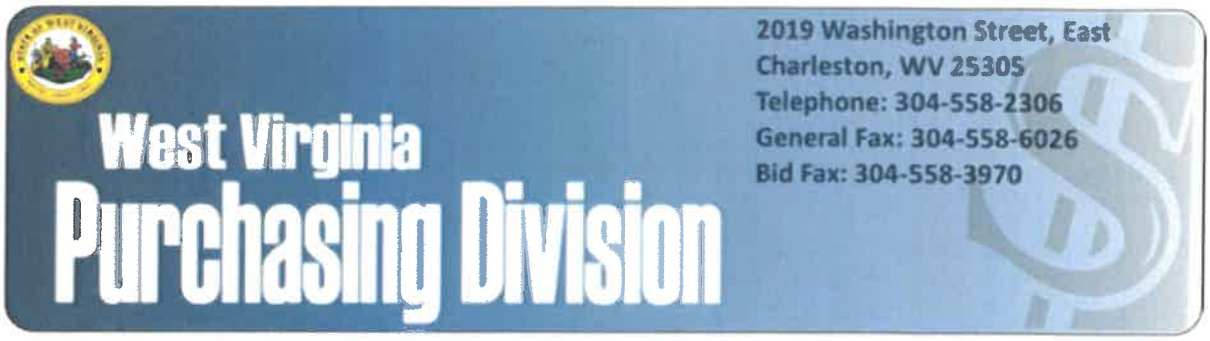
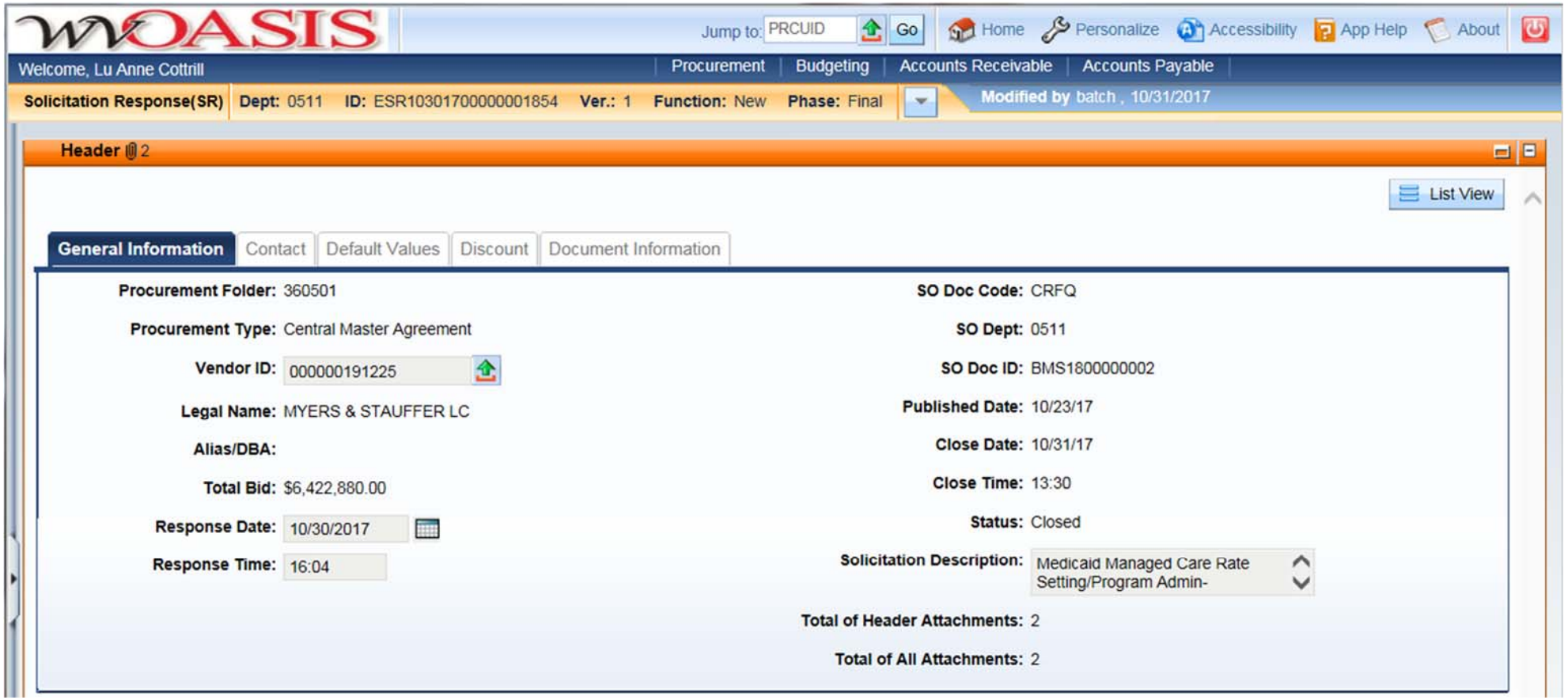


The following documentation is an electronically-submitted vendor response to an advertised solicitation from the *West Virginia Purchasing Bulletin* within the Vendor Self-Service portal at ***wvOASIS.gov***. As part of the State of West Virginia's procurement process, and to maintain the transparency 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
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Home
Personalize
Accessibility
App Help
About
Welcome, Lu Anne Cottrill
Procurement
Budgeting
Accounts Receivable
Accounts Payable
Solicitation Response(SR) Dept: 0511 ID: ESR10301700000001854 Ver.: 1 Function: New Phase: Final
Modified by batch , 10/31/2017
Header 2
List View
General Information
Contact
Default Values
Discount
Document Information
Procurement Folder: 360501
Procurement Type: Central Master Agreement
Vendor ID: 000000191225
Legal Name: MYERS & STAUFFER LC
Alias/DBA:
Total Bid: $6,422,880.00
Response Date: 10/30/2017
Response Time: 16:04
SO Doc Code: CRFQ
SO Dept: 0511
SO Doc ID: BMS1800000002
Published Date: 10/23/17
Close Date: 10/31/17
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

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

State of West Virginia
Solicitation Response

Proc Folder : 360501

Solicitation Description : Medicaid Managed Care Rate Setting/Program Admin-Addendum #7

Proc Type : Central Master Agreement

Date issued	Solicitation Closes	Solicitation Response	Version
	2017-10-31 13:30:00	SR 0511 ESR10301700000001854	1

VENDOR

000000191225

MYERS & STAUFFER LC

Solicitation Number: CRFQ 0511 BMS1800000002

Total Bid : $6,422,880.00 **Response Date:** 2017-10-30 **Response Time:** 16:04:09

Comments:

FOR INFORMATION CONTACT THE BUYER

April Battle

(304) 558-0067
april.e.battle@wv.gov

Signature on File **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				$411,840.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :
Lead Actuary Services
$ per hour x 2,080 hours

Comments: $198.00 Per Hour

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
2	Staff Actuary Services				$1,647,360.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :
Staff Actuary Services
$ per hour x 8,320 hours

Comments: $198.00 Per Hour

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
3	Managed Care Program Oversight Services				$1,725,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :
Managed Care Program Oversight Services Annual Cost

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
4	Ad Hoc Services Managed Care Oversight Projects				$825,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :
Ad Hoc Services Managed Care Oversight Projects
$ per hour x 5,000 hours

Comments: $165.00 Per Hour

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
5	Technical Support Staff (Non-Actuary)				$411,840.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description : Technical Support Staff (Non-Actuary) $ per hour X 2,080 hours

Comments: $198.00 Per Hour

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
6	Clerical Support Staff				$411,840.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description : Clerical Support Staff $ per hours X 2,080 hours

Comments: $198.00 Per Hour

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
7	Ad Hoc Services Actuarial Services Projects				$990,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description : Ad Hoc Services Actuarial Services Projects $ per hours X 5,000 hours

Comments: $198.00 Per Hour

MYERS AND STAUFFER LC
1977 - 2017
CERTIFIED PUBLIC ACCOUNTANTS

STATE OF WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Medicaid Managed Care Rate Setting and Medicaid Managed Care Program Administration

CRFQ 0511 BMS1800000002

October 31, 2017

Technical Proposal

MYERS AND STAUFFER LC
133 PEACHTREE ST NE, STE 3150
ATLANTA, GA 30303
866.758.3586
WWW.MSLC.COM

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
1977 - 2017
CERTIFIED PUBLIC ACCOUNTANTS

October 31, 2017

Ms. April Battle, Buyer
State of West Virginia
Department of Administration, Purchasing Divisions
2019 Washington Street East
Charleston, West Virginia 25305

Dear Ms. Battle and Members of the Evaluation Committee:

Myers and Stauffer LC is very pleased to present our proposal for *Centralized Request for Quotation (CRFQ) 0511 BMS1800000002: Medicaid Managed Care Rate Setting and Medicaid Managed Care Program Administration* for the West Virginia Department of Health and Human Services (DHHR or the Department), Bureau for Medical Services (BMS).

