 and maintains connection to Medicaid, Medicare, and commercial ACO models. Will work with the Department to develop an analytical approach to identify potential program changes to achieve untapped opportunities/goals. They will also analyze the impacts of the potential change(s) and make recommendations to the Department.
11. Meets requirements
D. Fiscal Management Analytics (FMA)
1. Bidder notes its expertise and experience in providing timely, comprehensive, and actionable projections of enrollment, utilization, and expenditures. Described quarterly projections, timeframe for updates, projection assumptions and methodology, and projected paid expenditures. Provided illustrations of the updates schedule, analysis of variance, claim lag triangle, and payment lag analysis.

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INDIVIDUAL EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: Milliman, Inc
DATE: 6/27/2025 (Eligibility), 8/3/2025, 8/4/2025, & 8/5/2025 (Remaining review)
EVALUATOR NAME: Charyl Malik
EVALUATOR DEPARTMENT: DHHS/OMS
****

2. Provider described its approach to include non-claims based expenditures and noted each of the expenditures noted in the RFP.
3. Provided considerations for development of enrollment/population categories.
4. Provided considerations for development of service categories.
5. Meets requirements
6. Bidder plans to customize Excel presentations for the Department. They described additional reporting elements to include in quarterly reporting.

Alignment Across Topics

- Bidder presented its thoughts for the mapping of enrollment/population groups across FMA, NET, AC, PCPlus, and other populations groupings.
- Their vision of synergies between NET, AC, and FMA analysis and reporting was also provided.

E. Upper Payment Limit (UPL)

1. Bidder describes its work assisting five state Medicaid programs with the development of annual FFS UPL demonstrations over the past five years.
Their plan for calculation of UPL demonstrations includes using AC data for FMA, developing UPL calculation demonstration methodologies, and calculating the required UPL demonstrations using a 9-step process.
Descriptions for calculating UPL demonstrations for all of the required services were provided and multiple states were referenced for current or recent calculations for each service.
2. Bidder demonstrates that they will proactively review CMS UPL guidance, track Medicare reimbursement policy updates, perform data collection and analysis, review UPL calculation options, prepare materials for UPL submissions to CMS, and assist the Department in addressing CMS UPL questions.

F. Requirements Related to Receiving Confidential Data

1. Meets requirements.
2. Meets requirements.
3. Meets requirements.
4. Meets requirements.
5. Meets requirements.

6. Bidder respects that the State will not host Milliman applications in its production environment, nor will Milliman consume State-hosted applications. Though the bidder requests sandbox API endpoints or read-only interfaces with representative test data to allow validation of file ingestion, schema mapping, and error handling in a secure staging environment.

G. Project Management

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

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EVALUATOR NAME: Charyl Malik
EVALUATOR DEPARTMENT: DHHS/OMS
****

Bidder follows three core phases for project management:

- initiation and planning phase, which includes identify and introduce key contacts, clarify project scope and deliverables, establish a regular meeting cadence, review and finalize project work plan, and conduct kick-off meeting
- work phase, which includes closely monitor budget and timing, conduct periodic status update meetings, provide consistent documentation, and immediately communicate issues of concern
- project completion phase, which includes wrap up outstanding requests, validate that all deliverables have been met, complete all necessary data transfers, provide training and materials, and project debrief.

Bidder will work with the Department to identify key State personnel to be involved throughout the project, set up in introduction meeting and establish open lines of communication.

Once the project plan is approved, regular meetings will occur for reporting of project status, issue resolution, and ongoing discussion with the Department. Following meetings, notes, deliverables, as well as data and decision trackers will be provided.

With open lines of communication with the Department, issues of concern will be addressed by setting up a meeting, committing needed resources to determine if any fiscal impact exists, notifying all affected parties of the issue, create a resolution plan, and following up with the Department to ensure the issue is resolved.

2. Bidder has created a governance structure to eliminate duplication and maintain aligned assumptions, methods, and timelines.
3. Bidder commits to attending at least 12 scheduled collaborative meetings between the Department and the ACs and is available further, as needed, and is prepared to provide appropriate presentation materials.

H. Ad Hoc Work

1. States they have the expertise and flexibility of meeting the Department's needs for ad hoc work. They will provide required ad hoc work description, timeline, estimate, and approval to proceed prior to initiating work.

