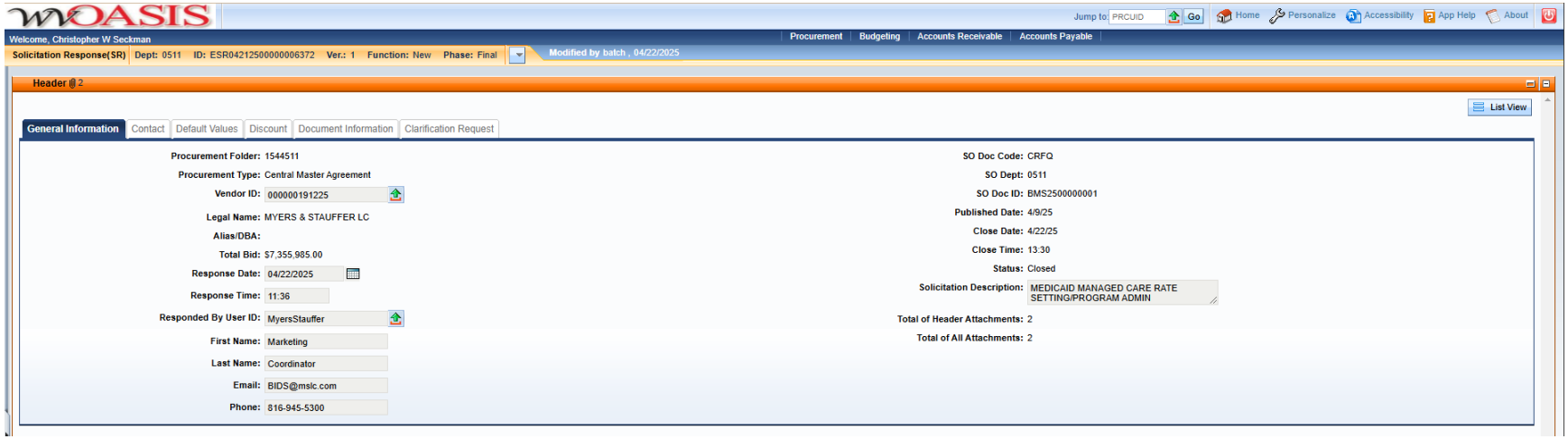
The following documentation is an electronically-submitted vendor response to an advertised solicitation from the *West Virginia Purchasing Bulletin* within the Vendor Self-Service portal at ***wvOASIS.gov***. As part of the State of West Virginia's procurement process, and to maintain the transparency of the bid-opening process, this documentation submitted online is publicly posted by the West Virginia Purchasing Division at ***WVPurchasing.gov*** with any other vendor responses to this solicitation submitted to the Purchasing Division in hard copy format.


WVOASIS
Jump to PRCUID Go
Home Personalize Accessibility App Help About
Welcome, Christopher W Seckman
Procurement Budgeting Accounts Receivable Accounts Payable
Solicitation Response(SR) Dept: 0511 ID: ESR04212500000006372 Ver.: 1 Function: New Phase: Final
Modified by batch , 04/22/2025
Header @ 2
List View
General Information
Contact
Default Values
Discount
Document Information
Clarification Request
Procurement Folder: 1544511
Procurement Type: Central Master Agreement
Vendor ID: 000000191225
Legal Name: MYERS & STAUFFER LC
Alias/DBA:
Total Bid: $7,355,985.00
Response Date: 04/22/2025
Response Time: 11:36
Responded By User ID: MyersStauffer
First Name: Marketing
Last Name: Coordinator
Email: BIDS@mslc.com
Phone: 816-945-5300
SO Doc Code: CRFQ
SO Dept: 0511
SO Doc ID: BMS2500000001
Published Date: 4/9/25
Close Date: 4/22/25
Close Time: 13:30
Status: Closed
Solicitation Description: MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN
Total of Header Attachments: 2
Total of All Attachments: 2

Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Solicitation Response

Proc Folder:	1544511
Solicitation Description:	MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN
Proc Type:	Central Master Agreement

Solicitation Closes	Solicitation Response	Version
2025-04-22 13:30	SR 0511 ESR04212500000006372	1

VENDOR

000000191225
MYERS & STAUFFER LC

Solicitation Number: CRFQ 0511 BMS2500000001

Total Bid: 7355985 **Response Date:** 2025-04-22 **Response Time:** 11:36:14

Comments:

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor
Signature X **FEIN#** **DATE**

All offers subject to all terms and conditions contained in this solicitation

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
1	Lead Actuary Services				0.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Lead Actuary Services
$_____Per Hour X 5,000 Hours Annually

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
2	Staff Actuary Services				0.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Staff Actuary Services
$_____Per Hour X 20,000 Hours Annually

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
3	Technical Support Staff (non-actuary)				0.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Technical Support Staff (non-actuary)
$_____Per Hour X 5,000 Hours Annually

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
4	Clerical Support Staff				0.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Clerical Support Staff
$_____Per Hour X 5,000 Hours Annually

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
5	Managed Care Program Oversight Services				5916600.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Managed Care Program Oversight Services Annual Cost
All-Inclusive Fixed Annual Amount (Inclusive of 12 Months)

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
6	Managed Care Oversight Ad Hoc Services				875000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments: $175.00 per hour x 5,000 hours annually

Extended Description:

Managed Care Oversight Ad Hoc Services
$____ per hour X 5,000 hours Annually

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
7	Actuarial Services Ad Hoc Services				0.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Actuarial Services Ad Hoc Services
$____ per hour X 5,000 hours Annually

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
8	Financial Services				564385.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Financial Services Annual Cost
All-Inclusive Fixed Annual Amount (Inclusive of 12 Months)

MYERS AND STAUFFER LC

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES
Bureau for Medical Services

Medicaid Actuarial Services and Managed Care Program Administration

CRFQ BMS2500000001

Price Quote

April 22, 2025

I. Transmittal Letter

April 22, 2025

Ms. Crystal Hustead, Senior Buyer
West Virginia Department of Administration, Purchasing Division
2019 Washington Street, East
Charleston, WV 25305

Dear Members of the Evaluation Committee:

Myers and Stauffer LC (Myers and Stauffer) is pleased to provide our Price Quote in response to the *Centralized Request for Quote (CRFQ) BMS2500000001: Medicaid Actuarial Services and Managed Care Program Administration* to the state of West Virginia, Department of Human Services (State), Bureau for Medical Services (BMS or the Bureau).

As the incumbent performing this work during the past three years, we have had the pleasure of supporting BMS with its advancement of the West Virginia Medicaid managed care program, and we look forward to the opportunity to continue this success.

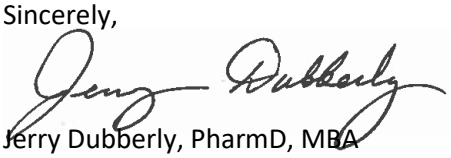
Using the instructions included in CRFQ Exhibit A: Pricing and the associated procurement documentation, we have completed the Pricing Page. We have also included our information directly in the Pricing Page on wvOASIS.

Please note that a rate of $0 per hour is provided for lines 1, 2, 3, 4, and 7, indicating Myers and Stauffer is not charging an hourly rate for the lead actuary services, staff actuary services, technical support staff (non-actuary), clerical support staff, or ad hoc actuarial services. We have built these costs into our Managed Care Program Oversight price. We want to offer BMS as much budget predictability as possible while removing complicated billing practices.

Our submitted pricing is based on our historical experience providing these services to BMS, as well as our assumptions based on the required level of effort to complete the additional work added through this procurement. We would be glad to provide any clarifications regarding our assumptions and pricing as BMS conducts its evaluation.

If you require additional information, please contact me at JDubberly@mslc.com or 404.290.8370. We look forward to working with the Bureau to support the future success of the West Virginia Medicaid program.

Sincerely,



Jerry Dubberly, PharmD, MBA
Principal

II. Pricing Pages (CRFQ Specifications: Section 5)

Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Centralized Request for Quote
Service - Misc

Proc Folder:	1544511
Doc Description:	MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN
Proc Type:	Central Master Agreement
Reason for Modification:	Addendum No. 2

Date Issued	Solicitation Closes	Solicitation No	Version
2025-04-09	2025-04-22 13:30	CRFQ 0511 BMS2500000001	3

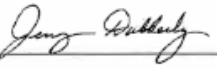
BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Customer Code: 000000191225
Vendor Name: Myers and Stauffer LC
Address : 1349
Street : Peachtree St, NE, Ste 1600
City : Atlanta
State : GA **Country : United States** **Zip : 30309**
Principal Contact : Jerry Dubberly, PharmD
Vendor Contact Phone: 866.758.3586 **Extension: N/A**

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor Signature X  **FEIN# 48-1164042** **DATE 4/16/2025**

All offers subject to all terms and conditions contained in this solicitation

Date Printed: Apr 9, 2025 Page: 1 FORM ID: WV-PRC-CRFQ-002 2020/05

ADDITIONAL INFORMATION
Addendum No. 2 issued to provide the following - 1. Provide responses to vendor questions. See attachment. 2. The bid opening remains ion 04/22/2025 at 1:30 pm EST. No other changes.

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Lead Actuary Services	1	5,000	$0	$0

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Lead Actuary Services

$__0__Per Hour X 5,000 Hours Annually

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Staff Actuary Services	1	20,000	$0	$0

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Staff Actuary Services

$__0__Per Hour X 20,000 Hours Annually

Date Printed: Apr 9, 2025 **Page: 2** FORM ID: WV-PRC-CRFQ-002 2020/05

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	Technical Support Staff (non-actuary)	1	5,000	$0	$0

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Technical Support Staff (non-actuary)

$__0__Per Hour X 5,000 Hours Annually

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	Clerical Support Staff	1	5,000	$0	$0

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Clerical Support Staff

$__0__Per Hour X 5,000 Hours Annually

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON US	WV	HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON US	WV

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
5	Managed Care Program Oversight Services	1	1	$5,916,600.00	$5,916,600.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Managed Care Program Oversight Services Annual Cost

All-Inclusive Fixed Annual Amount (Inclusive of 12 Months)

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON US	WV	HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON US	WV

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
6	Managed Care Oversight Ad Hoc Services	1	5,000	$175.00	$875,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Managed Care Oversight Ad Hoc Services

$ 175 per hour X 5,000 hours Annually

Date Printed: Apr 9, 2025 Page: 4 FORM ID: WV-PRC-CRFQ-002 2020/05

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
7	Actuarial Services Ad Hoc Services	1	5,000	$0	$0

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Actuarial Services Ad Hoc Services

$_0_ per hour X 5,000 hours Annually

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
8	Financial Services	1	1	$564,385.00	$564,385.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Financial Services Annual Cost

All-Inclusive Fixed Annual Amount (Inclusive of 12 Months)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	VENDOR QUESTION DEADLINE	2025-03-19

Date Printed: Apr 9, 2025 **Page:** 5 FORM ID: WV-PRC-CRFQ-002 2020/05

MYERS AND STAUFFER LC

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES
Bureau for Medical Services

Medicaid Actuarial Services and Managed Care Program Administration

CRFQ BMS2500000001

Technical Quote

April 22, 2025

I. Transmittal Letter

April 22, 2025

Ms. Crystal Hustead, Senior Buyer
West Virginia Department of Administration, Purchasing Division
2019 Washington Street, East
Charleston, WV 25305

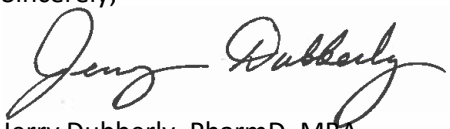
Dear Members of the Evaluation Committee:

Myers and Stauffer LC (Myers and Stauffer) is pleased to provide our technical quote in response to the *Centralized Request for Quote (CRFQ) BMS2500000001: Medicaid Actuarial Services and Managed Care Program Administration* to the state of West Virginia, Department of Human Services (State), Bureau for Medical Services (BMS or the Bureau). We acknowledge receipt of all CRFQ documents and addenda.

As the incumbent performing this work during the past three years, we have had the pleasure of supporting BMS with its advancement of the West Virginia Medicaid managed care program, and we look forward to the opportunity to continue this success.

It is our most sincere intent that our proposal clearly indicates that Myers and Stauffer is uniquely qualified and eager to continue our support of the Bureau with not only services that meet the specifications of the CRFQ, but also the experience and insight that will positively benefit the State and your Medicaid beneficiaries. If you require additional information or would like a presentation of our capabilities, please contact me at JDubberly@mslc.com or 404.290.8370. We look forward to working with the Bureau to support the future success of the West Virginia Medicaid program.

Sincerely,



Jerry Dubberly, PharmD, MBA
Principal

II. Table of Contents

List of Tables

List of Figures

Myers and Stauffer is a national CPA firm, specializing in accounting, consulting, program integrity, and operational support services to public health care auditing and social service agencies. We are a limited liability company organized in the state of Kansas. Myers and Stauffer is wholly owned and managed by its partners and does not have parent or subsidiary companies. We have elected to operate our CPA firm under an alternative practice structure, as defined by the American Institute of Certified Public Accountants (AICPA). Under this structure our staffing resources are obtained through a contract with the publicly traded company CBIZ, Inc. All staff we obtain through this relationship work exclusively for Myers and Stauffer. Specifically, in 1998, we entered into a transaction with CBIZ, which resulted in the creation of CBIZ M&S Consulting Services, LLC. CBIZ M&S Consulting Services, LLC is wholly owned by CBIZ. As part of this business model, Myers and Stauffer acquires office space, personnel, and other business resources from CBIZ M&S Consulting Services, LLC. These resources, including personnel and consultants, are assigned exclusively to serve the clients of Myers and Stauffer. AICPA professional standards provide specific guidance regarding independence within alternative practice structure firms. These professional standards are published in the Independence, Integrity and Objectivity section of the AICPA Code of Professional Conduct at ET Section. 1.220.020. We fully comply with this and all other professional standards.

III. Designated Contact Information Form

DESIGNATED CONTACT: Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

(Printed Name and Title) Jerry Dubberly, PharmD, MBA - Principal

(Address) Myers and Stauffer LC/1349 W Peachtree St. NE, Suite 1600/Atlanta, GA 30309

(Phone Number) / (Fax Number) Phone: 866.758.3586/Fax: 404.524.0782

(email address) JDubberly@mslc.com

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through *wv*OASIS, I certify that: I have reviewed this Solicitation/Contract in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation/Contract for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that this bid or offer was made without prior understanding, agreement, or connection with any entity submitting a bid or offer for the same material, supplies, equipment or services; that this bid or offer is in all respects fair and without collusion or fraud; that this Contract is accepted or entered into without any prior understanding, agreement, or connection to any other entity that could be considered a violation of law; that I am authorized by the Vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on Vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

By signing below, I further certify that I understand this Contract is subject to the provisions of West Virginia Code § 5A-3-62, which automatically voids certain contract clauses that violate State law; and that pursuant to W. Va. Code 5A-3-63, the entity entering into this contract is prohibited from engaging in a boycott against Israel.

Myers and Stauffer LC
(Company)

(Signature of Authorized Representative)
Jerry Dubberly, PharmD, MBA - Principal April 21, 2025
(Printed Name and Title of Authorized Representative) (Date)
Phone: 866.758.3586/Fax: 404.524.0782
(Phone Number) (Fax Number)
JDubberly@mslc.com
(Email Address)

Revised 8/24/2023

IV. Executive Summary

Myers and Stauffer understands BMS is seeking actuarial services and program oversight for the State's Medicaid managed care programs, including the Mountain Health Trust (MHT), West Virginia Children's Health Insurance Program (WVCHIP), and Mountain Health Promise (MHP) programs, and other programs, as needed.

MYERS AND STAUFFER LC At A Glance

47 years of experience as a national CPA firm with specialization in ***public sector health care programs and oversight***.

More than ***1,000 staff members***, including 43 partners and a vast network of professionals who work full-time serving our government clients.

National leader in ***managed care*** services; ***20 years*** of managing and monitoring managed care contractors.

Hands-on experience ***protecting financial interests*** of government agencies in ***all 50 states*** including ***19 years assisting West Virginia***.

Dedicated to serving only government agencies, the Myers and Stauffer Team has ***no conflicts of interest***.

Combining our client-first approach with our insight into health care programs across the country, Myers and Stauffer's Medicaid and other human services agency clients, including public health agencies in West Virginia, have spanned all 50 states, Washington D.C., the U.S. territories, and the federal government. With more than 20 years of experience providing Medicaid managed care program administration and consulting services across 27 states and for the Centers for Medicare & Medicaid Services (CMS), we far exceed the minimum experience required in the CRFQ. These services include managed care consulting, policy development, program design, procurement and contract development, readiness reviews, implementation, oversight and monitoring, and ongoing subject matter expertise. In fact, we have provided all of these services to BMS over the course of our current contract.

Our proposed solution includes Milliman Actuarial Consulting (Milliman) as our subcontractor for the provision of actuarial services. Milliman is nationally recognized for their actuarial and evaluation capabilities. They are the current actuary of record for 19 state Medicaid agencies, representing nearly four times the experience specified in the CRFQ. Each of these relationships include being the primary actuary certifying actuarially sound managed care capitation rates. Milliman has been serving many of its current Medicaid agency clients for more than 20 years and setting managed care rates for more than 30 years. This level of consistency speaks volumes to the quality and value they continue to bring to their state Medicaid agency partners.

What this Means for the Bureau

As shown on the following page in *Figure 1*, over the past three years, BMS has come to know Myers and Stauffer and Milliman (collectively referred to as "the Myers and Stauffer Team" or "the Team") as a trusted partner based on our:

- Experience.
- Knowledge and expertise.
- Quality service delivery.

We take our responsibilities seriously when it comes to serving the needs of the Bureau and its programs, and we always aim to provide value and deliver high-quality services. Our firm-wide culture is one that places quality above all other characteristics when delivering services. We have established review procedures and a mindset that each assignment must add value, serve the current project goal, and be completed timely and to the highest-quality standards.

Figure 1. Client Profile #1 – Medicaid Actuarial and Managed Care Program Administration: West Virginia

Medicaid Actuarial Services and Managed Care Program Administration

Since 2022, Myers and Stauffer, in partnership with Milliman, has provided oversight of current and new programs developed and operated under existing 1915(b) managed care waivers. West Virginia has two Medicaid managed care programs: Mountain Health Trust (MHT) and Mountain Health Promise (MHP). The MHT program provides essential health care coverage to children and adults with low income and eligible individuals with disabilities, and coverage for children enrolled in the Children's Health Insurance Program (WVCHIP). The MHP program is a specialized managed care program for children and youth in foster care or receiving adoption assistance services. Our consulting services include capitation rate setting, managed care organization (MCO) contract compliance oversight, policy analyses, directed provider payment calculations, medical loss ratio (MLR) examinations, contract development and updates, and dashboard analytical tool oversight.

Relevant Services Provided to the State

Medicaid Managed Care Monitoring and Oversight

MLR Examinations

- Managed the transition of MLR calculations from attestation by a third-party vendor every three years to annual examinations, ensuring MCO compliance with MLR regulations and the Bureau for Medical Services (BMS) requirements.
- Conduct standing meetings with client leadership and MCOs to identify issues as they arise and provide assistance and resolution.

Encounter Data Validation (EDV) Analysis

- Conduct bi-monthly EDV analysis and reporting to ensure MCO compliance with contractual requirements.
- Maintain a Known Issues Log of all historical and ongoing data issues and propose solutions to the State and the Medicaid Management Information System vendor, resulting in high quality and reliable encounters for monitoring the MHT, MHP, and WVCHIP programs.

Provider Network Analysis (PNA)

- Analyze MCO provider network adequacy reports to identify provider network gaps with emphasis on rural and underserved areas.
- Develop a final assessment of MCO provider network adequacy for use by BMS.
- Working with BMS to improve the PNA methodology for compliance with the Centers for Medicare & Medicaid Services (CMS) final rule.

MCO Reporting

- Oversight and analysis of required MCO reporting to identify trends in MCO performance and opportunities for improvement.
- Prepare and track submission of all required MCO regulatory and performance reporting, review MCO reports for contractual compliance, and work with client and MCOs to address issues in reporting.
- Responsible for completion and submission of the Managed Care Program Annual Report (MCPAR).

MCO Member and Provider Materials

- Conduct reviews of all MCO member and provider materials to ensure compliance with the MCO contract, and state and federal regulations. Materials include enrollee handbooks, provider manuals, subcontractor agreements, marketing plans, as well as others.
- Update document review requirements on an annual basis to adapt to policy or regulatory changes.

Rate Setting and Analyses

MCO Capitation Rate Setting

- Conduct annual MCO capitation rate setting for the MHT and MHP programs, including mid-year adjustments, ensuring actuarially sound rates approved by CMS.
- Coordinate meetings and written communication with MCOs to address the rate setting process and rates prior to CMS submission.
- Provide fiscal impact analysis on proposed benefit changes.

Provider Rate Setting

- Support Medicaid rate setting and payment methodology services related to inpatient hospital prospective payment system (PPS), outpatient hospital payment system, and physician Resource-Based Relative Value Scale (RBRVS) system.
- Review service rates and make rate methodology design recommendations for home and community-based services (HCBS) waivers.
- Review cost reports and supporting documentation to develop prospective payment system (PPS) rates for federally qualified health centers (FQHCs) and rural health clinics (RHCs) and assist the State with adjusting PPS rates for changes in scope of services.
- Provide cost reporting training for Certified Community Behavioral Health Clinics (CCBHCs) and develop PPS-1 rates with quality incentives.
- Conduct provider payment reviews associated with rate changes implemented by the State and/or requested by providers. This includes calculating estimated fiscal impacts of the changes.
- Responsible for nursing facility Patient-Driven Payment Model (PDPM) implementation and Capital Reimbursement redesign.
- Support the transition of rate setting from the Office of Accountability and Management Reporting (OAMR) to BMS for the following services: ambulance, ambulatory surgery centers (ASC), clinical lab, dental, durable medical

equipment (DME), graduate medical education (GME), FQHC/RHC, Home Health, Hospice, intermediate care facility (ICF), physician-administered drugs, physician fee schedule, substance use disorder (SUD), vaccines, and vision.

Support for West Virginia Finance Initiatives

Financial Analyses and Reporting

- Work closely with BMS to support the State's budget development, analysis of options to address shortfalls in BMS budget, and quantify their potential programmatic and fiscal impacts.
- Support BMS by evaluating draft and passed legislation to assess fiscal and operational impact to BMS.
- Calculate the annual Incurred But Not Reported (IBNR) liability for the West Virginia Medicaid fee-for-service (FFS) program.
- Support review of federal financial reporting (e.g., CMS-64 reports) to promote accuracy and ensure proper claiming of federal funds.
- Audit provider spending of American Rescue Plan Act (ARPA) funds to ensure funds were spent appropriately and in compliance with CMS guidelines.
- Conduct budget neutrality calculations for the 1115 Continuum of Care waiver.

Reports and Briefs

- During the annual legislative sessions, support client leadership in research, fiscal note analyses, preparation of leadership materials for Committee presentations, and budgetary projections in response to legislative priorities.
- Develop budget reports highlighting long-term risks to the client budget and strategies to continually improve quality and fiscal efficiency.
- Maintain a repository of briefs, anticipating key topics and client needs, to ensure leadership has immediate access to data and policy insights for budget hearings, legislative sessions, and other engagements.

Contracts and Waivers

- Amends MHT and MHP managed care contracts on a semiannual basis, accounting for policy changes, updates to federal regulations, and stakeholder input.
- Manage communications with MCOs regarding managed care contract changes, including new reporting requirements.
- Support negotiations with CMS for approval of program enhancements and capitation rates.
- Support the 1915(b) waiver extension and renewal application for both MHT and MHP, including cost effectiveness analyses, and negotiations with CMS.

Directed Payment Programs (DPP)

- Support for the State's hospital and physician DPPs, including annual updates to the existing program and assisting the State with significant program expansion in response to recent legislative changes.
- Calculate payments and monitor revenue requirements for two programs: eligible hospitals and contracted providers.
- Lead workgroup with the State and DPP stakeholders, including the West Virginia Hospital Association, to promote communication and collaboration regarding program oversight, regulatory changes and quality improvement.
- In collaboration with West Virginia Medicaid Finance, develop communications with MCOs regarding payments and timelines.

Quality

- Developed the BMS Quality Strategy for 2024 – 2027, including involvement of a stakeholder workgroup. The Quality Strategy included MHT and WVCHIP components, and newer BMS initiatives, such as Certified Community Behavioral Health Clinics (CCBHCs) and the MCO quality withhold program.
- Leading implementation of new quality initiatives under Senate Bill 820 (2024): Day one enrollment and MCO quality withhold program.

Program Integrity

- Conducted Non-Emergency Medical Transportation (NEMT) Provider reviews and provided consulting services to establish and implement a Fraud Risk Management (FRM) Plan that will serve as the framework for assessment of fraud risks facing the NEMT program.

Client Support and Engagement

- Develop annual reports for the MHT and MHP programs detailing member enrollment and demographics, MCO performance, and quality improvements.
- Support and oversee implementation of the 2024 Medicaid and CHIP Managed Care Final Rule.
- Facilitate standing meetings with client managed care and financial leadership to provide status updates, identify strategic priorities, and propose recommendations.
- Maintain and update the MC-Ops dashboard, a comprehensive data source for managed care demographics, MCO performance, and quality metrics over time. This tool supports the leadership decision-making process and provides readily available information for reporting purposes.
- Oversee preparation of client leadership presentations for MCO updates on managed care program changes, provider association meetings, national professional association conferences, and member advocate meetings.

Impact on West Virginia's Public Health Programs

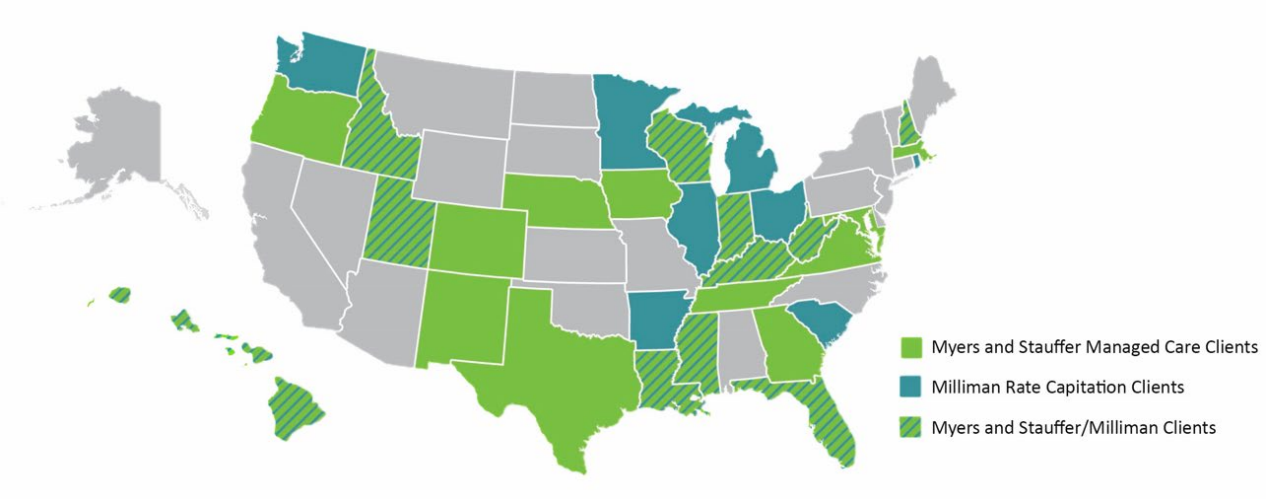
- Implementing quality initiatives under Senate Bill 820 (2024) focusing on improving SUD outcomes: automatic day one enrollment into managed care and the MCO quality withhold program.
- Providing recommendations to improve contractual language, reporting requirements, oversight, and MCO accountability for services delivered to Medicaid and Children's Health Insurance Program (CHIP) managed care members.
- Managing improvements in provider rate setting reviews and rate methodology design, including HCBS waivers, FQHCs/RHCs, and physician fee schedules, to enhance provider satisfaction and outcomes.
- Supporting West Virginia in identifying issues and opportunities for improvement in MCO performance, and quality.
- Supported BMS and the Bureau for Social Services in evaluating provider rate setting opportunities to improve in-state residential provider access for children and youth in foster care.
- Developed and implemented recommendations for enhancing encounter data integrity that resulted in improved accuracy, completeness, and timeliness of information available to BMS for MCO capitation rate setting, analytics, measuring quality, and evaluating the MHT and MHP managed care programs.

Why the Myers and Stauffer Team?

Together, the Myers and Stauffer Team combines Medicaid managed care and actuarial knowledge and experience that exceeds the requirements in the CRFQ. Furthermore, our Team has a demonstrated track record of providing an impeccable level of expertise and value to BMS.

As shown in *Figure 2,* our Team brings BMS our Medicaid managed care consulting and capitation rate setting experience and best practices from more than 30 states.

Figure 2. Myers and Stauffer Team: Current Managed Care and Capitation Client Map



Our West Virginia-specific experience as the incumbent vendor, coupled with our extensive national expertise in Medicaid managed care, means the transition to this new contract will be seamless.

What This Means for BMS

*The selection of the Myers and Stauffer Team will ensure the **continuity of critical work and initiatives** underway, alleviating the need for BMS staff to devote months to transition activities when it has access to a demonstrated, high-performing partner. Our Team not only **meets, but far exceeds all requirements** and has proven the ability to provide all services sought through this CRFQ.*

V. Qualifications (CRFQ Specifications: Section 3)

The Myers and Stauffer Team attests that we exceed the minimum qualifications listed in CRFQ Section 3.

Experience (3.1)

Medicaid Managed Care Contract and Policy Development and/or Oversight

The Vendor(s) must have a minimum of five years' experience in Medicaid managed care contract and policy development and/or oversight.

The Vendor is required to have experience providing both services in at least five states, either as a prime vendor or subcontractor.

The Myers and Stauffer Team offers an exceptionally qualified and experienced consulting team that combines West Virginia-specific experience with nearly 70 combined years of organizational experience supporting federal, state, and local health and public health agencies. We exceed all CRFQ specifications having worked on managed care-related contracts with more than 27 states since the early 2000s.

Our Team brings the Bureau considerable expertise with MCO strategic planning and best practices, program design, waiver development, procurement, program implementation, policy analysis, audits, operations, oversight, and evaluation. We have extensive experience conducting analyses of policy opportunities, legislation and regulations, and best practices. In addition to our Team's experience, many of these areas benefit from Myers and Stauffer staff's previous employment with state Medicaid agencies and CMS. Our scope of comprehensive services helps ensure that program design, procurement approaches, and ongoing oversight are aligned with the State's needs and are poised to achieve intended performance goals. As the incumbent, we will be able to continue our work providing support to BMS to ensure appropriate rate setting and oversight of MCO operations without disruption. As we do currently, we will leverage our multi-state managed care knowledge and experience as we offer West Virginia-specific solutions.

Highlights of our work with Medicaid agencies in MCO program design, procurements, contract development, program reviews, policy analyses, audits, encounter data validation (EDV), implementation, and monitoring activities, include the following:

Program Design

- Facilitating strategic planning activities to design or improve managed care programs, operations, and performance.
- Conducting options analyses (e.g., benefits, services, programmatic changes, etc.) and performing detailed fiscal and operational feasibility analyses.
- MCO program design, planning, and implementation.
- Development of managed care procurement vehicles (e.g., RFPs, RFAs, etc.) and draft contract language including performance standards.
- Designing, implementing, and evaluating DPPs authorized under 42 CFR 438.6, including activities, such as strategic planning, stakeholder engagement, drafting of concept papers and the CMS preprint, creating financial models, and designing the evaluation methodology.
- Identifying and pursuing appropriate federal authorities (e.g., State Plan, and 1115, 1135, 1915(b) and 1915(c) waivers, etc.) to accomplish states' objectives.
- Supporting stakeholder engagement and communications, including providers, professional associations, and State-affiliated contractors.
- Working across various Medicaid divisions, as well as sister agencies, in the design and implementation of Medicaid managed care monitoring and oversight activities. These Medicaid divisions may include policy, operations, quality management, utilization management, member services, provider services, pharmacy services, fiscal services, IT and decision support, program integrity, and legal services, as well as internal operational work groups across divisions. Sister agency involvement has included departments of social services, behavioral health, disabilities, aging, juvenile justice, corrections, public health, education, and others.
- Conducting readiness reviews, management of MCO corrective actions, and MCO monitoring activities to ensure managed care enrolled individuals have access to health care services and that our Medicaid agency clients have prompt access to data needed to manage health care programs.

Financial

- Conducting actuarially sound Medicaid managed care capitation rate setting and risk adjustment for state agencies.
- Performing provider payment reviews associated with rate changes implemented by the State and/or requested by providers, including calculating estimated fiscal impacts of the changes.
- Evaluating provider rate methodologies and performing rate setting, analysis, and fiscal modeling across the continuum of Medicaid service providers in both Medicaid FFS and Medicaid managed care environments.
- Providing state DPP design, implementation, and support services to advance states' quality and access agendas.
- Conducting MLR audits consistent with CMS requirements and best practices.
- Supporting states' financial and budget processes.

Legislative/Regulatory Support

- Coordinating states' fiscal note analyses, topic-specific briefs and reports, and presentations during states' legislative sessions and special hearings.
- Evaluating the impact of federal and state legislation and rules on states' managed care programs.
- Supporting negotiations with CMS for approval of program enhancements and capitation rates.

Compliance/Oversight

- Monitoring of MCO and state compliance with contractual, federal, and state regulations and reporting requirements.
- Conducting EDV analyses and providing MCO-specific reporting to improve data integrity and compliance with MCO contract requirements.
- Performing statewide provider network adequacy analyses, reviewing standardized reports for contractual compliance, conducting secret shopper testing, and making recommendations.
- Managing data analytics and presenting MCO performance in useful formats, including the customization and deployment of interactive and user-friendly dashboards.
- Preparing program assessments and evaluations, along with quality and performance improvement recommendations.
- Program integrity strategic planning, oversight, and coordination of activities with states, MCOs, the DOJ, the FBI, CMS, and MFCUs.
- Implementing automated MCO deliverable tracking and reporting systems.
- Facilitating the development of, or revision to, MCO contracts in support of states' goals and monitoring MCO performance and contract compliance.
- Conducting EQR activities to assess compliance with CMS requirements including the quality, timeliness, and access to care provided by the MCOs.
- Developing or revising contract compliance monitoring tools, including MCO reporting templates, to support analysis activities conducted by agency staff.
- Training support agency staff in their understanding of managed care and best practices in effectively monitor managed care programs.

Through our Team's collective nearly seven decades of successful work with state Medicaid agencies and managed care programs, we have gained significant expertise with managed care concepts, programs, and best practices. In addition, our staff are 100% dedicated to public health care programs, and many have previous experience serving in leadership positions within Medicaid agencies, CMS, Medicaid health plans, fiscal agent contractors, health care providers, and a multitude of state and local social service agencies. Our Team includes:

- Medicaid, managed care, and health policy subject matter experts (SMEs).
- Actuaries.
- Health care attorneys.
- Certified Public Accountants (CPAs).
- Certified Fraud Examiners (CFEs).

- Data developers.
- Certified medical record auditors.
- Analysts.
- Pharmacists.
- Medical directors.
- Registered nurses.
- Certified coders.
- Reimbursement system specialists.
- Certified professionals in health care quality.

We also have former staff from both state and federal health agencies and private sector health care entities including Medicaid directors, state Medicaid Surveillance and Utilization Review coordinators, state health officials, hospital accountants, and Medicare intermediary auditors, among other professionals.

As shown in *Table 1*, the Myers and Stauffer Team has the required experience to leverage our multi-state knowledge and experience as we offer state-specific solutions.

Table 1. Myers and Stauffer Managed Care Experience

Myers and Stauffer: Medicaid Managed Care Experience							
Client	**Dates of Service**	**Role**	**Technical Assistance**	**Policy Support**	**Financial Oversight**	**Operational Oversight**	**Encounter Data Oversight**
State Medicaid Programs							
Colorado Department of Health Care Policy & Financing	2016-Present	Prime	✓	✓	✓	✓	
District of Columbia Department of Health Care Finance	2023-Present	Prime	✓	✓	✓		✓
Florida Agency for Health Care Administration	2022-Present	Prime	✓	✓	✓		
Georgia Department of Community Health	2007-Present	Prime	✓	✓	✓	✓	✓
Hawai'i Department of Human Services	2022-Present	Prime	✓	✓	✓		✓
Idaho Department of Health and Welfare	2021-Present	Prime	✓	✓	✓		✓
Indiana Family & Social Services Administration	2022-Present	Subcontractor	✓	✓			✓
Iowa Department of Human Services	2016-Present	Prime	✓	✓	✓	✓	✓
Kentucky Cabinet for Health and Family Services	2018-Present	Prime	✓	✓	✓	✓	
Louisiana Department of Health	2012-Present	Prime	✓	✓	✓	✓	✓
Maryland Department of Health	2006-Present	Prime	✓	✓	✓		
Massachusetts MassHealth	2022-Present	Prime	✓	✓	✓		
Mississippi Division of Medicaid	2015-Present	Prime	✓	✓	✓	✓	✓
Nebraska Department of Health & Human Services	2022-Present	Prime	✓	✓	✓		✓

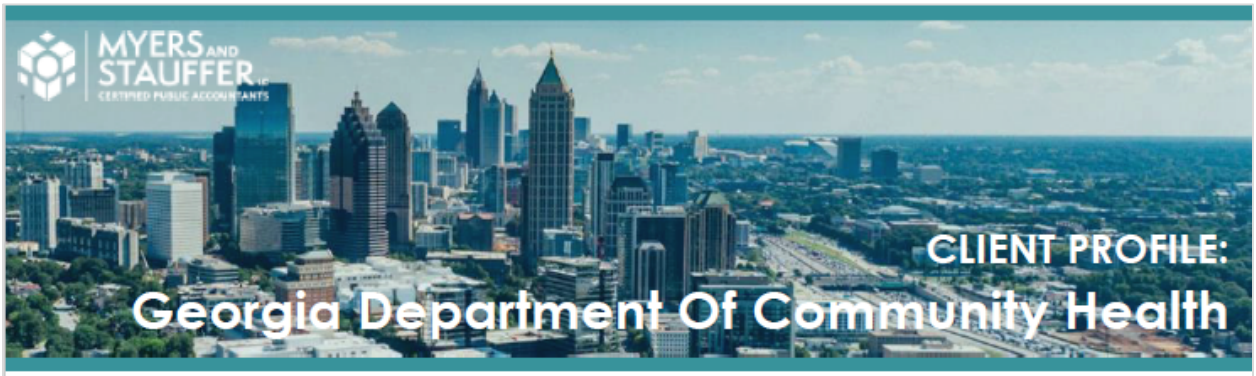
Myers and Stauffer: Medicaid Managed Care Experience							
Client	**Dates of Service**	**Role**	**Technical Assistance**	**Policy Support**	**Financial Oversight**	**Operational Oversight**	**Encounter Data Oversight**
Nevada Department of Health and Human Services	2015-2017	Prime	✓	✓	✓	✓	✓
New Hampshire Department of Health and Human Services	2022-Present	Prime	✓	✓		✓	
New Mexico Human Services Department	2015-Present	Prime	✓	✓	✓	✓	✓
North Carolina Department of Health and Human Services	2018-2019	Prime	✓				
Ohio Department of Medicaid	2020-2022	Prime	✓	✓	✓		
Oregon Department of Administrative Services	2019-Present	Prime	✓		✓		
Tennessee Department of Finance and Administration	2021-Present	Prime	✓	✓	✓	✓	
Texas Health and Human Services Commission	2014-Present	Prime	✓	✓	✓	✓	
Utah Department of Health	2020-Present	Prime	✓	✓	✓		✓
Virginia Department of Medical Assistance Services	2012-Present	Prime	✓	✓	✓		
Washington Health Care Authority	2012-2016	Prime	✓	✓	✓		
West Virginia Department of Human Services	**2022-Present**	**Prime**	✓	✓	✓	✓	✓
Wisconsin Department of Health Services	2018-Present	Prime/ Subcontractor	✓	✓	✓		✓
Federal Programs							
CMS *(Multiple Contracts)*	2008-Present	Prime/ Subcontractor	✓	✓	✓	✓	

In addition to the summary information provided in *Table 1,* we offer the following two representative client profiles to demonstrate our varied experience in supporting states with program design, MCO monitoring and oversight, procurement, and implementation activities.