Myers and Stauffer's mission is to provide professional accounting, auditing, consulting, data management, and analysis services to state and federal governmental health care agencies. Our purpose and vision are to deliver those services to our clients in an efficient, effective, and timely manner, and to do so according to the highest levels of integrity and accountability.

Myers and Stauffer is uniquely positioned to provide the requested services, with the necessary technical skill, quality, and timeliness required. Our experience, especially in the services required by the CRFQ, is unparalleled. We have more than 40 years of experience assisting Medicaid agencies in the performance of similar services requested in this CRFQ, and we have experience working with other agencies such as the Centers for Medicare & Medicaid Services (CMS), the Federal Bureau of Investigation (FBI), the U.S. Department of Health and Human Services (HHS) – Office of the Inspector General (OIG), Medicaid Fraud Control Units (MFCU), and Tricare.

Myers and Stauffer has 18 offices nationwide that collectively manage active engagements with state Medicaid and public agencies in 49 states, including engagements with the state of West Virginia. As a current West Virginia vendor, we have experience and knowledge of the BMS program objectives and project nuances that are unmatched by any other vendor. In addition, we already maintain the proper levels of insurance required.

The vast majority of our client engagements have been continued for longer than five years – a clear indication of our clients' ongoing satisfaction with the services we provide. Our exemplary track record has led to the development of a dedicated team of professionals, committed to providing the highest-quality, responsive, and personal service, while staying abreast of regulatory changes and receiving formal training that exceeds professional requirements. In addition to benefitting from our extensive regulatory health care experience, utilizing Myers and Stauffer to perform these technical services will afford BMS an additional level of quality and

133 Peachtree St NE, Ste 3150 | Atlanta, GA 30303
PH 404.524.0775 | PH 866.758.3586 | FX 404.524.0782
www.mslc.com

performance since certified public accounting (CPA) firms are held to the highest professional standards.

At Myers and Stauffer, we know it takes continuous effort to stay current on the latest issues and trends affecting health care. We have more than 800 full-time professionals who work exclusively with state and federal health care programs. Our extensive experience in managed care, bolstered by our depth of resources and commitment to client service, makes us the ideal organization to serve you. A sampling of qualities that sets us apart from the competition includes:

- ***Medicaid Managed Care Expertise.*** *We are currently assisting Medicaid programs with managed care organization (MCO) program review, audit, rate setting, quality improvement, and monitoring activities. We have also performed MCO monitoring activities to ensure Medicaid recipients have access to needed health care services, and our Medicaid agency clients have prompt access to the data they need to manage these critical health care programs. These efforts are designed to assist our Medicaid agency clients in realizing the goals and objectives for their managed care programs and to ensure that MCO contractors are performing in accordance with their contracts. This includes:*
    - *Review and validation of encounter data.*
    - *Readiness reviews.*
    - *Monitoring of MCO administrative costs to ensure only allowable costs are charged to the program; medical loss ratio (MLR) compliance.*
    - *Review of medical costs to ensure overpayments are not passed through to the state; monitoring of third party liability (TPL) payments and recoveries to ensure these are properly offset against costs.*
    - *Review of related-party transactions to ensure that costs are properly reported.*
    - *Contract compliance reviews to ensure that health plans are operating in accordance with both the contract with the state and with the provider community.*
    - *Utilization of management reviews to ensure Medicaid recipients have access to needed health care services and our Medicaid agency clients have prompt access to the data they need to manage these expensive health care programs.*
- ***Actuarial Expertise.*** *Through our partner Optumas, we bring more than 11 years of experience in providing actuarial services to state Medicaid agencies. This experience includes, but is not limited to:*
    - *Actuarially sound capitation methodologies for existing programs.*
    - *Actuarial assistance for new programs/populations.*
    - *Comprehensive rate development for Medicaid.*
    - *Risk adjusting rates.*
    - *Data validation.*
    - *Assistance with 1915 b/c and 1115 waiver submissions.*

The team at Optumas is comprised of more than 30 focused and committed health care consultants with a wealth of experience reforming health care initiatives across the country. Optumas works with all types of populations (e.g., Temporary Assistance for Needy Families [TANF], General Assistance [GA], Aged/Blind/Disabled [ABD], Developmentally Disabled [DD], Program for All-Inclusive Care for the Elderly [PACE], 1915(c) populations, Exchange, Children's Health Insurance Program [CHIP], and small/large employers), and all types of benefits/services (acute, ambulatory, long-term care (LTC), home and community-based, mental health, substance abuse [chemical dependency], dental, and pharmacy). Their skills have been honed through years of strategy and actuarial consulting experience with multiple programs, clients, and stakeholders. They have a successful track record of assisting various clients with similar actuarial, policy, rate development, and strategy projects – their consultants have worked to develop effective Medicaid care management programs in more than two dozen states in the last 20-plus years.

- ***Proven Track Record.*** *Myers and Stauffer has been successfully working with local, state, and federal health care agencies for 40 years, including 16 years with West Virginia. We continually invest our efforts in the state of West Virginia and in our professional relationships with all of our state and federal clients. We have a national reputation for delivering high-quality and timely services in a manner that meets and often exceeds expectations. Our understanding of Medicaid agency needs and challenges will bring the DHHR and BMS not only a unique perspective on the important issues, but also potential solutions and/or options that fit within the context of the DHHR's overall goals and objectives.*

- ***In-depth Knowledge of State and National Health Care Environment.*** *We maintain dialogues with CMS executives, state Medicaid officials, and industry leaders across the nation in order to provide our clients with guidance and assistance in a manner that other firms simply cannot match. We also closely monitor the activities of state and national health care regulatory environments regarding Medicaid compliance matters to keep a current knowledge base of legislative and regulatory issues relevant to BMS and this project. Many of our professionals contribute first-hand experience from prior employment with CMS, state Medicaid programs, and health plans.*

- ***Knowledge of Operations.*** *We have worked effectively with BMS and have established solid working relationships throughout the agency. Our historical and current work with BMS ensures that we understand the West Virginia-specific environment, including challenges as well as opportunities. Through this work, we have learned invaluable lessons that can only be gained through direct experience. This will benefit BMS in responding to the complex and evolving Medicaid program requirements.*

- ***Unmatched Team of Professionals.*** *The Myers and Stauffer Team offers a multi-disciplinary team of professionals for each of our engagements. We combine experience, education, training, and subject-matter expertise that yields an unparalleled team of policy experts, research analysts, program integrity specialists, actuaries, informaticists, pharmacists, medical doctors, registered nurses (RN), certified coders, former nursing home employees, former hospital accountants, former Medicare intermediary auditors, former state Medicaid management and staff, certified public accountants (CPAs), and certified fraud examiners (CFEs). Our team members dedicate their careers to health*

care improvement and compliance through continued engagements and a constantly growing knowledge base. This extensive and diversified background allows the Myers and Stauffer Team to provide West Virginia with experienced professionals who truly understand the needs and objectives of the state. It also enables us to draw upon different skills and experiences as circumstances may evolve over the course of a project.