They are prepared to assist the Department in unanticipated and unprecedented issues that may arise.

Brought attention to its work with maternal health initiatives. Also provided "Experience in Practice" examples of actuarial consulting, pharmacy consulting, and financial consulting projects they have participated in.

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EVALUATOR NAME: Charyl Malik
EVALUATOR DEPARTMENT: DHHS/OMS
****

2. Project team and its consultants are familiar with the proposed projects and provided detailed information related to the Medicaid Drug Rebate Program Revenue Forecasting work.

I. Reports

1. Bidder plans to utilize a customized data tracking tool to track all data collection as well as a consolidated Data Tracker to record data across all workstreams. Provided sample of potential tracking workbook.
2. Meets requirements. Bidder commits to proving frequent status updates to the Department for close monitoring of deliverable progress.

2. Staffing

a. Provided staff for each project team, with titles, job descriptions, and qualifications. Also provided general position titles, job descriptions and minimum qualifications for supporting positions for the work, but not specific team members named. These positions are actuaries, data analysts.
b. Bidder will not be using subcontractors.
c. Staffing plan meets the basic criteria of position titles and time allocation, in hours, per position for each project.

3. Implementation - Work Plan

a. Work plan meets required formatting.
Work plan did not reflect all AC deliverables, which include annual projections. annual reconciliation and biannual (as clarified in Q&A #23) reporting periods. AC rosters, TCOC reports, and affiliated processes and data elements would occur four times in total, rather than two.

STATE OF MAINE
INDIVIDUAL EVALUATION NOTES

RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting
BIDDER NAME: Milliman Inc
DATE: 06/27/25
EVALUATOR NAME: Lauren Metayer
EVALUATOR DEPARTMENT: DHHS OMS
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• Meets eligibility requirements

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• Milliman has extensive experience working with state Medicaid agencies, provides actuarial and consulting services. Services span healthcare, insurance, and employee benefit programs.
2. Subcontractors
• Not planning to use subcontractors
3. Project Team Organizational Chart
• Provided organizational chart as requested.
4. Litigation
• Has a pending case which alleges breach of contract, negligence, malpractice, fraud, and other additional causes of action.
5. Financial Viability
• Provided audited financial statements as requested. Seems financially viable, no concerns.
6. Certificate of Insurance
• Has a now expired certificate of insurance (was not expired at submission).
Additional requirements from Appendix D.
• Milliman has extensive experience working with state Medicaid agencies. They have worked to develop standalone NET rates (7 states) and UPL demonstrations (7 states). Founded in 1947 and is one of the largest actuarial consulting firms worldwide. Provides actuarial services for 19 states, including financial management analytics and alternative payment model supports.
• Has experience developing tools for South Carolina and Mississippi to provide FMA services. In South Carolina they developed an annual and mid-year budget forecast and created PMPM trends. In Mississippi they developed expenditure projections for the Medicaid program for twelve years.
• Have worked with multiple states to develop NET rates for both standalone NET programs and programs where NET is integrated into a managed care plan. Have worked with Florida, Ohio, Idaho, Indiana, Kentucky, Arizona, and Hawaii.

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• Has worked with several other states on payment reform efforts (12 states), including ACOs, shared savings programs, and innovations in primary care. They have been involved in several different phases of these projects including the designing, implementing and operationalizing phase. • States include Rhode Island, Ohio, and Idaho.
• Has extensive experience with UPL demonstrations, including experience across all service providers requested in the RFP. • Experience with Florida, Nebraska, Washington, and Wisconsin.

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. Meets requirements and has a qualified Fellow of the Society of Actuaries employed. The actuaries have experience certifying rates in many other states. 2. Stated that they will work with the department to create a project plan and structure during a kickoff meeting, will monitor the financial status of the NET program and provide analytics in a dashboard if desired. Will also work to create a capitation rate methodology letter early in the project. Pointed out that they may group certain regions together with certain cost profiles to enhance statistical credibility, which may be helpful for Maine. Milliman also stated that they recognize standalone NET programs require specific considerations compared to NET programs integrated in a managed care program. 3. Will meet with the Department to request data, receive claims data through a secure file transfer protocol, will store data in a location with encryption in place to protect Protected Health Information. Plan to have the same staff receive all data related to this RFP. (3a-3c). Stated that they would also propose conducting an annual survey of NET brokers in addition to collecting financial data from the broker. This survey would collect key information, such as incurred but not paid claims and can offer insights during the rate setting process. Outlined a five step process for monitoring broker encounter and financial data. This process included a DRIVE tool which it will use to monitor encounter data and create summaries and data comparisons. 4. • Stated that they will develop two distinct rate development reports, as required. Outlined a seven step process to develop the NET program