What This Means for BMS

*Our historical and current work for West Virginia demonstrates our **deep understanding of your specific health care environment**, including its challenges and opportunities. Through our collaborative work with BMS and other agencies, we have learned invaluable lessons that can be applied to this engagement, bringing BMS innovative solutions and best practices.*

Figure 3. Profile #2 – Managed Care Oversight: Georgia



Oversight and Support of Care Management Organizations

Since 2007, Myers and Stauffer has provided oversight of Care Management Organizations (CMOs) for the Georgia Department of Community Health (DCH). The CMOs are the risk-based managed care organizations in Georgia Medicaid that accept risk for Medicaid and Children's Health Insurance Program (CHIP) populations with the exception of individuals who are aged, blind, or disabled (ABD) and those receiving long-term care services and supports.

Relevant Services Provided to the State

Myers and Stauffer assists DCH with oversight and monitoring of the Georgia Families CMOs. We assess the policies and procedures of the program and provide oversight and monitoring of Georgia CMOs. This work includes: contract compliance; subcontractor oversight; encounter reconciliation and validation; performance testing; on-site audits; recommendations for process and contractual improvements; financial reconciliations; review of internal controls; medical loss ratio (MLR) audits; and claim repricing.

We also provide DCH with technical assistance to review subcontractor policies and procedures, contracts, systems, and staff, along with information reported by the CMOs, in order to ascertain whether subcontractors conducted a satisfactory level of program integrity activities.

Myers and Stauffer maintains an online report portal where the CMOs provide their daily, weekly, monthly, and annual reports. The portal tracks timely submission and identifies contract compliance issues using automated technology. Myers and Stauffer has developed online dashboards capturing the information provided in these reports as well as information gathered from submitted encounters. We also support DCH with the submissions of its annual Managed Care Program Annual Report (MCPAR), MLR Report, Network Adequacy and Access Assurances Report, and Medicaid Data Collection Tool (MDCT) for Managed Care Reporting to the Centers for Medicaid & Medicare Services (CMS).

Specific services include:

- Monitoring and reporting of health plan compliance with contractual and regulatory provisions.
- On-site financial and performance audits of the CMOs and their significant subcontractors and recommendations for process and contractual improvements.
- Financial reconciliations and MLR audits.
- Consultation with the Medicaid actuaries to provide input during the rate setting process.
- Reviews of internal controls.
- Post-payment review of claims for accuracy and contract compliance.

- Testing for network adequacy and availability and analyses on care management provider directories and appointment wait times.
- Researching and making recommendations regarding the development of policies and procedures related to the CMO program.
- Bi-monthly reconciliation of encounter data submitted by the health plans and their delegated vendors to the Department's Medicaid Management Information System vendor, Hewlett Packard Enterprise Services, to ensure completeness and accuracy.
- Collaboration with DCH's fiscal agent to identify issues with accurately storing and reporting health plan submitted encounter data.
- Recommendations of operational changes to enhance the reliability of encounter data.
- Reconciliation and testing of Affordable Care Act required payment increases for compliance with state and federal statutes.
- Review of International Classification of Diseases (ICD), 10th Revision, for readiness and identification of potential red flags to be addressed by the health plan and the Department.
- Post-payment review of claims for accuracy and contract compliance.
- Global analysis of claim payment, denial trends, and other care management performance-related utilization trends.
- Preparation of written and oral reports, including presentations to DCH, the Board of Community Health, and legislative committees.
- Supported onboarding and go-live of four CMOs through development of a Command Center strategy with clear lines of reporting, accountability, and authority across the CMOs and state staff.
- Provide assistance to DCH with the readiness review of CMOs. Reviews include assessing the CMOs' facility and system integration, member and provider outreach, training, communications, provider network management, and call center operations; determining system readiness for claim processing and timely provider payments; determining readiness to submit encounter claims; assessing subcontractor readiness; and assessing other systems readiness, including coordination of benefits, member and provider appeals, utilization review, quality improvement, and reporting.

Impact on Georgia's Public Health Programs

- Recommendations to improve encounter data resolution have positively impacted DCH's ability to analyze, manage, and evaluate the program by enhancing the accuracy, completeness, and timeliness of the information available to them.
- The enhancement of contractual language and CMO accountability has allowed DCH to focus on clear, measurable performance expectations, robust quality monitoring, and assess corrective action plans or liquidated damaged for non-compliance. DCH has been more proactive and can identify issues and opportunities for improvement, which allows DCH to anticipate problems and take preventative measures. It facilitates the identification of areas where improvements could be made, ultimately leading to better outcomes for the Georgia Families and Georgia Families 360 programs they manage.
- Readiness reviews for the CMOs and their subcontractors to ensure a smooth and successful implementation of Georgia Families and Georgia Families 360 programs. These reviews focus on key areas like network sufficiency, continuity of care protocols, and the adequacy of claims processing systems to minimize disruptions and provider issues. As part of its contract compliance reviews, Myers and Stauffer has identified a number of issues, including: inappropriate neonatal intensive care unit payments; inaccurate and untimely encounter data; untimely submission

of hospital statistical and reimbursement reports; inaccurate processing and payment of claims; inadequate provider networks and provider directories; and risks and weaknesses in internal controls through on-site audits. The Department uses the findings and recommendations provided in all analyses and reports to ensure the plans are operating in accordance with contractual requirements. Ultimately, our work has helped support better compliance by providing the Department in-depth insight into program issues.

- Assist with the implementation and assessment of corrective action plans as a result of the findings identified in ongoing monitoring and oversight of the CMO regulatory reports and on-site compliance audits

Figure 4. Profile #3 – Managed Care Oversight and Other Services: Kentucky

Managed Care and Other Consulting Services

Since 1998, Myers and Stauffer has assisted the state of Kentucky with a variety of engagements to support the administration and reporting for the Medicaid program. Over the course of more than 26 years, we have become a trusted advisor to both the Kentucky Cabinet for Health and Family Services (CHFS) and Kentucky Department for Medicaid Services (DMS) in that we routinely take on new projects for the agency, performing research, ensuring compliance, providing quality deliverables, and offering advice to our client representatives. We provide timely solutions to some of the Commonwealth's most challenging health care delivery issues. Our involvement provides transformation of the Medicaid program by using national best practices and subject matter expertise to develop innovative solutions for the programs.

Relevant Services Provided to the State

Managed Care and other Medicaid-Related Services

Medicaid Managed Care Organization (MCO) Request for Proposal (RFP) Development (2024-Present): Assist with the development of an RFP that incorporates best practices, innovation, and value-based purchasing and is compliant with federal and state laws, regulations, and policies. Previously performed a similar scope of work from 2018-2021 where we also supported implementation of the contracts.

Managed Care Consulting Services (2018-2022): Provided Medicaid managed care strategic planning, extensive stakeholder engagement, and review of managed care contracts in comparison states for DMS. Work included:

- Making recommendations for the next generation of managed care in Kentucky, drafting the Medicaid MCO procurement documents and procurement evaluation tools, and supporting the resulting contracts' implementation.
- Conducted a review of the Commonwealth's managed care quality and oversight team skill sets, training needs, and organizational structure.
- Assisted with strategic planning and development of the Supporting Kentucky Youth (SKY) Program for children and youth in out-of-home care, children receiving adoption assistance, youth who are dually involved, former foster care youth, and Medicaid-eligible youth in the juvenile justice system.
  - Worked with DMS, the Department for Community Based Services (DCBS), the Department of Juvenile Justice, and the Department for Behavioral Health, Developmental and Intellectual Disabilities to develop the program design and resulting contract materials.
  - Our team members also facilitated cross-agency collaboration for implementation of the SKY Program and supported DCBS planning to prepare for implementation and administration of the program.

Medicaid Pharmacy Administration Consulting (2021-Present): Designed a Managed Care Single Pharmacy Benefit Management (PBM) model, provided project management support and subject matter expertise for contract implementation activities, and continued support for ongoing operations of the model and for the DMS pharmacy program. Also supporting DMS with implementation activities for a new PBM contract for the fee-for-service delivery system and management of the single preferred drug list and rebates. Additionally, provided support for the Commonwealth's Medicaid pharmacy benefit including, but not limited to, analyses of drug ingredient reimbursement methodologies, professional dispensing fees, 340B policy compliance procedure coded over-the-counter drugs, drug rebate performance, and MCO PBM rates related to enacted legislation.

Waivers

Independent Assessment 1915(b) Waiver Program (2020-2021): Performed an independent assessment of the Commonwealth's 1915(b) waiver for the Kentucky Medicaid Managed Care Program as required by the Centers for Medicare & Medicaid Services (CMS) for renewal of the waiver program. Developed a research design, analyzed the quality, access, and cost-effectiveness of the program over a two-year program period, and developed a final report for submission to CMS, which was subsequently approved.

1915(i) State Plan Amendment (SPA) (2024-Present): Supports the 1915(i) cross-agency initiative, which facilitates community-based care for Medicaid-eligible individuals with severe mental illness (SMI) and co-occurring substance use disorders (SUDs). Provide project management services, as well as change management services supporting the design and implementation of services to enhance community participation and treatment access. Also provide technical assistance to support policy development, system integration, and stakeholder training. Our work involves creating communication strategies to increase awareness and engagement, along with monitoring systems to ensure compliance and effectiveness.

Children's Waiver Program Restructuring (2024-Present): Comprehensive review of existing programs, stakeholder engagement, and the design of new models to enhance service delivery for initiative and to develop innovative strategies to ensure children and youth in need of placement receive appropriate care and housing resources. Key activities include identifying service gaps, ensuring alignment with Medicaid guidelines, and restructuring waiver programs to provide a continuum of care. Myers and Stauffer's technical assistance also supports the development of performance metrics to evaluate program outcomes and create sustainability plans.

SMI 1115 Demonstration (2024-Present): Support activities that include the development of community-based care programs, workforce training, and the integration of telehealth services. Technical assistance to support program design, stakeholder collaboration, and the implementation of policy, regulations, protocols, and data-driven performance measures to ensure improved health outcomes.

SUD 1115 Demonstration: Recovery Residence (2024-Present): Program design, policy alignment, and stakeholder training to operationalize recovery residences. Deliverables include guidelines for program management, outreach strategies, and data collection protocols to assess program impact.

Recuperative Care 1115 Demonstration (2022-Present): Technical assistance involves designing recuperative care models, establishing partnerships with community organizations, and integrating services with Medicaid systems. Deliverables include comprehensive implementation plans, evaluation frameworks, and strategies for sustainability and scalability.

Reentry 1115 Waiver Demonstration (2023-Present): Developed Kentucky's DMS Reentry 1115 waiver application submitted in December 2023 and approved by CMS in July 2024. Provide project management and technical assistance services to support DMS with its Reentry 1115 demonstration and Consolidated Appropriations Act projects.

Other Relevant Projects

Transforming Care for the State's Children (TCKC) (2024-Present): Technical assistance and change management services to guide state leadership in the development and execution of strategic initiatives for this comprehensive, multi-year initiative aimed at enhancing the existing system of care for all Kentucky children, youth, and families.

School-Based Behavioral Health Services Enhancement (2024-Present): Developed the CMS-funded school-based services grant application on behalf of DMS and supports DMS' project to enhance access to behavioral health services for school-aged children through the implementation of evidence-based care models.

Statewide Behavioral Health Needs Assessment (2023-Present): Conduct a comprehensive analysis of the Commonwealth's behavioral health system to identify service gaps, unmet needs, and opportunities for improvement.

Community Co-Response (CCR) Project (2022-Present): Provide technical assistance, including strategic planning, workforce training, and the development of operational frameworks to develop and implement co-response models where law enforcement and behavioral health specialists work together to respond to crises.

Shared Consultant for Targeted Case Management (2022-Present): Restructuring of Medicaid payment models for medically necessary treatment services.

Certified Community Behavioral Health Clinic (CCBHC) Demonstration Grant and Quality Measures Consulting (2021-Present): Supports the Department's CCBHC Demonstration Program implementation, operations, and ongoing policy development with a strong focus on quality and monitoring and oversight activities.

Multisystemic Therapy (MST) Pilot Evaluation Consultant (2021-Present): Conduct an independent evaluation of the MST pilot program.

Medicaid Rate Setting (1998-Present): Medicaid rate setting and consulting services for the state.

Mobile Crisis Intervention (MCI) Consulting Services (2021-2024): Project management support, technical assistance, and strategic planning to DMS, supporting the Commonwealth's MCI Planning Grant Project with the goal to expand and strengthen Kentucky's mobile crisis services to better assist those experiencing a behavioral health crisis and divert them from hospitals, jails, and prisons.

Impact on Kentucky's Public Health Programs

- Promoted an efficient managed care delivery system for more than 1.2 million Kentuckians.
- Designed a health care delivery system focused on the needs of vulnerable children and youth served through foster care, adoption assistance, and the juvenile justice system.
- Facilitating a high-fidelity model that creates a true continuum of care for Kentucky's children with high needs.
- Created strategies to reduce Kentucky's home and community-based services (HCBS) waiver waitlist for children to connect them with services sooner.
- Helped integrate behavioral health providers and law enforcement to promote treatment over incarceration where appropriate.
- Supported increased payments to providers to recognize quality and improved health outcomes.

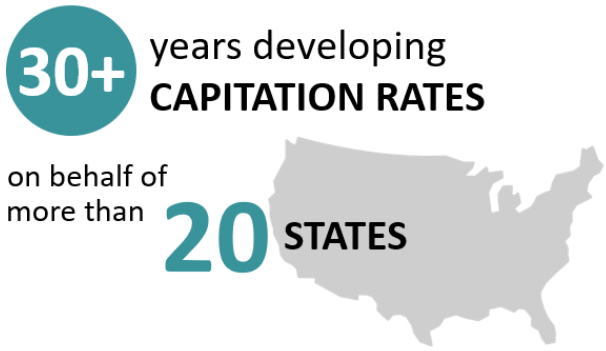
Experience: Capitation Rates for Medicaid Managed Care Organizations

The Vendor(s) must have a minimum of 10 years of experience in the development of capitation rates for Medicaid managed care organizations.

The vendor is required to have experience providing both services in at least five states, either as a prime vendor or subcontractor.

The Myers and Stauffer Team's actuarial partner, Milliman, has provided actuarial services to public health clients, including state Medicaid and CHIP agencies, for over 30 years with more than 20 states served during that time.

Milliman's staff consists of the highest credentialed Medicaid practice in the country in terms of the number of credentialed actuaries on staff and the level of their education. All lead actuarial personnel proposed for the BMS contract have achieved the highest level of professional certification available to actuaries in the United States, including fellowship in the Society of Actuaries (SOA) (FSA), as well as membership in the American Academy of Actuaries (MAAA).



The Medicaid actuarial space requires a highly unique set of skills that only certain firms can provide. Because only state actuaries can set and certify the rates to be accepted by CMS, the State owns the entire process of setting the rates. Even in a situation when plans may bid rates during the procurement, only the state actuary is able to sign the CMS certification and be responsible for the soundness of the rates. States must choose an actuarial consultant who is not only experienced, but whom they can trust to put the needs of the state at the forefront.

Our proposed lead and staff actuaries have the Medicaid managed care rate setting experience to meet requirements of this solicitation. While our lead actuaries have Medicaid health plan experience, their expertise is focused on the managed care capitation rate setting process for at least 10 years. Our staff actuaries also specialize in Medicaid managed care rate setting, which exceeds the requirements of this solicitation.

The following list summarizes how our actuarial subcontractor meets and exceeds the requirements to serve as the certifying actuarial vendor for the West Virginia Medicaid programs:

- **Rate Certifications.** Milliman actuaries are qualified and prepared to certify actuarially sound rates for programs receiving federal financial participation (FFP) while incorporating the broad and deep Medicaid managed care experience they have accumulated. They have also set rates for numerous state-only funded programs, and while not reviewed by CMS, they adhere to the same quality standard for those programs as well.

- **Risk Adjustment.** Milliman has extensive experience in developing and applying risk adjustments to Medicaid managed care capitation rates. For acute care rates, they have expertise in developing customized state-specific modeling weights for the Chronic Disability Payment System in several states. Although this is a primary risk adjustment tool in Medicaid, they have experience using a variety of other tools to best meet state needs. In addition, they have developed state-specific behavioral health and long-term care (LTC) risk adjustment tools.

Managed Care Focus

Because our Team specializes in Medicaid managed care, we have more than 10 years of continual experience in the development of capitation rates for Medicaid managed care programs. Managed care is our Team's primary focus.

Subject Matter Experts with Broad Knowledge Base

- **Capitated Health Plan Negotiation.** Milliman has a long history of developing constructive partnerships with capitated health plans and state Medicaid agencies to develop rates that are sufficient, but not excessive, and provide adequate service access and quality. To ensure that capitated health plans fully understand the rate setting methodology and assumptions, Milliman in collaboration with the state holds both collective and individual meetings with plans prior to rate setting, after draft capitation rates, and to present final results. This approach best allows prompt submission of rates to CMS and further ensures that all parties are able to follow the capitation rate calculations, understand all data, methodology, and assumptions used in the process. This process leads to fact-based productive dialogue during rate discussions with health plans.
- **Capitated Health Plan Re-Procurement Support.** Milliman has assisted many state clients in their Medicaid capitated health plan re-procurement efforts. Selecting quality capitated health plans is an important part of administering a Medicaid managed care program to ensure beneficiaries receive quality care in a cost-effective manner. Milliman supported many states with strategy considerations in designing the procurement structure, as well as structuring the requested information related to capitation rates, provider contracting, managed care savings opportunities, and administrative costs. They assist states with better understanding the information submitted by the capitated health plans, especially in cases where technical information was requested.
- **Supporting Documentation and other Stakeholder Communications.** For all major deliverables, Milliman will provide reports that clearly document the methodology and assumptions used to develop results. Clarity, transparency, and responsiveness are invaluable in establishing trust with capitated health plans and other key stakeholders. For any items needing further clarification or refinement, Milliman has worked with states, including West Virginia, to ensure they and the capitated health plans understand the methodology underlying the original or revised results.
- **Evaluating Legislative and Policy Changes.** Milliman is familiar with the legislative cycles that often impact Medicaid rate setting and financial projections and will work with BMS to incorporate new legislative and policy initiatives into the capitation rate development process on a timely basis.

- **Medicaid Policy Analysis.** Milliman actuaries have worked with clients to review and analyze major federal legislation and regulation affecting the Medicaid program and CHIP. They work with clients to understand and implement federal policy changes in the best interest of their programs.
- **Quality.** Milliman is committed to maintaining their national reputation for integrity and high-quality work. They ensure the highest quality results through internal control procedures, resulting in capitation rates that are as accurate as possible for the populations and benefits covered under a Medicaid managed care program. All work is peer reviewed before being submitted to clients. Milliman's actuarial credentialing process goes beyond the SOA, requiring individuals to demonstrate competency through experience, technical knowledge, and high sensitivity to quality before being granted authority to sign deliverables.
- **Collaboration and Training Opportunities.** Milliman provides opportunities for state Medicaid agency clients to discuss issues with other state clients. They annually host a live, free, State Medicaid Client Forum attended by the financial and policy leaders of Milliman's state Medicaid agency clients. Milliman's many Medicaid experts present on current issues facing Medicaid programs nationwide and allow state Medicaid agency participants to openly share ideas and concerns with each other. In addition, Milliman often hosts webinars discussing hot topics or recent federal regulation changes.
- **Innovation.** Milliman pursues continuous improvement of the data sources, methodologies, and strategies underlying the rate development services provided to state Medicaid agency clients.
- **Independence.** Milliman is wholly owned and managed by approximately 450 principals that have been elected in recognition of their technical, professional, and business achievements. Their sole business is providing independent consulting services and products to clients. The consultants of the firm are neither permitted to own stock in any insurance or reinsurance company, nor are they allowed to own stock in client organizations. Due to these policies, Milliman, like Myers and Stauffer, provides analyses and opinions that are entirely independent and objective. Most importantly, they do not answer to public shareholders or investment firms whose sole goal is maximizing profit. Rather, they put clients' needs first as their entire business model depends on their continued satisfaction.
- **Transparency.** Milliman is committed to transparency in the rate setting process with respect to the underlying data, assumptions, and adjustments utilized in the capitation rate development. They strive for a collaborative relationship with state Medicaid agency clients, where Milliman is viewed as a trusted partner. At the same time, they work towards a professional, positive relationship with the contracted capitated health plans with open lines of communication so issues can be identified and addressed proactively. They have found this type of relationship results in productive, fact-based discussions with capitated plans regarding their encounter data, financial data, and questions about the assumptions used in rate development. It is important for the capitated health plans to trust the rate development process and the information they receive from the State's actuary. Milliman often hears from health plans that their level of transparency in rate setting is by far the best in the industry.

Milliman continues to be a leader in providing transparent and robust actuarial documentation as is increasingly required by federal regulators. Because of their work with state clients providing thorough documentation and meeting rate development standards, four of their state clients have been selected by CMS to participate in an accelerated rate review pilot program. Our understanding is that only five state Medicaid programs were selected for this pilot. The accelerated review program is intended to reduce the CMS rate review time for Medicaid programs that have met certain criteria, including:

- Meeting all rate development standards.
- Having no known significant issues in rate setting.
- Submitting complete and thorough documentation.

Our Team is proud of the joint work Milliman and states have accomplished to be a part of this pilot program, and we look forward to continuing collaborative opportunities to further the Medicaid managed care rate development process in West Virginia. Milliman and Myers and Stauffer will continue to work closely together to draw from the expertise of each organization to ensure policy decisions and other technical assistance provided to BMS is highly coordinated between these areas and the rate setting process.

As shown in *Table 2*, our Myers and Stauffer Team is able to leverage our actuarial knowledge and experience as we offer state-specific solutions. Milliman exceeds all CRFQ specifications serving as a prime vendor in 18 of 19 states beyond the 10 years of experience required for current clients. Milliman has also supported capitation rate setting in the past in Arizona, Iowa, Nevada, and Puerto Rico.

Table 2. Capitation Rate Experience

Milliman: Capitation Rate Clients						
Client	Contract Duration	Role	Capitation Rate Setting/Risk Adjustment	Alternative Payment Method Development	Waiver Development and Support	Fee for Service Rate Support
Arkansas Dept of Human Services	2018-Present	Prime	✓			✓
Arizona Health Care Cost Containment System	2019-2022	Prime	✓			
Florida Agency for Health Care Administration	1999-Present	Prime	✓	✓	✓	✓
Hawai'i Department of Human Services	2005-Present	Prime	✓	✓	✓	
Idaho Department of Health and Welfare	2010-Present	Prime	✓		✓	
Illinois Department of Healthcare and Family Services	1998-Present	Prime	✓		✓	
Iowa Department of Human Services	2015-2018	Prime	✓		✓	✓
Indiana Family & Social Services Administration	2000-Present	Prime	✓	✓	✓	✓
Kentucky Cabinet for Health and Family Services	2020-Present	Prime	✓	✓	✓	
Louisiana Department of Health	2022-Present	Prime	✓		✓	

Milliman: Capitation Rate Clients						
Client	Contract Duration	Role	Capitation Rate Setting/Risk Adjustment	Alternative Payment Method Development	Waiver Development and Support	Fee for Service Rate Support
Michigan Department of Health and Human Services	1997-Present	Prime	✓	✓	✓	✓
Minnesota Department of Human Services	1992-Present	Prime	✓	✓	✓	
Mississippi Division of Medicaid	2008-Present	Prime	✓			✓
Nevada Department of Health and Human Services	2002-2020	Prime	✓		✓	
New Hampshire Department of Health and Human Services	2013-Present	Prime	✓		✓	✓
Ohio Department of Medicaid	2007-2011, 2015-Present	Prime	✓	✓	✓	✓
Puerto Rico Department of Health	2001-2022	Prime	✓	✓	✓	✓
Rhode Island Department of Human Services	2019-Present	Prime	✓			
South Carolina Department of Health and Human Services	2008-Present	Prime	✓		✓	✓
Utah Department of Health and Human Services	2010-Present	Prime	✓			✓
Washington Health Care Authority	1996-Present	Prime	✓	✓		
West Virginia Department of Human Services	**2022-Present**	**Subcontractor**	✓		✓	✓
Wisconsin Department of Health Services	2015-Present	Prime	✓	✓		✓

In addition to the summary information provided in *Table 2*, we offer two representative actuarial client profiles below to demonstrate our wide-ranging experience in supporting states with not only actuarial rate setting, but also with program design, MCO monitoring and oversight, procurement, and implementation activities. Milliman's experience in these areas allows the Myers and Stauffer Team to collectively support BMS in a seamless manner.

What This Means for BMS

*The Myers and Stauffer Team's direct experience in multiple states gives us the **deep knowledge base to create customized solutions** for West Virginia. This allows us to provide BMS comprehensive advice, consulting, actuarial, and audit services that other vendors cannot. We pride ourselves on understanding how audits, rate setting, and policy decisions impact all aspects of state programs.*

Figure 5. Client Profile #4 – Capitation Rate and Actuarial Consulting: Washington

Actuarial Consultant Services

Since 1996, Milliman has worked with the Washington Health Care Authority (HCA) on a variety of actuarial and benefits needs throughout the agency that vary in scope and nature. The typical needs and the most impacted agency organizations are described in detail below. The largest work efforts are rate setting for the Apple Health managed care organizations (MCOs) (Medicaid), rate setting for the self-insured Public Employees Benefit Board (PEBB) and School Employees Benefits Board (SEBB) plans, and rate negotiations with the PEBB and SEBB MCOs.

Relevant Services Provided to the State

Actuarial Analysis

Perform actuarial analysis necessary to support Apple Health programs and functions, including:

- On an as-needed basis, perform actuarial analysis and develop recommendations on possible changes to Apple Health program structure, premium subsidy policies and related issues to improve health care quality for Apple Health clients, and overall program cost effectiveness.
- Provide actuarial analysis and evaluation of proposed legislation relating to Apple Health programs to HCA staff and, as needed, staff legislative committees.
- Provide actuarial consulting services for development of capitation rates for Apple Health programs using standard practices, norms, and benchmarks in the health care industry, including the following:
  - Centers for Medicare & Medicaid Services (CMS) certification of rates.
  - Potential benefits and risks associated with each option, including impact on utilization, cost, and coordination of care.
  - Options to improve the quality of health care delivered to Apple Health clients.
  - Improve affordability to the State (i.e., health care purchasing).
- Work and communicate with MCOs to collect and process data, including confirmation of completeness and data integrity.
- Provide actuarial services to promote transparency and access to measures on quality of care, utilization, efficiency measures, and cost projections.
- Assist in developing an overall risk management strategy for Apple Health programs, including methods to manage risk selection associated with offering multiple health insurance products and health plans; geographic, demographic, and health status risk associated with the Apple Health population; and the financial exposure associated with new technologies, procedures, and pharmaceuticals.
- Peer review, as requested, of budget and legislative processes, fiscal notes, legislative mandates, or procurement activities to ensure projections, modeling, and assumptions are reasonable. Identification of areas of concern and sensitivity to brief turnaround requirements are critical.

- Provide assistance with meeting preparation and attend, or actively participate in, various HCA technical, strategic planning, or key stakeholder meetings, and legislative hearings.
- Assist in the analysis of medical and pharmaceutical claims/encounter data to cost management targets and assessment of formulary rebate methodologies.
- Assist with declaration responses to legal disputes in collaboration with HCA staff and HCA's Assistant Attorney General.

Apple Health Contracts

- Assist the Apple Health management team in evaluation of procurement methodology and approaches.
- Assist in the development of criteria for procuring health plan contracts for Apple Health programs, including criteria weighting as necessary.
- Provide assistance with meeting preparation and attend, or actively participate in the coordination, solicitation, negotiation, or performance review of Apple Health program contracts. Work may include, but is not limited to:
  - Recommend when it is appropriate to solicit proposals from new vendors for contracts supporting the delivery of benefits.
  - Assist in the development and execution of any request for proposal (RFP) or renewal for insured carriers, including development of evaluation criteria, consulting or taking the lead in vendor negotiations, participation in the solicitation selection committee, implementation planning, and stakeholder briefs.
  - Provide advice on vendor contracting, strategic partnerships, and health plan performance improvement strategies, including structuring performance incentives in health plan contracts using qualitative and quantitative performance metrics.
  - Assist with negotiations with health plan vendors on their respective medical rate submissions; identify technical problems; work with vendors to identify and correct assumptions, and negotiate appropriate payment amounts based on Legislative funding, populations served, provider networks, financial experience, and other factors that influence rate development.

Other HCA Program Actuarial and Financial Consulting

- Actuarial and financial analysis of selected health services and the Washington State preferred drug list.
- State-only health care programs.
- Utilization analysis.
- Cost benefit analysis.
- Peer review of work performed by HCA staff.
- Health services consulting.
- Market research and trend analysis.
- Communication strategies and activities related to technology assessment, employee wellness, etc.
- Public meeting assistance.

Milliman

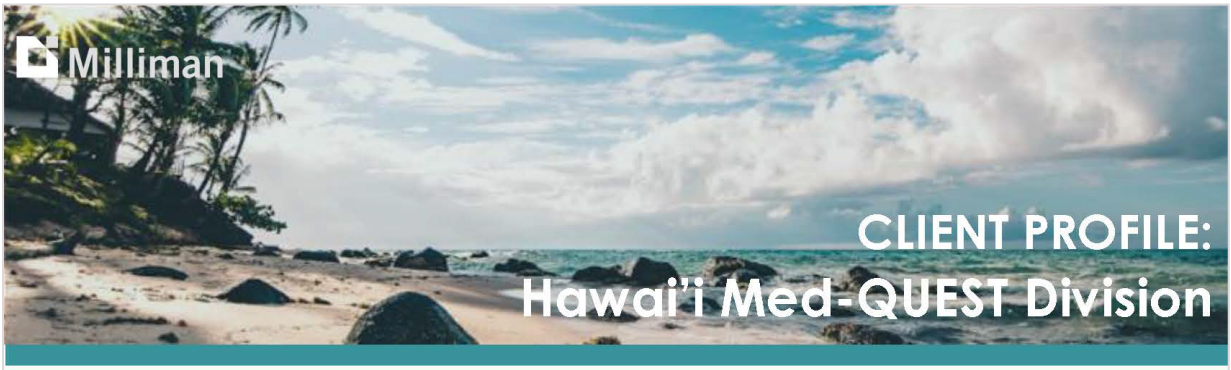
Impact on Washington's Public Health Programs

Over the past 25 years, worked closely with HCA (including prior agencies supporting this work), to support the development of key HCA programs, including most recently:

- Expansion of managed care to disabled members in the Apple Health program.
- Expansion of managed care to foster care members in the Apple Health program.
- Medicaid expansion through the Affordable Care Act (ACA), including conversion of the Medical Care Services program into the Apple Health program.
- Served a key role in developing the PEBB Accountable Care Program.
- Collaborated with HCA staff, Office of Financial Management, and Legislative staff in the development and implementation of the SEBB program.
- Support for the Washington Cascade Care program.
- Support for the development of 90/180 day civil commitment beds.
- Support for the Safety Net Assessment Fund.
- Developing rate structures to support the investment in primary care, prevention, and health promotion.
- Ongoing evaluation and support of efficient and cost-effective benefit programs.
- Supporting analytics designed to improve outcomes for high-need, high-cost individuals.
- Analyzing payment reform and alignment.
- Furthering the objectives of consistent unit cost evaluation across programs and provider types.
- Aligning the payment methodologies to support community-driven initiatives to improve population health.
- Programs of All-Inclusive Care for the Elderly rate development and support.
- Expansion of Alien Emergency Medical (AEM) to managed care.
- Support for various state initiatives, including re-entry, behavioral health fee schedule development, and Certified Community Behavioral Health Clinic (CCBHC).

Milliman

Figure 6. Client Profile #5 – Capitation Rate and Actuarial Consulting: Hawai'i



Actuarial Consultant Services

Milliman has supported the QUEST programs since 2005. This includes the prior QUEST program (without full expansion), Medicaid expansion, QUEST Expanded Access (QExA) with medical and long-term services and supports (LTSS), the conversion of Medicaid and dually eligible members to managed care, development of the Community Care Services (CCS) behavioral health program, and the transition to the QUEST Integration program. Milliman has been able to support these programs addressing the unique challenges in Hawai`i with five managed care organizations (MCOs) with varied mix of enrollment serving a relatively small population. The scope of work has included the following:

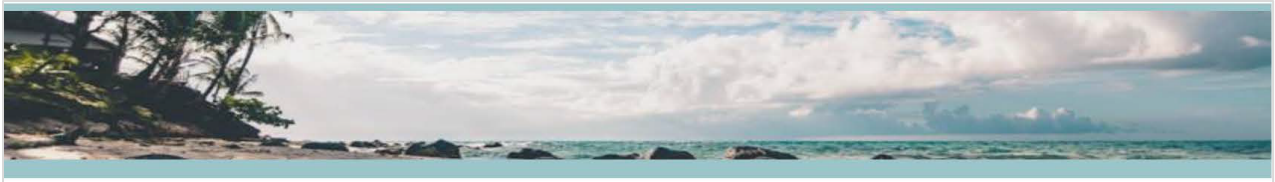
- Develop methodology for the capitated rates.
- Calculate MCO-specific rates for the 1115 waiver.
- Develop behavioral health rates under CCS.
- Develop rates for budget neutrality purposes.
- Develop other carved-out rates as needed by the State.
- Work with the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary on rate approval.
- Reset risk adjustment factors.
- Assist in the development of the medical request for proposal (RFP).
- Calculate risk share settlements.
- Calculate primary care physician enhancement.
- Resolve MCO encounter data issues.
- Attend in-person rate development meetings.
- Payment Transformation Support including directed payments, fee schedules, and States Advancing All-Payer Health Equity Approaches and Development (AHEAD) support.

Relevant Services Provided to the State

Actuarial Analysis

Perform actuarial analysis necessary to support QUEST Integration programs and functions.

- Provide actuarial consulting services for development of capitation rates for QUEST Integration programs using standard practices, norms, and benchmarks in the health care industry, including the following:
  - CMS certification of rates.
  - Potential benefits and risks associated with each option, including impact on utilization, cost, and coordination of care.
  - Options to improve the quality of health care delivered to QUEST Integration clients.
- Provide actuarial analysis and evaluation of proposed legislation relating to QUEST Integration programs to Med-QUEST Division (MQD) staff and, as needed, staff legislative committees.



- Work and communicate with MCOs to collect and process data, including confirmation of completeness and data integrity.
- Provide actuarial services to promote transparency and access to measures on quality of care, utilization, efficiency measures, and cost projections.
- Assist in developing an overall risk management strategy for QUEST Integration programs, including methods to manage risk selection associated with offering multiple health insurance products and health plans; geographic, demographic, and health status risk associated with the QUEST Integration population; and the financial exposure associated with new technologies, procedures, and pharmaceuticals.
- Directed payment support and payment reform.

Impact on Hawai'i's Public Health Programs

Over the past 20 years, worked closely with MQD to assist in a number of key program changes, including:

- Expansion of managed care to disabled members, including those dually eligible for Medicare.
- Conversion of LTSS services to managed care.
- Medicaid expansion through the Affordable Care Act (ACA).
- Implementation of risk adjustment in QUEST Integration.
- Establishment of risk mitigation programs to better manage the risk between MQD and MCOs, and among MCOs.
- Development of a separate behavioral health program (CCS).
- Current work on payment reform by assisting in a diagnosis-related group conversion.
- Provider tax support.
- Procurement support.
- Financial risk mitigation support.
- Utilization analytics, including Milliman Health Waste Calculator.
- Support of housing support program.
- Supporting Hawai`i in AHEAD program, including global budgets for hospitals.
- Support for current 1115 waiver renewal, including reentry and health-related social needs (HRSN) services.
- Home and community-based services (HCBS) and applied behavior analysis (ABA) fee schedule development, including stakeholdering.

Milliman has been able to transfer institutional knowledge as MQD staff has changed, and has listened intently as MQD shared the future vision of a program to serve the most vulnerable Hawai`ians.

Milliman

Why Choose the Myers and Stauffer Team

Team members — Myers and Stauffer and Milliman — have a history of successful contracting relationships in West Virginia and other states. As BMS has witnessed, we work cohesively as a single team with BMS' best interests at the forefront of our work.

The Myers and Stauffer Team is highly regarded for professional objectivity, integrity, innovation, expert staff, and quality service. We are focused on finding ways to protect and maximize our public clients' scarce resources while improving health outcomes. Our Team has the experience, expertise, and resources to meet your needs and exceed your expectations. The Myers and Stauffer Team's combined experience offers BMS an innovative perspective from SMEs with decades of managed care and actuarial experience.

Combining our client-first approach with our insight into health care programs across the country, we offer the following value-added competencies to benefit BMS and those served by its programs:

Seamless Transition

As your current contractor, we have established methodologies and systems with which providers and BMS are already familiar. Contracting with us allows for a seamless transition into the next contract period.

Reliability

As documented by past performance with West Virginia and states across the U.S., we offer the Bureau reliability and quality staff who specialize in these types of engagements.

Expertise

Our staff are experienced in managed care oversight and compliance, actuarial rate setting, provider reimbursement, accounting, and consulting services specific to the Medicaid program and CHIP. Through continuing education, our staff not only stay abreast of current professional accounting and auditing standards but also spend a significant amount of time on health care-related research and education.

Specialization

By limiting our clients to entities managing government-sponsored health care and human services programs, Myers and Stauffer offers a unique perspective to states, providing the accounting, auditing, and consulting services requested.

National Experience

Our expertise and related experience will provide greater efficiencies in our approach to performing these services for West Virginia. We provide similar services across the country and are positioned to provide the highest quality services for the best value.

Project Management

We have demonstrated experience managing large multi-faceted engagements. These contracts involve a high volume of expertly prepared deliverables as a result of complex and interrelated tasks requiring highly specialized resources.

Innovation

We have a history of innovating approaches to keep pace with the ever-changing landscapes of health care policy, managed care program design, auditing, program integrity, and technology. The importance of keeping pace with and striving to stay ahead of changes and new advancements is paramount to the benefits we will provide to support the needs and goals of BMS.

Staffing (3.2)

Summarized in CRFQ *Table 3* are the required key position staffing qualifications for each position that the Agency will utilize for both the actuarial services and program oversight components of the contract. The vendor shall not combine any key positions.

In addition to these key positions, the vendor shall provide technical, financial, and clerical support staff with administrative duties that do not have the required minimum qualifications, as needed.

The number of actuarial staff needed will be driven by individual Statements of Work (SOW), with an annual estimation of hours outlined in the pricing page for cost estimation purposes.

Myers and Stauffer will staff this engagement to meet and exceed BMS' expectations. Our proposed professional resources are highly skilled in the Medicaid managed care policy, operations, capitation rate setting, and compliance fields. Our Team is fully trained and ready to begin work immediately upon contract award. Nearly all members of our proposed team have supported the West Virginia Medicaid program as we have performed this work under the current contract. It will not be necessary for us to build capacity or spend contract hours training new staff.

Our proposed team members have the responsibility and authority to work collaboratively and across internal organizational lines to support this scope of work. This collaborative environment is how we approach work both internally and with our clients.

Required Key Staff

Myers and Stauffer is committed to providing the highest quality deliverables and services by deploying highly qualified and experienced resources to meet the requirements of this CRFQ.

Myers and Stauffer strives to maintain staffing consistency on all engagements. Upon contract award, we will seek BMS' approval of our proposed staffing plan. Our proposed staff are committed to this engagement for the duration of the contract and will not be changed without BMS approval. In the unlikely event of staff turnover, we will offer replacement personnel with equal or greater credentials and experience. We will provide written notice and a request for approval of staffing changes proactively, except in the event of an immediate vacancy. If an immediate vacancy occurs, we will convey that information to BMS with a plan to address immediate and longer-term staffing needs. In the unlikely event BMS does not approve our proposed staff or a staff member leaves the firm, we will present alternative candidates with the appropriate experience and skill set by drawing from our existing staff of Medicaid and actuarial professionals for BMS consideration.