- ***Excellent Oversight and Proactive Leadership.*** *BMS will benefit from hands-on service by our team's senior professionals. We can provide this level of service because our partner-to-staff ratio is similar to smaller firms — allowing our senior level professionals to be involved and immediately available throughout the entire client service process. Our approach ensures that all members of the engagement team will stay abreast of key issues and take an active role in addressing them.*
- ***Cost Effectiveness.*** *Through our utilization of experienced professionals, we are able to provide services efficiently without sacrificing quality. We have competitively priced our proposal using staff assignments we believe to be the most efficient and effective based on our first-hand experience dealing with the services outlined in the CRFQ. Our rates reflect the unsurpassed quality of the specialized staff members who we recruit, train, retain, and continually educate in order to provide BMS with the best service possible.*
- ***Flexibility.*** *Myers and Stauffer is large enough to meet any client's needs, yet it is structured in a manner that allows our professionals to have the flexibility to design customized solutions. In addition, our focus on quality while also investing in technology solutions designed for efficiency, has proven to be a valuable combination for our clients. Because Myers and Stauffer has a 40-year history of producing quality work and maintaining a culture of integrity, we are able to balance the profitability of our firm with affordability for our clients.*

In conclusion, it is our most sincere hope that our proposal clearly indicates that Myers and Stauffer is uniquely qualified and eager to provide you with not only services that meet the specifications of the CRFQ, but also the insight, information, and open communication that will benefit BMS. If you require additional information or would like a presentation of our capabilities, please contact me at MJohnson@mslc.com or 404.524.0775 x 305.

Sincerely,

Michael D. Johnson, CPA, CFE
Member

Table of Contents

Designated Contact/Certification

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.

[signature], Member
(Name, Title)
Michael D. Johnson, Member
(Printed Name and Title)
133 Peachtree St. NE, Ste 3150 Atlanta, GA 30303
(Address)
866.758.3586/404.524.0782
(Phone Number) / (Fax Number)
MJohnson@mslc.com
(email address)

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation 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 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 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.

Myers and Stauffer LC
(Company)

[signature], Member
(Authorized Signature) (Representative Name, Title)

Michael D. Johnson, Member
(Printed Name and Title of Authorized Representative)

10/3/2017
(Date)

866.758.3586/404.524.0782
(Phone Number) (Fax Number)

Revised 07/07/2017

Qualifications *(CRFQ Section 3)*

Firm Qualifications

Myers and Stauffer has worked with Medicare and Medicaid agencies for 40 years, including 16 years with West Virginia. Our long and highly successful Medicaid consulting and auditing practice is the result of focused services for our governmental clients; creative and competent staffing; extensive planning and training; and partnering with our clients to achieve their objectives.

At A Glance: The Myers and Stauffer Team

- *Work full time serving our Medicaid and Medicare agency clients, with the majority of our work being for state Medicaid programs.*
- *Sixteen years of experience working with the state of West Virginia and its provider community.*
- *Participation in past West Virginia Medicaid reimbursement program changes and initiatives as a consultant and resource for BMS.*
- *More than 13 years' experience with managed care-related services for numerous state Medicaid programs.*
- *Experience successfully defending our results against administrative and judicial scrutiny.*
- *Team of economists, strategists, actuaries, clinicians, and systems analysts that take a thoughtful, stepwise approach to identifying and then quantifying health care risk using recognized actuarial and econometric estimation techniques.*
- *Experienced consultants who have worked across the country developing effective Medicaid care management programs in more than two dozen states in the last 20-plus years.*
- *Extensive experience in developing actuarially sound capitation methodologies for existing programs, providing actuarial assistance for new programs/populations, performing program and policy change analyses, adjusting capitation rates, developing alternative payment methodologies, and assistance with 1915 b/c and 1115 waiver submissions.*

Our experience providing health care assurance and consulting services to state Medicaid programs, Medicare, the U.S. Department of Justice (DOJ), and other government health care agencies is unrivaled. As a firm, we have performed managed care oversight and administration, program integrity, data aggregation and analytics, full and limited scope audits, claim reviews, minimum data set (MDS) reviews, fiscal analyses, cost settlements, and rate setting, encompassing nearly every provider type throughout the country. We have represented and provided expert witness testimony on behalf of Medicaid and Medicare in various levels of appeals and judicial proceedings, and we have assisted the DOJ and state Medicaid Fraud Control Units (MFCUs) in both civil and criminal actions related to health care fraud. We have provided a variety of health care consulting services to multiple state and federal clients.

Myers and Stauffer employs more than 800 professionals, including 27 members/principals (partners), all of whom are fully engaged with our state and federal Medicaid/Medicare clients. Our team of health care experts is nationally recognized for insight and ability to effectively communicate the complexities of managing a Medicaid program, including program integrity and

complex Medicaid reimbursement systems. Our experts have repeatedly accepted invitations to educate national associations, industry groups, and elected officials regarding Medicaid and public health care concerns.

Myers and Stauffer will be strengthened by our collaboration with Optumas (collectively referred to as the Myers and Stauffer Team), a national actuarial consulting firm. Optumas was founded in 2006 in a quest to develop an independent consulting firm that focused on reforming health care for the right reason – people. Their consulting efforts bring about health care reform from two perspectives – not only who receives health care but also how people receive care.

The team at Optumas is comprised of more than 30 focused and committed health care consultants with a wealth of experience reforming health care initiatives across the country. The Optumas team works with clients to design the most appropriate, efficient, and effective health care initiative(s) to achieve their clients' policy goals of improving health care access, health care quality, and health care coverage.

The cornerstone of Optumas' health care consulting is a unique approach to quantifying the risk of health care programs. Optumas has a team of economists, strategists, actuaries, clinicians, and systems analysts that take a very thoughtful, stepwise approach to identifying and quantifying health care risk using recognized actuarial and econometric estimation techniques. What differentiates the Optumas team is the ability to convert those incredibly complex estimation techniques into simple, practical strategies, solutions, and information that clients can use to improve the effectiveness of their programs. And improving their health care programs ultimately meets Optumas' goal – improving the lives of people.

Optumas works with all types of populations (e.g., PACE, 1915 b/c populations, Exchange, CHIP, small/large employers, etc.) and all types of benefits/services [acute, ambulatory, long-term care (LTC), home and community based, mental health, substance abuse (chemical dependency), dental, and pharmacy]. Their skills have been honed through years of strategy and actuarial consulting experience with multiple programs, clients, and stakeholders. They have a successful track record of assisting various clients with similar actuarial, policy, rate development, and strategy projects – their consultants have worked across the country developing effective Medicaid care management programs in more than two dozen states in the last 20-plus years. The success of any consulting engagement is determined by the strength of the client/consultant relationship and that is an area where Optumas and Myers and Stauffer both excel.

Our Services

The Myers and Stauffer Team represents the highest level of technical experience in providing the services requested in the CRFQ. Our extensive exposure to state Medicaid programs enables us to draw upon compliance, program integrity and auditing features, experiences, and best practices from other Medicaid programs to address the requirements of these important initiatives for BMS. Our in-depth understanding of Medicaid policy, financing, and reimbursement will provide valuable insight during the course of this engagement. We offer a full array of services designed to assist our state and federal clients to succeed with every part of their operation. Some of the relevant services related to this CRFQ include:

- *Financial and performance audits of Medicare and Medicaid MCOs including Medical Loss Ratio (MLR) examinations.*
- *Developing and implementing comprehensive monitoring systems for Medicaid MCOs.*
- *MCO encounter data reviews and data validation.*
- *Establishment of provider reimbursement rates.*
- *Reimbursement methodology design and implementation.*
- *MDS data processing, audit, verification, roster production, and case mix index (CMI) distribution.*
- *Rebasing initiatives and related activities for rate setting.*
- *Value-based purchasing (VBP) policy design, review, and consulting.*
- *State plan and waiver development and support services.*
- *Technical risk assessment.*
- *Medicaid performance audits and consulting engagements.*
- *Fraud, waste, and abuse detection (FWAD) and identification of improper payments through claim/billing reviews.*
- *Medicaid policy and agency operations consulting.*
- *Pharmacy claims and pharmacy benefit manager (PBM) audits.*
- *Assistance with CMS and OIG audit findings.*
- *Medicaid funding consulting, including provider assessment plans.*
- *Delivery System Reform Incentive Payment (DSRIP) program development, operation, and independent assessor services.*
- *State Innovation Model (SIM) consulting.*
- *CMS 64 – quarterly expense report reviews.*
- *Actuarially sound rates and capitation methodologies. Comprehensive rate development for Medicaid (all populations and expansion and health reform populations and services).*
- *Partial rate development for shared risk arrangements with accountable care organizations (ACOs), independent practice associations (IPAs), and primary care case management (PCCM)/patient-centered medical home (PCMH) programs.*
- *Base data identification, homogenization, normalization, and organization.*
- *Development of sophisticated incurred but not reported (IBNR) claims.*
- *Provider reimbursement benchmarking.*
- *Development of non-medical load (NML) models to project administrative costs.*
- *Capitation rate adjustment.*
- *Risk corridors and risk sharing program development.*