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INDIVIDUAL EVALUATION NOTES

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capitation rates, including a review of claims completion and IBNR data, Program and Policy Adjustments, review NET encounter claims for consistency with the state plan and ensure federal requirements are met, apply appropriate trends to the rate, adjusting for quality and cost containment initiatives, adding administrative and non-benefit costs, and other adjustments as necessary. (4a) • Stated that as part of each rate certification package they will include a data book providing and overview of the rate development process meeting the requirements in CFR 438.7(e). Also provided other potential items to be included in the report (4b). • Stated that they will remain engaged with CMS throughout the process and will participate in calls as needed and willing to discuss the rate-setting methodology with all stakeholders (4c-4d).
B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables
1. Milliman has experience ingesting, processing, and validating claims and eligibility data and states thy would adhere to Maines OIT Access Control and Data Exchange policies. Provided detailed understanding of each data to be received from the department (claims, non-claims, other non-claims). Meets requirements. 2. Stated that they have a process to load, process, warehouse, and reconcile data, outlined a six step process (figure on page 34). Meets requirements.
C. AC and PCPlus Data Analysis
1. Stated that the project team would include several subject matter experts as required, and that staff has assisted many other states with designing and implementing VBP initiatives. Also stated that they have more than 80 Medicaid focused Fellows of the Society of Actuaries, specified one actuary as a Principal and Consulting Actuary and the AC/PCPlus Workstream lead.

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2. Stated that they are a reliable vendor to receive, organize, and store necessary files related to the AC program and PCPlus within the specified timeframes.
3. Stated that they would determine MaineCare members eligible for AC services using the methodology in Appendix K. Described the methodology and stated that they are confident they will be able to accurately apply the attribution process. Will then create AC rosters in accordance with the provided templates. Will also provide an AC roster comparison.
4. Will use claims and eligibility data as well as crosswalk files to determine members eligible for PCPlus. Also stated that they will assign MaineCare risk scores to each member attributed member record. Will undertake necessary steps to ensure the attribution process has been completed accurately.
5. Described the process it would use to create a retrospective Non-AC comparison group, as well as benchmark TCOC and Actual TCOC for each AC. Stated they will provided two TCOC reports each year, and will have each report undergo a multi-step quality assurance process including a financial tie-out to MaineCare financial reports, consistency checks, peer actuarial review, comparisons to prior reports, and review of non-AC comparison groups.
6. Stated that they would schedule meetings with the Department to discuss results, aims to provide high-level insights into the types of services driving favorable or unfavorable experiences for the ACs. Also has a proprietary algorithm to identify claims as potentially avoidable to assess the efficiency of care.
7. Stated that they would create the required extract package, has done similar extract work with Ohio.
8. Demonstrated the ability to create completion factors, stated they have actuaries with decades of experience developing completion factors. Will include these completion factors in the TCOC reports.
9. Stated that they will work to apply adjustments as required, currently provides similar adjustments in its work with other state Medicaid agencies. Did not state it was willing to work with the Department annually in a deliberative process as required in the RFP.
10. Met requirements, has been involved in ACO programs since the program was introduced by CMS in 2011, has supported multiple state Medicaid agencies in this work.
11. Meets requirements, will maintain methodology documentation and will share files with the ACs.

D. Fiscal Management Analytics (FMA)

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****

1.
   - Milliman stated that provide comprehensive fiscal and data analytics support to several Medicaid agencies across the country. Proposed quarterly reports as required in the RFP, but provided additional detail for each deliverable which would be helpful such as calculating the state share of expenditures for specific deliverables. Stated that they would also be able to collaborate with the department to provide other exhibits of interest, and that they would be available in excel and dynamic dashboards.
   - Provided an overview of their projections methodology, which is based on an incurred basis and a population based framework. This section demonstrated expertise in this area, and appropriately referenced other data sources that will inform their analysis.
   - Stated that for policy changes they would provide a list to the department for review, and the department would provide fiscal notes for each item.
   - Stated that even though the projection model is based on incurred data, they would be able to project paid expenditures as well utilizing paid lag assumptions.