Key Staff Coordination

The Myers and Stauffer Team will coordinate responsibilities among key staff positions, as applicable, to maximize communications and project outcomes. For example, the Project Administration Lead may work closely with the Finance Project Lead and Milliman personnel in the execution of finance, programmatic, and legislative deliverables stipulated in the CRFQ. This type of coordination could involve the Deputy Commissioner of Plan Management and Integrity, the Director of the Office of Managed Care, and the Deputy Commissioner of Finance/Chief Financial Officer (CFO) in the planning, implementation, and monitoring of targeted deliverables.

BMS leadership will have direct access to the Executive Project Director, Project Management Lead, Program Administration Lead, Finance Project Lead, and Lead Actuary. These key leadership team members will be responsible for ensuring collaboration, timely communications, and coordinated project updates to all parties, as needed.

Figure 7, *Table 3*, and *Table 4* highlight our proposed key staff for this project. We have included resumes for these staff members in *Appendix A: Resumes.*

Figure 7. Myers and Stauffer Team Organizational Chart

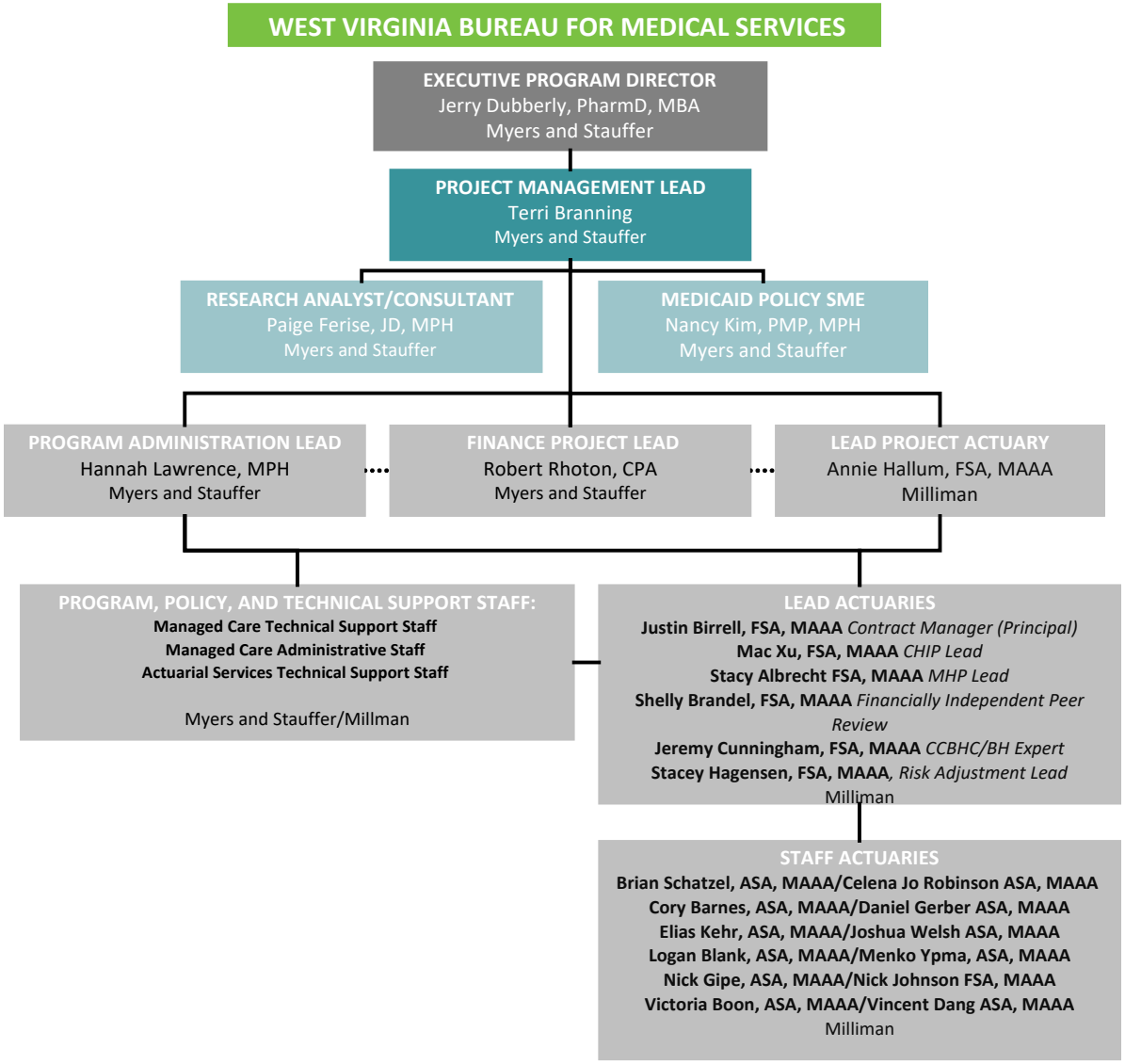


Table 3. Your Proposed Team: At-a-Glance

Myers and Stauffer Team: At-a-Glance						
Role	Degree/Certification		Years of Experience		BMS Experience	Requirements Met/Exceeded?
	Required	Actual	Required	Actual		
Executive Program Director	BS	Doctorate, MBA	3	34+	✓	Yes
Project Management Lead	BS	BS	5	40+	✓	Yes
Program Administration Lead	BS	MPH	3	10+	✓	Yes
Finance Project Lead	BS	CPA, BS	3	11+	✓	Yes
Research Analyst/Consultant	BS, JD	JD, MPH	2	7+	✓	Yes
Medicaid Policy SME	BS	Project Management Professional (PMP), MPH	10	16+	✓	Yes
Lead Actuaries	FSA or MAAA	FSA, MAAA	10	10-30+	✓	Yes
Staff Actuaries	FSA or MAAA	ASA or FSA, MAAA	5	5+	✓	Yes

Table 4. Proposed Key Staff

Myers and Stauffer Team: Proposed Key Staff				
Proposed Key Staff Name/Title/ Role	Qualifications Requirements	Overview of Qualifications	Requirements of the Role	Overview of Engagement Responsibilities
Executive Program Director (1 FTE) **Jerry Dubberly, PharmD, MBA** *Principal (Partner)* Myers and Stauffer	Minimum of a bachelor's degree, with three years' experience in Medicaid or Medicaid and CHIP managed care operations, either with a state agency, federal agency, or rendering services under contract to a state agency.	Dr. Dubberly exceeds all requirements including: ✓ More than 34 years of Medicaid/public health care experience, including as partner in charge of Medicaid managed care engagements. ✓ Former State Medicaid Director of Georgia managing three successful Medicaid MCO contracts serving more than 1.3 million Medicaid and CHIP lives. ✓ Leads Myers and Stauffer's current BMS Medicaid Actuarial Services and Managed Care Program Administration	✓ Have the ability and authority to commit the vendor and its resources, conduct oversight of the engagement, and ensure all deliverables and services are consistent with contract requirements, work plan tracking, project tracking, and taking minutes. ✓ Available for quarterly meetings with BMS leadership and staff, and ad-hoc meetings (virtual and on-site), as needed.	Dr. Dubberly will fulfill all requirements of the role, as well as: ✓ Operates in current capacity as contract signatory. ✓ Responsible for delivery of all contract deliverables. ✓ Responsible for subcontractor contract and performance. ✓ Serves as a SME, as needed, to support deliverable production and client/internal needs.

Myers and Stauffer Team: Proposed Key Staff				
Proposed Key Staff Name/Title/ Role	**Qualifications Requirements**	**Overview of Qualifications**	**Requirements of the Role**	**Overview of Engagement Responsibilities**
		and Oversight engagement and authority to commit the firm and its resources. ✓ Doctor of Pharmacy/Master of Business Administration (MBA).		
Project Management Lead (1 FTE) **Terri Branning** *Senior Manager* Myers and Stauffer	Minimum of a bachelor's degree, with five years' experience with Medicaid or Medicaid and CHIP managed care.	Ms. Branning exceeds all requirements including: ✓ More than 40 years of health care industry experience, including executive leadership roles in Medicaid, managed care, and self-funded health plans. ✓ Current Project Management Lead for BMS Medicaid Actuarial Services and Managed Care Program Administration and Oversight engagement. ✓ Health care consultant to Georgia Medicaid client during transition to full-risk managed care. ✓ Former Executive Business Analyst for Georgia DCH. ✓ Bachelor's degree in nursing.	✓ Oversee that all contractual deliverables are fulfilled and provided within the required timeframes.	Ms. Branning will fulfill all requirements of the role, as well as: ✓ Supports the Executive Program Director to ensure all contract deliverables are completed timely and are of the highest quality. ✓ Assigns and coordinates work across the Program Administration Lead, the Financial Administration Lead, and the Actuarial Lead. ✓ Maintains day-to-day contact and relationship with the client. ✓ Serves as the central point of contact. ✓ Serves as a SME, as needed.
Program Administration Lead (1 FTE) **Hannah Lawrence, MPH** *Senior Manager* Myers and Stauffer	Minimum of a bachelor's degree, with three years' experience in Medicaid or Medicaid and CHIP managed care operations, either with a state agency, federal agency, or rendering services under contract to a state agency.	Ms. Lawrence exceeds all requirements including: ✓ More than 10 years of experience consulting on projects related to Medicaid quality and program oversight. ✓ Currently serves as BMS Medicaid Actuarial Services and Managed Care Program Administration and Oversight engagement contract liaison responsible for Medicaid managed care program management. ✓ Provides strategic consulting through analysis and research in a wide variety of initiatives with health care agencies. ✓ Supports State initiatives, including Medicaid and child welfare services	✓ Oversight of managed care operations and deliverables under the contract. ✓ Responsibility for other projects assigned by the Deputy Commissioner, Division of Managed Care and Program Integrity. ✓ Coordinate with the Finance Project Lead in the execution of deliverables defined in the contract. ✓ Available for quarterly meetings with BMS leadership and staff, and ad-hoc meetings (virtual and on-site), as needed. ✓ Develop meeting agendas and	Ms. Lawrence will fulfill all requirements of the role, as well as: ✓ Works under the direction of the Project Management Lead. ✓ Serves as the primary point of contact for the Director of the Office of Managed Care. ✓ Supports BMS with tracking project activities, next steps, and actions needed from BMS. ✓ Serves as the day-to-day lead on MCO oversight and monitoring work. ✓ Proactively schedules and communicates upcoming project administrative work

Myers and Stauffer Team: Proposed Key Staff				
Proposed Key Staff Name/Title/ Role	**Qualifications Requirements**	**Overview of Qualifications**	**Requirements of the Role**	**Overview of Engagement Responsibilities**
		department, behavioral health provider capacity needs assessments, technical assistance to Medicaid managed care programs, including evaluation of subcontractor oversight and contract compliance, and administrative reviews for state departments of education child and adult care food programs. ✓ Master's degree in public health (health services, policy, and management).	send out to all parties 24 hours prior to meeting. ✓ Take meeting attendance, meeting notes, record action items and track action item completion. ✓ Send out approved meeting notes to participants.	based on annual/cyclical work, as well as new projects. ✓ Coordinates activities with the Actuarial Lead and the Financial Lead with the involvement of the Project Management Lead.
Finance Project Lead (1 FTE) **Robert Rhoton, CPA** *Senior Manager* Myers and Stauffer	Minimum of a bachelor's degree in finance, accounting, business administration, or related field with three years' experience in financial management in Medicaid or Medicaid program and CHIP, regulations, reimbursement processes, financial analysis, budgeting, and forecasting.	Mr. Rhoton exceeds all requirements including: ✓ More than 11 years of experience providing public accounting, financial auditing, compliance, and consulting services to multiple state Medicaid agencies. ✓ Experience with BMS through contracts for certified community behavioral health center (CCBHC) and substance use disorder (SUD) rate setting and consulting and 1115 waiver budget neutrality analysis. ✓ Areas of expertise include financial analysis, cost projections, and budget neutrality workbooks for various Medicaid programs and attest engagements of providers. ✓ Bachelor's degree in accounting and business/economics. ✓ CPA.	✓ Liaison with the Deputy Commissioner of Finance and the CFO in the oversight of finance and budget initiatives and other projects within the scope of the contract. ✓ Coordinate the deliverables of the actuarial vendor with BMS Finance. ✓ Coordinate with the Program Administration Lead in the execution of deliverables in the contract. ✓ Available for quarterly meetings with BMS leadership and staff, and ad-hoc meetings (virtual and on-site), as needed.	Mr. Rhoton will fulfill all requirements of the role, as well as: ✓ Works under the direction of the Project Management Lead. ✓ Serves as the day-to-day lead for all financial service needs. ✓ Serves as the point of contact for Deputy Commissioner of Finance and CFO. ✓ Coordinates with the Lead Actuary and Program Administration Lead, acting under the direction of the Project Management Lead.
Research Analyst/ Consultant (.50 FTE) **Paige Ferise, JD, MPH**	Minimum of a bachelor's degree, with two years' experience working with Medicaid or Medicaid and CHIP,	Ms. Ferise exceeds all requirements including: ✓ More than seven years of health care law, policy-related experience, and Medicaid consulting. ✓ Focus on public health law and policy	✓ Assistance in policy research and development, contract development and maintenance, contract compliance and reporting, and other MCO oversight activities as outlined within the solicitation.	Ms. Ferise will fulfill all requirements of the role, as well as: ✓ Works under the direction of the Project Management Lead. ✓ SME, as needed.

Myers and Stauffer Team: Proposed Key Staff				
Proposed Key Staff Name/Title/ Role	**Qualifications Requirements**	**Overview of Qualifications**	**Requirements of the Role**	**Overview of Engagement Responsibilities**
Senior Manager Myers and Stauffer	either with a state agency, federal agency, or rendering services under contract to a state agency. Juris Doctor (JD) for contract development and maintenance and corrective action plans.	including issues related to federal waivers and Medicaid State Plan amendments (SPAs), administrative rulemaking, and legislation and policy. ✓ Serves as a legal/policy resource for teams and projects across the firm. ✓ Licensed attorney with JD. ✓ Master's degree in public health.		
Medicaid Policy SME (.50 FTE) **Nancy Kim, MPH, PMP** *Senior Manager* Myers and Stauffer	Minimum of a bachelor's degree, with 10 years' experience in Medicaid or Medicaid and CHIP policy research and development, either with a state agency, federal agency, or rendering services under contract to either agency type. Experience crafting CMS managed care reports including 1915 (b) waiver applications/ amendments, Medicaid and CHIP Program Annual Report, and fraud, waste, and abuse compliance reports.	Ms. Kim exceeds all requirements including: ✓ More than 16 years of government-sponsored health care experience and has managed projects and provided technical assistance to numerous state Medicaid managed care programs. ✓ Assisted on BMS Medicaid Actuarial Services and Managed Care Program Administration and Oversight engagement supporting research and implementation of the 2024 Managed Care Final Rule. ✓ Extensive experience evaluating and implementing federal regulations and various federal waiver authorities. ✓ Worked with states to evaluate readiness to implement managed care programs, as well as serving as a rate review contractor. ✓ Worked with states to assess federal rules and guidance and determine impact to Medicaid operations. ✓ Master's degree in public health. ✓ Project Management Professional.	✓ Consultation services on federal Medicaid regulation and policy and serve as a SME under both the program oversight contract development and actuarial services sections.	Ms. Kim will fulfill all requirements of the role, as well as: ✓ Works under the direction of the Project Management Lead. ✓ Serves as an SME, as needed.

Myers and Stauffer Team: Proposed Key Staff				
Proposed Key Staff Name/Title/ Role	**Qualifications Requirements**	**Overview of Qualifications**	**Requirements of the Role**	**Overview of Engagement Responsibilities**
Lead Actuary (1 FTE) Lead Project Actuary: **Annie Hallum, FSA, MAAA** *Consulting Actuary (Principal)* Contract Manager: **Justin Birrell, FSA, MAAA** *Consulting Actuary (Principal)* CHIP Lead: **Mac Xu, FSA** *Consulting Actuary* MHP Lead: **Stacy Albrecht, FSA, MAAA** *Consulting Actuary* Financially Independent Peer Review: **Shelly Brandel, FSA, MAAA** *Consulting Actuary (Principal)* CCBHC/Behavioral Health SME: **Jeremy Cunningham, FSA, MAAA** *Consulting Actuary (Principal)*	Minimum of 10 years' experience with Medicaid or Medicaid and CHIP Managed Care rate setting. Be either a FSA and/or MAAA.	We are proposing at least seven qualified lead actuaries. All our lead actuaries exceed all requirements including: ✓ At least 10 years of Medicaid managed care rate setting experience working for state agencies. Some with over 25 years of Medicaid managed care experience. ✓ Lead Project Actuary has more than three years of experience leading actuarial services for BMS Medicaid Actuarial Services and Managed Care Program Administration and Oversight engagement. ✓ Lead actuaries proposed are FSAs and set capitation rates in at least two other states prior to this engagement. ✓ Milliman's team has at least 77 Medicaid FSAs to accommodate BMS, as needed. ✓ See *Appendix B: Actuarial Credentials* for copies of relevant credentials.	✓ Oversee that all deliverables within each approved Statement of Work (SOW) are fulfilled as defined within the SOW.	Ms. Hallum, along with the six other lead actuaries, will fulfill all requirements of the role, as well as: ✓ Works under the direction of the Project Management Lead. ✓ Coordinates closely with the Program Administration Lead and the Financial Administration Lead acting under the direction of the Project Management Lead.

Myers and Stauffer Team: Proposed Key Staff				
Proposed Key Staff Name/Title/ Role	**Qualifications Requirements**	**Overview of Qualifications**	**Requirements of the Role**	**Overview of Engagement Responsibilities**
Risk Adjustment Lead: **Stacey Hagensen, FSA, MAAA** *Consulting Actuary* Milliman				
Staff Actuary (2 FTEs) **Nick Gipe, ASA, MAAA** *Consulting Actuary* **Nick Johnson, FSA, MAAA** *Consulting Actuary (Principal)* **Brian Schatzel, ASA, MAAA** *Associate Actuary* **Celena Jo Robinson, ASA, MAAA** *Associate Actuary* **Cory Barnes, ASA, MAAA** *Associate Actuary* **Daniel Gerber, ASA, MAAA** *Associate Actuary* **Elias Kehr, ASA, MAAA** *Associate Actuary*	The staff actuaries will assist the Project Lead Actuary and Lead Actuaries in providing the deliverables defined within each approved SOW. Minimum of five years' experience with Medicaid or Medicaid and CHIP managed care rate setting or other insurance pricing. Either a FSA and/or MAAA.	Our staff actuaries exceed all requirements including: ✓ All our staff actuaries have at least five years' experience with Medicaid managed care rate setting or other insurance pricing. ✓ All our staff actuaries are credentialed with at least an ASA and MAAA. ✓ Milliman's team has at least 70 Medicaid ASAs to accommodate BMS, as needed. ✓ See *Appendix B: Actuarial Credentials* for copies of relevant credentials.	The staff actuaries will assist the Lead Actuary in providing the deliverables defined within each approved SOW.	Our staff actuaries will fulfill all requirements of the role, as well as: ✓ At least four staff actuaries will assist the lead actuaries with providing the deliverables defined within each approved SOW.

Myers and Stauffer Team: Proposed Key Staff				
Proposed Key Staff Name/Title/ Role	**Qualifications Requirements**	**Overview of Qualifications**	**Requirements of the Role**	**Overview of Engagement Responsibilities**
Joshua Welsh, ASA, MAAA *Associate Actuary* **Logan Blank, ASA, MAAA** *Associate Actuary* **Menko Ypma, ASA, MAAA** *Associate Actuary* **Victoria Boon, ASA, MAAA** *Associate Actuary* **Vincent Dang, ASA, MAAA** *Associate Actuary* Milliman				

Technical Support Staff and Clerical Support Staff

In addition to our proposed key staff, we will have supporting staff available to assist these team members with project work, as needed. *Table 5* includes supporting staff roles that will be assigned to this engagement.

Table 5. Support Staff

Myers and Stauffer: Support Staff	
Role	**Overview of General Qualifications**
Managed Care Technical Support Staff	✓ Medicaid/public health care compliance and consulting experience with specialization in managed care support and provider network analysis. ✓ Experience may range from two to more than 10 years depending on the level of skill required. ✓ Minimum of bachelor's degree in accounting, health care, or other relevant major. ✓ May hold one or more of the following certifications: CPA, CFE, or Certified in Healthcare Compliance.
Managed Care Administrative Staff	✓ Medicaid/public health care compliance and consulting experience.
Actuarial Services Technical Support Staff	✓ Robust staff of data and actuarial analysts that do not yet meet the qualifications of a lead or staff actuary but are able to support the work performed. ✓ Minimum of bachelor's degree in business, economics, statistics, public health, or a related field. ✓ Proficiency in data analysis tools (e.g., Excel, SQL). ✓ Strong analytical and critical thinking skills.

Capacity to Provide Services

The Bureau will benefit from our Team's unparalleled level of hands-on service. We can provide this level of service because our business model allows our professionals to be involved and immediately available throughout the entire engagement, from planning through final delivery of the product. Our approach ensures that Team management will continue to stay abreast of key issues in West Virginia and take an active role supporting the Bureau to address them.

Project Management

Myers and Stauffer's approach to using subcontractors on engagements is to seamlessly integrate the staff of the subcontractor with our staff. This ensures we maintain quality control standards and provide a consistent service approach. Myers and Stauffer and Milliman have a demonstrated record of success working together in prime and subcontractor roles not only in performing this scope of work for BMS, but also in our work with other states. Milliman's staff works alongside Myers and Stauffer staff and are involved in planning, meetings, and any team communications. They fully function as members of the Myers and Stauffer Team which means continuity of staff, consistent training, and the same engagement approach.

We have found our clients prefer this approach. While having full access to all team members, our clients only have to interact with one point of contact for services and deliverables and for contractual accountability. For this reason, we have designated Ms. Terri Branning as the Project Management Lead. While you will have access to all engagement leaders, Ms. Branning will work closely with our proposed Program Management Lead, Ms. Hannah Lawrence, our proposed Finance Administration Lead, Mr. Robert Rhoton, our Lead Actuary, Ms. Annie Hallum, and other team members to ensure all work, status updates, and issues are coordinated centrally for the engagement as a whole — saving BMS time and reducing miscommunication. This approach establishes one team with the appropriate supervision and oversight and helps us monitor contract and subcontractor compliance.

Our Team's Bench Strength

With Myers and Stauffer's proposal of an existing team, as well as 1,000-plus professionals nationally, we are able to staff this engagement immediately with a tenured team. We also have the flexibility to reallocate staff, as needed, to further support BMS' needs and the requirements of this engagement. Every one of Myers and Stauffer's professionals is dedicated to public health care agencies allowing us to truly understand the needs and objectives of our client.

Our actuarial partner, Milliman, is also committed to maintaining their global reputation for integrity and high-quality work. Milliman's staffing model ensures it has streamlined a highly efficient process related to actuarial rate setting that provides timely results of the highest quality. All work is managed by actuarial consultants with the highest level of credentials. Milliman has 77 FSAs and 70 ASAs that specialize in Medicaid agency work. This number of credentialed staff allows us to provide high-quality work on an ongoing basis and devote additional resources during times of increased workload.

What This Means for BMS

Our Team has the staffing numbers to provide the appropriate senior and mid-level expertise in real time to support the inevitable challenges from changes in the Medicaid environment. Not only do we have highly ***qualified and credentialed staff****, but we have demonstrated — as a Team — our* ***commitment to collaboration with the BMS' staff and other stakeholders****. This means BMS can trust our Team to work hand-in-hand with you on every detail no matter how large or small.*

VI. Mandatory Requirements (CRFQ Specifications: Section 4)

The Myers and Stauffer Team attests that we will fulfill all mandatory service requirements listed in Section 4 of the CRFQ.

Mandatory Contract Services Requirements and Deliverables (4.1)

Contract Services must meet or exceed the mandatory requirements listed below.

All managed care program administration requirements are applicable to both the MHT and MHP programs.

The fixed monthly payment for these services shall be inclusive of completing the defined activities for both programs.

Actuarial services shall be provided based on independent SOW and shall be reimbursed at the prevailing hourly rate upon the issuance of an approved delivery order.

The Vendor may subcontract Actuarial Services only.

Managed Care Program Administration (4.1.1)

As the incumbent, we have demonstrated our performance and qualifications directly to BMS through our current contract. In the matrix below, we indicate our commitment to provide all services required and summarize information regarding client-specific engagement examples that demonstrate our ability to meet and exceed all CRFQ requirements.

Table 6. Managed Care Administration Service Requirements and Deliverables (4.1.1)

Managed Care Administration Service: Response to Requirements	Meets/ Exceeds Req.
4.1.1.1. The State Medicaid Managed Care Program, both Mountain Health Trust and Mountain Health Promise, currently operate under a 1915(b) waiver. Requests for services related to waiver analyses outside of the Managed Care waivers shall be accounted for under ad hoc services. Services provided under the ad hoc section will be done at an hourly rate and will require execution of an approved SOW and delivery order before work can commence.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We understand that the State Medicaid Managed Care Program (MHT and MHP) operates under a 1915(b) waiver. The Myers and Stauffer Team has extensive experience with Medicaid managed care programs operated through 1915(b) waiver authority, SPAs, and 1115 authority and is qualified to fulfill this requirement.

For BMS, the Myers and Stauffer Team managed the 1915(b) waiver amendments and renewal application processes for both MHT and MHP. The renewal processes for both included cost effectiveness analyses. The Team also facilitated waiver meetings with CMS and responded to their waiver inquiries.

Myers and Stauffer has delivery system waiver experience in the following states:

- **1115:** Arizona, Colorado, Iowa, Kentucky, New Hampshire, New Jersey, Texas, Washington
- **1915(b):** Georgia, Hawai'i, Kentucky, Maine, Nevada
- **1915(b) with independent assessment:** Arkansas, Kentucky
- **1915(c):** Nebraska

In addition to our corporate experience, our individual team members bring prior experience:

- Working directly for state Medicaid programs and developing, operationalizing, managing, and evaluating managed care delivery models.
- Working directly for MCOs.
- Consulting with states on the program design, implementation, and operation of Medicaid managed care programs, including facilitating discussions with CMS about appropriate federal authorities and drafting required materials and applications to obtain those authorities.

For this contract, we understand that requests for services related to waiver analyses outside of the managed care waivers shall be accounted for under ad-hoc services, and services provided under the ad-hoc section will be performed at an hourly rate and require execution of an approved SOW and delivery order before work can commence.

Managed Care Administration Service: Response to Requirements	Meets/ Exceeds Req.
4.1.1.2. WVCHIP delivers benefits to members using managed care under the state plan option at section 3.0 which can be found at: https://chip.wv.gov/SiteCollectionDocuments/WVCHIP State Plan 11 13 24.pdf. WVCHIP members participate under the MHT umbrella. Administration and oversight requirements are the same as Medicaid but there is no associated waiver reporting and WVCHIP is not included in the Medicaid 1915(b) waiver.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform tasks specific to WVCHIP.

Qualifications:

We have demonstrated our experience through our support of WVCHIP. Past activities include the following:

- Transitioned the WVCHIP population and benefits and services into Medicaid.
- Developed fiscal impact analyses for transition of the WVCHIP program into Medicaid.
- Developed WVCHIP capitation rate.
- Produced WVCHIP quarterly reports.
- Conducted MCO MLR examinations for the WVCHIP population.
- Provided oversight of WVCHIP-specific MCO member materials.
- Provided management and oversight of WVCHIP-specific MCO reporting.

Additionally, we have successfully supported CHIP in other states, including the following examples:

- Identified the CHIP population and expenditures to support proper CMS reporting requirements (e.g., CMS-21 and CMS-64, where applicable). In these engagements, we review claims and capitation payments to ensure they are being correctly reported.
- Performed MLR examinations for CHIP populations.

4.1.1.3. The vendor shall ensure oversight of current and new programs developed and operating under existing managed care waivers, new waivers, or waiver renewals. There are currently two (2) Managed Care Waivers, MHT and MHP.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We have demonstrated our experience through our support of current and new BMS programs and waivers through activities, such as the following:

- **West Virginia 1915(b) MHT and MHP Programs:**
  - New Program Support and Oversight:
    - Development of MHT Request for Application.
    - Support for new MCO and MCO subcontractor readiness reviews, implementation, post-implementation support, and ongoing oversight.

Managed Care Administration Service: Response to Requirements	Meets/ Exceeds Req.

- Implementation of new initiatives under West Virginia Senate Bill (SB) 820 (2024): Day one enrollment and MCO quality withhold program.
- Planning, implementation, and monitoring of the 2024 Final Rules published by CMS.

- Existing Program Support and Oversight:
  - Annual provider network adequacy analysis, review of standardized reports for contractual compliance, and reporting.
  - Annual MCO MLR examinations.
  - Oversight of MCO-specific member and provider materials.
  - Management and oversight of MCO-specific reporting.
  - Conducting analyses to measure the reliability and accuracy of encounter and member data used to establish capitation rates, including development of reporting for each MCO and all MCO subcontractors.

Our most relevant clients for whom we provide oversight of current and new programs developed and operating under existing managed care waivers, new waivers, or waiver renewals include the following experience:

- **Kentucky 1915(b) Medicaid Managed Care Program:**
  - Assist with MCO contract amendment process. Conducting stakeholder engagement activities.
  - Develop MCO RFP and associated contract language.
  - Conduct MCO readiness reviews and reporting.
  - Perform provider network adequacy analysis, review standardized reports for contractual compliance, and reporting.
  - Complete 1915(b) Independent Assessment.
  - Design and draft 1915(b) waiver extension and renewal.
  - Create 1915(i) SPA, which facilitates community-based care for Medicaid-eligible individuals with serious mental illness (SMI) and co-occurring SUDs.
  - Support operational design and implementation of a Section 1115 Demonstration waiver, which includes: SMI, SUD, reentry services, recuperative care, and other program enhancements.
  - Assist with developing an 1115 Demonstration for member community engagement in compliance with state regulations.
  - Support the restructuring of the Children's Waiver Program.
  - Design and support a single MCO pharmacy benefit manager (PBM) RFP, associated contract language, implementation, and ongoing operational consulting.
- **Georgia 1915(b) Medicaid Managed Care Program:**
  - Conduct financial and performance audits of the care management organizations (CMOs) and their significant subcontractors and provide recommendations for process and contractual improvements.
  - Monitor and report on CMO compliance with contractual and regulatory provisions.

Managed Care Administration Service: Response to Requirements	Meets/ Exceeds Req.

- Perform analyses to measure the reliability and accuracy of encounter and member data and recommended improvements to drive more appropriate capitation rates.
- Conduct testing for network adequacy and availability and recommend actions to improve access to care and services.
- Review data from reporting and encounters to ensure contractual compliance, identify anomalies, and initiate actions to investigate those anomalies and their root cause.

- **Arizona 1115 Medicaid Managed Care Program:**
  - Project management for waiver renewal.
  - Support development of the waiver application.
  - Assist with stakeholder engagement.
  - Hold discussions and negotiations with CMS on waiver renewal activities.
- **Arkansas 1915(b):**
  - Produce the Independent Assessment report of two 1915(b) waiver programs to measure access, quality, and cost.
  - Develop reports for submission to CMS.
- **Iowa 1115 Work Requirements Waiver:**
  - Provide project management and strategic consulting services.
  - Prepare the work requirements waiver application.
  - Assist with public comment activities.

In addition to our corporate experience, our individual team members bring prior employment experience:

- Working directly for state Medicaid programs and developing, operationalizing, managing, and evaluating managed care delivery models.
- Working directly for MCOs.
- Consulting with states on the program design, implementation, and operation of Medicaid managed care programs.

4.1.1.4. The vendor shall draft and/or assist with waiver applications and associated quality strategies in addition to a quality strategy for WVCHIP.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

The Myers and Stauffer Team has years of technical assistance experience providing states with guidance in determining overall quality strategy and drafting waiver applications. Most recently, we were instrumental to our State partners in the success of the following quality strategy and waiver application initiatives:

- **West Virginia:**

Managed Care Administration Service: Response to Requirements	Meets/ Exceeds Req.

- Developed the BMS Quality Strategy for 2024-2027, including involvement of a stakeholder workgroup. The Quality Strategy included MHT and WVCHIP components, and newer BMS initiatives, such as CCBHCs and the MCO quality withhold program under SB 820 (2024).
- Supported the 1915(b) waiver extension and renewal application for both MHT and MHP, including cost effectiveness analyses.
- Led implementation of new quality initiatives under SB 820 (2024): Day one enrollment and MCO quality withhold program.

- **Arizona:** Supported development of quality measures used to determine provider payments funded by a provider fee assessment program.
- **Mississippi:** Leading the revision of the 2025-2028 Comprehensive Quality Strategy (CQS) that outlines the State's goals, values, objectives, compliance monitoring, and improvement interventions.
- **Kentucky:** Drafted the 1915(b) waiver extension renewal request. Prepared a 1915(b) Independent Assessment report, including quality reporting components and supported discussions with CMS, as needed.
- **Hawai'i:** Led the revision of the 2020 Hawai'i Quality Strategy that outlines the State's goals, objectives, improvement interventions, and quality system. Our work included enhancing the quality management system to include a quarterly performance review cycle grounded in clinical quality improvement.

Individual members of our proposed team have also supported waiver strategy, conducted planning sessions with CMS on appropriate federal authorities, drafted concept papers, and developed waiver applications in states, such as: Colorado, Georgia, Idaho, Indiana, Ohio, and Pennsylvania.

4.1.1.5. The vendor shall develop correspondence, including, but not limited to, waiver applications, letters to federal entities, etc. related to waivers or other managed care program needs.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Myers and Stauffer has experience communicating with a varied group of stakeholders, including the federal government, using methods with proven success. We have significant experience preparing correspondence and communications for all types of managed care program needs (including with and to federal health agencies [e.g., CMS]). This includes waiver applications, letters, meeting notes, status reports, documentation of questions and answers and CMS decisions, responses to ad-hoc requests from CMS and other entities in a timely manner, as well as other correspondences and communication. Samples of our recent experience include:

- **West Virginia:**
  - Draft MCO contract modifications and capitation rate documentation for CMS review and approval.
  - Draft 1915(b) waiver extension requests and renewals and coordinate negotiations with CMS.
  - Develop written communications with CMS, including responses to inquiries about waivers, directed payments, and capitation rates.
  - Conduct MCO readiness reviews and prepare readiness reports for CMS submission.
  - Draft MCO corrective action plans related to MCO performance.
  - Facilitate communications and follow-up correspondence related to monthly meetings with the BMS MCOs.

Managed Care Administration Service: Response to Requirements	Meets/ Exceeds Req.

- **Colorado:**
  - Support communications, presentations, briefings, and waiver and State Plan development with CMS federal partners to ensure required program authority and support is in place for the Colorado Hospital Transformation Program (HTP).
  - Facilitate a monthly HTP Workgroup that is comprised of hospitals invested in receiving ongoing information related to program operations and provide meeting materials and follow-up correspondence, as needed.
  - Draft correspondence to CMS and support the State's negotiations to secure the necessary federal authorities to administer the program.
- **Kentucky:**
  - Draft and support negotiation of the 1915(i) SPA, which facilitates community-based care for Medicaid-eligible individuals with SMI and co-occurring SUDs.
  - Draft 1115 Demonstration waiver materials for multiple initiatives the Commonwealth is implementing.
  - Draft correspondence to CMS including MCO contract modifications for federal review and approval.
  - Prepare correspondence and reports related to MCO readiness reviews for submission to CMS.
  - Support the development of correspondence related to the design, negotiation, implementation, and renewal of several managed care DPPs.
- **Hawai'i:**
  - Draft the Health Plan RFP and contract language for CMS review and approval.
  - Develop the Medicaid Quality Strategy.
- **Mississippi:** Draft correspondence to CMS to support the design and renewal of the managed care DPP.
- **New Jersey:** Draft correspondence related to the State's 1115 waiver Standard Terms and Conditions and Funding and Mechanics Protocol.
- **Washington:** Produce quarterly CMS communications related to value-based payment (VBP) program performance, as well as other correspondence as required under the State's 1115 demonstration waiver.

4.1.1.6. The vendor shall conduct analyses of waiver programs and develop recommendations for improving effectiveness and efficiency of waiver programs.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Myers and Stauffer has direct, hands-on experience conducting analyses of waiver programs and making recommendations for improvements. A few examples of our experience include the following:

- **Arkansas, Kentucky, and Maine:** Conduct 1915(b) Independent Assessment and develop findings report, which included an analysis of waivers as well as performance and opportunities related to access, quality, and cost effectiveness.
- **Colorado:** Conduct quarterly and annual analyses of the HTP waiver's performance and opportunities for improvement.

Managed Care Administration Service: Response to Requirements	Meets/ Exceeds Req.

- **Texas:** Conduct ongoing analyses of waiver participant performance and reported observations and recommendations to the State. Conduct the midpoint assessment evaluating the waiver's performance, which was reported to CMS.
- **Washington:** Support midpoint assessments of Accountable Communities of Health (ACH), as well as assessments of ACH project plans and semi-annual reports which were used to evaluate the waiver efficiency and effectiveness.

4.1.1.7. The vendor shall assist the Agency with activities related to its 1115 Continuum of Care waiver, including but not limited to, federal reporting requirements and other analyses, as needed, which will be administered under the managed care organizations.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Myers and Stauffer has experience as follows:

- **West Virginia:** Conduct budget neutrality calculations for the 1115 Continuum of Care waiver.
- **Kentucky:** Support the implementation of an 1115 waiver to address SUD, SMI, and other related services, such as recuperative care and reentry services, which are highly applicable to West Virginia's Continuum of Care waiver.
- **Nevada:** Draft the Nevada SUD 1115 waiver for an Institution for Mental Disease (IMD) exclusion to close gaps in the SUD continuum of care.

We also support several pharmacy and Mental Health Parity and Addiction Equity Act-related client projects, which include SUD-related issues, to assess parity, compliance with federal requirements, and opportunities for improvement.

4.1.1.8. The vendor shall provide policy impact analyses and support to the Agency, including, but not limited to, reviewing and analyzing policy options, developing documents for review, programmatic impact assessments, conducting federal regulatory review, developing presentations, and assisting with implementation of strategies (i.e. preparation of work plans, facilitation of meetings, monitoring, and evaluation).	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

The Myers and Stauffer Team has extensive experience conducting policy impact analyses as part of an ongoing effort to support our clients with improving their programs or in response to changes that may be placed on them, such as state or federal legislation and other influences. Examples of recent client successes include:

- **West Virginia:**
  - Conduct a number of options analyses related to benefit design and service coverage changes, as well as other programmatic changes. As part of these analyses, we performed detailed fiscal and operational feasibility analyses.
  - Review MCO contracts against new federal Managed Care Rule to update for compliance.

Managed Care Administration Service: Response to Requirements	Meets/ Exceeds Req.

- During the annual legislative sessions, support client leadership in research, fiscal note and policy impact analyses, preparation of leadership materials for Committee presentations, and budgetary projections in response to legislative priorities.
- Oversee preparation of client leadership presentations for MCO updates on managed care program changes, provider association meetings, national professional association conferences, and member advocate meetings.
- Maintain a repository of briefs, anticipating key topics and client needs, to ensure leadership has immediate access to data and policy insights for budget hearings, legislative sessions, and other engagements.
- Develop MHT and MHP annual reports.
- Conduct annual assessment of MCO provider network adequacy, review standardized reports for contractual compliance, and provide recommended actions for BMS' consideration.
- Provide oversight and analysis of MCO reports to identify trends in MCO performance and opportunities for improvement.
- Conduct annual MLR examinations to analyze MCO compliance with state and federal requirements.
- Coordinate meetings and written communication with MCOs to address the rate setting process and rates prior to CMS submission.
- Review home and community-based services (HCBS) waiver service definitions and rates and make recommendations for enhancements while assessing the corresponding fiscal and utilization impacts.

- **Kentucky:**
  - Conduct assessment of Department MCO oversight processes and developed recommended MCO monitoring and oversight improvements.
  - Conduct assessment of services and needs for children receiving Medicaid, child welfare, and juvenile justice services. This included performing an analysis of options for improvement as well as the advantages and constraints of each for the Commonwealth's consideration.
  - Review and presented pharmacy policy options, facilitated weekly strategy meetings, conducted fiscal and operational analyses, developed implementation strategies, and supporting implementation and ongoing operations, as well as evaluation of performance.
- **Georgia:**
  - Perform policy and fiscal analyses on numerous topics, including the impact of a physician rate increase on MCO and fee-for-service budgets as well as access to services.
  - Forecast costs due to policy changes, and financial costs due to pharmacy benefit structure changes.
- **Hawai'i:** Create options analysis for the introduction of VBP models into the MCO contracts.
- **Nevada:** Evaluate SUD policy options to improve access to services, facilitate extensive stakeholder engagement meetings, develop a strategic plan to improve access, and facilitate meetings with State leadership to present options and recommendations.