- *Comprehensive certification letter writing.*
- *Public presentations, including expert testimony for legislative oversight committees.*
- *Technical model development.*
- *Actuarial assistance for new programs/populations.*
- *Budget modeling, including calculating the impact of programmatic changes on budgets and premiums.*
- *Alternative payment methodologies development and evaluation.*
- *Encounter reporting requirements, specifications, and intake.*
- *Upper payment limit (UPL) development.*
- *Assistance with 1915 b/c and 1115 waiver submissions.*
- *Managed long-term services and supports (MLTSS)/home and community-based services (HCBS) waiver services.*
- *Establishment of efficient pharmacy pricing.*
- *Risk adjusted rates development.*
- *Health plans' capitation payments adjustments.*

Managed Care Program Oversight

Staffing (CRFQ Section 3.1)

The Myers and Stauffer Team is committed to performing this work within the desired time periods established in the CRFQ, and we have the resources available to efficiently and effectively manage this project. Our practice is well-rounded in terms of relevant experience and scope of services provided, and we do not experience the workload compression that other firms might experience during particular busy seasons. This means better client service and closer, personal attention for BMS.

We understand that our clients will not be successful unless we provide them with the highest-quality, responsive, and experienced professionals. Our resources and experience allow us to quickly respond to multiple tasks, regardless of engagement size. Equally important are the roles and responsibilities of each team member. We are confident that our proposed level of staffing will allow us to complete the contract requirements of this CRFQ, while concurrently and effectively addressing any unexpected problems or delays.

Our proposed project team possesses an abundance of experience to complete the work outlined in this CRFQ. We have more than 13 years' experience in providing managed care-related services for state Medicaid agencies and, as a result, we have staff who are trained, available, and ready to commit to the project. Our firm will provide support staff dedicated to your contract to ensure timely completion of contract requirements. Each of the individuals included on the project team is knowledgeable and has the requisite capacity, experience, and expertise to complete the

tasks assigned to him/her. Should we find the need for additional expertise, we have a firm-wide network of trained associates to utilize.

All staff members dedicated to this contract have direct, hands-on experience performing similar services for state and local health care agencies or CMS. We operate on the principles of extraordinary client service and an unwavering commitment to quality. We are highly regarded nationwide for our professional objectivity, innovation, quality staff, and unparalleled service. Our success has been achieved by providing our clients with excellent service on a timely basis, including those times when clients have made urgent requests with minimal turnaround time. We are committed to serving BMS as effectively and economically as possible, while maintaining the highest levels of integrity, quality, and service.

We will staff this project in order to exceed your expectations. The following is a brief summary of our proposed staff and their roles. Should we be the successful bidder, these professionals will be the personnel working on the project. In addition, we will assign additional associates as needed. We assure BMS that the quality of staff will be maintained over the term of the contract agreement due to the depth of our experience with Medicaid agencies.

Myers and Stauffer: Managed Care Program Oversight Staff		
Team Member *(*denotes key staff)*	**Role in Project**	**Qualifications**
Michael Johnson, CPA, CFE *Member, Myers and Stauffer*	***Co-Project Director:*** *Mr. Johnson will be responsible for the overall direction of the contract, contract execution, and client satisfaction.*	Mr. Johnson has more than 23 years leading audit and accounting services, including seven years of experience directly relevant to health care such as managed care. During his career at Myers and Stauffer, Mr. Johnson has worked in all capacities on projects, including project director, project manager, and quality assurance. He provides high-level strategic input to assure successful completion of the project and the full satisfaction of the client. One of his accomplishments includes the development of a strategy to reconcile MCO encounter claims back to financial records. With implementation of this strategy, the MCOs in several states have raised their completion rates and cleaned up erroneous encounters in the process. Mr. Johnson is a CPA, CFE, and holds a bachelor's degree in Accounting from the University of Georgia.
Jerry Dubberly, PharmD *Principal, Myers and Stauffer*	***Co-Project Director:*** *Dr. Dubberly will assist Mr. Johnson with the overall direction of the contract, contract execution, and client satisfaction.*	Dr. Dubberly leads the Center of Quality Analytics, Design, and Payment within the firm. Since joining Myers and Stauffer in January 2015, Dr. Dubberly has focused on the firm's integrated care model accounts, which include SIM, DSRIP, Certified Community Behavioral Health Clinics (CCBHC) programs, and other consulting activities. Dr. Dubberly, PharmD, has a doctorate degree in Pharmacy from the University of Arkansas Medical Sciences, a master's degree in Health Services Management from the University of Tennessee, and a