2. Demonstrated familiarity with non-claims data, suggested aligning projections with enrollment and reimbursement trend assumptions. Will collaborate with the department to ensure how these items are likely to grow in the future as well.
3. Listed several different relevant items to consider as part of enrollment projections and population categories. Proposed Major Population groups and Population groups for projections which may be helpful for different analyses and purposes.
4. Stated they would collaborate with the Department on service groupings and listed several items to be considered. Unclear if they are willing to break out projections by the sections of the MBM as required in the RFP.
5. Indicated that it would be able to provide projections by PMPM and enrollment as well as PMPM broken down by price and utilization components.
6. Proposed customizing excel exhibits as well as presentation decks, a report documenting key results, and access to the underlying data provided to staff at no additional fee.

Alignment Across Topics

- Would aim to create crosswalk and overlap between population groups defined in the FMA section and in the NET and AC programs. Also pointed out several synergies in the source data, data validation, population and service groups,

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****

aligning assumptions, projection methodologies, and overall awareness of each program.
- Demonstrated a good understanding of how having one vendor provide all of this work would be beneficial to the department

E. Upper Payment Limit (UPL)

1. Demonstrated a familiarity with UPL demonstrations and CMS's requirements. Have worked with Florida, Nebraska, Washington, Wyoming, Wisconsin with the development of FFS UPL Demonstrations. Stated how they would use data provided to them and develop UPL calculations following a nine step process. Went into great detail on calculations for each service, demonstrating expertise.
2. Stated that is will review new UPL guidance issued by CMS and will proactively review the current UPL demonstrations in Maine to identify any areas of concern. Will also review Medicare payment methodologies, relying on expert staff, to inform the department of any changes. Will also collect Medicaid utilization data, conduct the UPL calculation options, and prepare the materials for submittal to CMS. Meets requirements. Through their work with other states they are familiar with the types of questions CMS asks in response to UPL demonstrations which may be helpful in the future.

F. Requirements Related to Receiving Confidential Data

1. Meets requirements
2. Meets requirements
3. Meets requirements
4. Meets requirements
5. Meets requirements
6. Meets requirements, requests sandbox API endpoints (?).

G. Project Management

1. Has a standard project management approach which includes an initiation and planning phase, a work phase, and a project completion phase. Each phase has several steps to ensure collaboration between the department and Milliman, sets expectations clearly, documents decisions, and provides timely materials. States that their project management approach is backed by decades of experience working with state Medicaid agencies on long term and complex projects.
2. Recognize that the FMA work and AC work rely on same data sources which creates an opportunity to eliminate duplication and accelerate delivery.

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****

Proposes having a project lead and then two individuals handling the AC and FMA workstreams. 3. Meets requirements and states they will attend at least 12 meetings per year.
H. Ad Hoc Work
1. Milliman has several experts to help with ad hoc work and is well situated to provide it. States for any work that falls outside of the routine deliverables it will deliver a scope of work to the department before any work is initiated, which includes a timeline, cost, and workplan. 2. Milliman's pharmacy consultants are familiar with the Medicaid Drug Rebate program and have extensive experience forecasting the revenue.
I. Reports
1. Proposed using a consolidated Data Tracker to record data across all workstreams an complete each of the required reports listed in table 5. 2.Stated that the project work plan will include all required reports in Table 6 by the requested date.
2. Staffing
a. Provided list of staff which includes job descriptions and minimum qualifications. b. Will not be using subcontractors. c. Provided staffing plan which seems reasonable
3. Implementation - Work Plan
a. Work plan was realistic and detailed, begins October 2025 and covers two years.

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BIDDER NAME: Milliman INC
DATE: 8/05/2025
EVALUATOR NAME: Jordan Rhodes
EVALUATOR DEPARTMENT: DHHS Commissioner's office
****

Individual Evaluator Comments:

Part I. Preliminary Information
Eligibility Requirements
• P – meets eligibility requirements.