Managed Care Administration Service: Response to Requirements	Meets/ Exceeds Req.
4.1.1.9. The vendor must agree to revise all analyses based on future releases or revisions of information at the state or federal level within a mutually agreed upon timeframe between the vendor and Agency.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We understand change is inevitable in the Medicaid program. Whether prompted by changes in legislation, new rules, additional CMS guidance, or other factors, we agree to revise our analyses based on new releases or revisions to information at the state and federal level.

Examples of similar analysis revisions for our state clients include:

- **West Virginia:**
  - Develop MCO contract amendments to address new legislation, including new prior authorization requirements, WVCHIP transition to Medicaid, and implementation of day one enrollment and MCO quality withhold program initiatives.
  - Gather MCO feedback from our bi-monthly EDV analysis and reporting, annual MCO provider network adequacy analysis, and during the annual capitation rate setting process are all examples where we have updated our analyses and work product to incorporate changes, as needed, based on feedback received. Provider feedback was constructively applied during rate setting activities for HCBS waivers.
  - Update the budget neutrality calculations for the 1115 Continuum of Care waiver in an iterative process based on feedback received.
  - Update to the MHT and MHP 1915(b) waivers to incorporate CMS feedback.
  - Update the MHT waiver to include new state legislative requirements.
- **South Dakota:** Work plan included multiple drafts for review by the State. Stakeholder feedback from the initial draft was incorporated and included in the final draft for the Governor's Office.
- **Kentucky:** Analyses of MCO best practices were presented and discussed with the State. Stakeholder feedback was received with additional research conducted, where needed, and revisions made within an agreed-upon timeframe.

4.1.1.10. The vendor shall monitor federal regulations and requirements for potential changes and provide analyses on program impact within thirty (30) calendar days of notification.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We monitor federal regulations and requirements for potential changes and provide analyses of those regulations and requirements for clients. Myers and Stauffer receives daily alerts regarding federal regulation changes, identifies and tracks legislative items, and continuously analyzes the potential impact on our clients and we communicate our findings accordingly. A few examples of our experience in this area include:

- **Medicaid and CHIP Managed Care Access, Finance and Quality Final Rule:**

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▪ Tracked interim rule and assessed potential impact. ▪ Interpreted the final rule, created impact assessments for clients, and recommended next steps. ▪ Supported implementation of requirements. • **Ensuring Access to Medicaid Final Rule:** ▪ Tracked interim rule and assessed potential impact. ▪ Interpreted the Final Rule, created impact assessments for clients, and recommended next steps. ▪ Supported implementation of requirements. • **Patient-Driven Payment Model (PDPM):** ▪ Tracked the PDPM development and analyzed the fiscal and operational impact. ▪ Raised concerns to CMS and the National Association of Medicaid Directors, which contributed to changes in federal direction. • **2016 and 2020 Medicaid Managed Care Final Rules:** ▪ Monitored interim and final rules. ▪ Assessed impact and provided impact assessments to clients. ▪ Conducted a national webinar on Final Rule content. ▪ Assisted with Final Rule implementation. • **Patient Access and Interoperability Final Rule:** ▪ Conducted impact assessment of the Final Rule. ▪ Summarized rule, requirements, and potential impact to clients. ▪ Supported State initiatives to comply with the Final Rule.	
4.1.1.11. The vendor must develop and submit an Operations Plan within the first thirty (30) calendar days of contract award that addresses compliance with program requirements and services, including CMS submissions.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Myers and Stauffer develops operations plans as standard practice when initiating projects. The Operations Plan will include, at a minimum, details about the transition of the contractual responsibilities at the end of the engagement, all staff assignments, project milestones and deadlines, deliverables, and key stakeholder communications. Most relevant to this CRFQ, we have developed detailed operations plans for the following states:

- **West Virginia:** As the incumbent, the Myers and Stauffer Team developed and implemented an Operations Plan, including West Virginia Medicaid inbox management with the MCOs, revised MCO reporting templates, updated MCO member/provider materials requirements, development of a data warehouse before go-live, and implementation of a West Virginia-specific data dashboard.

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- **Kentucky:** Managed care consulting included the development of an operations plan for development of a MCO RFP and contract changes, stakeholder engagement, and design of a new managed care program, Supporting Kentucky Youth. It also included tasks for the assessment of the current MCO program and the identification of improvements for future procurement consideration.
- **Hawai'i:** Produced an operations plan to include activities related to the development of a managed care Request for Information, MCO RFP and contract, MCO reporting, and Quality Strategy.
- **Nevada:** Created comprehensive work plans and operational plans related to the State Innovation Model grant, CCBHC grant application and implementation, and Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act activities.

4.1.1.12. The vendor shall develop and maintain the MCO contracts associated with both MHT and MHP in compliance with CMS. The vendor shall seek contract updates from the MCOs and BMS 120 calendar days prior to contract implementation date.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task. We also understand the importance and agree to solicit desired contract updates from the MCOs and BMS at least 120 calendar days prior to the contract implementation date.

Qualifications:

Myers and Stauffer has experience developing and maintaining MCO contracts in a manner that complies with State and CMS requirements. Examples of our experience in this area includes the following:

- **West Virginia:**
  - Amend MHT and MHP managed care contracts on a semi-annual basis, accounting for policy changes, updates to federal regulations, and stakeholder input.
  - Manage communications with BMS team members, MCOs, and other BMS vendors regarding managed care contract changes, including new reporting requirements.
  - Support negotiations with CMS for approval, contract enhancements, and capitation rate approvals.
- **Kentucky:**
  - Support amendment process for MCO contracts.
  - Conduct national research to identify MCO contracting innovations to incorporate into new MCO contracts as part of the procurement and contract amendment process.
  - Conduct on-site meetings with each of the incumbent MCOs to identify successes and opportunities for improvement with the existing MCO contracts. Interview representatives from all Department divisions and sister agencies that support the managed care program to obtain input on the program and necessary contract changes.
  - Monitor and maintain all necessary MCO contract modifications and associated amendments.
- **Nevada:** Develop recommended contract language including performance guarantees for the State's incorporation into MCO contracts.

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4.1.1.13. The vendor shall conduct annual network adequacy assessments to be completed by October 1st every year for both MHT and MHP, with the approach approved in writing by the Agency. The vendor shall host a network adequacy kickoff meeting 30 calendar days prior to implementation of the network adequacy assessment. The vendor must outline the expected process for the assessment to be completed.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Our proposed process for conducting network adequacy assessments starts with our review of the contract to identify standards being applied. We will host a network adequacy kick-off meeting 30 calendar days prior to implementation of the network adequacy assessment. During the kick-off call, we will outline the expected process for the assessment to be completed and expectation of the MCOs. To perform the network adequacy assessment, we will compare the roster of in-network providers to beneficiaries to identify the percentage of each provider type that falls within standards. These percentages are reported through heat maps and charts and are tested based on the identified contractual standards. The interim draft is reviewed with each individual MCO for input, and the preliminary assessment results are reviewed with the State for feedback prior to finalizing the assessment report for delivery to BMS by October 1 of each year.

Myers and Stauffer has developed network adequacy methodology and reporting and assessed network adequacy for the states of West Virginia, Georgia, and Kentucky.

In addition to network adequacy testing, Myers and Stauffer performs EQR Protocol 4 procedures for Indiana and Wisconsin. These procedures also review network adequacy against contractual standards for each health plan in a given state.

4.1.1.14. The vendor shall analyze and monitor Managed Care contract performance by conducting program readiness documentation and desk reviews. This includes assessing new entrance initial go-live readiness, reviewing MCO operations, and evaluating new populations added to managed care. Ongoing reviews of the four (4) existing MCOs will also be performed as needed to ensure programmatic compliance. Readiness reviews for any new MCO entering the market must be completed within 4 (four) months. After the readiness review is completed, a detailed findings report, and the completion of the CMS readiness review tool must be submitted within 30 calendar days.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Myers and Stauffer has monitored MCO contract performance including development and performance of readiness reviews for multiple states. Our readiness review tool includes the CMS Readiness Checklist as a minimum threshold along with other state-specific and risk-oriented reviews. We understand and agree to comply with all CMS and BMS timeline requirements related to conducting MCO readiness assessments. We have used this approach to conduct readiness reviews in states, such as the following:

- **West Virginia:**
  - Conduct readiness reviews, including both desk and on-site reviews for the implementation of Highmark Health Options of West Virginia and its subcontractors. Perform a readiness review of a new dental subcontractor for Aetna Better Health West Virginia.
  - Develop readiness review tools, prepare readiness review reports and recommendations, and support management of MCO corrective actions.

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- Facilitate ongoing meetings with BMS and the MCO throughout the readiness process to ensure the MCO is making progress on addressing required corrective actions.

- **Georgia:** Conduct readiness reviews, including desk and on-site review of CMOs and subcontractors, develop readiness review tools, prepare readiness review reports and recommendations, and support management of CMO corrective actions. In addition, we conduct periodic reviews of each contracted CMO and its significant subcontractors to ensure ongoing compliance with contractual requirements and best practices.
- **Kentucky:** Develop readiness review tools, conduct staff training, facilitate desk reviews, support virtual MCO interviews, prepare reports for CMS, and monitor MCO corrective actions.

We also developed and facilitated Command Center activities to ensure successful onboarding of programs and MCOs pre- and post-contract operational dates. Our Command Center approach includes the development of detailed procedures and processes to ensure accountability and timely resolution of issues that arise during the critical first weeks of MCO implementation. Our Command Center approach also includes the development of dashboards and executive leadership reports to clearly convey implementation health, known issues, and responsiveness of the MCOs in resolving issues. We have used this approach in states such as Georgia, Kentucky, and Nevada.

4.1.1.15. The vendor shall develop an annual report on MCO performance and compliance with contractual obligations within ninety (90) calendar days of the end of the reporting period. The end of the reporting period is the end of the state fiscal year, which is June 30th. The annual report shall also address program enrollment, services available, cost savings resulting from the program, performance on key quality indicators, Medical Loss Ratio (MLR) overview, program integrity, improvement strategies implemented, program goals, and other information as requested by the Agency, at no additional cost to the Agency.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We understand and will comply with the timelines and the minimum reporting requirements for the annual report on MCO performance and compliance. We also understand the annual report may include information beyond the elements listed here based on BMS' needs, and we will make those necessary adjustments based on conversations with BMS.

Myers and Stauffer has experience producing contract performance review reports in numerous states including:

- **West Virginia:**
  - Produce an annual report for the MHT and MHP programs, which considers and includes the following information:
    - Program overviews, member demographics and enrollment, MCO profiles, quality summaries, and program integrity metrics.
    - Encounter data reconciliation and validation reports.
    - Analysis and report on the state directed payments programs.
    - Managed care metrics, such as program expenditures, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) reporting, and MCO community support outcomes.
    - Provide interactive dashboarding to facilitate monitoring and oversight for plan compliance.

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- **Georgia:**
  - Provide an annual report to the Department of Community Health to include financial and performance audits of the CMOs. Provide recommendations for process and contractual improvements, where identified.
  - Provide interactive dashboarding to facilitate monitoring and oversight for plan compliance.
- **Washington:** Conduct an annual review of MCO VBP payments arrangements to measure contract compliance.

We also perform recurring MLR and administrative expense analysis reports in multiple states including Colorado, Georgia, Hawai'i, Idaho, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, Nebraska, New Mexico, Ohio, Tennessee, Texas, Utah, Virginia, West Virginia, and Wisconsin.

4.1.1.16. The vendor shall perform analyses and conduct ongoing monitoring of MCO provider networks and conduct quarterly analyses of the MCOs' networks against program requirements.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Myers and Stauffer has provided monitoring and oversight for MCO provider networks to ensure compliance for various states. This work includes performing network analyses and reviewing standardized reports for contractual compliance. We have performed these services for multiple states including West Virginia, Arizona, Georgia, Kentucky, and Virginia. We have conducted network secret shopper testing in Arizona, Georgia, Indiana, New Mexico, and Virginia.

In addition to the above, Myers and Stauffer performs EQR Protocol 4 oversight in multiple markets, such as Indiana and Wisconsin, as a subcontractor to the Prime. This protocol is designed to perform oversight of plan networks in a market.

4.1.1.17. The vendor shall develop MCO-specific reports and maps showing providers, clinics, and hospitals by specialty and location. Information shall be submitted within ten (10) calendar days of request, unless otherwise noted.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Myers and Stauffer develops and delivers customized reports and maps for our clients, including West Virginia, which includes various provider types and specialties. We have produced these in the following states:

- **West Virginia:** Develop reports for the provider network adequacy assessment upon request**.**
- **Kentucky:** Develop and facilitate a Reporting Requirements Workgroup with six MCOs and State staff to design standardized reporting templates for monitoring provider network adequacy.
- **Indiana:** Develop and deploy an approach to map nursing facilities in the state and report on key data elements.
- **Georgia:** Generate MCO-specific maps to indicate regional provider participation and participation by provider specialty. Generate reports on an as-needed basis and per mutually agreed-upon specifications.

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4.1.1.18. The vendor shall work with the Agency to develop a comprehensive reporting calendar for the MHT and MHP programs that comply with federal, state, and agency-specific reporting requirements as defined by the managed care contracts. The current authorities can be accessed at: https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-final-rules/index.html#:~:text=On%20January%2017%2C%202017%2 C%20CMS%20released%20a%20final,under%20Medicaid%20managed%20care%20contracts%20and%20rate%20certifications.WV State Code Chapter 9: https://code.wvlegislature.gov/9/	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

As part of our current engagement with BMS, we worked closely with BMS to develop a reporting calendar and a process to monitor and report on MCO report submission compliance. We developed this calendar and MCO reporting instructions to ensure reporting was consistent with both state and federal requirements for content and timeliness. The calendar is updated with new requirements, as needed, with Myers and Stauffer providing updates on reporting compliance during recurring status meetings with BMS.

Myers and Stauffer has also developed detailed reporting calendars for states, such as Kentucky, Louisiana, and Nevada. For example, in Kentucky, we revised the MCO reporting templates, developed a detailed calendar for MCO reporting, included all state and federally mandated reports, and supported the training of staff regarding oversight and monitoring of report submission compliance.

4.1.1.19. The vendor must identify and comply with all federal and state Medicaid and WVCHIP laws, regulations, and policies, as outlined by the CMS and the BMS, which can be accessed at: https://www.medicaid.gov/medicaid/managed-care/index.html	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We understand and will comply with all federal and state Medicaid laws, regulations, and policies, as outlined by CMS and BMS. As new law, regulations, policies, guidance, and other forms of updates are issued, we will conduct our work in a compliant manner.

4.1.1.20. The vendor shall analyze Early Periodic Screening, Diagnosis, and Treatment (EPSDT) service provisions and track MCO contract compliance on a quarterly basis. The vendor will prepare federal and state reports on methods to improve efficiency, effectiveness, coordination and quality of those services in West Virginia as needed. The reports will be submitted in an agreed upon format and submission standard between the vendor and the Agency. Separate analysis and reporting for Medicaid and WVCHIP may be necessary.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We are prepared to analyze and track EPSDT service provision and MCO contract compliance on a quarterly basis and support the preparation state and federal reports (e.g., CMS-416 report, etc.). Where required, separate reports will be produced for WVCHIP.

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Examples of Myers and Stauffer's experience with EPSDT analysis and reporting is detailed below:

- **West Virginia:**
  - Compare screening and participation ratios for FFS and MCOs against CMS and Medicaid Management Information System (MMIS) vendor calculations. Work with MCOs to quantify and correct identified variances.
  - Coordinate analyses and inquiries with BMS SME.
  - Prepare EPSDT brief and analyses for BMS leadership and legislative session.
- **Kentucky:** Support all requirements of Section 5121 of the Consolidated Appropriations Act of 2023 to ensure provision of screening and diagnostic services, as well as targeted case management (TCM) services for eligible youth and young adults in correctional facilities.
- **Georgia:** Compare EPSDT performance for FFS and managed care plans against CMS and MMIS vendor calculations. Works with stakeholders to quantify and correct identified variances.
- **Hawai'i:** Support the development of the Quality Strategy, which includes strategies to increase access to EPSDT services.

4.1.1.21. The vendor must provide ad-hoc reports upon request on information including, but not limited to, comparisons of the Managed Care program with the fee-for-service program to improve the efficiency, effectiveness, and quality of the Managed Care program within the timelines established for each project. These ad-hoc reports and associated timelines will be based on an approved SOW.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Myers and Stauffer has the resources to provide ad-hoc services, as needed, and will ensure we meet all milestones and provide quality and responsive services to the Bureau.

Examples of our ad-hoc report production includes:

- **West Virginia:**
  - Develop forecasting model to show impact of changes in FFS and managed care programs. Work with BMS to develop multiple potential payment methodologies and estimate the cost of each approach.
  - Calculate financial impact of legislative requests, including fiscal note analyses. Assist the Bureau with responding to legislative requirements and requests.
  - Prepare topic-specific presentations and briefs for BMS leadership.
  - Prepare fiscal impact analyses of SB 820 (2024) and present for BMS leadership and the Legislature.
  - Develop fiscal impact analyses for transition of WVCHIP to MHT.
  - Prepare public health emergency fiscal impact analyses in multiple phases.
- **Georgia:**

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- Develop forecasting model to show impact of changes in FFS and managed care programs. Work with the State to develop multiple potential payment methodologies and the estimated cost of each approach.
- Calculate financial impact of legislative requests. Assists the Department in responding to legislative requirements and requests.

- **Kentucky:** Compare the outpatient pharmacy benefit under FFS and managed care environments, issue an ad-hoc report, and present to Medicaid leadership.

4.1.1.22. The vendor must provide an analysis dashboard with access for ten (10) state users for use in identifying medical service utilization patterns by category of service and medical and administrative cost profiles for all Managed Care cohorts, major lines of business, and individual Managed Care members to improve quality of care and outreach.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Myers and Stauffer has experience designing and implementing analytic tools needed to identify medical service utilization patterns by category of service and medical and administrative cost profiles for all managed care cohorts, major lines of business/categories of service, and individual managed care recipients to improve quality of care and outreach. We can provide different levels of access to reporting information from summarized reporting that can be shared publicly down to claim-level information, as required.

To fulfill this BMS requirement, we will use and periodically enhance as mutually agreed upon, the existing dashboard system that we deployed for BMS under our current contract. Features of this system include:

- Enrollment and demographic metrics.
- MCO financial performance.
- Network adequacy metrics.
- Quality and performance metrics.
- Program integrity trends.
- Managed care utilization trends and metrics by services, demographics, and financial requirements.

We have also deployed similar systems and reports for other states, such as Colorado, Georgia, Illinois, and Mississippi.

4.1.1.23. The vendor must provide all data, program and regulatory analyses required to respond to Legislative, Federal, State, Budgetary, Provider, Advocacy, or other requests in a timeframe that is mutually agreed upon by vendor and agency.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

The Myers and Stauffer Team has experience providing data, program, and regulatory analyses, and we understand the importance of delivering clear, complete, timely, and accurate responses. Our Team currently supports BMS in the following areas:

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- Support budget impact analyses and development of presentation materials.
- Conduct options analyses for budgeting, contracting, and programmatic changes.
- Prepare fiscal note analyses, topic-specific briefs, and presentations during legislative sessions and special hearings.
- Conduct targeted research to support assessments and programmatic and regulatory analyses.
- Evaluate legislative and policy changes that may impact program operations and Medicaid rate setting and financial projections.

Examples of similar work for other states includes:

- **Nevada:**
  - Assist with analysis of proposed state legislation to pursue federal authority for a Section 1115 waiver for mental health services provided in an IMD, including consultation regarding operational and fiscal impacts to the State.
  - Collect and analyze provider and advocacy feedback regarding services needed to support Therapeutic Foster Care through a 1915(i) SPA.
- **New Jersey:** Conduct analysis of provider requests for further analysis of calculated VBP performance measurements which were tied to incentive payments.

4.1.1.24. The vendor must submit within thirty (30) calendar days of award a plan to be approved by the Agency for MCO contracting, including but not limited to options for performance targets, incentives and penalties, modifications to program requirements, implementation and oversight of a Managed Care Medical Loss Ratio (MLR). Separate MLRs for Medicaid and WVCHIP will be necessary. The vendor must also address any additional requests from the Agency at no additional cost to the Agency.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Myers and Stauffer has extensive experience developing plans for states related to MCO contracting, including supporting MCO contract revisions and amendments, recommending contract language, drafting performance targets and requirements, as well as penalties for non-compliance. We have also included in our plans the process for performing MLR oversight and incorporating MLR expectations in MCO contracts. Examples of our experience in this area includes:

- **West Virginia:** The Myers and Stauffer Team conducts the following MCO contracting activities as the incumbent vendor:
  - Analyze existing MHT and MHP contracts for opportunities for improvement, including MCO reporting, key staffing, MLR requirements, CCBHC services, capitation rate setting, and new legislation.
  - Address current and upcoming contract amendments, which focus on quality initiatives under SB 820 (2024); high-cost drugs; key staffing; WVCHIP MLR requirements, provider network assessments, corrective actions and liquidated damages; 2025 legislation; and new federal requirements.
  - Identify potential amendments to bring MCO contracts into compliance with Medicaid Managed Care Final Rule and draft appropriate language for review.

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▪ Collaborate with another BMS vendor to understand MCO contracting requirements for CCBHCs, the 1115 Continuum of Care waiver and other BMS initiatives. ▪ Conduct annual MCO MLR examinations for MHT, MHP, and WVCHIP populations. Other MCO contracting examples include: • **Kentucky:** ▪ Provide extensive revisions to MCO contract, including language to strengthen the State's monitoring and oversight capabilities, such as provider network adequacy analysis, MCO non-compliance, MCO reporting, and MCO performance on improving health outcomes. ▪ Develop and implement a new managed care program and MCO contract for the foster care and adoptive assistance managed care program. The contract addresses specialized reporting for the foster care and adoptive assistance populations. ▪ Assist with the development and design of a new single MCO PBM model. Reviewed the Commonwealth's procurement approach, RFP, and scope of work. Assist with contract implementation readiness activities for the selected vendor and continue to provide project management and subject matter expertise support for ongoing operations. Recommend performance incentive program in MCO contracts, as well as performance penalties in MCO and single MCO PBM contracts. • **Hawai'i:** Draft significant revisions to MCO contract, including modifications to address MCO non-compliance, MCO reporting, VBP, and enhanced program integrity requirements. • **Nevada:** ▪ Analyze existing MCO contract for opportunities for improvement. ▪ Identify areas for amendment to bring contract into compliance with Medicaid Managed Care Final Rule and draft appropriate language for review. ▪ Recommend performance guarantees for MCO contract. ▪ Draft language to address MCO oversight and monitoring strategy. • **Louisiana:** Provide MCO contract language and instructions for MLR template and MLR filing requirements. • **Annual MCO MLR Examinations:** We also perform MLR and administrative expense analysis reports in multiple states, including: Colorado, Georgia, Hawai'i, Idaho, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, Nebraska, New Mexico, Ohio, Tennessee, Texas, Utah, Virginia, and Wisconsin.	
4.1.1.25. The vendor shall develop a comprehensive quality assessment and performance improvement strategy, that align with federal regulations, including the Quality Improvement Systems for Managed Care (QISMC) https://www.medicaid.gov/medicaid/quality-of-care/medicaid- managed-care-quality/state-quality-strategies/index.html, CMS standards, and other relevant quality review programs. This strategy shall integrate input from enrollees and advocates. Annually, the vendor shall update the QISMC in collaboration with Agency Quality and Managed Care staff. Collaborator engagement will include Managed Care organizations agency or other collaborators. Agency will work with these collaborators to identify options and recommendations for monitoring and evaluating the quality and appropriateness of care and service provided to enrollees. The vendor will conduct an annual evaluation of the Managed Care Quality Strategy utilizing the CMS toolkit as	**Yes**

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guidance. At the end of the three (3)-year Quality Strategy the vendor will craft an evaluation covering the entire Quality Strategy per CMS guidance and toolkit. https://www.medicaid.gov/medicaid/downloads/managed-care- quality-strategy-toolkit.pdf.	

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We assess and provide recommendations to improve the quality, efficiency, and delivery of care, leading to better patient experiences and reductions in costs. We have assisted numerous clients, including BMS, with quality improvement strategies. Our experience includes:

- **West Virginia:** Develop the state fiscal year (SFY) 2024-2027 Quality Strategy utilizing the CMS toolkit. The Quality Strategy outlines current and future quality improvement programs in West Virginia Medicaid and involves annual reviews to ensure improvements year over year.
- **Mississippi:**
  - Lead the revision of the 2025-2028 CQS that outlines the State's goals, values, objectives, compliance monitoring, and improvement interventions.
  - Our support includes project management, stakeholder engagement, drafting and document revisions, and public comment support.
- **New Jersey:**
  - Develop and implement quality assessment and improvement strategy to assess performance of VBP-participating hospitals.
  - Conduct learning collaborative forums based on the Plan Do Study Act approach.
  - Report activities and results to CMS.
- **Hawai'i:** Develop Medicaid Quality Strategy.

4.4.1.26. The vendor shall be available within one (1) business day for a virtual meeting or five (5) business days to meet in person with the Agency's Managed Care entities, provider groups, and other parties as determined necessary by the Agency, at a location to be determined based on space availability, at no additional cost to the Agency.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Our proposed fees are inclusive of meetings and associated costs. Details, such as meeting frequency and format will be agreed upon with BMS upon contract award.

We have extensive experience meeting with MCOs in the states of: Georgia, Kentucky, Iowa, Illinois, Indiana, Louisiana, New Mexico, Ohio, Tennessee, Texas, Virginia, Washington, and Wisconsin.

We also have facilitated larger managed care and delivery system stakeholder groups consisting of various stakeholders (states, providers, community members, advocates, etc.) for the following states: Georgia, Hawai'i, Kentucky, Michigan, Nevada, New Hampshire, New Jersey, and Washington.

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4.1.1.27. The vendor shall assist in developing options for program expansion and assist in implementation of program expansion, including preparation of documents outlining options for program expansions, including cost savings, policy considerations, risks, issues, agency and bureau coordination requirements, and legal constraints, etc.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Myers and Stauffer has extensive experiencing in the design, development, procurement, implementation, and ongoing operations for Medicaid managed care programs. Should program expansion be a consideration the Bureau wishes to explore, we will provide expertise to facilitate that process, including performing research, conducting an options analysis, facilitating strategic planning, and identifying policy considerations, costs, risks, and other areas identified by BMS. Most recently, we provided similar services to:

- **West Virginia:**
  - Support client leadership in research, fiscal note analyses, topic-specific reports, budgetary projections in response to legislative priorities, and prepare leadership materials for Committee presentations during the annual legislative sessions.
  - Develop budget reports highlighting long-term risks to the client budget and strategies to continually improve quality and fiscal efficiency.
  - Conduct options analyses (e.g., benefits, services, programmatic changes, etc.) and perform detailed fiscal and operational feasibility analyses.
  - Transition the WVCHIP population and benefits and services into the MHT program, including performing a fiscal impact analysis for this transition.
  - Complete amendments to the MHT contract addressing the WVCHIP transition, including ongoing amendments.
  - Develop WVCHIP capitation rate.
  - Conduct MCO MLR examinations for the WVCHIP population.
  - Transitioned former foster care youth to the MHP program.
  - Support the State's hospital and physician DPPs, including annual updates to the existing program and assisting the State with significant program expansion in response to recent legislative changes.
  - Onboard a fourth MCO into the MHT program, including a readiness review, management of corrective actions, and reviews of all member and provider materials.
- **Georgia:** Conduct analysis assessing costs for changing payment methodologies, including rate setting and specific changes (e.g., outliers, and outpatient, inpatient, pharmacy, and physician payments).
- **Kentucky:** Develop reentry 1115 waiver application, which was approved by CMS in 2024.
- **New Mexico:** Work with the State to implement the Coverage Expansion Plan, which provides coverage to uninsured New Mexican residents who do not have access to federal premium assistance that makes health coverage affordable to lower- and middle-income residents.
- **Nebraska:** Support the State with consolidating the operation of several 1915(c) waiver programs. The outcome increased the State's internal capacity for assisting vulnerable members, eliminated the waitlist for 1915(c) services, added technology services to support independence in the community, and increased access to Katie Beckett eligibility for children who may not require 1915(c) waiver services to remain with their families.

Managed Care Administration Service: Response to Requirements	Meets/ Exceeds Req.

- **South Dakota:** Conduct an analysis of expanding programs and restructuring existing programs in the Medicaid division. The analysis included options, advantages/constraints, operational/ fiscal impacts, and required federal authorities among other factors.

4.1.1.28. The vendor shall assist with the development of reports for WV House Bill 4217, which can be found at: http://www.legis.state.wv.us/Bill Status/bills text.cfm?billdoc=H B4217%20SUB%20ENR.htm&yr=2014&sesstype=RS&billtype= B&houseorig=H&i=4217.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

As the incumbent contractor, Myers and Stauffer produces the West Virginia House Bill 4217 report for BMS' review and approval. This report is produced in compliance with state regulations. We collect relevant data from each MCO and retrieve pertinent information from our MC-Ops dashboard and data warehouse.

With the addition of Highmark Health Options in 2024, Myers and Stauffer worked with the new MCO to incorporate all available data to complete the report with caveats where applicable.

Myers and Stauffer has assisted our clients with similar reports and other materials to present to state legislative bodies and other entities:

- Developed annual reports for legislative requests in Georgia and Louisiana, as well as other states.
- Produced report for the Medicaid and CHIP Payment and Access Commission, the legislative branch agency that provides policy and data analysis and makes recommendations to Congress and other government divisions.

4.1.1.29. The vendor shall be responsible for collecting all required reports of the MCOs, reviewing reporting for any errors or omissions, generating reports for the Agency based on the data reported, and maintaining a tracking log of the submission to be used in monitoring MCO contract compliance. Required reports and due dates of the MCOs are included in Exhibit C. The vendor will conduct an individual MCO meeting once a month to review and discuss results from submitted reports including but not limited to the Cash Disbursement Journal, EPSDT results, and dashboard results. Separate Medicaid & WVCHIP reporting is necessary.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

As the incumbent, we serve as the central collection hub of all required MCO reports. We review all reports to ensure timeliness, completeness, and reporting anomalies. We meet with individual MCOs, as needed, to address reporting issues, data integrity and completeness issues, and overall compliance with reporting requirements.

We will continue to use technology to collect, track, and archive BMS MCO reporting to ensure contractual and regulatory compliance. In addition, Myers and Stauffer will continue to utilize the MC-Ops dashboard to communicate MCO reporting and performance.

Managed Care Administration Service: Response to Requirements	Meets/ Exceeds Req.
Myers and Stauffer provides oversight monitoring and support of MCO-submitted reports, as well as dashboards and other similar tools for other states, such as Georgia, Iowa, and Louisiana.	
4.1.1.30. The vendor shall provide an electronic tool compatible with Agency Systems, which are currently Microsoft Windows 10 or equal Microsoft 365 or equal, or Google Workspace or Equal that serves as a program compliance dashboard that will allow the Agency to track at a minimum, but to be refined by the Agency: • All deliverables submitted by the MCOs as outlined under the Managed Care contract • MCO policies and procedure documents • Contract and amendment language and version history • MCO quality metrics and report card • Network adequacy documents and readiness review materials • Grievances and Appeals • Vendor shall provide MCO-related training to staff and maintain a training manual for reference. • Platform must be hosted by the vendor and allow access for up to ten (10) users at any time. Settings must be configurable to meet agency needs. The current agency operating system is Windows 10. For teleconference capabilities, the Agency currently uses Google Workspace.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

- Myers and Stauffer developed the MC-Ops secure web portal with multiple interactive dashboard reports covering various functional areas to support BMS oversight of its Medicaid managed care programs.
- We provide regular data updates to the dashboards which incorporate information from managed care contractual reports and data extracts supplied by the MMIS contractor, Gainwell Technologies. We have expanded the scope of reporting since initial deployment in 2022 based on feedback from BMS staff and known areas of interest for BMS staff and stakeholders.
- Myers and Stauffer also supports BMS with review and oversight of managed care contractual reporting. In this role, our Team reviews MCO report files to validate report completeness and formatting. We work directly with the MCOs to remediate potential reporting issues. We also work with BMS and the MCOs to enhance MCO reporting templates to support more detailed data collection and simplified reporting.

Our IT team has developed custom collaboration and analytics tools to support a variety of client initiatives. These tools facilitate data collection and allow users to upload/download documentation, host forums, build electronic surveys, publish project calendars, offer electronic project management tools and resources, store project and training documents and frequently asked questions, monitor progress, and retrieve reports. Our IT development staff can leverage these tools to expand the existing MC-Ops platform to support document submission, tracking, and file management requirements defined by BMS. We will work with BMS to define more specific development requirements and adjust the tool functionality to best meet BMS' needs.

Managed Care Administration Service: Response to Requirements	Meets/ Exceeds Req.
4.1.1.31. The vendor shall support Program Integrity strategic planning, oversight, and coordination activities with the MCOs in collaboration with the West Virginia Program Integrity (PI) Director and Program Integrity Unit. These activities shall include: • Program Management Support Services • Support BMS PI with coordination of PI activities across multiple workstreams • PI process improvement • Operational Support • Conduct a comprehensive PI risk assessment • Work with MCOs on validation of claims, identification of errors and policy recommendations • Medicaid Managed Care Program Integrity • Review MCO compliance plans • Audit claims paid to network providers • Review referrals made to BMS PI or the Medicaid Fraud Control Unit (MFCU) • Participate in internal meetings and BMS-led meetings with the MCOs and/or MFCU • The vendor will facilitate in collaboration with OPI the annual MCO Compliance Plan training. The training will be held on a mutually agreed upon date in November of each year.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Myers and Stauffer specializes in providing program integrity expertise and support to our state and federal partners designed to ensure provider and health plan compliance. We have provided audits and other program integrity support services on behalf of government-sponsored health and human services programs, specifically supplying program integrity services in nearly every state in the country and for the DOJ, the FBI, and CMS, helping our clients achieve resource maximization, improved health outcomes, and overall program effectiveness.

We also have extensive experience working with MFCUs and have made a significant number of referrals for potential fraud, a number of which have resulted in convictions. We also support clients by meeting with MFCU investigators, as necessary, to discuss cases, clarify the issues, and help them navigate the complexities involved.

We are highly qualified to provide program integrity strategic planning and support the oversight and coordination of program integrity activities with the MCOs. As we do in other states, we will do this in collaboration with the BMS Program Integrity Director and the Program Integrity Unit. Our expertise will support assessing the current program, identify opportunities for improvement, develop a roadmap to implement those improvements, support implementation and training, and develop a mechanism to evaluate effectiveness.

The following are examples of our program integrity work:

- **West Virginia:**

Managed Care Administration Service: Response to Requirements	Meets/ Exceeds Req.

- Audit provider spending of American Rescue Plan Act (ARPA) funds to ensure funds were spent appropriately and in compliance with CMS guidelines.
- Conduct non-emergency medical transportation (NEMT) provider reviews and provided consulting services to establish and implement a Fraud Risk Management Plan that will serve as the framework for assessment of fraud risks facing the NEMT program.

- **Georgia:**
  - Identify potential duplicates of managed care enrollment, as well as improper capitation rates paid. Our work has helped the State identify members who were not historically identified and helped to correct those overpayments. Recoupments have ranged from $5 million-$100-plus million annually.
  - Test paid claims against the Department's billing and policy rules to identify overpayments and make recommendations (e.g., policy clarifications, MMIS edits, provider education, etc.) to avoid these costs in the future. This process has netted over $26 million in a single year in affirmed overpayments.
  - Provide referrals to the MFCU; one of which resulted in a $2.95 million recovery from a hospital provider.
  - Support coordination of FFS program integrity efforts, including active cases, with managed care program integrity activities.
  - Conduct Recovery Audit Contractor audits for inpatient and outpatient services, physician and specialty care providers, LTC providers, and other ancillary service providers.
- **Hawai'i:**
  - Assist with revision of the Memorandum of Understanding with the MFCU.
  - Assist the client with reconciling managed care claims data with program integrity approaches not previously utilized.
  - Compare capitation data and identify several variations of duplicate payments for recipients in a managed care plan. Our work has resulted in a cost savings of $3.85 million.
- **Louisiana:** Conduct credit balance audits, identify duplicate capitation payments, and conduct audits for inpatient and outpatient services, pharmacy providers, physician and specialty care providers, LTC providers, and other ancillary service providers.
- **Texas:** Conduct performance audits to determine whether services billed and paid under the state Medicaid program were provided in accordance with applicable federal and state Medicaid laws, regulations, rules, policies, and contractual requirements. The scope includes audits of various Medicaid managed care and/or FFS providers, including pharmacies, speech therapy, home health, durable medical equipment (DME), hospitals, nursing facilities, dental providers, behavioral health services, and adult day care centers. Before appeals, $800,000 was identified for recoupment.

Actuarial Services (4.1.2)

As part of the Myers and Stauffer Team, Milliman will provide the actuarial services outlined in the CRFQ. The experience and qualifications of Milliman consistently exceed the actuarial requirements set forth in the CRFQ. In *Table 7,* we provide summary information on client-specific engagements that address the CRFQ requirements.

Table 7. Actuarial Services Requirements and Deliverables (4.1.2)

Actuarial Services: Response to Requirements	Meets/ Exceeds Req.
4.1.2.1. The vendor shall complete the development, setting, certification, and/or review of rates for the State's Managed Care programs. Capitation rates for Managed Care shall be developed based on readily available State data and set by cohorts, including, but not limited to, age, gender, eligibility category, geographic location, and population risk factors. The vendor will host a MCO rate setting kick off meeting prior to implementation of activities to outline the process of rate development with the MCOs and will conduct meetings throughout the rate setting process with the MCOs.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Our actuaries will provide technical and professional services to ensure the capitation rate setting process fully complies with 42 CFR 438.4, the most recent Medicaid Managed Care Rate Development Guide published by CMS, additional CMS regulations as they are passed, and all professional actuarial standards of practices. Our Medicaid capitation rate setting methodology follows a standard underlying process but is customized to each client and population based on local characteristics, the MCO market, benefits, and program maturity. Our experience in Medicaid rate setting has included traditional modified adjusted gross income; aged, blind, and disabled (ABD); Affordable Care Act (ACA) expansion; dual-eligible; and special needs populations, which has provided us the ability to benchmark MCO managed care efficiency on a population-specific basis. We frequently meet with MCOs to kick off rate setting and during rate development to discuss MCO concerns regarding capitation rates. We also use a robust question and answer process to ensure we communicate clearly with the MCOs. Our collaboration with MCOs leads to a more transparent rate development process.

We complete this task in every state where we serve as a certifying actuary.

4.1.2.2. Vendor shall develop high, mid, and low capitation rate ranges for review.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

If requested by BMS and as approved by CMS, we will develop high, mid, and low capitation rate ranges for review. These approaches are not commonly used currently, and we would also engage in discussions with BMS related to the pros and cons of such a methodology and the limitations under the current rule.

Actuarial Services: Response to Requirements	Meets/ Exceeds Req.

Given CMS restrictions related to use of rate ranges in the certification, we have not certified rate ranges often but below are states where we have done this in the past:

- **Utah:** Develop and certify rate ranges for medical and behavioral health programs.
- **Vermont:** Develop and certify a range of rates where the high end of the rate range represents the allowable range for federal match.