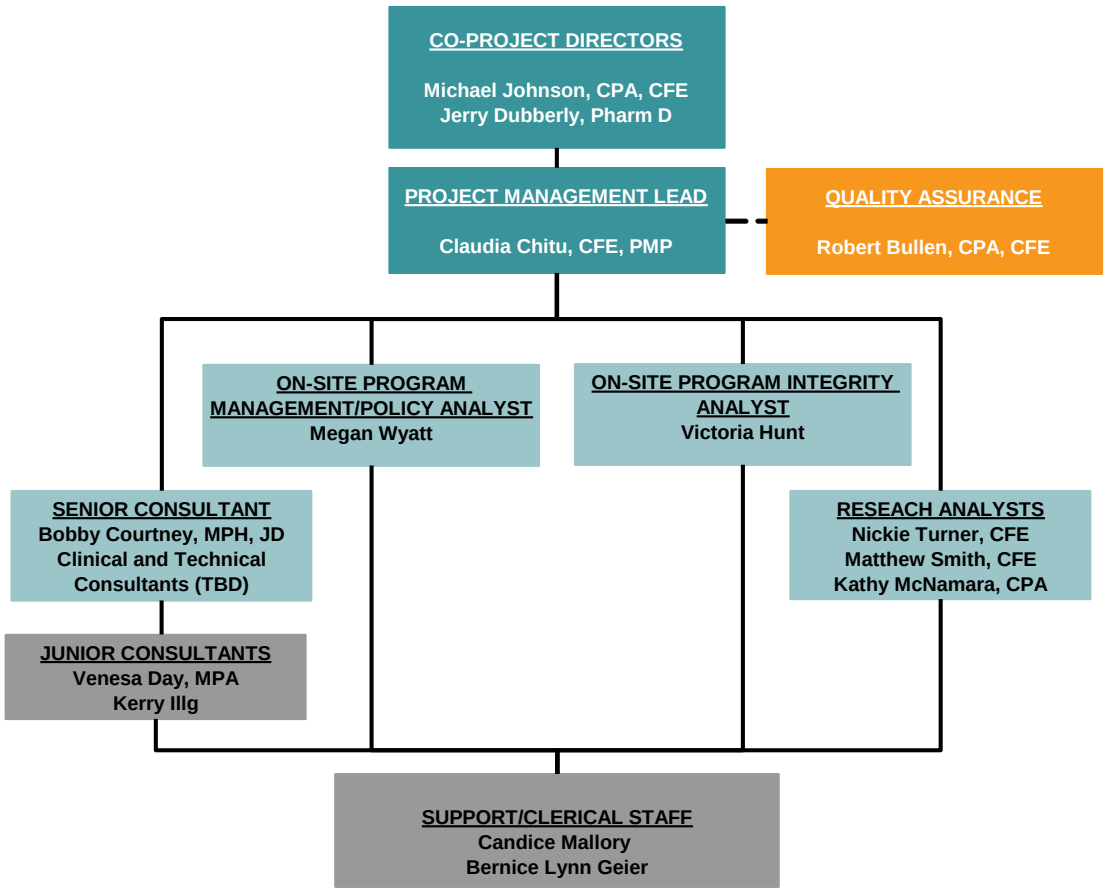
Myers and Stauffer: Managed Care Program Oversight Staff		
Team Member ***(*denotes key staff)***	**Role in Project**	**Qualifications**
		bachelor's degree in Pharmacy from the University of Georgia.
Claudia Chitu, CFE, PMP* *Senior Manager, Myers and Stauffer*	***Project Management Lead:*** *Ms. Chitu will serve as the project management lead of this engagement, overseeing the activities of the team and ensuring project deliverables are met and communication is maintained with all parties.*	Ms. Chitu, a senior manager with Myers and Stauffer, managed several Medicaid managed care projects that focus on analysis of encounter claims data to assess data quality and completeness. She has experience in the implementation, evaluation, and monitoring of Medicaid managed care encounter data submissions. As part of this work, she performs encounter data reconciliations, on-site encounter process reviews, and data validation. In addition, she has reviewed plans for contract and reporting compliance and has identified relevant best practice standards for consideration. Ms. Chitu is a CFE, PMP, and holds a bachelor's degree in Economics from Emory University.
Robert M. Bullen, CPA, CFE *Member, Myers and Stauffer*	***Quality Assurance Partner:*** *Mr. Bullen will assist with quality assurance across all areas of the project.*	Mr. Bullen has more than 34 years leading auditing and accounting services, including more than 15 years of experience working in managed care. He is one of two partners-in-charge of the firm's national managed care practice. Mr. Bullen has extensive experience relating exclusively to health care-related audit and compliance services, including overseeing audits of Medicaid MCOs, Medicare Advantage Organizations (MAO), Prescription Drug Plans (PDPs), and PBMs. Mr. Bullen is a CPA and CFE and holds a bachelor's degree in Accounting from the University of Baltimore.
Megan Wyatt* *Senior Manager, Myers and Stauffer*	***On-site Program Management/Policy Analyst (Implementation Period):*** *Ms. Wyatt will provide program management support and will assist Ms. Chitu to ensure all project deliverables are met and communication is maintained with all parties. Ms. Wyatt will be on-site at the Department. After award and during the implementation period, the Myers and Stauffer Team will secure a permanent resident of West Virginia who is acceptable to BMS to fill this role.*	Ms. Wyatt has more than 23 years of experience in state government in the areas of policy and fiscal analysis, program management and review, budgeting, and provider reimbursement. For the past 11 years, she worked on Medicaid and CHIP, with a focus on managed care, provider reimbursement, and analysis of state and federal health care legislation and regulatory impacts at the state level. Prior to joining Myers and Stauffer, she served as the Director of Reimbursement Policy and Fiscal Analysis and as the Medicaid Analysis Manager at the Georgia Department of Community Health (DCH). In this capacity, she supported the Medicaid director and agency CFO by conducting and coordinating major policy and fiscal analysis. For nearly five years she was responsible for managing the MCO capitation rate setting process for the $4.3 billion Georgia Families Program. Ms. Wyatt's prior experience also includes work as an analyst in the Georgia Governor's Office of Planning and Budget, and as a health care consultant for Health Management Associates.

Myers and Stauffer: Managed Care Program Oversight Staff		
Team Member ***(*denotes key staff)***	**Role in Project**	**Qualifications**
		Ms. Wyatt has a bachelor's degree in Geography from the University of Illinois at Urbana-Champaign.
Bobby Courtney *Senior Manager, Myers and Stauffer*	***Senior Consultant:*** *Mr. Courtney will assist with managed care program administration, including waiver analyses, policy impact analyses, and other consultation services as needed.*	Mr. Courtney specializes in public health law and policy, and has more than 18 years of experience working in the health care industry. He is a senior manager and provides a broad range of consulting services, including issues related to Medicaid waivers, managed care, LTSS, as well as federal health care regulations and policies. Mr. Courtney's work spans across the firm's service areas. Prior to joining Myers and Stauffer, Mr. Courtney served as a senior consultant with SVC, Inc., an Indianapolis-based health policy firm. In this role, he counseled clients on a variety of matters, including Medicaid waivers, managed care, statutory and regulatory compliance, as well as public health program design and implementation. He has developed and supported states in the negotiation of federal health care waivers, including facilitation of the public notice and comment process. He has also supported states to review existing waiver programs for compliance and areas of improvement and efficiency. Most recently, he worked with the state of Iowa to secure federal approval for implementation of the Iowa Health Link managed care program, which required development and negotiation of a series of §1115, §1915(b), and §1915(c) waivers. Mr. Courtney has a Juris Doctorate degree in Health Law, a Master of Public Health degree in Health Policy from Indiana University, a master's degree in English from Bradley University, and a bachelor's degree in Philosophy from the University of Illinois.
Venesa Day *Senior Manager, Myers and Stauffer*	***Junior Consultant:*** *Ms. Day will assist with managed care program administration, including waiver analyses, policy impact analyses, and other consultation services as needed.*	Ms. Day has more than 15 years' experience working in health care policy, including experience ensuring state and provider compliance with federal financial requirements. For Myers and Stauffer, she recently completed a project identifying and documenting potential FWA risks and vulnerabilities for several CMS alternative payment models (APMs), including Comprehensive Primary Care Plus (CPC+), Medicare Shared Savings Program (MSSP), Comprehensive end stage renal disease (ESRD) Care (CEC), and Independence at Home (IAH) Demonstration. In addition, she worked with CMS program offices to identify potential mitigation strategies for risks and vulnerabilities. Ms. Day has a master's of Public Administration degree from American University and a bachelor's

Myers and Stauffer: Managed Care Program Oversight Staff		
Team Member ***(*denotes key staff)***	**Role in Project**	**Qualifications**
		degree in Political Science from Morgan State University.
Kerry Illg *Manager, Myers and Stauffer*	***Junior Consultant:*** *Mr. Illg will assist with managed care program administration, including waiver analyses, policy impact analyses, and other consultation services as needed.*	Mr. Illg has extensive experience providing health care auditing, accounting, and consulting services. As a manager with Myers and Stauffer, he oversees the production of MDS case mix reports and MDS reviews. He has experience performing desk reviews of provider financial reports, resulting in changes to their Medicaid LTC rates. Mr. Illg also has experience planning and leading on-site reviews of provider financial reports to determine compliance with Medicaid rate setting criteria. Mr. Illg has a bachelor's degree in Accounting from Ball State University.
Kelly McNamara *Manager, Myers and Stauffer*	***Research Analyst:*** *Ms. McNamara will assist the Department and Ms. Chitu with managed care program administration, including policy impact analyses, network adequacy topics, and other consultation services as needed.*	Ms. McNamara, a manager with Myers and Stauffer, has more than 23 years of professional experience, including extensive experience with government health care programs such as contract administration and compliance monitoring. Ms. McNamara has completed engagements related to the performance of MCOs under contract with states of Georgia, Louisiana, Mississippi, and New Mexico. Areas of focus include corporate and contract compliance, subcontractor oversight, program integrity oversight, encounter submissions, and payment systems. Ms. McNamara has a master's degree in Business Administration and a bachelor's degree in Business Administration from Kennesaw State University.
Nickie Turner *Senior Analyst, Myers and Stauffer*	***Research Analyst:*** *Ms. Turner will assist the Department and Ms. Chitu with managed care program administration, including policy impact analyses, network adequacy topics, and other consultation services as needed.*	Ms. Turner, a senior analyst with Myers and Stauffer, has extensive experience with government health care programs, including contract administration and compliance monitoring. Ms. Turner has completed engagements related to the performance of MCOs under contract with states of Georgia and New Mexico. Areas of focus include corporate and contract compliance, subcontractor oversight, program integrity oversight, encounter submissions, and payment systems. Ms. Turner has a master's degree in Health Services Administration from Strayer University and a bachelor's degree in Business Administration from Auburn University.
Matthew Smith *Senior Accountant, Myers and Stauffer*	***Research Analyst:*** *Mr. Smith will assist the Department and Ms. Chitu with managed care program administration, including program*	Mr. Smith, a senior accountant with Myers and Stauffer, has approximately five years' experience performing Medicaid Integrity Contractor (MIC) audits for CMS. Mr. Smith has performed audits across 12 states for Medicaid providers, including West Virginia Medicaid for hospice audits. These engagements are