Part IV. Section II. Organizational Qualification and Experience
1. Overview of the Organization
• P – recent experience conducting overlapping work with multiple states.
2. Subcontractors
• None.
3. Project Team Organizational Chart
• Provided.
4. Litigation
• Ongoing litigation, although unrelated to project work.
5. Financial Viability
• Operating loss in most recent year (2022).
6. Certificate of Insurance
• Expired 6/30/2025.
Additional requirements from Appendix D.
• P – experience conducting RFP project requirements for other states.
• P – Direct experience conducting FMA work with two other states.
• P – experience conducting standalone NET rate setting.
• P – prior experience working with numerous states to conduct payment reform efforts.
• Q – did Milliman support efforts for all states listed in the included table? (There is no title, and the period/timeframe is unclear).

Part IV, Section III. Proposed Services
Part II
A. Independent Annual Development and Certification of Non-Emergency (NET) Services Reimbursement
1. P – primary lead has five years of experience in NET capitation rate setting. 2. P – exhibits comprehensive understanding of project planning, financial status, and rating approaches associated with NET program analysis.

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3. P – outlines interest in receiving three years of historical data to further support trend analysis and other aspects of rate development.
   P – outlines key empirical questions that will be examined when reviewing encounter data.
   P – proposes use of DRIVE tool to customize analysis.
4. P – Proposed team members have a robust understanding of regulatory environment and familiarity with rate development processes.

B. Receive and Manage Data Files Necessary to Produce Accountable Communities (AC) / PCPlus, Fiscal Management Analytics (FMA), and Upper Payment Limit (UPL) Deliverables

1. Meets requirement.
2. P – outlines thorough 6-step process of data receiving and processing steps.

C. AC and PCPlus Data Analysis

1. Q – Milliman highlights a number of other related initiatives that they have worked on with other states. Will the team members from those initiatives overlap with the work outlined for Maine?
   Certified actuary requirement met.
2. Meets requirement.
3. Meets requirement.
4. P – highlights the importance of comparing data files against those corresponding to prior quarters to identify unexpected changes.
5. Outlined approach for generating TCOC reports aligns with requirements.
6. P – offers to recalculate shared savings amounts for each AC using various combinations of optional service categories.
   P – will present results in a dashboard that will be updated quarterly.
7. Q – did not confirm that extract package will be delivered as .txt files.
8. Will employ RTS system to conduct IBNR analysis.
9. P – provides a list of potential relevant policy changes, and previous examples of applying relevant work.
10. P – relevant experience working with other states and stakeholders.
    Q – what analytic approaches will Milliman employ to identify changes that warrant actions?
11. Meets requirement.

D. Fiscal Management Analytics (FMA)

1. P – cites a robust set of external data sources that could support enrollment and expenditures projections, including NHE, BLS, ACS, CBO, and KFF.
   P – demonstrates understanding, including strengths and limitations, of analysis of variance techniques.

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2.P – exhibits understanding of and projections methodologies associated with non-claims based payments. 3.P – proposed a sample population structure. While actual population categories may differ, sample structure exhibits understanding of MaineCare population groups and modelling considerations. 4.Meets requirement. 5.P- demonstrates importance of distinguishing between price and utilization in scrutinizing PMPM analysis. 6.P- dynamic Dashboards will be made available, in addition to the requested Excel deliverables. P – proposed to supplement Excel deliverables with more in-depth analysis of findings.
Alignment Across Topics
• P – outlines a broad set of synergies from alignment across topics, including data validation, assumption and projection alignment, and understanding of broad regulatory changes.
E. Upper Payment Limit (UPL)
1.P – outlines detailed process for calculating each UPL demonstration. P – recent experience working with multiple states on various UPL demonstrations. 2.P – significant experience working with HCRIS data to use in UPL calculations.
F. Requirements Related to Receiving Confidential Data
1. Meets requirement. 2. Meets requirement. 3. Meets requirement. 4.Meets requirement. 5.Meets requirement. 6.Requests adjustment to ensure file ingestion in a secure staging environment.
G. Project Management
1. P – Provides detailed overview of project planning, meetings, decision trackers, and deliverables. 2.P – notes record of consolidating parallel reporting structures, with example provided of work conducted for another state. 3. Meets requirement.
H. Describe in detail how the Bidder will provide Ad Hoc Work
1.P – recognizes the importance of conducting ad hoc work in a timely manner.