4.1.2.3. Vendor must develop Managed Care rates at the individual MCO level, if the Agency chooses to develop MCO-specific rates based on risk stratification.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We have generally pooled experience for rating purposes but then made plan-specific adjustments, as warranted, including the following:

- Adjusted for risk profile, including standard risk adjustment but also adjustments for levels of homelessness, autism, and long-term services and supports (LTSS) needs.
  - We perform medical and pharmacy risk adjustment in the 20-plus states we support.
    - **Washington and Hawai'i:** Modify the risk adjustment weights to include homelessness, where these individuals may not be distributed evenly across plans and so we adjust accordingly.
    - **Utah:** The behavioral health plans have unique unit costs based on how rural or urban they are and if they are a staff model or traditional managed care plan. We adjust each plan based on their unique risk and unit cost profiles. We similarly create plan-specific rates for the Utah CHIP medical and dental programs to account for various health plan risk, administrative costs, and reimbursement rates.
    - **Washington (Program of All-Inclusive Care for the Elderly [PACE]), Hawai'i, and Florida:** Perform risk adjustment based on the LTSS factors to create unique risk profiles for each plan that each plan then needs to manage to over the contract year.
    - **Hawai'i:** Adjust rates by plan to account for engagement with providers and members who need applied behavior analysis (ABA)services.
- Unique plan unit costs, such as federally qualified health center (FQHC) use rates where the prospective payment system (PPS) rates are included in the capitation rates.
  - **Hawai'i:** Participating plans have vastly different FQHC use rates from none to heavy. Rates are adjusted unique to each plan to account for predicted use patterns of FQHC, which are paid at a higher unit cost than other providers.
- Plan adjustments based on procurement strategies where a plan may commit to assumptions as part of the bidding process.
  - **Washington, Hawai'i, and Florida:** In past procurements, plans bid unique rates or promised outcomes and we were able to modify rates by plan to recognize the procurement agreements.
- Particular high-cost pharmacy or high-risk newborn costs, specific to plan membership.
  - **Florida:** Create a pharmacy risk pool such that each plan is ultimately paid based on the unique costs by plan.

Actuarial Services: Response to Requirements	Meets/ Exceeds Req.

- **Hawai'i:** Develop a high-risk newborn risk pool. These costly cases are predictable in aggregate but not by plan. The risk pool addresses this and redistributes based on outcomes.

4.1.2.4. Vendor shall participate and provide support in rate setting discussions and meetings as needed, and provide supporting documentation, including but not limited to, presentations, rate workbooks, spreadsheet files, and rate memos, as requested by Agency staff for meetings	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Our Team is prepared to provide a complete, detailed explanation of the rate setting methodology for key stakeholders in any format required. We propose one-on-one meetings with the MCOs prior to the rate development to understand issues specific to each plan and during the rate development to present SFY rates. We will also meet with MCOs for any material mid-year adjustments and/or risk adjustments. We complete similar tasks in every state where we serve as certifying actuary.

Open communication with the State and all stakeholders has produced an efficient model where we are able to submit MCO rates at least 90 days prior to the rating period.

As an example, we are sharing a link to our publicly available rate reports and exhibits for the state of Wisconsin: https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Reimbursement_and_Capitation/Home.htm.spage#crbp

4.1.2.5. Vendor shall work collaboratively with Agency staff to improve the accuracy and efficiency of the existing data sources and new data sources used for rate development, and the methodologies used in the rate setting process. Collaboration shall include attending meetings, conference calls, and other requests that the Agency deems necessary. It is the expectation of the Agency that the vendor shall provide new and innovative ideas around the rate setting process and efficiencies of such. The Vendor shall facilitate direct communication channels between Actuary and the Agency. The frequency shall be on an as-requested basis. The location of the meetings will be determined by the Agency and whether they will be held in-person or virtually.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We will work to improve the accuracy and efficiency of the existing data sources and new data sources used for rate development, and the methodologies used in the rate setting process. We complete this task in every state where we serve as a certifying actuary.

Myers and Stauffer will also facilitate direct communication channels between BMS and Milliman. In addition, Ms. Hallum will serve as a main point of contact for BMS for actuarial matters.

The following is an example of innovative ideas around the rate setting process and efficiencies:

Actuarial Services: Response to Requirements	Meets/ Exceeds Req.

- In addition to the accuracy of the data, we also support the State in reviewing benchmarks to determine where plans can improve performance. We have recently run the Milliman Health Waste Calculator (https://info.medinsight.milliman.com/category/health-waste-calculator/) in Hawai'i and Washington to guide plans to areas that need improvement.
- We developed risk adjustment processes to address social determinants of health issues including homelessness and LTSS needs.
- We created unique risk mitigation strategies to address plans with unique member mix or limited populations with high-cost newborns or pharmacy.
- We monitor performance of each plan related to State initiatives.

4.1.2.6. Vendor shall provide the Agency with reports and calculations in the formats specified by the Agency, including all formulae, databases, data sets, and other documents as requested on an as needed basis in an agreed-upon standard format compliant to the data being requested.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We complete this task in every state where we serve as a certifying actuary.

4.1.2.7. The vendor shall assist the Agency in identifying where rate uniformity can occur to ensure payments are made consistently across all agencies by conducting a rate uniformity workgroup and analysis of all rates currently administered in a schedule to be coordinated between the vendor and Agency. The analysis shall identify inconsistencies and recommendations to the Agency for improving its rate setting process and helping align areas that are not in uniformity.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We will participate in all activities as they relate to rate uniformity efforts. We currently assist several states with varying levels of provider uniformity analyses including:

- **Washington:** Support the development of minimum fee schedules for behavioral health services that can be used by Medicaid and other payers for establishing provider payment rate uniformity.
- **Hawai'i:** Perform rate studies across agencies supporting behavioral health to ensure consistent payment rates and eliminate incentives to direct care to one agency over another due to increased payments. The work bridges Medicaid and includes uninsured as well.

Actuarial Services: Response to Requirements	Meets/ Exceeds Req.
4.1.2.8. Vendor shall update the capitation rates based on data, pricing trends, changes resulting from federal and/or state requirements, program changes and certify such amendments, at a minimum of one time per fiscal year.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Our actuaries perform this task regularly and always maintain a level of flexibility allowing us to respond to the changes, as needed. As an example, in recent years, we worked with our states to monitor data related to COVID-19 impacts. We reviewed the need to update risk mitigation models, rates, and real-time hospital capacity. In Florida, at the peak of the COVID-19 pandemic, we had daily and weekly updates by hospital of actual and projected needs as cases increased.

We complete this task in every state where we serve as a certifying actuary.

4.1.2.9. The vendor shall develop a transition plan for Agency approval that must be submitted to the Agency ninety (90) days in advance of the contract end date. The vendor must complete transition activities to transition all data, methodologies, documentation, and ongoing projects to the next succeeding vendor, at least sixty (60) calendar days in advance of the contract end date.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We will develop and successfully implement a plan to transition all data, methodologies, documentation, and ongoing projects to the next succeeding vendor, at least 60 calendar days in advance of the contract end date.

4.1.2.10. The vendor shall coordinate with the State's fiscal agent to ensure accurate encounter claims, and eligibility data is used for rate setting. Vendor shall review encounter data for completeness and/or inconsistencies as part of rate setting process and provide a summary report of any inconsistencies to the Agency for review on an ad hoc basis in a format agreed upon between the vendor and Agency.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Our actuaries understand the needs and requirements related to the actuarial services that BMS has set forth in this CRFQ. As encounter data serves as the base experience in the capitation rate setting process, significant resources will be invested by our Team to validate the completeness and accuracy of MCOs' encounter data. We will utilize validated encounter and other data to develop managed care capitation rates, produce MCO risk adjustment analyses, and thoroughly carry out all necessary actions to produce the most comprehensive, compliant, and highest quality services as outlined by this CRFQ. In addition, we will provide any reports on an ad-hoc basis, as requested. We complete similar tasks in every state where we serve as a certifying actuary.

Actuarial Services: Response to Requirements	Meets/ Exceeds Req.
4.1.2.11. Vendor shall work with fiscal agent to ensure completeness of all reports used for state and federal reporting, as requested by the Agency.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Our actuaries, data analysts, and policy advisors will work with the fiscal agent (i.e., Gainwell Technologies) to ensure completeness of all reports used for state and federal reporting, as requested by BMS. We have experience working directly with the state, plans, or other third parties to gather and validate data required for all necessary tasks.

4.1.2.12. The vendor must gather, process, validate and analyze Managed Care encounter and claims data, including carved out services and provide technical assistance to the Managed Care organizations on data issues.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Our MCO data collection process is customized to fit the populations covered and services provided under each managed care program. This process is not only inclusive of encounter claims submissions, but also various financial performance metrics (MLR, administrative loss ratio, underwriting margin), detailed revenue and expense elements, and additional details pertaining to an MCO's business and carved-out services. We complete this task in every state where we serve as a certifying actuary.

4.1.2.13. The vendor shall develop methodologies for calculating Directed Payment Program amounts or other supplemental payments, and the associated preprints and quality strategies for such programs.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Our Team will complete the updated CMS DPP pre-print forms for each SFY, review methodology, recalculate amounts or other supplemental payments, and incorporate these amounts into the capitation rates. We complete similar tasks in every state where we serve as a certifying actuary. Between Myers and Stauffer and Milliman, we have reviewed almost every directed payment model approved in the country and participated in the approval of many of them. This partnership allows for a streamlined integration between directed payments, quality program, pay-for-performance models, and certified rates.

4.1.2.14. The vendor must perform actuarial analysis and valuation of the costs or savings established by implementing programmatic changes, including, but not limited to, the transitioning of populations from FFS to managed care or alternate coverage options.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Actuarial Services: Response to Requirements	Meets/ Exceeds Req.

Qualifications:

As part of our rate setting process, Milliman develops program savings adjustments. We adjust the projected utilization and cost per unit data to reflect anticipated levels of managed care efficiency between the base period and the contract period.

Milliman has assisted in several procurements and transitions of members from FFS to managed care, as well as Medicaid expansion, including:

- Integrating West Virginia former foster care youth.
- Medicaid expansion in Washington.
- Statewide integration of behavioral health and physical health programs.
- Hawai'i transition of ABD population to managed care including LTSS.

Milliman understands the complexity of evaluating the costs or savings of program changes, such as FFS to managed care transitions, and is capable of performing this task.

4.1.2.15. The vendor must agree to provide a detailed billing report with each invoice for actuarial services, which details the hours billed per staffing position, per staff member. 4.1.4 7 The vendor must produce a quarterly report on expected total program revenues and expenditures for WV CHIP that covers the current fiscal year plus six (6) future years. The projections should consider pricing and enrollment trends plus any impacts expected from federal or state laws or regulations. Estimates for IBNR should be updated on each report. WVCHIP uses these reports to monitor program fiscal stability and prepare requests for additional federal or state funding.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Our Team will provide a detailed billing report with each invoice for actuarial services which details the hours billed per staffing position, per staff member. Additionally, Milliman will produce a quarterly report on expected total program revenues and expenditures for WVCHIP that covers the current fiscal year plus six future years. Milliman has been producing this report for BMS and understands the complexity of the incurred but not reported (IBNR), enrollment, pricing, and other trends given the significant transitions in the WVCHIP program in the past few years.

4.1.2.16. The vendor must annually provide assurance to the director, by letter, that all program and administrative costs, including IBNR, do not exceed 90 (ninety) percent of the funding available to the program for the applicable fiscal year.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Our Team will analyze the enrollment, pricing, and IBNR trends and will summarize the findings in a letter outlining whether costs will exceed 90% of funding for the program by fiscal year. Milliman has been producing this report for WVCHIP for the past few years and understands the complexity of the program and projections.

Financial Services (4.1.3)

The experience and qualifications of the Myers and Stauffer Team consistently exceed the financial services requirements set forth in the CRFQ. Further, as the incumbent, we have demonstrated our performance directly to BMS through our current contract. Our Team also has national experience providing Medicaid financial support and solutions. In *Table 8*, we provide summary information on client-specific engagements examples that address the CRFQ requirements.

Table 8. Financial Services Requirements and Deliverables (4.1.3)

Financial Services: Response to Requirements	Meets/ Exceeds Req.
4.1.3.1. The vendor shall provide financial services which will include but not be limited to MLR template review and audit, rate studies and reimbursement support, legislative planning and support, budget support, financial projections and analysis, federal and state reporting support, implementation support for all federal and state projects and rules, Directed Payment Program (DPP) calculations and support, provider payment reviews, MCO tax settlement calculations, waiver support, and audit support, including IBNR calculations	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform these tasks.

Qualifications:

We have demonstrated our experience through our support of BMS through the following activities:

- Conduct annual MLR review and audits including development of associated materials.
- Support rate studies and reimbursement for various providers and services, including intermediate care facilities (ICFs), SUD residential services, and dental services.
- Support for the State's hospital and physician DPPs, including annual updates to the existing program and assisting the State with significant program expansion in response to recent legislative changes.
- Support Medicaid rate setting and payment methodology services related to inpatient hospital PPS, outpatient hospital payment system, and physician Resource-Based Relative Value Scale system. In addition, we review cost reports and supporting documentation to develop PPS rates for FQHCs and rural health clinics (RHCs) and assist the State with adjusting PPS rates for changes in scope of services.
- Provider payment reviews associated with rate changes implemented by the State and/or requested by providers. This includes calculating estimated fiscal impacts of the changes.
- Support BMS by evaluating draft and passed legislation to assess fiscal and operational impact to the Bureau.
- Work closely with BMS to support the Bureau's budget development, defend it during legislative session, and identify budgetary impacts. We also support analysis of options to address shortfalls in BMS budget and quantify their potential programmatic and fiscal impacts.
- Support review of federal financial reporting (e.g., CMS-64 reports) to promote accuracy and ensure proper claiming of federal funds.
- Calculate the annual IBNR liability as of June 30 for the West Virginia Medicaid FFS program.

Financial Services: Response to Requirements	Meets/ Exceeds Req.

Additionally, we have successfully supported other states with various financial services, including:

- Rate studies and reimbursement support addressing a wide range of services, including waiver services, applied behavioral analysis, SUD, and behavioral health services for numerous states, including Idaho, Illinois, Iowa, Kentucky, New Hampshire, and Utah.
- Develop MLR template and conduct audits under American Institute of Certified Public Accountants guidelines in states, such as Colorado, Georgia, Hawai'i, Idaho, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, Nebraska, New Mexico, Ohio, Tennessee, Texas, Utah, Virginia, and Wisconsin.
- Develop DPPs for the states of Iowa, Kentucky, Mississippi, and New Jersey.
- Develop a new health care provider tax program applied to MCO services for New York.

4.1.3.2. The vendor shall analyze the accuracy of payments and reimbursements related to changes under the Affordable Care Act (ACA) or other federal or state health care and/or payment provision rules, regulations, laws, or codes.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

The following are examples of Myers and Stauffer's work related to payments and reimbursement under ACA:

- **West Virginia:** Audit provider spending of ARPA funds to ensure funds were spent appropriately and in compliance with CMS guidelines.
- **Arizona:** Provide project management support, technical assistance, and consulting services to support successful and timely implementation of ARPA spending plan initiatives as approved by CMS and the Substance Abuse and Mental Health Services Administration.
  - Provide a menu of ARPA compliance support services to assist with oversight of ARPA grant payments made to providers.
  - Support services include audit process template creation and maintenance, provider risk stratification, audit guide document development and maintenance, provider audit surge support, data analysis, technical assistance during audits, and audit process training.
- **Florida:** Implement ARPA funding, including development of distribution strategies, provider applications, and outcome measurements for mandatory CMS reporting. Include spending plan compliance to ensure funds are being spent by providers as intended.
- **Georgia:** Develop a management tool related to costs associated with the ACA. Assist the State in calculating the impact of potential legislative requests.
- **North Dakota**: Provide program coordination, reporting, and evaluation services for North Dakota's implementation of Section 9817 of ARPA.
  - Track progress of individual ARPA spending plan initiatives, coordinate work group meetings as necessary, monitor expenditures, and ensure procurement and human resources timelines are followed.
  - Perform an evaluation of three ARPA spending plan initiatives to ensure they are effective in meeting stated outcomes and goals.

Financial Services: Response to Requirements	Meets/ Exceeds Req.
4.1.3.3. The vendor shall provide assistance in development of payment methodologies for other programs, including, but not limited to, long-term care, nursing home, and Home and Community Based Services waivers.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We have provided assistance with developing payment methodologies for various programs across a number of state Medicaid programs. Our experience includes payment methodology consulting for almost every type of provider and associated program, including LTC facilities and services, nursing homes, and HCBS. For nursing homes, Myers and Stauffer is one of the only vendors in the country that specializes in acuity-based rate setting systems like the one operated by the state of West Virginia. This includes the processing and evaluation of the required minimum data set (MDS) resident assessment submissions that are the foundational basis of acuity measures and payment adjustment.

- **LTC and Nursing Facility Reimbursement:** Alaska, Alabama, Arkansas, Colorado, Connecticut, Georgia, Hawai'i, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, South Dakota, Tennessee, Vermont, Virginia, and Wyoming.
- **Nursing Facility MDS Processing and Evaluation:** West Virginia, Arkansas, Colorado, Connecticut, Georgia, Hawai'i, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maryland, Mississippi, Missouri, Montana, Nevada, North Carolina, Ohio, Pennsylvania, South Dakota, Tennessee, Vermont, and Wyoming.
- **HCBS:** Alaska, Arkansas, Colorado, Connecticut, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, Utah, Virginia, and West Virginia.
- **Pharmacy:** Alabama, Alaska, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wyoming, and CMS.

4.1.3.4. The vendor shall assist with all facets of the provider rate development and implementation process.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Rate development and implementation has been a core service of Myers and Stauffer since its inception, and our services in this area have touched almost every state and the federal government. We have assisted the state of West Virginia and other states through all phases of the development and implementation process, including environmental scans for best practices, stakeholder engagement, rate methodology design, rate development, implementation, and the CMS approval process. Examples of recent large-scale state rate system support and redesign efforts are as follows:

- **West Virginia:**
  - HCBS waiver rate setting and rate methodology design.
  - Nursing facility PDPM implementation and capital reimbursement redesign.

Financial Services: Response to Requirements	Meets/ Exceeds Req.

- Transition of rate setting services from the Office of Accountability and Management Reporting to Myers and Stauffer: ambulance, ambulatory surgery centers, clinical lab, dental, DME, graduate medical education, FQHC/RHC, home health, hospice, ICF, physician-administered drugs, physician fee schedule, SUD, vaccines, and vision.
- CCBHC rate setting.

- **Indiana:** Nursing facility rate modernization and implementation of managed LTSS, ICF rate modernization, FQHC/RHC reimbursement design and modification, dental rates, ABA services rate setting, CCBHC rate setting and support for grant implementation, physician fee schedule updates, psychiatric residential treatment facility rate updates, PACE rate setting, and establishment of a rate sustainability matrix with planned rate update/evaluation intervals for all Medicaid services.
- **Connecticut:** Rate evaluation report pertaining to all Medicaid services with recommendations for rate redesign and rate updates, nursing facility rate modernization and PDPM implementation, HCBS rate methodology design and implementation, and FQHC/RHC rate support.

4.1.3.5. The vendor shall assist in overseeing the ongoing implementation, support, federal and state reporting, and financial projections of all relevant waiver programs.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We have demonstrated our experience through our support of BMS through the following activities:

- Assist BMS with a review of the State's federal reporting and claiming processes for medical assistance expenditures reported on the CMS-64 and CMS-21 reports. The purpose of the review was to evaluate current processes and provide recommendations for improvements and optimization of federal funds claiming.
- Assist BMS with required federal reporting and financial projections associated with waivers, such as the budget neutrality calculations related to the Continuum of Care 1115 waiver.

We have successfully supported other states with federal and state reporting. Our goal is to help states ensure their federal reporting processes are accurate and that states are claiming federal funds to which they are entitled. Our experience includes the following examples:

- **Alabama:** Assist with the preparation of the quarterly federal expenditure reports. Our process included obtaining the various data sources needed to complete the CMS-64 and CMS-21 reports for all Medical Assistance Payments program benefits and administrative payment accounts.
- **Delaware:** Provide consulting services related to claims made by the State against Medicaid and CHIP federal funds and the reporting of those claims on federal forms. We research CMS disallowances from quarterly expenditure reports and determine root causes of discrepancies between FFP claimed and Medicaid grant cash draw amounts.
- **Tennessee:** Conduct reviews of federal reporting and claiming processes for medical assistance and administrative expenditures reported on the CMS-64 and CMS-21 reports. Review reports, support work papers, and review other relevant documentation for quarterly reports submitted to CMS for a two-year time period.

Financial Services: Response to Requirements	Meets/ Exceeds Req.
• **Virginia:** Assist with the preparation of the federal reporting forms and review processes. Make specific recommendations to improve and streamline the reporting processes. We have also successfully supported other states with financial projections of waiver programs. Our services routinely include supporting budget neutrality models and calculations for demonstration waiver applications to ensure federal expenditures under the waiver are no greater than expenditures would likely have been without the waiver. Our relevant experience includes: ▪ **New Jersey:** We successfully supported New Jersey in the negotiation of Section 1115 Special Terms and Conditions, which contain critical elements that drive the calculation of budget neutrality. ▪ **Colorado, Kentucky, Nevada, and New Jersey:** We designed the budget neutrality model and performed calculations for 1115 waivers.	
4.1.3.6. The Vendor shall provide support for items including, but not limited to, MLR Audits, IBNR, and risk adjustment. The vendor shall host a kickoff meeting with the MCOs prior to implementation of MLR Audit activities, IBNR and risk adjustment activities to communicate expectations to the MCO.	**Yes**
The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform these tasks. **Qualifications:** We have outlined our MLR experience in *Managed Care Program Administration (4.1.1)* and our IBNR/risk adjustment in *Actuarial Services (4.1.2).*	

Ad-Hoc Services (4.1.4)

We understand that all ad-hoc services will have to be approved by BMS prior to the delivery. We will draft detailed Delivery Orders to outline the ad-hoc scope, as requested. The experience and qualifications of the Myers and Stauffer Team consistently exceeds the ad-hoc requirements set forth in the CRFQ. In *Table 9,* we provide information that addresses the CRFQ requirements.

Table 9. Ad-Hoc Services Requirements and Deliverables (4.1.4)

Ad Hoc Services: Response to Requirements	Meets/ Exceeds Req.
4.1.4.1. The vendor must provide the Agency with additional consultation and actuarial services and complete other work as requested.	**Yes**
The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.	
4.1.4.2. The vendor shall provide a Statement of Work, including but not limited to, the number of project hours, resources to be used, and cost affiliated with each ad hoc request for review by the Agency.	**Yes**

Ad Hoc Services: Response to Requirements	Meets/ Exceeds Req.
The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.	
4.1.4.3. The vendor shall provide a fixed hourly rate for programmatic services and a fixed hourly rate for actuarial services.	**Yes**
The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.	
4.1.4.4. The vendor shall assist with programmatic activities needed within other divisions of BMS outside of the Managed Care Unit.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Under our current engagement, we have worked with other divisions and units of BMS outside the Managed Care Unit, including the Division of Plan Management and Integrity, Division of Finance, Division of Policy Coordination and Operations Management, Office of Legal and Regulatory Services, and the Bureau for Social Services.

Many of our engagements supporting state Medicaid managed care programs involve coordination and collaboration across multiple divisions within the Medicaid and sister agencies, as well as key contractors and other stakeholders involved in the program or initiative under consideration. We have worked with Medicaid divisions including policy, operations, quality management, utilization management, member services, provider services, pharmacy services, fiscal services, IT and decision support, program integrity, and legal services, as well as internal operational work groups across multiple divisions.

4.1.4.5. The vendor shall conduct research and recommend approaches in key areas of chronic care/disease management, pharmacy, eligibility and coverage, quality improvement, rural health, and other as requested.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

Myers and Stauffer has more than 47 years of experience conducting research and providing recommendations in key Medicaid programmatic areas. This experience includes the following BMS examples:

- **West Virginia:**
  - The Myers and Stauffer Team leads the implementation of two key quality initiatives under SB 820 (2024) focusing on improving SUD outcomes: automatic day one enrollment into managed care and the MCO quality withhold program.
  - Milliman is working with BMS on a potential solution for high-cost drugs for SFY 2026 MHT rates. The solution is essentially to create a separate layer of risk adjustment specific to high-cost drugs through the use of a risk pool.
  - The provider network analysis conducted by Myers and Stauffer addresses health care shortages in rural areas of the state and offers recommendations for improving member access.

Ad Hoc Services: Response to Requirements	Meets/ Exceeds Req.

- The Myers and Stauffer Team conducts research on variety of topics to support policy management and fiscal planning, including briefs and reports on the impact of potential federal changes on the BMS budget (e.g., block grants, per capita cap, elimination of Medicaid expansion), state legislative changes to provider and MCO taxes, or introduction of new waiver programs, such as Work Requirements for Medicaid enrollees.

Additionally, we have supported research and provided recommendations in key Medicaid programmatic areas, such as the following examples:

- **Kentucky's 1115 Waiver:**
  - Conduct research to assess the State's needs and to identify opportunities.
  - Support operational design and implementation of a Section 1115 Demonstration waiver, which includes SMI, SUD, reentry services, recuperative care, and other program enhancements.
- **Arizona's 1115 Waiver:** The project examines business process change necessary for implementation of the new Housing and Health Opportunities (H2O) program, which provides health-related social needs (HRSN) services, including housing supports to targeted populations. We provide technical assistance as follows:
  - Research state and federal policies, analyze other similar HRSN services or programs, data analytics, planning for future HCBS data collection, and perform other ad-hoc requests, including supporting the development of a reentry program waiver for individuals who are incarcerated.
- **Nebraska HCBS 1915(c) Waiver:**
  - Assist the State with transitioning from a non-standardized level of care assessment to a fully standardized and validated assessment tool that enables the State to create a more consistent eligibility determination for participants.
  - Analyze the method for providing TCM and the budgetary impacts of any programmatic changes.
- **Mississippi Maternal Outcomes for Safety (MOMS):**
  - Design the Mississippi MOMS program that includes the development of a real-time risk assessment of severe maternal morbidity prior to delivery.
  - Coordinate with Mississippi's health plans and providers, as well as the state's health information exchange (HIE) to ensure the increased maternal risk is noted in the HIE to promote follow-up care.

4.1.4.6. The vendor shall assist in overseeing the ongoing implementation of the State's Children with Serious Emotional Disorder (CSED) 1915(c) waiver, including those under the Mountain Health Promise program and any other relevant waivers.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task.

Qualifications:

We have assisted the following states with waiver strategies:

- **Nevada:** Support the design, development, and approval of 1915 authority to support the needs of individuals with serious emotional disturbances under the care of the State's foster care program.

Ad Hoc Services: Response to Requirements	Meets/ Exceeds Req.
• **Kentucky:** Design and develop an MCO program under 1915 authority to provide high-fidelity services to individuals served through the Commonwealth's foster care program. Provide recommendations regarding implementation and oversight of the program. • **Oregon:** Assist the State with developing an 1115 Medicaid demonstration waiver renewal, incorporating new policy priorities, as well as separately supporting the state with a 1915 authority to expand access to services for children. We assisted with policies and programs to ensure the equitable distribution or redistribution of resources. Policies include addressing HRSN and complex challenges for those experiencing major life transitions, such as children aging out of foster care and youth with complex medical needs approaching adulthood.	

Service-Level Agreement (4.1.5)/All Services (4.1.6)

As the incumbent, the Myers and Stauffer Team has demonstrated our performance directly to BMS through our current contract. In *Table 10*, we provide summary information on client-specific engagements examples that address the CRFQ requirements.

Table 10. Service-Level Agreement/All Services Requirements and Deliverables (4.1.5/4.1.6)

Service-Level Agreement/All Services: Response to Requirements	Meets/ Exceeds Req.
4.1.5.1. The vendor shall agree to be bound to all service level agreements as defined within Attachment 3: Exhibit B Service Level Agreements.	**Yes**
The Myers and Stauffer Team understands and is capable of performing this requirement. We agree to be bound to all service-level agreements as defined within CRFQ Attachment 3: Exhibit B Service Level Agreements and the resulting contract.	
4.1.6.1. The vendor agrees that the Agency has the right to review and approve hiring of key staff and to request replacement staff if it is felt that qualifications and/or needs are not being adequately met.	**Yes**
The Myers and Stauffer Team understands and is capable of performing this requirement. We agree that the Bureau has the right to review and approve hiring of key staff and to request replacement staff if it is felt that qualifications and/or needs are not being adequately met.	
4.1.6.2. The vendor shall submit, along with their bid, a conflict mitigation plan applicable to the prime vendor and subcontractor for Actuarial Services. This plan must detail the vendor's approach to identifying, addressing, and mitigate any conflicts of interest that may arise during the term of the contract.	**Yes**
The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task. Myers and Stauffer does not have any actual, potential, and/or apparent conflicts of interest to mitigate. However, we have included our conflict mitigation plan in *Appendix C: Conflicts of Interest Mitigation Plan*. In completing our due diligence on our subcontractor, Milliman, we requested, reviewed, and are including their Conflict Mitigation Plan also in *Appendix C*.	

Service-Level Agreement/All Services: Response to Requirements	Meets/ Exceeds Req.
4.1.6.3. The vendor must ensure that all staff performing work under this contract adhere to their designated roles and responsibilities throughout the duration of the contract.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task. We ensure that all staff performing work under this contract adhere to their designated roles and responsibilities throughout the duration of the contract.

4.1.6.4. The Prime Vendor shall not, within a five (5) year period before or at any time during the duration of the contract, hold contract(s) with any managed care organization, provider, provider group, or provider association doing business for any service related to this contract in the State of West Virginia or whose parent organization does business in the State of West Virginia.	**Yes**

The Myers and Stauffer Team understands this requirement, has the required experience and qualifications, and agrees to perform this task. Since its inception, Myers and Stauffer has been dedicated to servicing government health care and human services agencies in a way that avoids any conflicts in fact or appearance. Unlike most of our competitors, Myers and Stauffer does not work for any MCOs, provider, provider group, or provider association in West Virginia or in any state. The results of our provider and MCO oversight activities are free from real or perceived bias. We have been, are, and will remain conflict-free.

When working with subcontractors, as we will be working with Milliman on this engagement, we closely examine any potential conflict of interest and our subcontractor's conflict mitigation plan. Should a real or perceived conflict be identified, we will raise this to BMS along with our assessment of the subcontractor's mitigation strategy and our plan to oversee the plan's effectiveness.

4.1.6.5. The Vendor must demonstrate capacity to meet CMS reporting requirements by submitting with bid a minimum of two certifications from at least two (2) different states submitted to CMS meeting the ninety (90) day submission guideline in the last two years.	**Yes**

The Myers and Stauffer Team understands and is capable of performing this task. See *Appendix D: Example Certifications* for certification examples.

These were submitted to CMS meeting the 90-day submission guideline.

Qualifications:

This metric is a key metric tracked in the Medicaid and CHIP Scorecard. The 2024 Scorecard, including data from federal fiscal year 2023, includes 120 certifications submitted and only nine that were submitted 90 or more days prior to the start of the rating period. It is our understanding that CMS tracks the number of submissions by the date of submission, and all submissions during a fiscal year are scored together.

Based on information provided by CMS, the following states had certifications submitted 90 or more days prior to the contract period during each of the following fiscal years (Milliman supported states are in **bold**):

- FFY 2025: **Hawai'i, Indiana**, Oregon, Tennessee.
- FFY 2024: **Hawai'i, Indiana**, Oklahoma, Oregon, Washington.
- FFY 2023: **Hawai'i, Indiana, Minnesota, New Hampshire,** Oklahoma, **Washington.**

VII. Contract Award

Contract Award/Pricing Page (CRFQ – Specifications: Section 5.1/2)

We understand that the contract will be awarded to the Vendor that provides the contract services meeting the required specifications for the lowest cost as shown on the Pricing Page.

We have included our Price Quote, as required in CRFQ Exhibit A and using the Pricing Page, separately through wvOASIS (with pricing entered electronically and also uploaded as an electronic document). Our pricing is based on our understanding of BMS' request and our previous experience providing Medicaid actuarial services and managed care program administration in numerous states.

VIII. Additional Information

Performance (CRFQ Specifications: Section 6)

Myers and Stauffer understands and accepts that we shall agree upon a schedule for performance of contract services and contract service deliverables, unless such a schedule is already included herein by BMS. In the event that this contract is designated as an open-end contract, we shall perform in accordance with the release orders that may be issued against this contract.

Payment (CRFQ Specifications: Section 7)

Myers and Stauffer understands and accepts that BMS will pay a fixed fee for the managed care program management services, and an hourly rate for actuarial and ad-hoc services as shown on the Pricing Pages, for all contract services performed and accepted under this contract. We agree to accept payment in accordance with the payment procedures of the state of West Virginia.

Travel (CRFQ Specifications: Section 8)

Myers and Stauffer understands and accepts that we shall be responsible for all mileage and travel costs, including traveling time, associated with performance of this contract. Any anticipated mileage or travel costs are included in the flat fee or hourly rate listed on our bid, but such costs will not be paid by BMS separately.

Facilities Access (CRFQ Specifications: Section 9)

Myers and Stauffer understands and accepts that performance of contract services may require access cards and/or keys to gain entrance to BMS' facilities. In the event that access cards and/or keys are required, we will comply with the following requirements:

- Vendor must identify principal service personnel, which will be issued access cards and/or keys to perform service (CRFQ Section 9.1).
- Vendor will be responsible for controlling cards and keys and will pay a replacement fee if the cards or keys become lost or stolen (CRFQ Section 9.2).
- Vendor shall notify BMS immediately of any lost, stolen, or missing card or key (CRFQ Section 9.3).
- Anyone performing under this contract will be subject to BMS' security protocol and procedures (CRFQ Section 9.4).
- Vendor shall inform all staff of BMS' security protocol and procedures (CRFQ Section 9.5).

Vendor Default (CRFQ Specifications: Sect 10)

Myers and Stauffer understands and accepts that the following shall be considered a vendor default under this contract:

- Failure to perform contract services in accordance with the requirements contained herein (CRFQ Section 10.1.1).
- Failure to comply with other specifications and requirements contained herein (CRFQ Section 10.1.2).
- Failure to comply with any laws, rules, and ordinances applicable to the contract services provided under this contract (CRFQ Section 10.1.3).
- Failure to remedy deficient performance upon request (CRFQ Section 10.1.4).

We also understand and accept that the following remedies shall be available to BMS upon default:

- Immediate cancellation of the contract (CRFQ Section 10.2.1).
- Immediate cancellation of one or more release orders issued under this contract (CRFQ Section 10.2.2).
- Any other remedies available in law or equity (CRFQ Section 10.2.3).

Miscellaneous (CRFQ Specifications: Sect 11)

The primary Contract Manager for the engagement will be as follows:

Contract Manager: Jerry Dubberly, PharmD, MBA
Telephone Number: 404.290.8370/Toll-free Number: 866.758.3586
Fax Number: 404.524.0782
Email Address: JDubberly@mslc.com

Please also see completed contract manager information in *IX. Forms*.

Additional Information

The Myers and Stauffer Team has read and understands all Terms and Conditions set forth in the CRFQ. We have no exceptions to the specifications in the solicitation, which we understand will become the basis for the contractual agreement.

IX. Forms

Original Cover Sheet

Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Centralized Request for Quote
Service - Misc

Proc Folder: 1544511			**Reason for Modification:**
Doc Description: MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN			
Proc Type: Central Master Agreement			
Date Issued	**Solicitation Closes**	**Solicitation No**	**Version**
2025-03-12	2025-04-02 13:30	CRFQ 0511 BMS2500000001	1

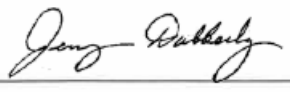
BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION PURCHASING
DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Customer Code: 000000191225
Vendor Name : Myers and Stauffer LC
Address :
Street : 1349 W. Peachtree St, NE, Ste 1600
City : Atlanta
State : GA **Country :** United States **Zip :** 30309
Principal Contact : Jerry Dubberly, PharmD
Vendor Contact Phone: 866.758.3586 **Extension:** N/A

FOR INFORMATION CONTACT THE BUYER Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor Signature X  **FEIN#** 48-1164042 **DATE** 4/16/2025

All offers subject to all terms and conditions contained in this solicitation

Date Printed: Mar 12, 2025 **Page:** 1 FORM ID: WV-PRC-CRFQ-002 2020/05

Addendum Acknowledgement

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFQ BMS2500000001

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

- [x] Addendum No. 1
- [x] Addendum No. 2
- [ ] Addendum No. 3
- [ ] Addendum No. 4
- [ ] Addendum No. 5
- [ ] Addendum No. 6
- [ ] Addendum No. 7
- [ ] Addendum No. 8
- [ ] Addendum No. 9
- [ ] Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Myers and Stauffer LC
Company

Authorized Signature

4/21/2025
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

Addendum Cover Sheets

Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Centralized Request for Quote
Service - Misc

Proc Folder: 1544511			**Reason for Modification:**
Doc Description: MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN			ADDENDUM 1 TO EXTEND BID OPENING
Proc Type: Central Master Agreement			
Date Issued	**Solicitation Closes**	**Solicitation No**	**Version**
2025-03-26	2025-04-22 13:30	CRFQ 0511 BMS2500000001	2

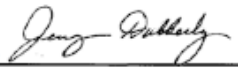
BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION PURCHASING DIVISION
2019 WASHINGTON ST E CHARLESTON WV 25305
US

VENDOR

Vendor Customer Code: 000000191225
Vendor Name : Myers and Stauffer LC
Address :
Street : 1349 W Peachtree St, NE, Ste 1600
City : Atlanta
State : GA **Country :** United States **Zip :** 30309
Principal Contact : Jerry Dubberly, PharmD
Vendor Contact Phone: 866 758 3586 **Extension:** N/A

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor Signature X  **FEIN#** 48-1164042 **DATE** 4/16/2025

All offers subject to all terms and conditions contained in this solicitation

Date Printed: Mar 26, 2025 Page: 1 FORM ID: WV-PRC-CRFQ-002 2020/05

Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Centralized Request for Quote
Service - Misc

Proc Folder:	1544511	**Reason for Modification:**
Doc Description:	MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN	Addendum No. 2
Proc Type:	Central Master Agreement	

Date Issued	Solicitation Closes	Solicitation No	Version
2025-04-09	2025-04-22 13:30	CRFQ 0511 BMS2500000001	3

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Customer Code: 000000191225

Vendor Name: Myers and Stauffer LC

Address : 1349

Street : Peachtree St, NE, Ste 1600

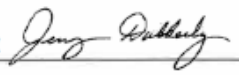
City : Atlanta

State : GA **Country : United States** **Zip : 30309**

Principal Contact : Jerry Dubberly, PharmD

Vendor Contact Phone: 866.758.3586 **Extension: N/A**

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor Signature X  **FEIN# 48-1164042** **DATE 4/16/2025**

All offers subject to all terms and conditions contained in this solicitation

Date Printed: Apr 9, 2025 Page: 1 FORM ID: WV-PRC-CRFQ-002 2020/05

Contract Manager

REQUEST FOR QUOTATION
CRFQ BMS2500000001
Medicaid Actuarial Services and Managed Care Program Administration

10.1.2. Failure to comply with other specifications and requirements contained herein.

10.1.3. Failure to comply with any laws, rules, and ordinances applicable to the Contract Services provided under this Contract.

10.1.4. Failure to remedy deficient performance upon request.

10.2. The following remedies shall be available to Agency upon default.

10.2.1. Immediate cancellation of the Contract.

10.2.2. Immediate cancellation of one or more release orders issued under this Contract.

10.2.3. Any other remedies available in law or equity.

11. MISCELLANEOUS:

11.1. Contract Manager: During its performance of this Contract, Vendor must designate and maintain a primary contract manager responsible for overseeing Vendor's responsibilities under this Contract. The Contract manager must be available during normal business hours to address any customer service or other issues related to this Contract. Vendor should list its Contract manager and his or her contact information below.

Contract Manager: Jerry Dubberly, PharmD - Principal
Telephone Number: 866.758.3586
Fax Number: 404.524.0782
Email Address: JDubberly@mslc.com

Revised 12/12/2017

Federal Funds Addendum

Attachment 1

FEDERAL FUNDS ADDENDUM
2 C.F.R. §§ 200.317 – 200.327

Purpose: This addendum is intended to modify the solicitation in an attempt to make the contract compliant with the requirements of 2 C.F.R. §§ 200.317 through 200.327 relating to the expenditure of certain federal funds. This solicitation will allow the State to obtain one or more contracts that satisfy standard state procurement, state federal funds procurement, and county/local federal funds procurement requirements.