Myers and Stauffer: Managed Care Program Oversight Staff		
Team Member ***(*denotes key staff)***	**Role in Project**	**Qualifications**
	integrity topics and other consultation services as needed.	responsible for detecting FWA; they involve provider types such as hospitals, physicians, hospices, home health agencies (HHAs), dentists, and orthotics and prosthetics. He is responsible for assisting coordination and performing complex Medicaid audits to ensure compliance with federal laws and regulations; CMS requirements and guidance; and state laws, regulations, and standards. In addition, he is an active member of the Association of Certified Fraud Examiners (ACFE). Mr. Smith has a master's degree in Health Care Administration from the University of Maryland University College and bachelor's degree in Accounting from University of Baltimore.
Victoria Hunt* *Senior Accountant, Myers and Stauffer*	***On-site Program Integrity Analyst:*** *Ms. Hunt will support the Department with program integrity matters and will assist Ms. Chitu to ensure all project deliverables are met and communication is maintained with all parties. Ms. Hunt will be on-site at the Department.*	Ms. Hunt, a senior accountant with Myers and Stauffer, has more than seven years of experience performing various types of Medicaid audits in multiples states. These audits include Virginia Medicaid cost report audits of nursing facilities and program integrity compliance audits, disproportionate share hospital (DSH) payment audits in multiple states, and CMS MIC audits for a variety of provider types. She is responsible for research and application of relevant laws and regulation in the development of audit plans, as well as performing and coordinating Medicaid audits to ensure compliance with federal and state laws and regulations, CMS requirements, and contractor (Health Integrity) requirements. Ms. Hunt has a master's degree in Accounting from North Carolina State and a bachelor's degree in Accounting from North Carolina Agricultural and Technical State University.
Candice Mallory *Specialist, Myers and Stauffer*	***Support/Clerical Staff:*** *Ms. Mallory will provide administrative support to the Department and team members during the duration of the project.*	Ms. Mallory is new to Myers and Stauffer and currently assists with administrative and support services for our health care audit and compliance clients.
Bernice Lynn Geier *Specialist, Myers and Stauffer*	***Support/Clerical Staff:*** *Ms. Geier will provide administrative support to the Department and team members during the duration of the project.*	For the past 10 years, Ms. Geier has assisted with support services for a variety of clients, including health care contracts for Georgia and Kansas.

Managed Care Program Oversight Team Organizational Chart



Resumes of Managed Care Program Oversight Key Staff (CRFQ Section 3.2)

On the following pages, please find resumes of our key managed care program oversight staff, as defined in the CRFQ. In addition to the key staff positions designated in the CRFQ (project management lead, on-site program management/policy analyst, and on-site program integrity analyst), we have also included resumes of proposed non-key staff members in *Appendix A: Resumes*.

Claudia Chitu, CFE, PMP

Senior Manager, Myers and Stauffer

Summary

Ms. Chitu, a senior manager with Myers and Stauffer, managed several Medicaid managed care projects that focus on analysis of encounter claims data to assess data quality and completeness. She has experience in the implementation, evaluation, and monitoring of Medicaid managed care encounter data submissions. As part of this work, she performs encounter data reconciliations, on-site encounter process reviews, and data validation. In addition, she has reviewed plans for contract and reporting compliance and has identified relevant best practice standards for consideration.

Other projects have included assisting the Georgia Department of Community Health with the implementation of the new Medicaid Management Information System (MMIS) by creating and submitting 837 and National Council for Prescription Drug Programs (NCPDP) format test claims and encounters to evaluate system edits and processing issues, as well as performing benefits testing and claims reimbursement analysis.

Education

B.A., Economics and Mathematics, Emory University, 2005

Experience

11 years professional experience

Certifications

Certified Fraud Examiner
Project Management Professional

Relevant Work Experience

Georgia Department of Community Health (2009 – Present)

Care Management Organization Compliance

Scope of Work:

Myers and Stauffer assists the Georgia Department of Community Health with providing oversight and monitoring of the Georgia Families care management organizations (CMOs).

Responsibilities:

- Manage the encounter reconciliation work for evaluating Georgia Medicaid CMOs' compliance with contractual obligations for encounter data submissions.
- Assist in the development of the data analysis plan for CMO on-site encounter process reviews and data validation work.
- Provide enhanced member and encounter data extracts and analysis to the State's actuarial firm to assist in the rate setting process. Ensure work identifying data issues and potential adjustments and corrections is not duplicated as part of rate setting and/or other reporting.
- Reviewed CMO payments to providers for primary care rate increases under the Affordable Care Act (ACA) for accuracy and appropriateness. Identified and helped address data issues with provider enrollment and CMO claims payment processing.

- Perform ad-hoc data analyses to estimate impact of potential changes in policy, legislation, and program budget.
- Serve as a subject matter expert for encounter submissions.

Louisiana Department of Health (2012 – Present)

Louisiana MCO

Scope of Work:

Myers and Stauffer assists the Louisiana Department of Health with providing oversight and monitoring of the Bayou Health MCOs.

Responsibilities:

- Manage the encounter reconciliation work for evaluating Louisiana Medicaid MCOs' compliance with contractual obligations for encounter data submissions.
- Serve as a subject matter expert for encounter submissions and assisted in the development of the data analysis plan for MCO on-site encounter process reviews and data validation work.

Mississippi Division of Medicaid (2017)

Coordinated Care Organization Compliance

Scope of Work:

Myers and Stauffer performs financial reviews and analytical activities for (CCOs) related to the MississippiCAN and MississippiCHIP programs. Projects include encounter data validation and reconciliations (including Protocol 4), capitation and rate reviews, TPL reviews, and health insurance providers' fee calculation review.

Responsibilities:

- Assist the Division in reviewing and evaluating high rates of claim denials by a CCO. This project includes a review of the CCO's internal processes, claims adjudication and system edits configurations, provider and member communication, and encounters reporting.

Georgia Department of Community Health (2009 – 2010)

Benefits Testing

Scope of Work:

Myers and Stauffer assists the Georgia Department of Community Health to evaluate the accuracy of benefit payments made through the Medicaid program and CHIP.

Responsibilities:

- Developed fee-for-service (FFS) and encounter test claims and reviewed the MMIS system for processing and payment accuracy.
- Developed 837I and 837P claims for MMIS process testing and served as electronic data interchange (EDI) subject matter expert during testing.
- Evaluated FFS claim reimbursement and policy compliance, and developed automated testing processes for several categories of service.

Georgia Department of Community Health (2015 – 2016)

Inpatient Hospital Rebase

Scope of Work:

Georgia Medicaid engaged Myers and Stauffer to update their prospective payment system (PPS) for inpatient hospital services and to implement an outpatient hospital reimbursement system.

Responsibilities:

- Assisted the Department with the implementation of an updated inpatient hospital payment system and reimbursement review methodology that effectively incorporated best practices and potential risk areas identified as part of the engagement's work.

Georgia Department of Community Health (2014 – Present)

Recovery Audit Contractor

Scope of Work:

Myers and Stauffer provides recovery audit contractor (RAC) services to the Georgia Department of Community Health.

Responsibilities:

- Helped develop algorithms utilized in the engagement to identify potential over- and under-payments to health care providers for FFS and encounter claims.

New Mexico Human Services Department (2015)

Audit Agent

Scope of Work:

Myers and Stauffer performed examinations and reviews of hospitals, HHAs, and LTC institutional facilities (nursing facilities and intermediate care facilities) that participate in the New Mexico Medicaid program.

Responsibilities:

- Assisted in the development of the data review plan for New Mexico Medicaid MCO hospital encounter claim payment reviews.

Presentations

"Driving Program Improvements and Controlling Costs With Advanced Analytics and Reporting," MESC - Medicaid Enterprise Systems Conference, St. Louis, Missouri, 2016.