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EVALUATOR DEPARTMENT: DHHS Commissioner's office
****

2. P – demonstrates significant understanding of ongoing policy initiatives in Maine, including TMaH and MaineMOM.
I. Reports
1.Meets requirement. 2.Meets requirement.
1. Staffing
a. Meets requirement. b. Will not be using subcontractors. c. Meets requirement.
2. Implementation - Work Plan
a. Meets requirement.

STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner

AGREEMENT AND DISCLOSURE STATEMENT
RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting

I, Roger Bondeson, accept the offer to become a member of the Request for Proposals (RFP) Evaluation Team for the State of Maine Department of Health and Human Services. I do hereby accept the terms set forth in this agreement AND hereby disclose any affiliation or relationship I may have in connection with a bidder who has submitted a proposal to this RFP.

Neither I nor any member of my immediate family have a personal or financial interest, direct or indirect, in the bidders whose proposals I will be reviewing. “Interest” may include, but is not limited to: current or former ownership in the bidder’s company; current or former Board membership; current or former employment with the bidder; current or former personal contractual relationship with the bidder (example: paid consultant); and/or current or former relationship to a bidder’s official which could reasonably be construed to constitute a conflict of interest (personal relationships may be perceived by the public as a potential conflict of interest).

I have not advised, consulted with or assisted any bidder in the preparation of any proposal submitted in response to this RFP nor have I submitted a letter of support or similar endorsement.

I understand and agree that the evaluation process is to be conducted in an impartial manner without bias or prejudice. In this regard, I hereby certify that, to the best of my knowledge, there are no circumstances that would reasonably support a good faith charge of bias. I further understand that in the event a good faith charge of bias is made, it will rest with me to decide whether I should be disqualified from participation in the evaluation process.

I agree to hold confidential all information related to the contents of Requests for Proposals presented during the review process until such time as the Department formally releases the award decision notices for public distribution.

Signed by:
Roger.Bondeson@maine.gov
7E9EE59E990A439...

Signature

Jun-24-2025

Date

STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner

AGREEMENT AND DISCLOSURE STATEMENT
RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting

I, Philip Dubois, accept the offer to become a member of the Request for Proposals (RFP) Evaluation Team for the State of Maine Department of Health and Human Services. I do hereby accept the terms set forth in this agreement AND hereby disclose any affiliation or relationship I may have in connection with a bidder who has submitted a proposal to this RFP.

Neither I nor any member of my immediate family have a personal or financial interest, direct or indirect, in the bidders whose proposals I will be reviewing. “Interest” may include, but is not limited to: current or former ownership in the bidder’s company; current or former Board membership; current or former employment with the bidder; current or former personal contractual relationship with the bidder (example: paid consultant); and/or current or former relationship to a bidder’s official which could reasonably be construed to constitute a conflict of interest (personal relationships may be perceived by the public as a potential conflict of interest).

I have not advised, consulted with or assisted any bidder in the preparation of any proposal submitted in response to this RFP nor have I submitted a letter of support or similar endorsement.

I understand and agree that the evaluation process is to be conducted in an impartial manner without bias or prejudice. In this regard, I hereby certify that, to the best of my knowledge, there are no circumstances that would reasonably support a good faith charge of bias. I further understand that in the event a good faith charge of bias is made, it will rest with me to decide whether I should be disqualified from participation in the evaluation process.

I agree to hold confidential all information related to the contents of Requests for Proposals presented during the review process until such time as the Department formally releases the award decision notices for public distribution.

Signed by:
Philip Dubois
A30E79F80683456...

Signature

Jun-24-2025

Date

STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner

AGREEMENT AND DISCLOSURE STATEMENT
RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting

I, Charyl Malik, accept the offer to become a member of the Request for Proposals (RFP) Evaluation Team for the State of Maine Department of Health and Human Services. I do hereby accept the terms set forth in this agreement AND hereby disclose any affiliation or relationship I may have in connection with a bidder who has submitted a proposal to this RFP.