Instructions: Vendors who are willing to extend their contract to procurements with federal funds and the requirements that go along with doing so, should sign the attached document identified as: "REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317)"

Should the awarded vendor be unwilling to extend the contract to federal funds procurement, the State reserves the right to award additional contracts to vendors that can and are willing to meet federal funds procurement requirements.

Changes to Specifications: Vendors should consider this solicitation as containing two separate solicitations, one for state level procurement and one for county/local procurement.

State Level: In the first solicitation, bid responses will be evaluated with applicable preferences identified in sections 15, 15A, and 16 of the "Instructions to Vendors Submitting Bids" to establish a contract for both standard state procurements and state federal funds procurements.

County Level: In the second solicitation, bid responses will be evaluated with applicable preferences identified in Sections 15, 15A, and 16 of the "Instructions to Vendors Submitting Bids" omitted to establish a contract for County/Local federal funds procurement.

Award: If the two evaluations result in the same vendor being identified as the winning bidder, the two solicitations will be combined into a single contract award. If the evaluations result in a different bidder being identified as the winning bidder, multiple contracts may be awarded. The State reserves the right to award to multiple different entities should it be required to satisfy standard state procurement, state federal funds procurement, and county/local federal funds procurement requirements.

State Government Use Caution: State agencies planning to utilize this contract for procurements subject to the above identified federal regulations should first consult with the federal agency providing the applicable funding to ensure the contract is complaint.

County/Local Government Use Caution: County and Local government entities planning to utilize this contract for procurements subject to the above identified federal regulation should first consult with the federal agency providing the applicable funding to ensure the contract is complaint. For purposes of County/Local government use, the solicitation resulting in this contract was conducted in accordance with the procurement laws, rules, and procedures governing the West Virginia Department of Administration, Purchasing Division, except that vendor preference has been omitted for County/Local use purposes and the contract terms contained in the document entitled "REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317)" have been added.

FEDERAL FUNDS ADDENDUM

REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317):

The State of West Virginia Department of Administration, Purchasing Division, and the Vendor awarded this Contract intend that this Contract be compliant with the requirements of the Procurement Standards contained in the Uniform Administrative Requirements, Cost Principles, and Audit Requirements found in 2 C.F.R. § 200.317, et seq. for procurements conducted by a Non-Federal Entity. Accordingly, the Parties agree that the following provisions are included in the Contract.

1. **MINORITY BUSINESSES, WOMEN'S BUSINESS ENTERPRISES, AND LABOR SURPLUS AREA FIRMS:** (2 C.F.R. § 200.321)

   a. The State confirms that it has taken all necessary affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible. Those affirmative steps include:

      (1) Placing qualified small and minority businesses and women's business enterprises on solicitation lists;
      (2) Assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;
      (3) Dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority businesses, and women's business enterprises;
      (4) Establishing delivery schedules, where the requirement permits, which encourage participation by small and minority businesses, and women's business enterprises;
      (5) Using the services and assistance, as appropriate, of such organizations as the Small Business Administration and the Minority Business Development Agency of the Department of Commerce; and
      (6) Requiring the prime contractor, if subcontracts are to be let, to take the affirmative steps listed in paragraphs (1) through (5) above.

   b. Vendor confirms that if it utilizes subcontractors, it will take the same affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible.

2. **DOMESTIC PREFERENCES:** (2 C.F.R. § 200.322)

   a. The State confirms that as appropriate and to the extent consistent with law, it has, to the greatest extent practicable under a Federal award, provided a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United

States (including but not limited to iron, aluminum, steel, cement, and other manufactured products).

b. Vendor confirms that will include the requirements of this Section 2. Domestic Preference in all subawards including all contracts and purchase orders for work or products under this award.

c. Definitions: For purposes of this section:

(1) "Produced in the United States" means, for iron and steel products, that all manufacturing processes, from the initial melting stage through the application of coatings, occurred in the United States.
(2) "Manufactured products" means items and construction materials composed in whole or in part of non-ferrous metals such as aluminum; plastics and polymer-based products such as polyvinyl chloride pipe; aggregates such as concrete; glass, including optical fiber; and lumber.

3. **BREACH OF CONTRACT REMEDIES AND PENALTIES:**
(2 C.F.R. § 200.327 and Appendix II)

(a) The provisions of West Virginia Code of State Rules § 148-1-5 provide for breach of contract remedies, and penalties. A copy of that rule is attached hereto as Exhibit A and expressly incorporated herein by reference.

4. **TERMINATION FOR CAUSE AND CONVENIENCE:**
(2 C.F.R. § 200.327 and Appendix II)

(a) The provisions of West Virginia Code of State Rules § 148-1-5 govern Contract termination. A copy of that rule is attached hereto as Exhibit A and expressly incorporated herein by reference.

5. **EQUAL EMPLOYMENT OPPORTUNITY:**
(2 C.F.R. § 200.327 and Appendix II)

Except as otherwise provided under 41 CFR Part 60, and if this contract meets the definition of "federally assisted construction contract" in 41 CFR Part 60–1.3, this contract includes the equal opportunity clause provided under 41 CFR 60–1.4(b), in accordance with Executive Order 11246, "Equal Employment Opportunity" (30 FR 12319, 12935, 3 CFR Part, 1964–1965 Comp., p. 339), as amended by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and implementing regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

6. **DAVIS-BACON WAGE RATES:**
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that if this Contract includes construction, all construction work in excess of $2,000 will be completed and paid for in compliance with the Davis–Bacon Act (40 U.S.C. 3141–3144, and 3146–3148) as supplemented by Department of Labor regulations (29 CFR Part 5, "Labor Standards Provisions Applicable to Contracts Covering Federally Financed and Assisted Construction"). In accordance with the statute, contractors must:

(a) pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor.
(b) pay wages not less than once a week.

A copy of the current prevailing wage determination issued by the Department of Labor is attached hereto as Exhibit B. The decision to award a contract or subcontract is conditioned upon the acceptance of the wage determination. The State will report all suspected or reported violations to the Federal awarding agency.

7. **ANTI-KICKBACK ACT:**
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that it will comply with the Copeland Anti-KickBack Act (40 U.S.C. 3145), as supplemented by Department of Labor regulations (29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States"). Accordingly, Vendor, Subcontractors, and anyone performing under this contract are prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled. The State must report all suspected or reported violations to the Federal awarding agency.

8. **CONTRACT WORK HOURS AND SAFETY STANDARDS ACT**
(2 C.F.R. § 200.327 and Appendix II)

Where applicable, and only for contracts awarded by the State in excess of $100,000 that involve the employment of mechanics or laborers, Vendor agrees to comply with 40 U.S.C. 3702 and 3704, as supplemented by Department of Labor regulations (29 CFR Part 5). Under 40 U.S.C. 3702 of the Act, Vendor is required to compute the wages of every mechanic and laborer on the basis of a standard work week of 40 hours. Work in excess of the standard work week is permissible provided that the worker is compensated at a rate of not less than one and a half times the basic rate of pay for all hours worked in excess of 40 hours in the work week. The requirements of 40 U.S.C. 3704 are applicable to construction work and provide that no laborer or mechanic must be required to work in surroundings or under working conditions which are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

9. **RIGHTS TO INVENTIONS MADE UNDER A CONTRACT OR AGREEMENT.**
(2 C.F.R. § 200.327 and Appendix II)

If the Federal award meets the definition of "funding agreement" under 37 CFR § 401.2 (a) and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement," the recipient or subrecipient must comply with the requirements of 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

10. **CLEAN AIR ACT**
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that if this contract exceeds $150,000, Vendor is to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401–7671q) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251–1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

11. **DEBARMENT AND SUSPENSION**
(2 C.F.R. § 200.327 and Appendix II)

The State will not award to any vendor that is listed on the governmentwide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp., p. 189) and 12689 (3 CFR part 1989 Comp., p. 235), "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

12. **BYRD ANTI-LOBBYING AMENDMENT**
(2 C.F.R. § 200.327 and Appendix II)

Vendors that apply or bid for an award exceeding $100,000 must file the required certification. Each tier certifies to the tier above that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier must also disclose any lobbying with non–Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the non–Federal award.

13. **PROCUREMENT OF RECOVERED MATERIALS**
(2 C.F.R. § 200.327 and Appendix II; 2 C.F.R. § 200.323)

Vendor agrees that it and the State must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the

Environmental Protection Agency (EPA) at 40 CFR part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired during the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

14. PROHIBITION ON CERTAIN TELECOMMUNICATIONS AND VIDEO SURVEILLANCE SERVICES OR EQUIPMENT.
(2 C.F.R. § 200.327 and Appendix II; 2 CFR § 200.216)

Vendor and State agree that both are prohibited from obligating or expending funds under this Contract to:

(1) Procure or obtain;
(2) Extend or renew a contract to procure or obtain; or
(3) Enter into a contract (or extend or renew a contract) to procure or obtain equipment, services, or systems that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. As described in Public Law 115–232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

(i) For the purpose of public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities).
(ii) Telecommunications or video surveillance services provided by such entities or using such equipment.
(iii) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of the National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

In implementing the prohibition under Public Law 115–232, section 889, subsection (f), paragraph (1), heads of executive agencies administering loan, grant, or subsidy programs shall prioritize available funding and technical support to assist affected businesses, institutions and organizations as is reasonably necessary for those affected entities to transition from covered communications equipment and services, to procure replacement equipment and services, and to ensure that communications service to users and customers is sustained.

State of West Virginia	Vendor Name:
By: _____	By: Jerry Dubberly
Printed Name: _____	Printed Name: Jerry Dubberly
Title: _____	Title: Principal, Myers and Stauffer LC
Date: _____	Date: 4/21/2025

HIPAA Business Associate Addendum

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective as of the date of execution of the Addendum.

The Associate performs certain services on behalf of or for the Agency pursuant to the underlying Agreement that requires the exchange of information including protected health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act"), any associated regulations and the federal regulations published at 45 CFR parts 160 and 164 (sometimes collectively referred to as "HIPAA"). The Agency is a "Covered Entity" as that term is defined in HIPAA, and the parties to the underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and to bring the underlying Agreement into compliance with HIPAA.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas, it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, the HITECH Act and its associated regulations, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE: the parties agree that in consideration of the mutual promises herein, in the Agreement, and of the exchange of PHI hereunder that:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

    a. **Agency Procurement Officer** shall mean the appropriate Agency individual listed at: http://www.state.wv.us/admin/purchase/vrc/agencyli.html.

    b. **Agent** shall mean those person(s) who are agent(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).

    c. **Breach** shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except as excluded in the definition of Breach in 45 CFR § 164.402.

    d. **Business Associate** shall have the meaning given to such term in 45 CFR § 160.103.

    e. **HITECH Act** shall mean the Health Information Technology for Economic and Clinical Health Act. Public Law No. 111-05. 111th Congress (2009).

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f. **Privacy Rule** means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and 164.

g. **Protected Health Information or PHI** shall have the meaning given to such term in 45 CFR § 160.103, limited to the information created or received by Associate from or on behalf of Agency.

h. **Security Incident** means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.

i. **Security Rule** means the Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR Parts 160 and 164.

j. **Subcontractor** means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

2. **Permitted Uses and Disclosures.**

a. **PHI Described.** This means PHI created, received, maintained or transmitted on behalf of the Agency by the Associate. This PHI is governed by this Addendum and is limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the original Agreement, and is described in Appendix A.

b. **Purposes.** Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original Agreement, or as required by law, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or Associate, or violate the minimum necessary and related Privacy and Security policies and procedures of the Agency. The Associate is directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Agency.

c. **Further Uses and Disclosures**. Except as otherwise limited in this Addendum, the Associate may disclose PHI to third parties for the purpose of its own proper management and administration, or as required by law, provided that (i) the disclosure is required by law, or (ii) the Associate has obtained from the third party reasonable assurances that the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party by the Associate; and, (iii) an agreement to notify the Associate and Agency of any instances of which it (the third party) is aware in which the confidentiality of the information has been breached. To the extent practical, the information should be in a limited data set or the minimum necessary information pursuant to 45 CFR § 164.502, or take other measures as necessary to satisfy the Agency's obligations under 45 CFR § 164.502.

3. **Obligations of Associate.**

a. **Stated Purposes Only.** The PHI may not be used by the Associate for any purpose other than as stated in this Addendum or as required or permitted by law.

b. **Limited Disclosure.** The PHI is confidential and will not be disclosed by the Associate other than as stated in this Addendum or as required or permitted by law. Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual's PHI unless Agency gives written approval and the individual provides a valid authorization. Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Associate will report to Agency any use or disclosure of the PHI, including any Security Incident not provided for by this Agreement of which it becomes aware.

c. **Safeguards.** The Associate will use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the PHI, except as provided for in this Addendum. This shall include, but not be limited to:

i. Limitation of the groups of its workforce and agents, to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary or a Limited Data Set;

ii. Appropriate notification and training of its workforce and agents in order to protect the PHI from unauthorized use and disclosure;

iii. Maintenance of a comprehensive, reasonable and appropriate written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations, in compliance with the Security Rule;

iv. In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information.

d. **Compliance With Law.** The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.

e. **Mitigation.** Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum, and report its mitigation activity back to the Agency.

f. Support of Individual Rights.

i. **Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying, and in electronic format, if requested, within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524 and consistent with Section 13405 of the HITECH Act.

ii. **Amendment of PHI.** Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

iii. **Accounting Rights.** Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528 and consistent with Section 13405 of the HITECH Act. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

- the date of disclosure;
- the name of the entity or person who received the PHI, and if known, the address of the entity or person;
- a brief description of the PHI disclosed; and
- a brief statement of purposes of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

iv. **Request for Restriction**. Under the direction of the Agency, abide by any individual's request to restrict the disclosure of PHI, consistent with the requirements of Section 13405 of the HITECH Act and 45 CFR § 164.522, when the Agency determines to do so (except as required by law) and if the disclosure is to a health plan for payment or health care operations and it pertains to a health care item or service for which the health care provider was paid in full "out-of-pocket."

v. **Immediate Discontinuance of Use or Disclosure.** The Associate will immediately discontinue use or disclosure of Agency PHI pertaining to any individual when so requested by Agency. This includes, but is not limited to, cases in which an individual has withdrawn or modified an authorization to use or disclose PHI.

g. **Retention of PHI.** Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

h. **Agent's, Subcontractor's Compliance.** The Associate shall notify the Agency of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract and shall be delivered to the Agency Procurement Officer. The Associate will ensure that any of its subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder. The Agency may request copies of downstream subcontracts and agreements to determine whether all restrictions, terms and conditions have been flowed down. Failure to ensure that downstream contracts, subcontracts and agreements contain the required restrictions, terms and conditions may result in termination of the Agreement.

j. **Federal and Agency Access.** The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI, as well as the PHI, received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504. The Associate shall also make these records available to Agency, or Agency's contractor, for periodic audit of Associate's compliance with the Privacy and Security Rules. Upon Agency's request, the Associate shall provide proof of compliance with HIPAA and HITECH data privacy/protection guidelines, certification of a secure network and other assurance relative to compliance with the Privacy and Security Rules. This section shall also apply to Associate's subcontractors, if any.

k. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, compliance with 74 FR 19006 Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII is required, to the extent practicable. If Associate chooses not to adopt such methodologies as defined in 74 FR 19006 to secure the PHI governed by this Addendum, it must submit such written rationale, including its Security Risk Analysis, to the Agency Procurement Officer for review prior to the execution of the Addendum. This review may take up to ten (10) days.

l. **Notification of Breach.** During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology immediately by e-mail or web form upon the discovery of any Breach of unsecured PHI; or within 24 hours by e-mail or web form of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and,

unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or https://apps.wv.gov/ot/ir/Default.aspx.

The Associate shall immediately investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency Procurement Officer, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) Date of discovery; (b) What data elements were involved and the extent of the data involved in the Breach; (c) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (d) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (e) A description of the probable causes of the improper use or disclosure; and (f) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

Agency will coordinate with Associate to determine additional specific actions that will be required of the Associate for mitigation of the Breach, which may include notification to the individual or other authorities.

All associated costs shall be borne by the Associate. This may include, but not be limited to costs associated with notifying affected individuals.

If the Associate enters into a subcontract relating to the Agreement where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum, all such subcontracts or downstream agreements shall contain the same incident notification requirements as contained herein, with reporting directly to the Agency Procurement Officer. Failure to include such requirement in any subcontract or agreement may result in the Agency's termination of the Agreement.

m. **Assistance in Litigation or Administrative Proceedings.** The Associate shall make itself and any subcontractors, workforce or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inaction or actions by the Associate, except where Associate or its subcontractor, workforce or agent is a named as an adverse party.

4. **Addendum Administration.**

a. **Term.** This Addendum shall terminate on termination of the underlying Agreement or on the date the Agency terminates for cause as authorized in paragraph (c) of this Section, whichever is sooner.

b. **Duties at Termination.** Upon any termination of the underlying Agreement, the Associate shall return or destroy, at the Agency's option, all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents

and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying Agreement.

c. **Termination for Cause.** Associate authorizes termination of this Agreement by Agency, if Agency determines Associate has violated a material term of the Agreement. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.

d. **Judicial or Administrative Proceedings.** The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA/HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined. Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA/HITECH and shall be responsible for any and all costs associated with prosecution.

e. **Survival.** The respective rights and obligations of Associate under this Addendum shall survive the termination of the underlying Agreement.

5. **General Provisions/Ownership of PHI.**

a. **Retention of Ownership.** Ownership of the PHI resides with the Agency and is to be returned on demand or destroyed at the Agency's option, at any time, and subject to the restrictions found within section 4.b. above.

b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an individual must be held confidential and is also the property of Agency.

c. **Electronic Transmission.** Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an individual must not be transmitted to another party by electronic or other means for additional uses or disclosures not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. **No Sales.** Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

e. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

f. **Interpretation.** The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. **Amendment.** The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. **Additional Terms and Conditions.** Additional discretionary terms may be included in the release order or change order process.

AGREED:

Name of Agency:_____

Signature:_____

Title:_____

Date:_____

Name of Associate: Jerry Dubberly

Signature: Jerry Dubberly

Title: Principal, Myers and Stauffer LC

Date: 4/21/2025

Form - WVBAA-012004
Amended 06.26.2013

APPROVED AS TO FORM THIS 26th
DAY OF June 20 25
Patrick Morrisey
Attorney General
BY _____

8

Appendix A

(To be completed by the Agency's Procurement Officer prior to the execution of the Addendum, and shall be made a part of the Addendum. PHI not identified prior to execution of the Addendum may only be added by amending Appendix A and the Addendum, via Change Order.)

Name of Associate: Jerry Dubberly, Principal, Myers and Stauffer LC

Name of Agency: DoHS-BMS

Describe the PHI (do not include any actual PHI). If not applicable, please indicate the same.

Member, Provider, Claims data and profile

X. Appendix

- Appendix A: Resumes
- Appendix B: Actuarial Credentials
- Appendix C: Conflicts of Interest Mitigation Plan
- Appendix D: Example Certifications

Appendix A: Resumes

Jerry Dubberly, PharmD, MBA

Principal (Partner), Myers and Stauffer LC

ROLE: EXECUTIVE PROGRAM DIRECTOR

- ✓ More than 30 years of Medicaid/public health care experience, including as partner in charge of Medicaid managed care engagements.
- ✓ Former State Medicaid Director of Georgia, managing three successful Medicaid managed care organization (MCO) contracts serving more than 1.3 million Medicaid and Children's Health Insurance Program (CHIP) lives.
- ✓ Leads Myers and Stauffer's current Bureau for Medical Services (BMS) Medicaid Actuarial Services and Managed Care Program Administration and Oversight engagement and authority to commit the firm and its resources.
- ✓ Doctorate in Pharmacy/ Master's of Business Administration.

Dr. Dubberly leads the Consulting practice area within the firm. He focuses on providing executive support and strategic planning assistance to Medicaid and other government-sponsored health and human service programs. He has assisted our clients with delivery system and payment transformation initiatives including the design, implementation, and oversight of managed care programs, integration of behavioral and physical health services, architecture of value-based payment (VBP) programs, advancing home and community-based services (HCBS) and support models, and other delivery system and payment enhancements. He has also been on the forefront of analytics and evaluation of programs and developing continuous improvement strategies to improve the effectiveness and efficiency of those programs.

Prior to joining Myers and Stauffer, Dr. Dubberly served as Georgia's Medicaid Director, where he was responsible for oversight and management of the MCO contracts and the contractors' performance. He brings a wide range of experience with Medicaid policy and financing, delivery of integrated care models, pharmacy services, clinical practice, health information technology (health IT), and experience with a variety of other state and federal health care programs.

Education

PharmD, Pharmacy, University of Arkansas Medical Sciences, 2005/M.B.A., Health Services Management, University of Tennessee at Chattanooga, 1995/B.S., Pharmacy, University of Georgia, 1990

Experience

34 years of professional experience

Licenses/Certifications

Registered Pharmacist

Relevant Work Experience

Myers and Stauffer LC (2015-Present), Principal (Partner)

- **West Virginia Department of Human Services, Bureau for Medical Services (2021-Present):** Supports the Team's oversight of the West Virginia managed care program and the delivery of actuarial services. This includes MCO contract reviews and amendments, procurement and readiness reviews, plan performance, provider network adequacy, quality strategy development, state directed payments, medical loss ratio (MLR) audits, legislative and budget support, and all other contractual areas of responsibility. Accountable for all of the Myers and Stauffer Team's contractual responsibilities.
- **Hawai'i Department of Human Services (2018-2022):** Supported managed care procurement, post-implementation MCO stabilization, and aspects of VBP program design and quality strategy development for the State's delivery system reform efforts.
- **Kentucky Cabinet for Health and Family Services (2018-Present):** Provide technical assistance for the Medicaid managed care program, including opportunity analyses for program improvement, managed care procurement activities, contract maintenance and updates, drafting and supporting requests for

federal authorities, and directed payment program design and operations as well as supporting a number of other Medicaid policy and program areas.

Georgia Department of Community Health (2004-2015), Medicaid Director, Deputy Director Medical Assistance Policy Section, Director of Pharmacy Services

- **Oversight and Expansion of Medicaid MCOs.** As the Medicaid Director, Dr. Dubberly held ultimate responsibility for oversight and monitoring of three Medicaid MCOs covering more than 1.4 million Georgians. He also led an initiative to build an enhanced care coordination and increased medical oversight managed care model for children in foster care, adoption assistance, and certain children in the juvenile justice system to achieve improved health outcomes.
- **Aged, Blind, and Disabled (ABD) Care Coordination Project.** Recognizing the ABD population's absence of meaningful access to medical coordination and case management, along with their significant fiscal contribution to total Medicaid expenditures, a program was designed to address this gap. The program was developed to include features of patient-centered medical homes, primary care case management (PCCM), disease management, and care coordination.
- **Executive Sponsor of Medicaid Management Information System (MMIS) Implementation.** This effort replaced the Georgia MMIS system utilized to pay claims, manage utilization, and provide all federal and state reporting. To accomplish this objective, the implementation approach was defined by the business owners with the systems staff supporting the business needs of the organization. This project culminated in what providers and the Centers for Medicare & Medicaid Services (CMS) deemed as the smoothest implementation in recent history.
- **Procurement of a Medicaid Pharmacy Benefits Manager (PBM) Contract.** As Pharmacy Director, his responsibilities included Request for Proposal (RFP) creation, evaluation of responses, contracting, and implementation of the PBM vendor contract. This effort resulted in savings of more than $12.2 million over the 5.5 year life of the contract. Designed end-user functionality of new pharmacy claims processing platform. This project required analysis of current system functionality, current and future business needs, and efficiency and ease of use for end-users. Each of these parameters had to be evaluated and implemented under the guidance and limitations of industry transaction standards.

Terri Branning

Senior Manager, Myers and Stauffer LC

ROLE: PROJECT MANAGEMENT LEAD

- ✓ More than 40 years of health care industry experience, including executive leadership roles in Medicaid, managed care, and self-funded health plans.
- ✓ Current Project Management Lead for Bureau for Medical Services (BMS) Medicaid Actuarial Services and Managed Care Program Administration and Oversight engagement.
- ✓ Health care consultant to Georgia Medicaid client during transition to full-risk managed care.
- ✓ Former Executive Business Analyst for Georgia Department of Community Health.
- ✓ Bachelor's degree in nursing.

Ms. Branning has worked in the health care industry for over 40 years. She has extensive experience supporting state Medicaid agencies with strategic planning, health care funding, program design, process improvement, managed care organization (MCO) procurements, readiness reviews, implementation planning, monitoring and oversight, stakeholder engagement, and program management. She has supported states with new initiatives, including implementation of a Certified Community Behavioral Health Clinics (CCBHC) Demonstration, and development of specialized managed care programs for children and youth in foster care or receiving adoption assistance services. Her experience spans both public and private health care settings, which has provided her with in-depth knowledge of managed care delivery models.

Education

B.S., Nursing, Emory University, 1979

Experience

Over 40 years of professional experience

Relevant Work Experience

Myers and Stauffer LC (2015-Present), Senior Manager

- **West Virginia Department of Human Services, Bureau for Medical Services (2022-Present):** Provide ongoing Medicaid Actuarial Services and Managed Care program administration and oversight, including MCO capitation rate development and certification, ongoing data management, policy analysis, research, MCO contract updates and maintenance, 1915(b) waiver renewals and amendments, assessment of provider network adequacy, MCO reporting, Medical Loss Ratio (MLR) audits, and maintenance of data management dashboards.
    - As the Project Management Lead, responsible for oversight of all contractual deliverables and ensuring completion within the timeframes agreed upon with BMS.
    - Managed the transition of the incumbent BMS vendor to Myers and Stauffer and Milliman in 2022, including implementation planning, review of relevant materials and documentation supporting transition planning, and development of a comprehensive data warehouse for capitation rate setting, analytics, and reporting.
    - Directs contractual deliverables and activities with the Myers and Stauffer and Milliman team, BMS leadership, BMS departments, contracted MCOs, and BMS contractors, such as BerryDunn.
    - Facilitates meetings with BMS managed care and financial leadership to provide status updates, identify strategic priorities, coordinate planning with BMS vendors, and propose recommendations.
    - Manages BMS leadership support required for legislative sessions, Committee meetings, and budget hearings, including research, budgetary projections, fiscal analyses, and preparation of topic-specific briefs, reports, and other presentation materials.
    - Supports the oversight of the 1915(b) managed care waivers including renewals and amendments, including negotiations with the Centers for Medicare & Medicaid Services (CMS).
    - Oversees Myers and Stauffer and Milliman in the development and implementation of MCO contract amendments to account for policy changes, updates to federal regulations, and stakeholder input.
    - Partners with Milliman in the MCO capitation rate setting process and communications with BMS and MCOs.

- Coordinates deliverables with BMS Finance on budget reporting, fiscal impact analyses, Directed Payment Programs, tracking, and provider rate setting.
- Coordinates Myers and Stauffer and Milliman planning and implementation of quality initiatives: automatic day one enrollment into managed care and an MCO quality withhold program.
- Oversees preparation of client leadership presentations for MCO updates for provider association meetings and national conferences.
- Directed fiscal analyses and reporting on the unwinding of the public health emergency (PHE) for the Coronavirus disease (COVID-19) pandemic.
- With the State, managed development of the State Fiscal Year 2024-2027 Quality Strategy.
- Provided oversight of the transition of the West Virginia Children's Health Insurance Program (WVCHIP) into the Mountain Health Trust program.

- **Hawai'i Department of Human Services (2018-2022):** Support managed care procurement and aspects of value-based purchasing program design for the State's delivery system transformation efforts:
  - Managed the development of a Request for Information (RFI) to obtain stakeholder insights about VBP models and other delivery system considerations. Conducted stakeholder engagement with the State's contracted MCOs and external quality review organization (EQRO).
  - Coordinated MCO managed care program design considerations and developed the MCO Request for Proposal (RFP) for the Medicaid managed care procurement.
  - Led the development of MCO policy manual modules.
  - Supported development of the Medicaid Quality Strategy.

- **Kentucky Cabinet for Health and Family Services (2018-Present):** Provide technical assistance to the Department for Medicaid Services, including supporting managed care procurement activities and recommendations for performance management oversight of the contracted MCOs:
  - Managed development of program design considerations for procurement of MCOs to administer services to Medicaid enrollees, including development of a new managed care single MCO delivery model, Supporting Kentucky Youth (SKY), for children and youth in foster care or receiving adoptive assistance, and certain youth involved in the juvenile justice system. Drafted the SKY RFP and MCO contract requirements.
  - Supported the Medicaid and child welfare services departments with implementation of the SKY program and MCO contract. Conducted an environmental assessment of the child welfare services department and recommended staffing, business processes, technology, communications, and training.
  - Assisted with MCO readiness reviews, including development of a readiness review tool.

- **Nevada Department of Health and Human Services (2017):** Supported implementation and onboarding of four Medicaid MCO contracts and development of a managed care information strategy, and reviewed key business processes for redesign and reengineering to improve the effectiveness and efficiency of the Medicaid Division:
  - Assisted with planning and evaluation of the State Innovation Model (SIM).
  - Developed and implemented the MCO onboarding Command Center to support an efficient and well-organized MCO onboarding process.
  - Created an external dashboard reporting on MCO performance results for public posting.
  - Directed the development of the application for the Community Behavioral Health Clinic (CCBHC) Demonstration. Provided project management for implementation, monitoring, and oversight of the CCBHC program.

- **Georgia Department of Community Health (2017):** Oversight and monitoring of Georgia Families Care Management Organizations (CMOs):
  - Assisted with CMO readiness reviews and CMO onboarding Command Center operations.
  - Assisted with the development of CMO performance dashboards during onboarding.

Georgia Department of Community Health (2010-2015), Executive Business Analyst

- Led major Medicaid procurements and supported implementation with dedicated internal project teams.
- Developed and implemented a Medicaid program in collaboration with multiple child-serving state agencies to transition approximately 24,000 children and youth in foster care, adoption assistance, and the juvenile justice system into risk-based managed care with enhanced care coordination and increased clinical oversight.
    - Developed the new program CMO contract and supported development of capitation rates.
    - Led the CMO readiness review and supported the management and resolution of corrective actions.

Georgia Department of Community Health (2007-2010), Consultant

- Consultant to the Georgia Department of Community Health (DCH) during program design, procurement, and implementation of the Medicaid managed care program, which transitioned more than one million Medicaid beneficiaries to full-risk managed care. Led readiness review and Command Center activities for onboarding the new CMOs. Responsible for DCH Commissioner stakeholder reporting and monitoring corrective actions for CMOs' claims processing and provider network development.
- Served as the interim Chief of the State Health Benefit Plan with responsibility for administering benefits for more than 700,000 Georgia state and public school employees and retirees with a $2.6 billion budget.

HealthCare Advisory Services, Atlanta, Georgia (1994-2006), President

- Served in leadership roles and provided managed care expertise to health care systems and provider organizations in the southeast U.S.

CIGNA HealthCare of Georgia, Atlanta Georgia (1983-1994), Vice President and Health Plan Manager for Georgia and Alabama; Director of Operations; Director of Planning, Analysis and Development; Director of Provider Relations

Egleston Children's Hospital and Grady Memorial Hospital, Atlanta, Georgia (1979-1983), Pediatric Critical Care Nurse

Hannah Lawrence, MPH

Health Care Manager, Myers and Stauffer LC

ROLE: PROGRAM ADMINISTRATION LEAD

- ✓ More than 10 years of Medicaid experience, including Medicaid managed care consulting contracts.
- ✓ Currently serves as Bureau for Medical Services (BMS) Medicaid Actuarial Services and Managed Care Program Administration and Oversight engagement contract liaison responsible for Medicaid managed care program management.
- ✓ Medicaid managed care policy and operations expertise.
- ✓ Master's Degree in Public Health.

Ms. Lawrence provides strategic consulting to state governments through analysis and research of managed care data, assumptions and methodologies used for rate development, ensuring compliance with state and federal regulations, and developing processes to measure outcomes of technical and administrative business functions.

Prior to joining Myers and Stauffer, Ms. Lawrence spent several years supporting the state of South Carolina in managing the Medicaid Promoting Interoperability Program (formerly the Medicaid Electronic Health Record [EHR] Incentive Program) by advancing the adoption and meaningful use of certified EHR technology and health information exchange (HIE) in the state. She has extensive experience working directly with providers and facilitating conversations regarding health information technology (health IT) and HIE. In her role, she was responsible for communications with the Centers for Medicare & Medicaid Services (CMS) and industry leadership and provided oversight of the program.

Education

M.P.H, Health Services, Policy and Management, University of South Carolina, 2014/B.S.P.H., Community Health, Indiana University, 2012

Experience

10 years of professional Medicaid experience

Licenses/Certifications

Pursuing Project Management Professional (PMP) Certification

Relevant Work Experience

Myers and Stauffer LC (2017-Present), Health Care Manager

- **West Virginia Department of Human Services, Bureau for Medical Services (2021-Present):** Support ongoing oversight, including ongoing data management, Medicaid waiver support, policy analysis, research, contract development and maintenance, assessment of provider network adequacy, managed care organization (MCO) reporting and analytical tool development and maintenance (includes dashboards), and MCO contract development and maintenance.
    - Support BMS with day-to-day Medicaid Managed Care program management, including both the delivery and management of activities, as directed, toward effective outcomes.
    - Support client needs by facilitating and managing operational meetings to support the client and its contractors as it relates to addressing vendor inquiries and concerns.
    - Conduct research and develop recommendations to support the development of compliant business operations, processes, and policies in accordance with state-specific Medicaid Managed Care program requirements.
    - Manage MCO contracts and waiver amendment and renewal processes.
    - Support the design of new programmatic features upon request (e.g., Day One Enrollment).
    - Support managed care program contract development and maintenance.
    - Draft annual managed care program reports, including legislative reporting and briefs.

- **Arizona Health Care Cost Containment System (AHCCCS) (2023-2024):** Provide project management, staff augmentation, and executive consultant services for activities related to American Rescue Plan Act of 2021 (ARPA) funds as approved by CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA).
  - Served as primary point of contact to client, including leading all key meetings and project activities.
  - Provided project management support for all ARPA career, education, and training workforce development initiatives.
  - Supported AHCCCS communications department in marketing and communications needs.
  - Monitored public commentary and support project management for the state's Parents as Paid Caregivers (PPCG) project.
  - Supported the development of the AHCCCS Mental Health and Community Mental Health Block Grant manual.
- **Kentucky Cabinet for Health and Family Services (2018-Present):** Provide technical assistance to the Department for Medicaid Services (DMS) for its Medicaid managed care program, including supporting managed care procurement activities and recommendations for the Department's performance management oversight of the contracted MCOs.
  - Reviews and analyzes the current managed care program, including current contracts and national best practice literature, to support the development of option analyses detailing a best-in-class system, noting best practices and recommendations for change.
  - Assist in the development of questions to survey MCOs to review the existing Kentucky Medicaid MCO environment and provide feedback and key considerations to DMS.
- **Mississippi Division of Medicaid (2019-2021):** Outsourced Financial Reviews of Mississippi Coordinated Access Network (MississippiCAN) and Health Information Technology/Health Information Exchange (Health IT/HIE).
- **Nevada Department of Health and Human Services (2017-2019):** Health IT Consulting Services and Technical Assistance.

Robert Rhoton, CPA

Senior Manager, Myers and Stauffer LC

ROLE: FINANCE PROJECT LEAD

- ✓ More than 11 years' experience in financial management in Medicaid programs including regulations, reimbursement processes, financial analysis, budgeting, and forecasting.
- ✓ Experience with the Bureau for Medical Services (BMS) through contracts for Certified Community Behavioral Health Clinic (CCBHC) and substance use disorder (SUD) rate setting and consulting and 1115 Waiver Budget Neutrality Analysis.
- ✓ Bachelor's degree in accounting and business economics.
- ✓ Certified Public Accountant.

Mr. Rhoton specializes in financial analysis and consulting for public health care, rate setting, compliance and financial auditing. Specific to West Virginia, he has experience performing general financial analysis, fiscal impact analysis, rate setting, and reimbursement process consulting associated with the state's CCBHC program, 1115 Waiver, SUD residential program, and mobile crisis program. His Medicaid audit experience includes performing and reviewing attest engagements of CCBHCs, nursing facilities, federally qualified health centers (FQHCs), intermediate care facilities for the intellectually disabled (ICF/IDs), and hospitals. He has performed rate setting engagements for CCBHCs, FQHCs, and Rural Health Clinics (RHCs), as well as ad-hoc projects such as Mobile Crisis Units and SUD residential Institutions for Mental Disease (IMD) service. Mr. Rhoton also has extensive experience providing training for both state employees and provider groups.

Education

B.A., Accounting and Business Economics, Randolph-Macon College, 2014

Experience

11 years of professional experience

Licenses/Certifications

Certified Public Accountant

Relevant Work Experience

Myers and Stauffer LC (2014-Present), Senior Manager

- **West Virginia Department of Human Services, Bureau for Medical Services (2023-Present):** Performs consulting and rate setting services for CCBHC program.
  - Served as the Project Manager during the initial CCBHC program creation with responsibility for project oversight, quality of deliverables, and ongoing communications with the client.
  - Consulted on all aspects of the CCBHC program as it related to reimbursement. Provided ad-hoc consulting, including out-of-state program research, financial/fiscal impact analysis, and Substance Abuse and Mental Health Services Administration (SAMHSA) grant and State Plan Amendment (SPA) writing.
  - Oversaw the entire Prospective Payment System (PPS) rate setting process, including state and provider training, ongoing technical assistance for providers, and cost report audits.
- **West Virginia Department of Human Services, Bureau for Medical Services (2022-2024):** Performed consulting, financial/fiscal impact analysis, and budget neutrality calculations for the 1115 waiver renewal.
  - Performed financial analysis, including cost and utilization estimation, for various state programs to update and complete the 1115 waiver budget neutrality analysis for the most recent waiver renewal.
  - Participated in the Centers for Medicare & Medicaid Services (CMS) negotiations as part of the waiver renewal process, answering questions from CMS associated with the budget neutrality analysis.
  - Presented the budget neutrality model to CMS officials, answering questions and providing detailed explanations behind the reasoning and purpose of calculations.
- **West Virginia Department of Human Services, Bureau for Medical Services (2024-Present):** Performs consulting and rate setting services for SUD residential program.

  - Serves as the Project Manager with responsibility for project oversight, quality of deliverables, and ongoing communications with the client.
  - Created a rate setting model incorporating provider specific, national, and statewide metrics to calculate updated rates per American Society of Addiction Medicine (ASAM) level for the existing SUD residential providers.

- **West Virginia Department of Human Services, Bureau for Medical Services (2022-2023):** Performed a rate setting engagement to set fee-for-service (FFS) rates for the mobile crisis program.
  - Created a rate setting model incorporating state-specific and national level data to calculate FFS reimbursement rates for the mobile crisis program.
  - Collaborated with the State's project manager vendor and actuarial vendor to ensure timeliness of deliverables.

- **New Hampshire Department of Health and Human Services (2023-Present):** Performed CCBHC rate setting engagements and provided general reimbursement consulting as the state implements their CCBHC program.
  - Serve as the Project Manager with responsibility for project oversight, quality of deliverables and on-going communications with the client.
  - Consulted and oversaw the creation and implementation of the reimbursement portion of the CCBHC program for the state including provider training, cost report audits, and general financial analysis/consulting.

- **Nevada Department of Health and Human Services (2019-Present):** Ensure cost reports follow state and federal regulations for nursing facilities, ICFs, and hospitals. Myers and Stauffer also performs agreed-upon procedures (AUPs) on FQHCs for the purposes of initial, baseline, and change in scope rate setting.
  - Serve as the Project Manager with responsibility for project oversight, quality of deliverables, and ongoing communications with the client.
  - Provide cost report/technical trainings to Agency staff on an annual basis.
  - Provide trainings to Provider's and/or provider associations as requested.

- **Nevada Department of Health and Human Services (2020-2021):** Performed a rate setting engagement to set rates for IMD Providers and the associated budget neutrality analysis for the 1115 waiver.
  - Created rate setting models utilizing publicly available and provider-specific data. Utilized the rate models to create the 1115 budget neutrality analysis to be submitted with the state's 1115 waiver.
  - Collaborated with health care subject matter experts to ensure rate setting assumptions met industry standards and guidelines.