Megan Wyatt

Senior Manager, Myers and Stauffer

Summary

Ms. Wyatt is a senior manager and recent addition to Myers and Stauffer. She has more than 23 years of experience in state government in the areas of policy and fiscal analysis, program management and review, budgeting, and provider reimbursement. For the past 11 years, she worked on Medicaid and the CHIP, with a focus on managed care, provider reimbursement, and analysis of state and federal health care legislation and regulatory impacts at the state level. She also has extensive knowledge of the state budget and appropriation process; experience conducting issue/financial analysis, legislative fiscal notes, and program evaluations; and experience with Medicaid provider reimbursement, including Medicaid managed care capitation, physician rates, and inpatient hospital prospective payment rates.

Education

B.A., Geography, University of Illinois at Urbana-Champaign, 1988

Experience

23 years professional experience

Affiliations

Georgia Society of Certified Public Accountants

Relevant Work Experience

Nevada Department of Health and Human Services (2017 – Present)

Managed Care Organization Onboarding and Business Process Reengineering

Scope of Work:

Myers and Stauffer provides monitoring and oversight of activities performed by the MCOs.

Responsibilities:

- Reviewed and presented findings on agency Medicaid MCO reporting requirements for compliance with the latest federal MCO rules.
- Reviewed MCO standard reporting requirements, instructions, and templates to identify opportunities to improve agency monitoring and oversight.
- Reviewed and made recommendations to current MCO contract for the purpose of improving agency monitoring and oversight.
- Evaluated and made recommendations to improve the Nevada Medicaid agency document review and approval process.
- Coordinated with agency staff to develop MCO standard reporting templates and instructions.

Additional Work Experience

*Please note Ms. Wyatt is a new addition to Myers and Stauffer; therefore, this section includes additional work experience from past employment.

Georgia Department of Community Health (2012 – 2017, 2006 – 2010)

Department of Community Health Budget Director, Director of Reimbursement Policy and Fiscal Analysis, Medicaid Analysis Unit Manager – Financial Service

Responsibilities:

- Responsible for administering the $14 billion DCH budget in compliance with the annual state appropriations act.
- Responsible for Medicaid managed care program rate setting and policy/financial analysis, including VBP, risk adjustment, and viability of supplemental payments for the $4.3 billion Georgia Families managed care program.
- Performed rate setting and analysis for various Medicaid categories of service, including physician services and psychiatric rehabilitation treatment facilities (PRTF).
- Coordinated, analyzed, and implemented changes to the Medicaid hospital inpatient PPS, including automation of inpatient outlier payments.
- Prepared public notices, state plan amendments (SPAs), and other documentation required by CMS in response to Medicaid policy and reimbursement changes.
- Prepared presentations, narratives, policy briefs, and legislative fiscal notes for agency internal and external stakeholders, including DCH board members, the DCH Hospital Advisory Committee, government officials, and media requests.
- Assisted with updates to the Georgia MMIS (claims payment system) to reflect changes in Medicaid reimbursement.
- Performed and presented analysis on the federal Patient Protection and ACA impacts to Medicaid and CHIP including agency budget requests specific to ACA. Projected the impact of Medicaid expansion to Georgia Medicaid.
- Projected Medicaid and CHIP enrollment and expenditures for FFS and managed care populations. Also projected provider fee revenues.

Georgia Governor's Office of Planning and Budget (1995 – 2006)

Budget Analyst/Senior Budget Analyst/Coordinator

Responsibilities:

- Developed, analyzed, and monitored policy and budgets for the Department of Community Health, the Department of Juvenile Justice, and the Division of Family and Children's Services. Policy and budget areas included Medicaid, the State Employees Health Plan, CHIP, child welfare, juvenile justice, child care, and public assistance.
- Performed and presented program evaluations on Georgia's teen pregnancy prevention programs and children's therapeutic residential treatment programs.
- Analyzed federal and state legislation impacting assigned budget and policy areas.

Health Management Associates Inc. (2010 – 2012)

Senior Consultant

Responsibilities:

- Provided health care information and analysis to company clients with a focus on Medicaid and CHIP; specialized in financial analysis and program review.
- Assisted clients in developing and writing proposals in response to state Medicaid managed care procurements.
- Surveyed state Medicaid and CHIP programs for details on program operations, policy, provider reimbursement, and dual eligible (Medicare-Medicaid) initiatives.
- Assisted in a study for the Georgia Department of Public Health on how to improve outcomes in terms of the incidence of very low birth weight babies.

Victoria Hunt

Senior Accountant, Myers and Stauffer

Summary

Ms. Hunt, a senior accountant with Myers and Stauffer, has more than seven years of experience performing various types of Medicaid audits in multiples states. These audits include Virginia Medicaid program integrity compliance audits with pre-field coordination and planning; on-site visits; reviewing clinical documentation; supervising and training of staff; report preparation; interaction with provider personnel; and maintaining up-to-date knowledge of Medicaid program regulations. Additional audits include Virginia Medicaid cost report audits of nursing facilities; DSH payment audits in multiple states; and CMS MIC audits for a variety of provider types. She is responsible for research and application of relevant laws and regulations in the development of audit plans, as well as performing and coordinating Medicaid audits to ensure compliance with federal and state laws and regulations, CMS requirements, and contractor (Health Integrity) requirements.

Education

Master of Accounting, North Carolina State, 2009
B.S., Accounting, North Carolina Agricultural and Technical State University, 2004

Experience

Seven years professional experience

Affiliations

Association of Certified Fraud Examiners

Relevant Work Experience

Virginia Department of Medical Assistance Services (2011 – 2012)

Medicaid Program Integrity Audit Services

Scope of Work:

Myers and Stauffer provided post-payment claims reviews of service providers that participate in the Virginia Medicaid program.

Responsibilities:

- Responsible for completion of Medicaid program integrity compliance testing. This includes pre-field coordination and planning, on-site visits, reviewing clinical documentation, supervising and training of staff, report preparation, interaction with provider personnel, and maintaining up-to-date knowledge of Medicaid program regulations. Test procedures include review of numerous filed claims, reconciliation to the VAMMIS database, medical records and financial records for personal care, respite, home health, private duty nursing, hospice, laboratories, residential treatment facilities, service facilitators, and physicians.
- Worked with management on the newly assigned service facilitator audits to refine the related audit program and error codes by documenting and researching issues noted while completing the initial round of audits.

U.S. Center for Medicare & Medicaid Services (2013 – Present)

Medicaid Integrity Contractor Audits

Scope of Work:
Myers and Stauffer provides audit management, subject matter expertise, and audit staff to support Health Integrity, the MIC with CMS.

Responsibilities:

- Perform Medicaid claim audits to determine whether claims were paid in accordance with federal and state Medicaid laws, regulations, and policies.
- Collaborate with management and the audit team to plan and execute audit; report the resulting audit findings in accordance with Health Integrity, CMS, and applicable state guidelines. This includes research and application of federal and state rules, regulations, and laws.
- Responsible for drafting reports to CMS and states discussing results and recommendations for potential expansion of audit procedures or conclusion of the audit.
- Effectively communicate with providers throughout the audit process and ultimately communicate audit results.
- Provider types include hospice, pharmacy, and hospital credit balances in states including West Virginia, Florida, Louisiana, Mississippi, North Carolina, and Texas.

Virginia Department of Medical Assistance Services (2010 – 2011)

Medicaid Cost Report and Consulting

Scope of Work:
Myers and Stauffer provides cost report regulatory compliance audits, cost settlement desk reviews, and rate setting for the Virginia Medicaid program.

Responsibilities:

- Performed compliance audits specific to cost report audits of nursing facilities and home office organizations. Responsibilities included pre-field coordination, planning, and on-site visits.
- Analyzed financial data to verify accurate reporting.
- Performed testing on various expense accounts related to Medicaid/Medicare reimbursement.
- Compiled audit adjustment reports to present to the provider, and assisted in conducting the exit conferences for provider cost report audits.

West Virginia Department of Health & Human Resources (2010)

Disproportionate Share Hospital Audit

Scope of Work:
Myers and Stauffer provided independent certified audits of state DSH payments.

Responsibilities:

- Performed desk reviews for compliance with CMS final rule.
- Analyzed cost report data, harmonizing large data sets, determined Medicaid and uninsured costs and payments, computed hospital DSH limits, and determined eligibility for DSH programs.