Neither I nor any member of my immediate family have a personal or financial interest, direct or indirect, in the bidders whose proposals I will be reviewing. “Interest” may include, but is not limited to: current or former ownership in the bidder’s company; current or former Board membership; current or former employment with the bidder; current or former personal contractual relationship with the bidder (example: paid consultant); and/or current or former relationship to a bidder’s official which could reasonably be construed to constitute a conflict of interest (personal relationships may be perceived by the public as a potential conflict of interest).

I have not advised, consulted with or assisted any bidder in the preparation of any proposal submitted in response to this RFP nor have I submitted a letter of support or similar endorsement.

I understand and agree that the evaluation process is to be conducted in an impartial manner without bias or prejudice. In this regard, I hereby certify that, to the best of my knowledge, there are no circumstances that would reasonably support a good faith charge of bias. I further understand that in the event a good faith charge of bias is made, it will rest with me to decide whether I should be disqualified from participation in the evaluation process.

I agree to hold confidential all information related to the contents of Requests for Proposals presented during the review process until such time as the Department formally releases the award decision notices for public distribution.

Signed by:
Charyl Malik
GD63A6DB11704DC...

Signature

Jun-24-2025

Date

STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner

AGREEMENT AND DISCLOSURE STATEMENT
RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting

I, Lauren Metayer, accept the offer to become a member of the Request for Proposals (RFP) Evaluation Team for the State of Maine Department of Health and Human Services. I do hereby accept the terms set forth in this agreement AND hereby disclose any affiliation or relationship I may have in connection with a bidder who has submitted a proposal to this RFP.

Neither I nor any member of my immediate family have a personal or financial interest, direct or indirect, in the bidders whose proposals I will be reviewing. “Interest” may include, but is not limited to: current or former ownership in the bidder’s company; current or former Board membership; current or former employment with the bidder; current or former personal contractual relationship with the bidder (example: paid consultant); and/or current or former relationship to a bidder’s official which could reasonably be construed to constitute a conflict of interest (personal relationships may be perceived by the public as a potential conflict of interest).

I have not advised, consulted with or assisted any bidder in the preparation of any proposal submitted in response to this RFP nor have I submitted a letter of support or similar endorsement.

I understand and agree that the evaluation process is to be conducted in an impartial manner without bias or prejudice. In this regard, I hereby certify that, to the best of my knowledge, there are no circumstances that would reasonably support a good faith charge of bias. I further understand that in the event a good faith charge of bias is made, it will rest with me to decide whether I should be disqualified from participation in the evaluation process.

I agree to hold confidential all information related to the contents of Requests for Proposals presented during the review process until such time as the Department formally releases the award decision notices for public distribution.

Signed by:
Lauren Metayer
779B59320E1140C...
Signature

Jun-24-2025
Date

STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner

AGREEMENT AND DISCLOSURE STATEMENT
RFP #: 202504053
RFP TITLE: Assorted Actuarial Services and Fiscal Management Analytics and Reporting

I, Jordan Rhodes, accept the offer to become a member of the Request for Proposals (RFP) Evaluation Team for the State of Maine Department of Health and Human Services. I do hereby accept the terms set forth in this agreement AND hereby disclose any affiliation or relationship I may have in connection with a bidder who has submitted a proposal to this RFP.

Neither I nor any member of my immediate family have a personal or financial interest, direct or indirect, in the bidders whose proposals I will be reviewing. “Interest” may include, but is not limited to: current or former ownership in the bidder’s company; current or former Board membership; current or former employment with the bidder; current or former personal contractual relationship with the bidder (example: paid consultant); and/or current or former relationship to a bidder’s official which could reasonably be construed to constitute a conflict of interest (personal relationships may be perceived by the public as a potential conflict of interest).

I have not advised, consulted with or assisted any bidder in the preparation of any proposal submitted in response to this RFP nor have I submitted a letter of support or similar endorsement.

I understand and agree that the evaluation process is to be conducted in an impartial manner without bias or prejudice. In this regard, I hereby certify that, to the best of my knowledge, there are no circumstances that would reasonably support a good faith charge of bias. I further understand that in the event a good faith charge of bias is made, it will rest with me to decide whether I should be disqualified from participation in the evaluation process.

I agree to hold confidential all information related to the contents of Requests for Proposals presented during the review process until such time as the Department formally releases the award decision notices for public distribution.

Signed by:
Jordan Rhodes
2C479B90EF3C40F...

Signature

Jun-24-2025

Date