Paige Ferise, JD, MPH

Health Care Senior Consultant, Myers and Stauffer LC

ROLE: RESEARCH ANALYST/CONSULTANT

- ✓ More than 7 years of work on Medicaid projects.
- ✓ JD and Member of the Bar.
- ✓ Master's degree in public health.
- ✓ Bachelor's degree in organizational communication and peace and conflict studies.

Ms. Ferise is a health care consultant experienced in health care law and policy. In her role at Myers and Stauffer, she has worked on several projects across both the consulting and pharmacy engagement teams. Her work focuses on public health law and policy, including issues related to federal waivers and Medicaid State Plan Amendments (SPAs), administrative rulemaking, and pharmaceutical legislation and policy. As a licensed attorney in the state of Indiana, she also serves as a legal/policy resource for teams and projects across the firm. She has prepared client deliverables, conducted research, and tracked relevant legislation relating to client concerns.

Education

J.D., Indiana University McKinney School of Law, 2022/MPH, IUPUI Fairbanks School of Health, 2022/B.A., Organizational Communication and Peace and Conflict Studies, Butler University, 2017

Experience

7 years of professional experience

Licenses/Certifications

Remember of the Indiana Bar, Active in Good Standing (License Number 37703-49)

Relevant Work Experience

Myers and Stauffer LC (2021-Present), Senior Health Care Consultant

- **Arizona Health Care Cost Containment System (2022-Present):** Provides project management, staff augmentation, and executive consultant services for the Arizona Health Care Cost Containment System for activities related to American Rescue Plan Act of 2021 (ARPA) funds as approved by the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA).
  - Serves as the health care consultant for this engagement and assists on various client deliverables including, but not limited to, issues related to federal grants management and compliance.
  - Assists with project management activities, operational support, stakeholder engagement, and reporting.
- **Kentucky Cabinet for Health and Family Services (2022-Present):** Provides a variety of services for the state of Kentucky, including rate setting, waiver support, procurement support, and pharmacy consulting services.
  - Provides research and policy support for the State's Section 1115 demonstration waiver and related initiatives.
- **Illinois Department of Healthcare and Family Services (HFS) (2022-2023):** Supported HFS in pursuing the Certified Community Behavioral Health Clinic (CCBHC) Planning Grant application and subsequent CCBHC Demonstration application. Myers and Stauffer provided comprehensive services to support design, implementation, operations, and ongoing policy development.
  - Assisted in development of deliverables, including designing the State's Request for Application (RFA).
  - Provided research and policy support for the State's CCBHC planning grant proposal.

- **Michigan Department of Health and Human Services (2021-2022):** Supported the Department's CCBHC Demonstration Program implementation, operations, and ongoing policy development.
    - Provided research and policy support for the State's CCHBC demonstration.
    - Assisted with the certification process for the State's participating CCBHCs.
- **Centers for Medicare & Medicaid Services (2021-Present):** CMS rate setting for the National Average Drug Acquisition Cost (NADAC), updated via a monthly voluntary national survey process and weekly through changes in published prices. Additional ad hoc analysis is performed as requested. Myers and Stauffer also consults in areas of reimbursement, including specialty drugs, blood clotting factor, and the 340B drug program.
    - Assists in research and writing deliverables, including legislative and policy reporting on topics including, but not limited to, drug pricing transparency and the federal 340B drug pricing program.
- **Iowa Department of Health and Human Services (2024-Present):** Supports the Department's CCBHC Demonstration Program implementation, operations, and ongoing policy development.
    - Provided research and policy support for the State's CCHBC demonstration.
    - Assisted with ongoing technical assistance and trainings for the State's participating CCBHCs.

Nancy Kim, PMP, MPH

Senior Manager, Myers and Stauffer LC

ROLE: MEDICAID POLICY SUBJECT MATTER EXPERT

- ✓ More than 16 years of experience crafting Centers for Medicare & Medicaid Services (CMS) managed care reports, including 1115 waivers/amendments, 1915(b) waiver applications/amendments, independent assessments, Medicaid and CHIP Program Annual Reports (MACPAR), and Fraud, Waste, Abuse (FWA) compliance reports.
- ✓ Master's degree in health policy and administration.
- ✓ Bachelor's degree in education and social policy.

Ms. Kim directs projects and provides technical assistance support to various states' Medicaid managed care programs, which include training staff in monitoring key program metrics and performance issues related to managed care organizations (MCOs), assisting in the maintenance of a data repository which houses performance measure data used to create performance profile reports, and researching key policy topics for the states, such as dual eligibles and value-based purchasing.

Prior to joining Myers and Stauffer, Ms. Kim was a Senior Research Analyst for NORC at the University of Chicago, responsible for planning qualitative and quantitative data collection for various federal agencies, including case studies, environmental scans, informant interviews, focus groups, and expert panels. She was also a Public Health Analyst at U.S. Department of Health and Human Services, Health Resources and Services Administration.

Education

M.P.H., Health Policy and Administration, Yale University, 2009/
B.S., Education and Social Policy, Northwestern University, 2006

Experience

16 years of professional experience

Licenses/Certifications

Project Management Professional

Relevant Work Experience

Myers and Stauffer LC (2021-Present), Senior Manager

West Virginia Department of Human Services, Bureau for Medical Services (2021-Present): Support ongoing oversight including for Medicaid waiver support, policy analysis, and research.

- Developed tool to assess the State's compliance with new federal regulations.
- Assisted with the development of an implementation plan of key requirements, including any requirements that require vendor collaboration, such as with the External Quality Review Organization (EQRO).

Iowa Health and Human Services (2024-Present): Provides project management, staff augmentation, and executive consultant services for Iowa Health and Human Services (HHS).

- Serves as project manager for the engagement and assists the State with various technical assistance needs.
- Provides support for the development of 1115 waiver applications/amendments, development of State Plan Amendment (SPA) language, tracking and monitoring of new federal regulations, and guidance on interpreting new federal rules.

Arizona Health Care Cost Containment System (2022-Present): Provides project management, staff augmentation, and executive consultant services for the Arizona Health Care Cost Containment System (AHCCCS) for activities related to the American Recovery Plan Act of 2021 (ARPA) funds and implementation of new federal regulations.

- Serves as project manager for the engagement and assists the State in the implementation of their ARPA Home and Community-Based Services (HCBS) Spending Plan.

- Serves as project manager for implementation of new federal rules, specifically Ensuring Access to Medicaid Services and Medicaid and Children's Health Insurance Program (CHIP) Managed Care final rules.
- Provides technical assistance and operational support on select ARPA initiatives, including issuing directed payments to providers, implementing the NCI-AD survey, assisting with the amendments to the 1115 Waiver, assessing the State's Olmstead plan, and supporting workforce development.
- Assisted with the development of a block grant manual for the Community Mental Health Services Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS) program.

Arkansas Department of Human Services (2021-Present): Conduct an independent evaluation/assessment of the State of Arkansas's Section 1915(b) Waiver for the Provider-led Arkansas Shared Savings Entity (PASSE) project for the State's Medicaid program (Waiver Number: AR.0007.R00.01), as mandated in Title 42 Code of Federal Regulations (CFR) §431.55(b)(4).

- Assist with the analysis of State documents and reports to evaluate access and quality of the programs.
- Conduct stakeholder engagement with internal State staff as well as external stakeholders, including MCOs and other state vendors, to elicit information about the PASSE program.
- Work with the state to develop a final report to submit to CMS regarding findings from the independent assessment of the State's program.

Guidehouse (2012-2021), Associate Director, Health Care

- Direct projects and provide technical assistance support to various states' Medicaid managed care programs, which include conducting procurement and contracting activities, training staff in monitoring key program metrics and performance issues related to MCOs, assisting in the maintenance of a data repository which houses performance measure data used to create performance profile reports, and researching key policy topics for the states, such as dual eligibles and VBP.
- Develop a national survey for states regarding the health and welfare of their 1915(c) waiver participants. This included conducting a literature scan, compiling data from existing 1915(c) waiver applications, and releasing a national survey. Findings were presented in a series of national training calls with CMS.
- Support rate rebasing for a 1915(c) waiver program by conducting stakeholder engagement meetings, administering a provider survey, and developing a rate model for each service.
- Review state's compliance with federal and state regulations related to the 1915(c) waiver application for HCBS and provide guidance with regards to rate setting methodologies, quality and oversight measures, and critical incident management systems.

NORC at the University of Chicago (2010-2012), Senior Research Analyst, Health Care Research

- Performed and led a wide range of research activities, such as the planning of qualitative and quantitative data collection activities, for the development of reports to various federal agencies, including case studies, environmental scans, informant interviews, focus groups, and expert panels.
- Major projects included: a report on the use of open source technologies in safety net settings, a study on payment incentives for providers excluded from the Health Information Technology for Economic and Clinical Health Act (HITECH), a report on assistive services technologies for seniors and persons with disabilities, a report on the use of health information technology (health IT) in oral health for Medicaid providers, and a study to support the national Early and Periodic Screening, Diagnostic and Treatment (EPSDT) workgroups.

US DHHS - Health Resources and Services Administration - Office of HIT (2009-2010), Public Health Analyst

- Facilitated the successful reporting requirements of grantees on governmentwide and agency-specific measures related to meaningful use of health IT systems.
- Reviewed proposed rules and programmatic guidance, including Stage 1 of Meaningful Use, to provide key recommendations on policies and procedures to senior agency administrators.

Annie Hallum, FSA, MAAA

Principal and Consulting Actuary, Milliman

ROLE: ACTUARIAL PROJECT LEAD

- ✓ 15 years of experience with Medicaid Managed Care rate setting.
- ✓ Fellow of the Society of Actuaries (FSA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Ms. Hallum is a principal and consulting actuary with Milliman's Seattle Health practice. She joined the firm in 2009 and has more than 15 years of experience providing actuarial support and consulting to state Medicaid agencies. Annie's experience includes capitation rate setting, cost effectiveness projections, fiscal analysis, benchmarking of experience, and provider payment design and evaluation.

Annie will serve as an overall Actuarial Project Lead and a point of contact for the Bureau for Medical Services (BMS).

Education

B.S., Statistics, Magna cum Laude, University of Washington, 2009/B.A., Mathematics and Economics, Magna cum Laude, University of Washington, 2009

Experience

15 years professional actuarial experience, including:

Medicaid managed care rate setting:

- Hawai'i 2010-2015; 2019-2020
- Nevada 2009-2015
- Utah 2019-Present
- Vermont 2019-2021
- Washington 2009-2015; 2019-Present
- West Virginia 2022-Present
- Wyoming 2017-2018

Other rate setting (e.g., provider payment rates):

- Colorado 2019
- Idaho 2017-2018
- Minnesota 2017-2018
- Nebraska 2017-2018; 2021-Present

Relevant Work Experience

Milliman (2009-2015; 2019-Present), Principal & Consulting Actuary

- **State of Hawai'i, Department of Health and Human Services**
  - Development of Medicaid capitation rates for Community Care Services (CCS) (2019-2020) and Quest Integration (2012-2015).
  - Risk mitigation settlements (2019-2022).
  - Development of Affordable Care Act (ACA) enhanced physician fee schedule for provider payments as well as quarterly calculation of enhanced payments by provider (2013-2015).
- **State of Nevada, Department of Healthcare Financing and Policy**
  - Development of Medicaid capitation rates for Temporary Assistance for Needy Families (TANF), State Children's Health Insurance Program (SCHIP), disabled, and expansion populations (2009-2015).
  - Risk adjustment and risk mitigation settlements (2010-2015).

- **State of Utah, Department of Health**
  - Development and certification of Medicaid capitation rates for TANF, SCHIP, disabled, and expansion populations (2019-Present).
  - Risk adjustment (2019-Present).
  - Assistance with 1115 waiver design and evaluation (2019-2021).
- **State of Vermont, Agency of Human Services**
  - Development and certification of Medicaid capitation rates for TANF, disabled, long-term services and supports (LTSS), and expansion populations (2019-2021).
- **State of Washington, Health Care Authority**
  - Development and certification of Medicaid capitation rates for TANF, SCHIP, foster care, disabled, expansion, and Program of All-Inclusive Care for the Elderly (PACE) populations (2010-2015; 2019-Present).
  - Risk adjustment (2010-2015; 2019-Present).
  - Provider payment rate and hospital tax program updates (2018; 2020-Present).
- **State of West Virginia, Bureau for Medical Services**
  - Development and certification of Medicaid capitation rates for TANF, CHIP, foster care, disabled, and expansion (2022-Present).
  - Risk adjustment (2022-Present).
  - Provider payment rate and other fiscal analyses (2022-Present).
  - Assistance with fiscal modeling for 1915(b), 1915(c), and 1115 waivers, State Plan Amendment (SPA) changes, and other Medicaid policy and budget work.
- **State of Wyoming, Health Care Authority**
  - Development and certification of Medicaid capitation rates for PACE and youth behavioral health care management populations (2017-2018).
- **State of Colorado, Department of Healthcare Policy and Financing**
  - Development of all-payer hospital budget model (2019).
- **State of Idaho, Division of Medicaid**
  - Assisted with provider payment rate development for LTSS (2017 to 2018).
  - Review of Medicaid Managed Care dental rates (2018).
- **State of Minnesota, Department of Health**
  - Assisted with payment rate calculations and simulation modeling of the fiscal impact of updating its Medicaid inpatient All Patient Refined Diagnosis Related Groups (APR-DRG) payment system (2018).
- **State of Nebraska, Division of Medicaid**
  - Assisted with payment rate calculations and simulation modeling of the fiscal impact of annual updates to its Medicaid inpatient APR-DRG based methodology and converting its outpatient payment system from a cost-based methodology to Enhanced Ambulatory Patient Groupings (EAPGs) (2017-2018).
  - Development of disproportionate share hospital (DSH) allotment and upper payment limit (UPL) calculations (2017-2018; 2021-Present).

Justin C. Birrell, FSA, MAAA

Principal and Consulting Actuary, Milliman

ROLE: LEAD ACTUARY (Contract Manager)

- ✓ 25+ years of Medicaid Managed Care rate setting.
- ✓ Fellow of the Society of Actuaries (FSA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Mr. Birrell joined Milliman's Seattle Health practice in 1995.

He has 30 years of actuarial experience with a variety of health-related issues. His primary focus over the last 25 years has been Medicaid. This involves work for states including Hawai'i, Idaho, Nevada, Utah, Washington, West Virginia, and Vermont, as well as non-state clients where he has supported Medicaid populations in Kentucky, Arizona, Georgia, and Massachusetts. He has worked on a variety of projects, including medical, long-term care, behavioral health, transportation, disease management, procurement, health care reform, and other state-specific analyses. In addition to the development of capitation rates, Mr. Birrell has worked with states to negotiate final rates and produce required Centers for Medicare & Medicaid Services (CMS) documentation.

Education

B.S., Mathematics Brigham Young University, 1994

Experience

30 years of professional experience with approximately 25 years in Medicaid managed care, including Florida, Hawai'i, Idaho, Nevada, Utah, Vermont, Washington, and West Virginia.

- Current work in multiple states to develop rates and an appropriate structure integrating both the Medicare and Medicaid component of costs into a rate for members eligible for both programs.
- Experience in developing rate structures for integrated (medical, mental health, chemical dependency, and long-term care) health care models for Medicaid recipients that improve healthcare and reduce expenditures, including CMS documentation of rates and rate structures.
- Expertise in the development and documentation of Medicaid capitation rates in multiple states for managed care services for Temporary Assistance for Needy Families (TANF), Aged, Blind, disabled, and other unique Medicaid populations, including those eligible for Medicare as well as those only eligible for Medicaid benefits.
- Experience in documentation of cost effectiveness for Medicaid programs.
- Experience risk-adjusting Medicaid capitation rates.
- Experience in developing Non-Emergency Medical Transportation (NEMT) rates for Medicaid populations.
- Expertise in analyzing large claims databases and health care modeling.
- Design and evaluation of pay-for-performance (P4P) incentives in Medicaid managed care programs.
- Development of Program of All-Inclusive Care for the Elderly (PACE) rates.

Relevant Work Experience

Milliman (1995-Present), Principal and Consulting Actuary

- **Florida Agency for Health Care Administration (AHCA) – External Peer Reviewer**
  - Acute care services for children, parents, pregnant women, disabled, human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), Serious Mental Illness (SMI), child welfare, long-term care, and dual eligible populations. Long-term services and supports (LTSS) for elderly and physically disabled populations. Additionally, development of PACE, dental, and NEMT rates. Member of Florida's Statewide Medicaid Managed Care procurement negotiation team (1999-Present).
  - CDPS+Rx with category weights customized to Florida covered benefits and provider payment levels, including model customization for SMI individuals and children receiving private duty nursing (PDN) services. Use of functional assessment-based risk scores for the PACE program (2010-Present).
- **State of Hawai'i, Department of Human Services (DHS)**

  - Preparation and management of risk adjustment analysis for managed care plans (2014-Present).
  - Development of Medicaid capitation rates for TANF, disabled, dually eligibles, State Children's Health Insurance Program (SCHIP) and expansion populations, including medical, LTSS, and behavioral health (2005-Present).
  - Development of projections of the impact of benefit and enrollment changes including the impact of Patient Protection and Affordable Care Act (PPACA) legislation on state expenditures (2012-2014).
  - Development of reporting guide to evaluate plan performance and medical loss ratio (MLR) review (2002-Present).
  - Produced data book and scoring methodology for managed care organization (MCO) procurements (2005-Present).
  - Fiscal impact analyses on ad hoc basis (2005-Present).

- **State of Idaho, Department of Health and Welfare (DHW)**
  - Development of projections of the impact of benefit and enrollment changes, including the impact of PPACA legislation on state expenditures (2013-Present).

- **State of Nevada, Division of Health Care Financing and Policy (DHCFP)**
  - Development of Medicaid capitation rates (TANF and SCHIP) for dual demonstration program (2013-2019).
  - Fiscal impact analyses on ad hoc basis (2002-2009).

- **State of Utah, Department of Health**
  - Development of behavioral health and non-emergency transportation rates (2010-Present).

- **State of Vermont, Agency of Human Service**
  - Development of Medicaid expansion capitation rates for newly eligible population (2012-2020).

- **State of Washington, Health Care Authority (HCA)**
  - Preparation and management of risk adjustment analysis for managed care plans, including LTSS risk adjustment (2000-Present).
  - Development of Medicaid capitation rates for TANF, disabled, dually eligibles, SCHIP, and expansion populations. Some programs included LTSS and behavioral health as well as medical (2000-Present).
  - Development of cost effectiveness documentation for new programs (2012-Present).
  - Development of reporting templates for expansion risk mitigation and financial reporting, including MLR evaluation (2000-Present).
  - Produced data book and scoring methodology for MCO procurements (2000-Present).
  - Fiscal impact analyses on ad hoc basis (2000-Present).

- **Aging and Long-Term Support Administration, Washington**
  - Development of PACE rates (2007-Present).

- **State of West Virginia, Bureau for Medical Service**
  - Development and certification of Medicaid capitation rates for TANF, CHIP, foster care, disabled, and expansion (2022-Present).
  - Risk adjustment (2022-present).
  - Provider payment rate and other fiscal analyses (2022-Present).

Mac Xu, FSA, MAAA

Consulting Actuary, Milliman

ROLE: LEAD ACTUARY (CHIP Lead)

- ✓ More than 15 years of experience with Medicaid managed care rate setting.
- ✓ Member of the American Academy of Actuaries (MAAA).
- ✓ Fellow of the Society of Actuaries (FSA).

Mr. Xu is an experienced Medicaid actuary with 18 years in Medicaid managed care consulting. He joined Milliman's Seattle Health practice in 2021. His expertise includes developing and certifying actuarially sound capitation rates for both managed acute care and long-term service and support (LTSS) programs, multi-year Children's Health Insurance Program (CHIP) revenue and cost projection, state directed payment analysis, health plan financial analysis, risk adjustment design and implementation, hospital diagnosis related group (DRG) rate rebasing, fee for service rate review and development, medical cost benchmarking, and analyzing regulatory changes such as the Centers for Medicare & Medicaid Services (CMS) final rules, medical loss ratio (MLR) reporting, risk corridor reconciliation, Medicaid expansion, and fiscal impacts of legislative initiatives.

Education

M.S., Actuarial Science, Georgia State University, Atlanta, GA, 2006/M.A., Economics, Fudan University, Shanghai, China, 2002/B.A., Economics, Fudan University, Shanghai, China, 1999

Experience

18 years professional actuarial experience including certifying and/or developing Medicaid managed care rates:

- West Virginia (2022-2024)
- Washington (2023-2024)
- Idaho (2021-2024)
- New Jersey (2018-2021)
- California (2018-2021)
- Kansas (2014-2017)
- Tennessee (2013-2014)
- Georgia (2012-2014)
- Florida (2010-2012)
- North Carolina (2010-2012)

Relevant Work Experience

Milliman (2021-Present), Consulting Actuary

- **State of West Virginia, Department of Human Services, Bureau for Medical Services (2022-Present)**
  - Lead and manage WVCHIP capitation rate development and quarterly revenue and cost projection.
  - Lead and manage key components of Mountain Health Trust (MHT) and Mountain Health Promise (MHP) rate setting including health plan financial review, state directed payment add-on rate development, and non-benefit load assumption development.
  - Lead and manage MHT and MHP annual managed care organization (MCO) tax reconciliation.
- **State of Idaho, Department of Health and Welfare (2021-Present)**
  - Develop and/or certify actuarially sound capitation rates for the State's fully integrated duals programs (Medicare Medicaid Coordinated Plan [MMCP]) and Medicaid-only duals program (Idaho Medicaid Plus Program [IMPlus]), which cover Medicaid covered acute care, behavioral health, and LTSS for dually eligible members.
  - Lead and manage annual retrospective premium reconciliation and MLR settlement calculations.
  - Assisted the State for MCO re-procurement for the duals programs.
  - Re-designed the rate structure and risk mitigation arrangements for the State's duals programs to promote the State's program goals for duals.
- **State of Washington, Health Care Authority (2021-Present)**
  - Lead and manage key components of Apple Health Integrated Managed Care (IMC) capitation rate setting, including non-claims base data development, provider incentive data review, base data

financial reconciliation, encounter data incurred but not reported (IBNR) calculation, and non-benefit load assumption development.
    - Lead and manage the initial design and development of Clinical Risk Groups dashboard for Apple Health program.
    - Lead and manage the actuarial component of the legislatively required behavioral health service comparison rate development.

- **State of Washington, Department of Social and Health Services (2022-2023)**
    - Led and managed the actuarial component of the legislatively required contracted community residential services rate study.

- **State of Texas, State Auditor's Office (2022)**
    - Led and managed the legislatively required concurrent in-depth rate review of state fiscal year (SFY) 2023 capitation rates for second opinion of the actuarial soundness for Texas' STAR Kids and STAR+PLUS programs.

- **State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services (2018-2021)**
    - Developed and certified actuarially sound capitation rates for the State's managed LTSS (MLTSS) program which covers approximately 60,000 members, including home and community-based services (HCBS) and nursing facility (NF).
    - Modified the rate development process related to patient liability inclusion with improved rate accuracy for rates gross of patient liability.
    - Collaborated with risk adjustment team to apply MLTSS specific risk adjustment model and membership enrollment mix adjustment model to the development of MCO-specific blended payment rates.
    - Performed HCBS and NF enrollment mix scenario testing to model the uncertainties of COVID impact on blended rates.
    - Partnered with clinical team to apply efficiency adjustment to the blended rate development by integrating clinical approach and actuarial approach.
    - Designed and visualized key performance indicators specific to the MLTSS program for the State to monitor plan-level performance variations and ongoing change.

- **State of Kansas, Department of Health and Environment (2014-2017)**
    - Developed and certified actuarially sound capitation rates for KanCare, the State's comprehensive Medicaid managed care program which covers approximately 450,000 acute care and long-term care (LTC) members.
    - Estimated the 10-year enrollment and budget impact of Medicaid expansion to the State, which was presented during the State legislation process.
    - Designed and implemented a budget-neutral risk adjustment process with a nationally recognized risk adjustment model, including a feasibility study, rate cell reconfiguration, and risk weight calibration.
    - Designed and implemented a service setting mix-based risk adjustment process for the blended LTSS capitation rates across HCBS and NF members.
    - Redesigned a risk corridor program for intellectual/developmental disability rates, which reduced the State's risk corridor settlement payments to the health plan by millions of dollars.

- **State of Tennessee, Division of TennCare (2013-2014)**
    - Developed and certified actuarially sound capitation rates for the State's integrated Medicaid managed care program, TennCare's, non-CHOICES (acute care) and CHOICES (LTSS) programs, which covers approximately 1.3 million non-CHOICES members, including Temporary Assistance for Needy Families (TANF) and related, uninsured and uninsurable, disabled, and dual-eligible populations, and 30,000 CHOICES members.

- **State of Georgia, Department of Community Health (2012-2014)**
    - Developed and certified actuarially sound capitation rates for the Georgia Families program, the State's Medicaid managed care program, which covers approximately one million members, including low-income families, CHIP, and foster care and adoption assistance.
    - Designed and implemented a new Georgia Families 360 program which covers foster care and adoption assistance children who were previously served under fee-for-service (FFS).
    - Developed and certified incurred but not reported estimates for the State's entire Medicaid and CHIP program, including both FFS and managed care members.

Stacy Albrecht, ASA, MAAA

Consulting Actuary, Milliman

ROLE: LEAD ACTUARY (MHP Lead)

- ✓ More than 10 years of experience with Medicaid managed care rate setting.
- ✓ Member of the American Academy of Actuaries (MAAA).
- ✓ Associate of the Society of Actuaries (ASA).

Ms. Albrecht is a consulting actuary with Milliman's Seattle Health Practice. She joined the firm in 2013 and has more than 10 years of experience providing actuarial support and consulting to state Medicaid agencies. Ms. Albrecht's experience includes capitation rate setting, incurred but not reported (IBNR) reserve estimates, fiscal projections, Medicare and Medicaid integration, and risk adjustment.

Education

B.S., Actuarial Science, Magna cum Laude, Central Washington University, 2013

Experience

More than a decade of Medicaid managed care experience, including Medicaid managed care rate setting:

- Hawai'i 2014-Present
- Utah 2018-Present
- West Virginia 2023-Present
- Idaho 2020-2021
- Washington 2014-2021

Relevant Work Experience

Milliman (2013-Present), Consulting Actuary

- **State of Hawai'i, Department of Health and Human Services**
  - Development of medical, long-term care, and behavioral health Medicaid capitation rates for Temporary Assistance for Needy Families (TANF), disabled, dually eligibles, State Children's Health Insurance Program (SCHIP), and expansion populations (2014-Present).
  - Development of Medicaid capitation rates for Community Care Services behavioral health population (2017-Present).
  - Development of reporting guide to evaluate plan performance and medical loss ratio (MLR) review (2014-Present).
  - Produced data book and scoring methodology for managed care organization (MCO) procurements (2014-Present).
  - Development of analyses for legislative sessions (2014-Present).
  - Fiscal impact analyses on ad hoc basis (2014-Present).
  - Client communication and data management (2014-Present).
  - Policy and program strategy, quantification, and implementation (2014-Present).
  - Prepare documents for the Centers for Medicare & Medicaid Services (CMS) review and respond to CMS questions (2014-Present).
- **State of Utah, Department of Health**
  - Development and certification of Medicaid capitation rates for SCHIP, behavioral health, developmental disability, and expansion programs (2018-Present).
  - Assistance with 1115 waiver design and evaluation (2018-Present).
  - Development of reporting guide to evaluate plan performance and MLR review (2018-Present).
  - Client communication and data management (2018-Present).
  - Policy and program strategy, quantification, and implementation (2018-Present).

- **State of West Virginia, Bureau for Medical Services**
  - Development of Medicaid capitation rates for Mountain Health Promise (MHP) (2023-Present).
- **State of Idaho, Department of Health and Welfare (DHW)**
  - Expansion budget development (2020-Present).
- **State of Washington, Health Care Authority**
  - Development of Medicaid capitation rates for TANF, disabled, SCHIP, and expansion populations (2014-Present).
  - Payment enhancement to physicians and safety net hospitals (2014-Present).
  - Client communication and data management (2014-Present).

Shelly S. Brandel, FSA, MAAA

Principal and Consulting Actuary, Milliman

ROLE: LEAD ACTUARY (High-Level Peer Review)

- ✓ 25+ years of experience with rate setting in managed Medicaid and Medicare health care programs.
- ✓ Member of the American Academy of Actuaries (MAAA).
- ✓ Fellow of the Society of Actuaries (FSA).

Ms. Brandel is a principal and consulting actuary with Milliman's Chicago-Milwaukee-Hartford Health practice. She originally joined the firm in 1995 and re-joined in 2008. Shelly's expertise is in managed Medicaid and Medicare health care programs, with over 25 years of consulting experience in these areas. She also has extensive experience with Medicare Advantage Part D and Prescription Drug Plans.

Education

B.S., Mathematics & Statistics, Miami University, 1995

Experience

More than 25 years professional experience, including:

Medicaid managed care development and certification:

- Wisconsin 2015-Present
- Florida 2010-2014
- Oklahoma 2008-2013

Other Experience:

- Review of Medicaid capitation rate development for Financial Alignment Initiative demonstration programs in five states on behalf of the Centers for Medicare and Medicaid Services (CMS) (2012-Present)
- Virginia Medicaid forecasting and rate setting review (2019)
- Maryland Medicaid managed care rate setting study (2018)
- Medicaid managed care rate review on behalf of health plan associations in New Jersey, Virginia, and Pennsylvania (2010-2018)
- Nebraska Program of All-Inclusive Care for the Elderly (PACE) Upper Payment Limits (UPLs) (2010-2012)

Relevant Work Experience

Milliman (1995-2004; 2008-Present), Principal and Consulting Actuary

- **Wisconsin Department of Health Services**
  - Managed care capitation rate development and certification, risk adjustment, and fee-for-service (FFS) modeling.
  - Managed care capitation development for Wisconsin's BadgerCare and Supplemental Security Income (SSI) Medicaid managed care programs that provide acute care services for children, parents, pregnant women, childless adults, disabled, and dual eligible populations. Implemented financial reporting template to collect health plan financial data and established process for encounter data validation to financial data. Programs are administered by Medicaid managed care organizations.
  - Development of CDPS+Rx risk adjustment with category weights customized to Wisconsin covered benefits and provider payment levels.
  - Modeling of provider reimbursement rates for care coordination services provided to individuals enrolled in hospital-based special needs program for medically complex children.
- **Florida Agency for Health Care Administration (AHCA)**
  - Managed care capitation rate development and certification.
  - Behavioral services provided by Prepaid Mental Health Plans.
  - Acute care services for dual eligibles enrolled in Medicare Advantage Dual Special Needs Plans.

- **Oklahoma Health Care Authority (OHCA)**
  - Managed care capitation rate development and certification.
  - Non-emergency transportation services provided by OHCA's contracted statewide vendor to children, parents, and disabled populations.
- **Nebraska Department of Health and Humana Services (DHHS)**
  - Managed care capitation rate development and certification.
  - PACE UPL rates.
- **University of Maryland, Baltimore County**
  - Managed care rate setting study.
  - Medicaid managed care rate setting and payment innovation study to recommend potential improvements to Maryland's Medicaid managed care rate setting system.
- **Commonwealth of Virginia, Department of Medical Assistance Services**
  - Managed care rate study.
  - Medicaid forecasting and rate setting review to recommend potential improvements to Virginia's forecasting process.
- **CMS Medicare-Medicaid Coordination Office**
  - Financial alignment initiative assistance.
  - Review of Medicaid portion of capitation rate development for five state "dual demonstration" programs.
  - Preparation of calculations for risk mitigation mechanism results. Provision of feedback and advice on financial-related terms in three-way contracts between CMS, states and managed care organizations (MCOs). Provision of strategic advice around program structure and evaluation approach.
- **New Jersey Association of Health Plans**
  - Medicaid consulting.
  - Review acute care capitation rates for children, parents, adults, disabled, and elderly populations.
  - Summarize and project aggregate financial results using health plan financial data.
- **Virginia Association of Health Plans**
  - Medicaid consulting.
  - Review acute care capitation rates for the Medallion and Family Access to Medical Insurance Security (FAMIS) populations.
  - Provide comments on actuarial recommendations from the Virginia General Assembly, Joint Legislative Audit and Review Commission (JLARC).
- **Pennsylvania Health Care Association**
  - Medicaid consulting.
  - Summarize and project aggregate financial results using health plan financial data. Review managed care efficiency adjustments included in capitation rates.

Jeremy Cunningham, FSA, MAAA

Principal and Consulting Actuary, Milliman

ROLE: LEAD ACTUARY (CCBHC/ Behavioral Health SME)

- ✓ 15 years of experience providing actuarial support to state Medicaid agencies, health plans, and provider organizations.
- ✓ Fellow of the Society of Actuaries (FSA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Mr. Cunningham is a principal and consulting actuary with Milliman's Indianapolis Health practice. He joined the firm in 2010 and has over 15 years of experience providing actuarial support to state Medicaid agencies, health plans, and provider organizations. Mr. Cunningham regularly provides consulting expertise to a variety of states to support services and supports for individuals with needs related to behavioral health and intellectual/developmental disabilities.

His experience includes rate development, risk adjustment, provider rate development, extensive data analytics, and monitoring behavioral health and home and community-based services (HCBS). Most recently, he led an analysis of Support Intensity Scale (SIS) assessment data to assess the relationship between SIS scores and HCBS service utilization. Mr. Cunningham has also led the development of multiple dynamic dashboards including the DRIVE™ suite of dashboards.

Education

B.S., Actuarial Science, Purdue University, 2011

Experience

15 years of professional experience

Relevant Work Experience

Milliman (2010-Present), Principal & Consulting Actuary

- **State of Alaska, Department of Health & Social Services**
  - Supported the development of 1115 demonstration budget neutrality projection and narrative for the state of Alaska's behavioral health transformation. Provides ongoing consulting related to monitoring of the behavioral health services in relation to goals of increased access and movement to community-based care (2017-Present).
  - Supported the development of capitation rates for medical services managed care program, including Temporary Assistance for Needy Families (TANF), Disabled, and Affordable Care Act (ACA) Adult populations, including risk adjustment calculations and analysis of policy changes (2018).
- **State of Illinois, Department of Healthcare & Family Services (HFS)**
  - Development of capitation rates for acute care and long-term supports and services (LTSS) for TANF, Disabled, and ACA Adult populations, including risk adjustment, encounter data validation, and analysis of policy changes (2016).
  - Supported improvement in encounter data and financial reporting by working with HFS' managed care encounters team, including the implementation of a comprehensive process to reconcile Encounter Utilization Monitoring (EUM) reports deployed using the DRIVE™ tool (2016-2017).
- **State of Washington, Health Care Authority (HCA)**
  - Currently supporting the design and implementation planning for a Certified Community Behavioral Health Clinic (CCBHC) initiative, enabling the state to define provider requirements and care model expectations, and ensuring the payment methodology aligns with the care model to advance the state's behavioral health quality goals. Developing Medicaid behavioral health care comparison payment rates, including mental health and substance use disorder (SUD) outpatient services and SUD residential services (2021-Present).
  - Led the development of a comprehensive legislative report exploring the design and implementation of a CCBHC care model and payment methodology to support state planning of a statewide CCBHC

initiative. Developed prospective payment system (PPS) and non-PPS payment options for consideration by HCA and stakeholders. Facilitated stakeholder discussions to obtain provider input on the program. Synthesized research findings, stakeholder feedback, and state preferences in a comprehensive report (2022).

- **State of Michigan, Department of Health & Human Services**
  - Development of behavioral health and HCBS provider rates, including services for populations with intellectual and developmental disabilities, serious mental illness and substance use disorder. Work has included leading a series of meetings with multiple workgroups and key stakeholders across the state, provider interviews, provider survey development, and development of a standard cost allocation methodology (2018-Present).
  - Development of capitation rates for populations with intellectual and developmental disabilities, serious mental illness, and SUD. This work has included evaluation of encounter and financial cost data, monitoring of eligibility changes, evaluation of risk adjustment variables (2011-Present).
  - Development of 1115 demonstration budget neutrality projection and narrative for the state of Michigan's transition of their managed behavioral health and HCBS program from a 1915(b)/(c) to an 1115 waiver, which included incorporating other waiver populations which were previously covered on a fee-for-service basis benefit (2016-Present).
- **State of Rhode Island, Executive Office of Health & Human Services**
  - Development of behavioral health and HCBS provider rates, including multiple discussions with state personnel and key provider stakeholders (2019-Present).
- **State of Ohio, Department of Medicaid**
  - Development of 1115 demonstration budget neutrality projection and narrative for the state of Ohio's substance use disorder residential services (2018-Present).
  - Currently assisting with the development of psychiatric residential treatment facility services rates. Researching other state payment models, cost report structures (including Title IV-E cost reports), and covered services (2021).

Stacey Hagensen, FSA, MAAA

Consulting Actuary, Milliman

ROLE: LEAD ACTUARY
(Risk Adjustment Lead)

- ✓ 4 years of experience with Medicaid managed risk adjustment settlement.
- ✓ Member of the American Academy of Actuaries (MAAA).
- ✓ Fellow of the Society of Actuaries (FSA).

Ms. Hagenson is a consulting actuary with Milliman's Seattle Health Practice. She joined the firm in 2013 and has more than 12 years of experience providing actuarial support and consulting to state Medicaid agencies, the Department of Veterans Affairs, and Medicare Advantage plans. Ms. Hagenson's experience includes risk adjustment settlement and program changes.

Education

B.S., Mathematics, Summa cum Laude, Pacific Lutheran University, 2012/B.A., Economics, Summa cum Laude, Pacific Lutheran University, 2012

Experience

More than a decade of professional experience

Relevant Work Experience

Milliman (2013-Present), Consulting Actuary

- **State of Washington, Health Care Authority (2015-2020)**
  - Program change and fee schedule analysis for Medicaid programs.
- **State of West Virginia, Bureau for Medical Services (2022-Present)**
  - Risk adjustment for Mountain Health Trust capitation rates.

Nick Gipe, ASA, MAAA

Consulting Actuary, Milliman

ROLE: STAFF ACTUARY

- ✓ 9 years of experience in Medicaid rate setting.
- ✓ Member of the American Academy of Actuaries (MAAA).
- ✓ Associate of the Society of Actuaries (ASA).

Mr. Gipe is a consulting actuary with Milliman's Seattle Health Practice. He joined the firm in 2015 and has almost a decade of experience providing actuarial support and consulting to state Medicaid agencies and health plans.

Mr. Gipe has provided actuarial consulting services to state Medicaid agencies, health plans, and provider organizations. His experience includes capitation rate setting, financial projections, benchmarking of experience, and trend development.

Education

B.S., Applied Mathematics and Statistics, John Hopkins University, 2015

Experience

Nearly a decade of professional actuarial experience including capitation rate setting, cost projection, and other support

Relevant Work Experience

Milliman (2015-Present), Consulting Actuary

- **State of Hawai'i, Department of Health and Human Services (2015-Present)**
  - Development of Medicaid capitation rates for Temporary Assistance for Needy Families (TANF), disabled, dual eligibles, State Children's Health Insurance Program (SCHIP), and expansion populations.
- **State of Hawai'i, Department of Health and Human Services (2015-Present)**
  - Development of Medicaid capitation rates for Community Care Services behavioral health population.
- **State of Washington, Health Care Authority (2018-2021; 2024-Present)**
  - Development of Medicaid capitation rates for TANF, disabled, SCHIP, and expansion populations.
- **Nevada Association of Counties (2020)**
  - Development of long-term cost projection for non-federal share of long term-care costs for Medicaid beneficiaries.

Nick Johnson, FSA, MAAA

Principal and Consulting Actuary, Milliman

ROLE: STAFF ACTUARY

- ✓ 15 years of experience with Medicaid and Medicare Advantage managed care rate setting.
- ✓ Fellow, Society of Actuaries (FSA).
- ✓ Member, American Academy of Actuaries (MAAA).

Mr. Johnson is a principal and consulting actuary specializing in health care in Milliman's Seattle Health Practice. He joined the firm in 2009. Mr. Johnson's primary expertise is helping clients understand the financial implications of trends and changes in the health care delivery system, particularly in Medicare and dual-eligible populations.

Mr. Johnson has worked with a broad range of clients, including health plans, integrated delivery systems, provider groups, state Medicaid agencies, and the Veterans Health Administration. He has significant experience in Medicare Advantage, Medicare Part D, Medicaid, commercial, and Affordable Care Act (ACA) markets.

Education

M.S., Applied Statistics, Portland State University, 2009/BA, Mathematics, Augustana College, 2006

Experience

15 years professional experience, including:

Medicare Advantage/Part D:

- Bid development and certification.
- Product development and feasibility analysis.
- Risk score monitoring, forecasting, and optimization.
- Risk-sharing contract support for health plans and providers.

Managed long-term services and supports (MLTSS):

- State Medicaid capitation rate setting.
- Medicaid MLTSS request for proposal (RFP) response.
- Nursing home to home and community-based services (HCBS) transition monitoring.
- Forecasting and analysis of programmatic changes.
- Medicare/Medicaid integrated financing modeling.

Relevant Work Experience

Milliman (2009-Present), Principal & Consulting Actuary

- **State of Washington, Department of Social and Health Services (2018-Present)**
  - Development of Medicaid capitation rates for Program of All-Inclusive Care for the Elderly (PACE) populations.
- **State of Ohio, Department of Medicaid (2024-Present)**
  - Medicare/Medicaid integrated financing actuarial modeling and policy guidance.
- **State of Idaho, Division of Medicaid (2021-Present)**
  - Review of Idaho Medicaid Plus and Medicare Medicaid Coordinated Plan capitation rates.
- **Nevada Association of Counties (2020)**
  - Development of long-term cost projection for non-federal share of long term-care costs for Medicaid beneficiaries.
- **Health Plan in Southwestern US (2011-Present)**
  - Medicare Advantage and Dual Eligible Special Needs Plans (D-SNPs) bid development.
  - Development of cost components of bid in response to Medicaid Managed Care RFPs.

- Miscellaneous ongoing support, including incurred but not paid (IBNP) estimates and medical loss ratio (MLR) reporting guidance.

- **California Health Plan (2021-Present)**
  - D-SNP feasibility assessment and financial modeling.
  - Medi-Cal rate review.
  - IBNP estimate.

Brian Schatzel, ASA, MAAA

Associate Actuary, Milliman

ROLE: STAFF ACTUARY

- ✓ 7+ years of experience developing Medicaid capitation rates and fiscal analyses.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Mr. Schatzel is an associate actuary with Milliman's Seattle Health practice. He joined the firm in 2018 and has more than seven years of experience in health care consulting. Mr. Schatzel has experience in rate development across the health care spectrum, including Medicare Advantage, Medicare Supplement Insurance (Medigap), Commercial Dental, and Medicaid. Mr. Schatzel has supported state Medicaid agencies in capitation and delivery case rates development, fiscal analysis and budgeting, and state directed payment analysis.

Education

B.A., Business Administration, Magna cum Laude University of Washington, Michael G. Foster School of Business, 2018

Experience

7+ years professional experience

Relevant Work Experience

Milliman (2018-Present), Associate Actuary

- **State of Washington, Health Care Authority (2018-Present)**
  - Development of Medicaid capitation and delivery case rates for Temporary Assistance for Needy Families, State Children's Health Insurance Program, disabled, and expansion populations.
  - Sub-capitation arrangement analysis.
  - Fiscal budget projections and analysis.
  - State directed payment projections and managed care organization compliance analysis.
  - Value-based purchasing and provider incentives analysis.
  - Risk adjustment and risk corridor settlement development.
- **State of West Virginia, Health and Human Services (2022-Present)**
  - Development of Medicaid capitation rates for foster care population.
  - Provider payment rate analysis.

Celena Jo Robinson, ASA, MAAA

Associate Actuary, Milliman

ROLE: STAFF ACTUARY

- ✓ 7 years of experience with Medicaid actuarial work in health plans, insurance, and consulting.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Ms. Robinson is an experienced actuary with seven years of experience in Medicaid actuarial services across health plans, insurance, and consulting. Prior to joining Milliman's Seattle Health Practice in 2024, Ms. Robinson worked at Guidehouse, a global consulting firm, where she led the development of Medicaid capitation rates and provided strategic advisory services. At Centene, a multinational health care company, she developed actuarial analysis and co-certified specialty care rates.

Education

B.S., Mathematics and Economics, University of California, San Diego, 2015

Experience

7 years professional actuarial experience, including:

Medicaid rate setting and analysis:

- Oklahoma 2021
- West Virginia 2022

Other rate setting (e.g., provider payment rates):

- Wyoming tri-agency project (Department of Education [WDE], Department of Health [WDH], Department of Family Services [DFS]) 2017-2018

Relevant Work Experience

Milliman (November 2024-Present), Associate Actuary

Guidehouse (May 2021-October 2024), Managerial Consultant

Centene (Jan 2017-May 2021), Senior Actuarial Analyst

- **State of Oklahoma, Medicaid Program**
  - Lead developer and project manager for Medicaid capitation rate setting with a projected $3B annual premium (2021-Present).
  - Co-certifying actuary for Children's Specialty Medicaid capitation rates.
  - Led the development of Non-Emergency Medical Transportation capitation rate setting.
- **State of West Virginia, Medicaid Program**
  - Lead analyst in developing capitation rates for state fiscal year 2022 Medicaid program.
- **State of Wyoming, Tri-agency Project (WDE, WDH, DFS)**
  - Project manager and liaison for developing per diems for youth care facilities, including Medicaid-related rate development (2017-2018).

Cory Barnes, ASA, MAAA

Associate Actuary, Milliman

ROLE: STAFF ACTUARY

- ✓ 10 years of experience with Medicaid managed care rate setting.
- ✓ Member of the American Academy of Actuaries (MAAA).
- ✓ Associate of the Society of Actuaries (ASA).

Mr. Barnes is an associate actuary with Milliman's Seattle Health practice. He joined the firm in 2014 and has more than a decade of experience providing actuarial support to state Medicaid agencies and the Department of Veterans Affairs. Mr. Barnes's experience includes rate development and certification, program changes, and trend analysis.

Education

B.A., Mathematics and Physics, Carleton College, 2011/M.S., Mathematics, University of Washington, 2013

Experience

More than a decade of professional experience, including:

Medicaid managed care rate setting:

- Hawai'i 2018-Present
- Utah 2015-2020
- Washington 2018-Present
- West Virginia 2022-Present

Other Experience:

- Department of Veterans Affairs 2014-Present
- Stop Loss Model (QWIZ) Development 2014-Present
- Commercial Managed Care Organization (MCO) Arrangements 2014-Present

Relevant Work Experience

Milliman (2014-Present), Associate Actuary

- **State of Hawai'i: Medicaid Managed Care (2018-Present)**
  - Data processing and incurred but not reported (IBNR) analysis.
- **State of Utah: Medicaid Managed Care (2015-2020)**
  - Trend Analysis, rate development, and certification.
- **State of Washington: Medicaid Managed Care (2018-Present)**
  - Sub-capitation arrangements, program changes.
- **State of West Virginia: Medicaid Managed Care (2022-Present)**
  - Mountain Health Promise capitation rate development and ad hoc analyses.

Daniel Gerber, ASA, MAAA

Associate Actuary, Milliman

ROLE: STAFF ACTUARY

- ✓ 8 years of Medicaid managed care rate setting.
- ✓ Member of the American Academy of Actuaries (MAAA).
- ✓ Associate of the Society of Actuaries (ASA).

Mr. Gerber is an associate actuary with Milliman's Seattle Health Practice. He joined the firm in 2017 and has eight years of experience in Medicare Advantage and Medicaid, specifically in behavioral health and long-term care rate setting. Mr. Gerber has been the lead analyst on several annual rate setting projects, managed multiple teams, developed timelines, and communicated results to various stakeholders. He has developed and presented Medicaid-related training to internal and external audiences.

Education

B.A., Mathematics and Neuroscience, Carthage College, 2011

Experience

8 years of professional actuarial experience, including:

Medicaid managed care rate setting:

- Nevada 2017-2019
- Washington Program of All-Inclusive Care for the Elderly (PACE) 2018-Present
- Washington Apple Health 2019-Present
- West Virginia Mountain Health Trust 2022-Present

Relevant Work Experience

Milliman (2017-Present), Associate Actuary

- **State of Nevada: Medicaid Managed Care**
  - Trend analysis, rate development, risk adjustment, data management.
- **State of Washington: PACE (Medicaid LTC) Managed Care**
  - Project management, trend analysis, incurred but not paid (IBNP), program changes, rate development and presentation.
- **State of Washington: Apple Health (Medicaid) Managed Care**
  - Unwind impacts, program changes, waiver support, rate development and presentation.
  - Data acquisition and management, trend analysis, public health emergency (PHE) unwind impacts and membership projections, certification and presentation.
- **State of West Virginia: Mountain Health Trust (Medicaid) Managed Care**
  - Trend analysis, PHE unwind impacts, program changes, custom risk adjustment, waiver support, rate development and presentation.

Elias Kehr, ASA, MAAA

Associate Actuary, Milliman

ROLE: STAFF ACTUARY

- ✓ 7 years of experience with Medicaid Managed Care rate setting.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Mr. Kehr is an Associate Actuary with Milliman's Seattle Health practice. He joined the firm in 2018. Mr. Kehr has seven years of actuarial consulting experience, including multiple years of expertise in Medicaid managed care rate setting and Medicare Advantage bids.

Education

B.S., Mathematics, summa cum laude, Eastern Mennonite University, 2013

Experience

7 years of actuarial experience, including:

Medicaid managed care rate setting:

- Hawai'i 2018-Present
- Nevada 2018-2019
- Utah 2018-Present
- West Virginia 2022-Present

Other Experience:

- Medicare Advantage bid development 2018-Present
- Public Employees Benefits Board of Washington 2019-Present
- Department of Veterans Affairs 2018-2023

Relevant Work Experience

Milliman (2018-Present), Actuarial Analyst and Associate Actuary

- **State of Utah: CHIP and Mental Health Managed Care**
  - Trend analysis, rate development, incurred but not paid, risk adjustment, data management, project management.
- **State of Hawai'i**
  - Data management, risk adjustment, financial reconciliation, other analyses.
- **State of West Virginia**
  - Risk adjustment, acuity analyses, and other rate development activities.
- **Public Employees Benefits Board**
  - Data processing and management, rate development, other analyses.

Joshua Welsh, ASA, MAAA, MS

Associate Actuary, Milliman

ROLE: STAFF ACTUARY

- ✓ 5 years of Medicaid managed care rate setting.
- ✓ Member of the American Academy of Actuaries (MAAA).
- ✓ Associate of the Society of Actuaries (ASA).

Mr. Welsh is an Associate Actuary with Milliman's Seattle Health Practice. Since joining Milliman in 2019, he has worked with state Medicaid agencies, performing capitation rate setting, experience studies, and modeled rate adjustments among other projects. Additional experience includes incurred but not paid (IBNP) development, risk score projections and Medicare Advantage bids.

Education

M.S., Mathematics, Western Washington University, 2019/B.S., Mathematics, Western Washington University, 2017

Experience

5+ years professional experience, including:

Medicaid Managed care rate setting:

- Hawai'i Quest Integration 2019-2022
- Washington Apple Health 2020-Present
- West Virginia Mountain Health Trust 2024-Present

Other Experience:

- Budget Forecast Development for Idaho Department of Health and Welfare 2024-Present
- Medicare Advantage Bid Development 2019-2021
- Commercial Individual and Small-Group rate filings and pricing 2020-2022
- Department of Veterans Affairs 2019-2021

Relevant Work Experience

Milliman (2019-Present), Associate Actuary

- **State of Hawai'i: Quest Integration (Medicaid) Managed Care**
  - Data processing and validation, sub-capitation encounter proxy pricing, trend analysis and rate development.
- **State of Washington**
  - Rx Trend analysis, program changes, data review.
- **State of West Virginia: Mountain Health Trust (Medicaid) Managed Care**
  - Custom risk weight methodology for risk adjustment.
  - Implementing a withhold within the capitation rates.
  - Modeling acuity adjustments.
- **State of Idaho: Department of Health and Welfare (Medicaid)**
  - Budget forecasting for Medicaid program which included among other items like, trend analysis, data reconciliation, membership projections.

Logan Blank, ASA, MAAA

Associate Actuary, Milliman

ROLE: STAFF ACTUARY

- ✓ 5+ years of experience in Medicare Advantage rate setting.
- ✓ Member of the American Academy of Actuaries (MAAA).
- ✓ Associate of the Society of Actuaries (ASA).

Mr. Blank is an associate actuary who joined Milliman's Seattle Health Practice in 2024. He has experience in Medicare advantage rate development with a focus in dual eligible special needs plans. He also has experience in commercial rate development, valuation, and predictive analytics.

Education

B.S., Mathematics and Statistics, University of Florida/Minor, Actuarial Science, University of Florida, 2015

Experience

Nearly a decade of professional experience with over 5 years in rate setting

Relevant Work Experience

Milliman (2024-Present), Associate Actuary

- **State of West Virginia, Health and Human Services (2024-Present)**
  - Development of acuity factors for the state fiscal year (SFY) 2025 rates' mid-year update and SFY 2026 rates.
- **California Dual Eligible Special Needs Plan (D-SNP) Feasibility and Bidding**
  - Part of a team assisting regional health plans prepare for CalAim's new integrated care requirements which includes the launching of integrated D-SNP plans.
  - Assisting clients set strategy and prepare bids for Medicare Advantage bidding for their new D-SNPs.
- **State D-SNP Integration Support**
  - Part of a team supporting states to make policy decisions around further integration of their D-SNPs.

Belong Health (2022-2024), Actuarial Associate

- Worked on a small analytics team at a startup whose model was to partner with local health plans who were entering the D-SNP market.
- Work spanned multiple functional areas, serving as the main Medicare Advantage and D-SNP subject matter expert (SME), including collaborating with partners on rate development.

Aetna (2016-2022), Actuarial Assistant

- **Commercial Predictive Analytics and Valuation**
  - Worked in collaboration with data science to develop predictive analytics models for use in commercial underwriting and rate development.
- **Medicare Advantage Rate Development**
  - Developed Part C bids as part of the Arizona/Nevada regional team and was the owner of the primary Part C pricing model.
- **Valuation**
  - Managed the valuation process for various products and regions.

Capital Health Plan (2015-2016), Actuarial Analyst

- Supported small group and large group rate development.

Menko Ypma, ASA, MAAA

Associate Actuary, Milliman

ROLE: STAFF ACTUARY

- ✓ 6 years of experience with Medicaid managed care rate setting.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Mr. Ypma is an actuary with Milliman's Seattle Health Practice. Since joining Milliman in 2019, his experience includes assisting state Medicaid agencies, Medicare Advantage carriers, and commercial clients in a range of projects. He has supported state Medicaid agencies in Washington, Idaho, and West Virginia in the development of Medicaid managed care capitation rates.

Education

B.S., Bioengineering, University of Washington, 2015

Experience

6 years professional experience, including:

Medicaid managed care rate setting:

- Washington Apple Health 2019-Present
- Washington Program of All-Inclusive Care for the Elderly (PACE) 2022-Present
- Idaho Medicare Medicaid Coordinated Plan and Idaho Medicaid Plus 2019-Present
- West Virginia Mountain Health Trust 2023-Present

Other Experience:

- Medicare Advantage bid development 2019-Present
- Idaho Health Connections Value Care Program support 2019-Present
- Washington Cascade Select Public Option support 2023-Present

Relevant Work Experience

Milliman (2019-Present), Associate Actuary

- **State of Washington: Apple Health (Medicaid) Managed Care**
  - Data processing and validation, non-system payment analysis, trend analysis, acuity analysis, program changes, waiver support, rate development and certification, budget forecast support.
- **State of Washington: PACE (Medicaid Long-Term Care) Managed Care**
  - Data processing and validation, trend analysis, program changes, rate development and certification.
- **State of Idaho: Idaho Medicare Medicaid Coordinated Plan and Idaho Medicaid Plus (Medicaid Duals)**
  - Data processing and validation, trend analysis, program changes, acuity and membership projections, retrospective settlements, rate development and certification.
- **State of West Virginia: Mountain Health Trust (Medicaid) Managed Care**
  - Data intake and validation, incurred but not paid, non-benefit expense analysis.

Victoria Boon, ASA, MAAA

Associate Actuary, Milliman

ROLE: STAFF ACTUARY

- ✓ Nearly a decade of experience with Medicaid state agencies and health plans.
- ✓ Member of the American Academy of Actuaries (MAAA).
- ✓ Associate of the Society of Actuaries (ASA).

Ms. Boon is an associate actuary with Milliman's Seattle Health practice. She joined the firm in 2016 and has nine years of experience. Ms. Boon has provided actuarial consulting services to state Medicaid agencies, the Department of Veterans Affairs, and health plans. Ms. Boon's experience includes capitation rate setting, fiscal analysis, and provider payment design.

Education

B.S., Actuarial Science, Summa cum Laude, Washington State University, 2015

Experience

Nearly a decade of Medicaid managed care experience, including:

- Washington Medicaid 2016-2022
- Hawai'i Medicaid 2016-Present
- Utah Medicaid 2018-Present
- Puerto Rico Medicaid May 2019-2022

Relevant Work Experience

Milliman (2016-Present), Associate Actuary

- **State of Hawai'i, Department of Health and Human Services**
  - Development of medical Medicaid capitation rates.
  - Risk mitigation settlements.
  - Assisting with payment rate calculations and simulation modeling of the fiscal impact of converting its Medicaid inpatient payment system from per diem rates to an All Patient Refined Diagnosis Related Groups (APR-DRG) based methodology, including subsequent updates to grouper versions and rate factors.
  - Hospital APR-DRG payment system rebasing.
- **State of Utah, Department of Health**
  - Development of dental and medical Medicaid capitation rates for State Children's Health Insurance Program (SCHIP) populations.
- **State of Washington, Health Care Authority**
  - Development of medical Medicaid capitation rates for Temporary Assistance for Needy Families, disabled, SCHIP, and expansion populations.
  - Hospital APR-DRG payment system rebasing.

Vincent Dang, ASA, MAAA

Associate Actuary, Milliman

ROLE: STAFF ACTUARY

- ✓ 7 years of experience in Medicaid capitation rate setting.
- ✓ Member of the American Academy of Actuaries (MAAA).
- ✓ Associate of the Society of Actuaries (ASA).

Mr. Dang is an associate actuary with Milliman's Seattle Health Practice. He joined the firm in 2016 and has more than eight years of experience providing actuarial support and consulting to state Medicaid agencies.

Education

B.A., Statistics and BA, Economics, University of California, Berkeley, 2016

Experience

Nearly a decade of professional actuarial experience

Relevant Work Experience

Milliman (2016-Present), Associate Actuary

- **State of Hawai'i, Department of Health and Human Services (2016-Present)**
  - Development of Medicaid capitation rates for Temporary Assistance for Needy Families (TANF), disabled, dually eligibles, State Children's Health Insurance Program (SCHIP), and expansion population.
  - Risk mitigation and settlements.
- **State of Utah, Department of Health and Human Services (2023-Present)**
  - Development of Medicaid behavioral health capitation rates for Medicaid populations.
- **State of Washington, Health Care Authority (2018-2021)**
  - Development of model to estimate community bed capacity requirements for civil commitments transitioning from state psychiatric hospitals.
  - Evaluation of inpatient and outpatient reimbursement levels relative to fee-for-service (FFS) through the application of diagnosis related group (DRG) and enhanced ambulatory patient grouping (EAPG) payment methodologies.
  - Development of model to analyze historical trends in physical health benefit costs and to estimate prospective trends for Medicaid capitation rates.
- **State of West Virginia, Bureau for Medical Services (2022-Present)**
  - Development of Medicaid capitation rates for TANF, disabled, foster care, and expansion populations.
- **State of Idaho, Department of Health and Welfare (2023-Present)**
  - Development of Medicaid budget forecast.
  - Calculation of total cost of care program results.

Appendix B: Actuarial Credentials

The Actuarial Directory

Anne Pankow Hallum

FSA MAAA

Email annie.hallum@milliman.com

Designations

MAAA 2012
FSA 2013

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

Academic degrees

B.A.
B.S.

Industry

Consulting

Primary area of practice

Health

Society of Actuaries Sections

Health

The Actuarial Directory

Justin Crayton Birrell

FSA MAAA

Designations

MAAA 2007
FSA 2010

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

The Actuarial Directory

Jianbin Xu

FSA MAAA

Email mac.xu@yahoo.com
Email mac.xu@milliman.com

Designations

MAAA 2010
FSA 2012

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

Academic degrees

M.S.

Industry

Consulting

Primary area of practice

Health

Specializations

Health Insurance – Public Systems
Risk Management

The Actuarial Directory

Stacy Hannah Albrecht

FSA MAAA

Milliman Inc

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Seattle
Washington 98101-2603
United States

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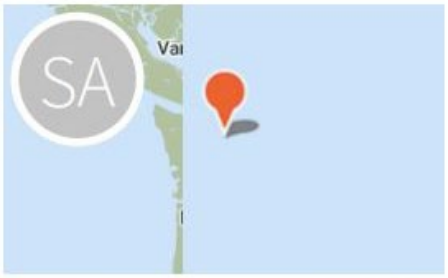

Designations

MAAA 2017
FSA 2022

SOA CPD attestation status

Compliant(2023-2024)
Compliant(2022-2023)

The Actuarial Directory

Shelly S Brandel

FSA MAAA
Principal and Consulting Actuary

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Brookfield
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Tel +1(262)796-3482

Designations

MAAA 1999
FSA 2001

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

Academic degrees

B.S.

Industry

Consulting

The Actuarial Directory

Jeremy Adam Cunningham

FSA MAAA

Tel +1(812)887-0254

Designations

MAAA 2013
FSA 2014

SOA CPD attestation status

Non-compliant(2023-2024)
Compliant(2022-2023)

Academic degrees

B.S.

Industry

Consulting

Primary area of practice

Health

Society of Actuaries Sections

Health

The Actuarial Directory

Stacey Hagensen

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Milliman Inc

1301 5th Ave
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Washington 98101-2603
United States

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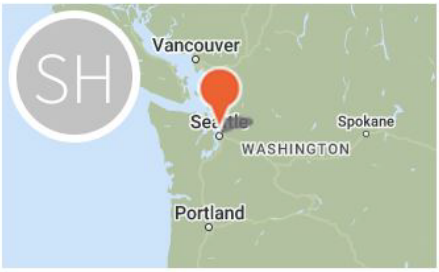

Designations

MAAA 2018
FSA 2022

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

Society of Actuaries Sections

Health

The Actuarial Directory

Nicholas Joseph Johnson

FSA MAAA
Principal & Consulting Actuary

Milliman Inc

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Seattle
Washington 98101-2605
United States

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Fax +1(206) 3401380
Tel +1(206)504-5941

Designations

MAAA 2012
FSA 2014

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

Academic degrees

B.A.
M.S.

Industry

Consulting

The Actuarial Directory

Nicholas B Gipe

ASA MAAA

Milliman Inc

1301 5th Ave
Seattle
Washington 98101-2603
United States

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Designations

MAAA 2018
ASA 2018

SOA CPD attestation status

Compliant(2023-2024)
Compliant(2022-2023)

Academic degrees

B.S.

Industry

Consulting

Primary area of practice

Health

The Actuarial Directory

Brian Schatzel

ASA MAAA

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Tel +1(360)562-7988

Designations

MAAA 2022
ASA 2022

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

Industry

Consulting

Primary area of practice

Health

The Actuarial Directory

Celena Jo Robinson

ASA MAAA

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Tel +1(760)509-5505

Designations

ASA 2021
MAAA 2022

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

Society of Actuaries Sections

Health

The Actuarial Directory

Cory Pate Barnes

ASA MAAA
Associate Actuary

Milliman Inc

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United States

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Designations

ASA 2016
MAAA 2018

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

Academic degrees

B.A.
M.Sc.

The Actuarial Directory

Daniel Gerber

ASA MAAA

Designations

ASA 2020
MAAA 2020

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

The Actuarial Directory

Elias Kehr

ASA MAAA

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Tel +1(206)624-7940 EXT 8175

Designations

MAAA 2022
ASA 2022

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

Academic degrees

B.S.

Society of Actuaries Sections

Education & Research
Health

The Actuarial Directory

Joshua M Welsh

ASA MAAA

Designations

ASA 2023
MAAA 2023

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

The Actuarial Directory

Logan Blank

ASA MAAA

Designations

ASA 2020
MAAA 2020

SOA CPD attestation status

Compliant(2023-2024)
Compliant(2022-2023)

Primary area of practice

Health

The Actuarial Directory

Menko Ypma

ASA MAAA

Designations

ASA 2023
MAAA 2023

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

The Actuarial Directory

Victoria Mei Kay Boon

ASA MAAA

Designations

MAAA 2019
ASA 2019

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

The Actuarial Directory

Vincent Tieu Dang

ASA MAAA

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Designations

ASA 2018
MAAA 2019

SOA CPD attestation status

Compliant(2023-2024)
Compliant(2022-2023)

Appendix C: Conflicts of Interest Mitigation Plan

Myers and Stauffer Conflicts of Interest Mitigation Plan

Myers and Stauffer takes a comprehensive approach to ensure and verify there are no actual or potential conflicts of interest. This approach includes four components:

1) Restricting the firm's client base to state, federal, and local government clients;
2) Avoiding making management decisions or performing management functions;
3) Vetting projects internally against our client base for conflicts;
4) Ensuring we obtain and maintain employee representations of independence, integrity, and objectivity; and
5) Conducting due diligence regarding our subcontractors' potential conflicts of interest.

First, Myers and Stauffer's business philosophy intentionally restricts the firm's client base to government health care and social service agencies. We do not accept health care providers or health plans as clients. Therefore, Myers and Stauffer's client base is limited to state Medicaid and Children's Health Insurance Program agencies, the Centers for Medicare & Medicaid Services, the United States Department of Justice, and other governmental agencies. This intentional restriction minimizes the potential of developing a real or perceived conflict of interest.

Second, Myers and Stauffer intentionally avoids engagements that could require making management decisions. As a certified public accounting firm, we are required by the American Institute of Certified Public Accountants Professional Standards to maintain independence both in fact and in appearance. To maintain such independence, Myers and Stauffer may not make management decisions for our clients. Myers and Stauffer provides our clients with consulting and analyses services, and certain audit or attest functions to support the management of their programs. Therefore, we do not accept engagements that could impede our ability to support our clients with their analytical needs, or which could limit our ability to perform engagements that opine on the effectiveness of the operational aspects of government programs.

Third, Myers and Stauffer uses a systematic client vetting process that includes confirmation that new clients are eligible to be a Myers and Stauffer client, and that the firm does not have other contracts that could interfere with or otherwise contradict the services that will be provided. Prior to initiating a new engagement, the project director assigned to the engagement is responsible for vetting the engagement for any potential conflict of interest. Information such as state, provider categories, provider names, a description of the work to be completed, or other relevant information is reviewed by management for evaluation of any potential conflict of interest. In the event that a potential conflict is identified, a mitigation strategy is developed and reviewed with the client.

Fourth, Myers and Stauffer requires all personnel to sign and submit an annual "Independence, Integrity, and Objectivity Representation" form, a copy of which can be found on the following page. Through this process, personnel identify any circumstances or relationships that may create a potential threat to independence, conflict of interest, or violation of the firm's ethical requirements policy. In adherence to the firm's quality control policies and procedures, the Quality Control Committee presents

any issues identified from this process to firm management so appropriate action can be promptly taken.

Lastly, Myers and Stauffer thoroughly reviews all our subcontractors. We start with our due diligence process, operating under a mutual confidentiality agreement, to discuss the current work, relationships, and potential conflicts of the potential subcontractor. As we move to contracting, we incorporate a Third-Party Code of Conduct in our subcontractor agreement defining an actual or potential conflict of interest. The Contractor, its personnel, and the personnel's family members are all subject to the provision of the Code of Conduct. Contractually, the subcontractor is required to immediately disclose any potential or actual conflict of interest to the Myers and Stauffer Chief Compliance Officer. Conflicts of interest or failure to comply with notification requirements may result in termination of the subcontractor agreement.

Subcontractor Conflicts of Interest Mitigation Plan

Milliman Organizational Conflict Mitigation Plan

State agencies and Milliman have successfully mitigated all potential conflicts of interest over our 30-year relationship serving as actuary for state agencies. We will continue to successfully mitigate any potential conflicts in the future. Additionally, the Milliman consulting team proposed for this work has not and will not consult with any current or potential capitated plan on any work related to the West Virginia Medicaid program.

Milliman has a strong reputation for integrity and quality in all its work products, and these have been core values of Milliman since our formation in 1947. Because of the depth of our expertise and the scope of our clientele, Milliman has long-established procedures that prevent inappropriate sharing of information in such situations.

Milliman follows strict procedures to avoid conflicts of interest in our work and has successfully used these procedures in numerous situations. Specifically, we have successfully implemented our conflict avoidance process in numerous states where different Milliman consultants work either for the state Medicaid agency or for Medicaid health plans within a state.

Our conflict mitigation plan is built around the following procedural steps and safeguards. This process takes place before a consultant can proceed with a new project and continues during the project if there is any change in the situation.

1. At the beginning of any client relationship, the lead Milliman consultant for the new client is required to notify all other consultants of the nature of the relationship through our conflict check notification system. This process ensures that other Milliman consultants with potential conflicts of interest are aware of the new relationship and can act accordingly. Milliman consultants are also required to use the conflict check notification system for any client project with existing clients that has the potential for conflicts with other clients.
2. After a potential conflict of interest has been identified, the next step is to notify all affected parties. All parties must agree to the conflict avoidance arrangements before any new project or

any work with a new client can begin. Milliman maintains a need-to-know policy, meaning that no judgment or material factual information will be shared between Milliman consultants representing competing parties, unless Milliman is jointly retained by those parties, or such disclosure is approved by all the affected clients. This policy restricts concurrent similar assignments from competing clients without sufficient physical separation of the consulting services for the competing clients.

3. We create internal structures so all information is kept strictly confidential to the specifically assigned client team. Milliman regularly builds walls between teams of consultants for projects with similar circumstances. We utilize separate teams of consultants and support staff, secure file storage, and a communication blackout between teams of consultants. In addition, any Milliman actuarial consultants leading each project are Members of the American Academy of Actuaries and are thereby bound to confidentiality by the Actuarial Code of Conduct.

Milliman's Organizational Conflict Mitigation Plan is administered by the Corporate Secretary and the relevant Global Practice Director. Mary Clare is Milliman's Chief Legal Officer and Corporate Secretary. Tom Snook is Milliman's Global Health Practice Director. Mr. Snook sits on Milliman's Board of Directors and provides leadership for all Milliman health consulting and product practices around the world.

In addition to our client and project-specific conflict mitigation procedures and safeguards, Milliman also has strict policies that guard against personal conflicts of interest and the release of confidential information:

- Milliman maintains an employee policy that restricts any ownership or financial interest in outside organizations that pose a conflict of interest. The policy restricts ownership of any insurance companies and prohibits financial interest by an employee in any entity that the employee consults for in his/her practice.
- Each employee who has access to client information is required to sign an agreement with Milliman regarding the protection of sensitive client information. Milliman maintains internal procedures designed to protect the confidentiality of sensitive client information, including administrative, technical, and physical safeguards as appropriate for the information. In addition, employees are instructed regarding any specific handling procedures required by contract with respect to client information.
- Milliman's Governing Principle on Fee Arrangements stipulates that neither the firm nor any employee may accept or share in contingent fees or any other form of compensation that may cause, or give the appearance of causing, a compromise of professional objectivity or independence.

Appendix D: Example Certifications

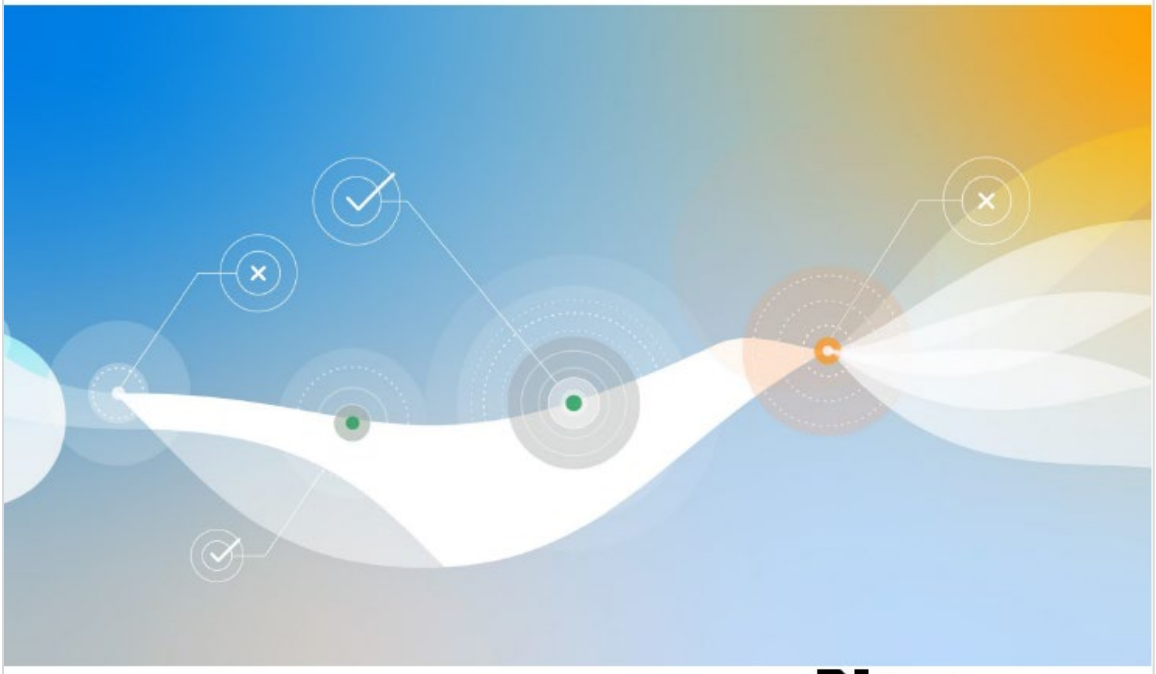
Example #1: Washington

MILLIMAN REPORT

Apple Health Integrated Managed Care: CY 2025 Capitation Rate Development

September 30, 2024

Davis G Burge, FSA, MAAA
Jennifer L Gerstorff, FSA, MAAA
Annie P Hallum, FSA, MAAA
Sean P Hanratty, FSA, MAAA
Daniel T Gerber, ASA, MAAA
Joseph E Whitley, MPP
Jeremiah A Mason, FSA, MAAA
Mac Xu, FSA, MAAA



Milliman

MILLIMAN REPORT

Actuarial Certification

I, Davis G. Burge, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by the State of Washington Health Care Authority (HCA) and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for the state's managed care program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the twelve-month period of calendar year (CY) 2025.

To the best of my information, knowledge, and belief, for the CY 2025 period, the capitation rates offered by HCA are actuarially sound and comply with the requirements of 42 C.F.R. §438.4 and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

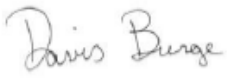
- have been developed in accordance with standards specified in 42 C.F.R. § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on MCOs, PIHPs, and PAHPs in 42 C.F.R. § 438.206, 42 C.F.R. § 438.207, and 42 C.F.R. § 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under 42 C.F.R. § 438.8, of at least 85 percent for the rate year.

I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

This certification is intended for the State of Washington and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

The capitation rates developed herein may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with HCA. The health plan may require rates above, equal to, or below the actuarially sound capitation rates that are associated with this certification.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.



September 30, 2024

Davis G Burge, FSA, MAAA
Principal & Consulting Actuary

Date

Example #2: Hawai'i

MILLIMAN REPORT

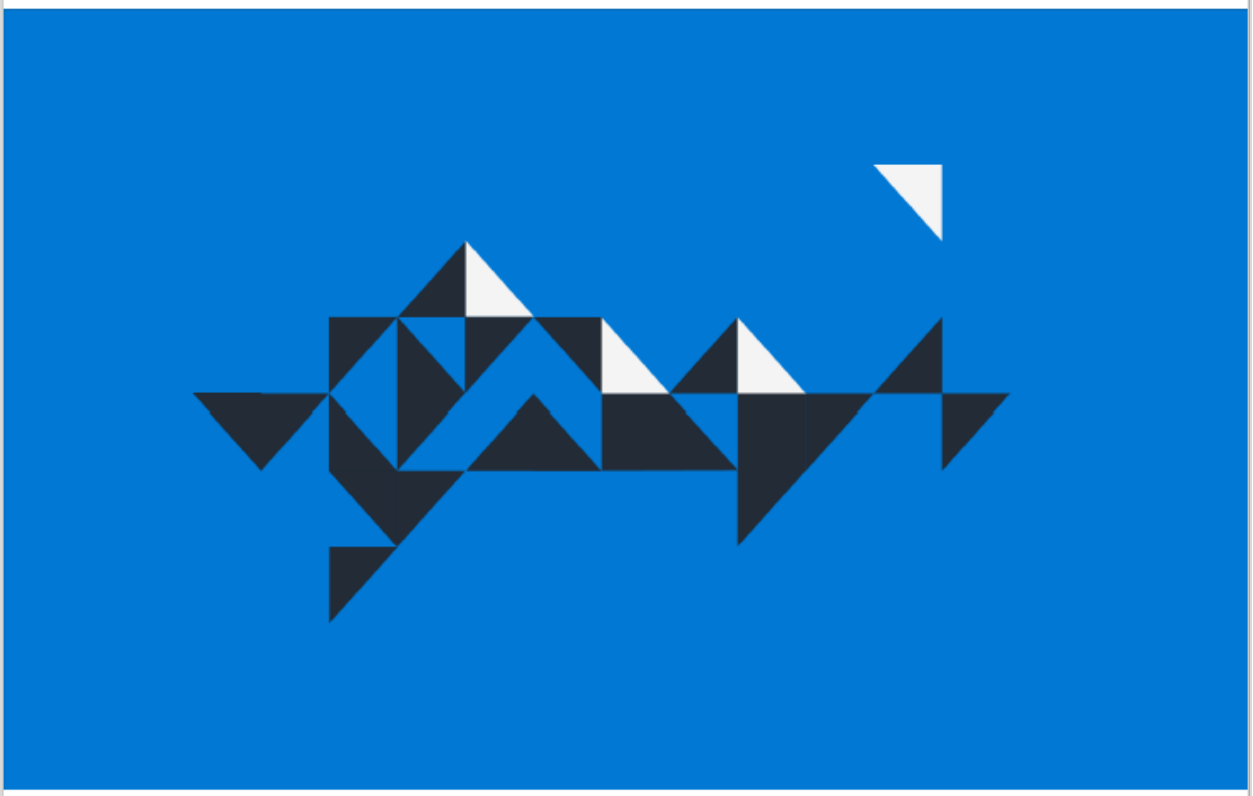
QUEST Integration Program: CY 2025 Capitation Rate Development

State of Hawai'i, Department of Human Services – Med-QUEST Division

October 1, 2024

Rachel Kullman, FSA, MAAA
Stacy Albrecht, FSA, MAAA
Justin Birrell, FSA, MAAA

Nick Gipe, ASA, MAAA
Vince Dang, ASA, MAAA
Victoria Boon, ASA, MAAA
Lauren Brening, ASA, MAAA



XII. Actuarial Certification

I, Rachel E. Kullman, am a Principal & Consulting actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by The Hawai'i Department of Human Services – Med-QUEST Division and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for the state's managed care program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the 12-month period of calendar year (CY) 2025.

To the best of my information, knowledge and belief, for the CY 2025 period, the capitation rates offered by Med-QUEST are actuarially sound and comply with the requirements of 42 C.F.R. § 438.4 and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

- have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on MCOs, PIHPs, and PAHPs in § 438.206, 438.207, and 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year.

I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

This certification is intended for Med-QUEST and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted MCO's situation and experience. Models used in the preparation of our analysis were applied consistent with their intended use.

The capitation rates developed herein may not be appropriate for any specific MCO. An individual MCO will need to review the rates in relation to the benefits that it will be obligated to provide. The MCO should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with Med-QUEST. The MCO may require rates above, equal to, or below the actuarially sound capitation rates that are associated with this certification.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Rachel Kullman

October 1, 2024

Rachel Kullman, FSA, MAAA
Principal & Consulting Actuary

Date