Nevada Department of Health and Human Services (2012 – 2013)

Disproportionate Share Hospital Audits

Scope of Work:
Myers and Stauffer has been engaged to perform the annual DSH examination since CMS began requiring DSH audits.

Responsibilities:

- Assigned as the lead auditor for the Nevada DSH audits.
- Performed hospital desk and field reviews for DSH audits related to compliance with CMS final rule. Responsibilities included contact with providers, analyzing cost report data, determining Medicaid and uninsured costs and payments, determining eligibility for DSH programs, and computing hospital DSH limits.

Washington Health Care Authority (2010)

Disproportionate Share Hospital Audit

Scope of Work:

Myers and Stauffer conducts the examination of the Washington State Health Care Authority DSH program for Medicaid state plan (MSP) rate year 2013 in accordance with the DSH Audit Rule (42 Code of Federal Regulations [CFR] 455).

Responsibilities:

- Performed desk and field reviews for compliance with CMS final rule.
- Analyzed cost report data, harmonized large data sets, determined Medicaid and uninsured costs and payments, computed hospital DSH limits, and determined eligibility for DSH programs.

Oklahoma Health Care Authority (2010)

Disproportionate Share Hospital Audit

Scope of Work:

Myers and Stauffer provides independent certified audits of state DSH payments for the Oklahoma Health care Authority (OHCA).

Responsibilities:

- Performed desk and field reviews for compliance with CMS final rule.
- Analyzed cost report data, determined Medicaid and uninsured costs and payments, computed hospital DSH limits, and determined eligibility for DSH programs.

Consultant and Research Analyst Staff (CRFQ Section 3.3)

All proposed consultant and research analyst staff have at least a bachelor's degree and exceed the minimum requirement of at least two years' experience working with state Medicaid programs. Our proposed Senior Consultant, Bobby Courtney, exceeds the minimum requirements of at least a bachelor's degree in business management or a related field, and at least five years' experience working with state Medicaid programs. Please reference *Staffing (CRFQ Section 3.1)* and associated resumes in *Appendix A: Resumes* for details.

Project Management Lead (CRFQ Section 3.4)

Our proposed Project Management Lead, Claudia Chitu, CFE, PMP, will be responsible for ensuring project deliverables are met and communication is maintained with all parties. Ms. Chitu meets the requirements of having a bachelor's degree, at least five years' experience with projects of similar size and complexity within Medicaid, and a Project Management Professional (PMP) certification. Please reference *Staffing (CRFQ Section 3.1)* for additional details.

On-site Program Integrity Analyst (CRFQ Section 3.5)

Our proposed On-site Program Integrity Analyst, Victoria Hunt, exceeds the minimum requirement of at least three years of experience in reviewing Medicaid FWA cases and issuing recovery notices. Please reference *Staffing (CRFQ Section 3.1)* for additional details.

On-site Project Management/Policy Analyst (CRFQ Section 3.6)

Our proposed On-site Project Management/Policy Analyst, Megan Wyatt, exceeds the minimum requirement of at least three years of experience in Medicaid managed care and at least a bachelor's degree. Please reference *Staffing (CRFQ Section 3.1)* for additional details.

References (CRFQ Section 3.7)

Myers and Stauffer has more than 13 years' experience in providing managed care-related services for state Medicaid agencies. We bring to this project the technical knowledge and skills we have amassed from our experience and work providing managed care program administration, oversight, and rate development.

Managed Care Audit and Related Experience

Myers and Stauffer is at the forefront of assisting states with monitoring and oversight of their managed care contractors and can bring this direct experience to BMS by assigning staff that have already performed similar work in other states. We bring to this project an expert knowledge of industry practices related to managed care operations, including such issues as the complex organizational and operating structures employed by the large affiliated group corporations that are typical to the industry; industry practices in applying administrative overhead rates; and reporting of affiliate transactions. We understand the challenges that complex contractual relationships can pose for our state and federal clients. As a result, we approach each engagement with a proven framework that allows us to gain a full understanding of the performance, compliance, and financial reporting aspects of each contract. This proven framework has led us to identify material areas of contractor non-compliance which has resulted in millions of dollars contractors have had to pay back to the state as well as the assessment of liquidated damages against the contractors.

We are currently assisting more than 10 Medicaid programs and CMS with their audit, consulting, and monitoring efforts related to their managed care programs. These efforts are designed to assist our Medicaid and Medicare agency clients in realizing their goals and objectives for their managed care programs. Our work includes:

- *Encounter data validation and reconciliation.*
- *Risk assessments.*
- *Financial reviews, including MLR examinations and monitoring of MCO administrative costs to ensure only allowable costs are charged to the program.*
- *Operational performance audits.*
- *Readiness reviews.*
- *Review of medical costs to ensure overpayments are not passed through to the state.*
- *Monitoring of TPL payments and recoveries to ensure these are properly offset against costs.*
- *Contract compliance reviews to ensure that health plans are operating in accordance with both the contract with the regulatory agency and with the provider community.*
- *Oversight and monitoring training and support to state staff, ensuring related-party transactions are reported in accordance with program requirements.*
- *Utilization management reviews to ensure that recipients have access to needed health care services and that our agency clients have prompt access to the data they need to manage these expensive health care programs.*
- *Compliance audits of PBMs and third-party administrators (TPAs).*

Noted below, we have outlined selected examples of our work with other MCO audit and consulting contracts:

Georgia Department of Community Health (DCH)
Since 2007, we have assisted the DCH with nearly all aspects of their Medicaid managed care initiative, the Georgia Families program. This Medicaid managed care program serves nearly two million members statewide, through four national health plans and a large number of subcontractors. We conduct managed care compliance consulting, including encounter reconciliation and validation, performance testing, on-site audits and recommendations for process and contractual improvements, financial reconciliations, review of internal controls, MLR audits, and the development of policies and procedures. Our experience also includes:

- *Post-payment review of claims for accuracy and contract compliance.*
- *On-site readiness reviews of four CMOs for the Department in 2017. These reviews included assessing call center operations readiness; determining system readiness for claim processing and timely provider payments; determining readiness to submit encounter claims to the Department following Go Live; assessing subcontractor readiness; and assessing other systems readiness, including coordination of benefits and provider appeals (ability to receive and track complaints, etc.).*

- *Assistance to the Department with new CMO contract open enrollment activities in 2017. These activities include development of management reports and dashboards related to CMO open enrollment activities; development of an open enrollment communication plan for internal and external stakeholders, including providers/provider organizations, consumers, consumer advocates, sister agencies, legislators, DCH task forces, vendors, and others; and support in the development of contingency plans and options around any CMO failing to meet statewide network access requirements prior to open enrollment.*
- *Conducting testing for network adequacy and availability, including conducting secret shopper calls and appointments.*
- *Monitoring and reporting on health plan compliance with contractual and regulatory provisions.*
- *On-site financial audits and performance audits.*
- *Preparation of written and oral reports, including presentations to the Department of Community Health and the Board of Community Health in Georgia and legislative committees.*
- *Bi-monthly reconciliation of the encounters being submitted by the health plans and their subcontractors to the Department's MMIS vendor, DXC (formerly Hewlett Packard [HP] Enterprise Services), to ensure completeness and accuracy. Work with DXC to identify issues with accurately storing and reporting health plan submitted encounter data. Recommend operational changes in order to enhance the reliability of the encounter data.*
- *Analysis of the encounter processes and documentation utilized by the MMIS and/or the fiscal agent contractor (FAC). By utilizing information supplied by the MCOs to the FAC and the Department, the analysis determined the accuracy and effectiveness of the encounter processes and documentation utilized by MCOs and/or the fiscal agent contractor.*
- *Analyses to measure the reliability and accuracy of encounter and member data used to establish capitation rates (i.e., inaccurate encounter and member data could lead to higher than necessary capitation rates). Test for member duplicates and claims paid as FFS when a member is assigned to a health plan.*
- *Provide assistance to the Department's actuarial vendor in reconciling and understanding the encounter data being used for capitation rate setting purposes.*
- *Reconcile and test ACA required payment increases for compliance with state and federal statutes.*
- *Conduct review of ICD-10 readiness and identify potential red flags to be addressed by the health plan and the Department.*

Texas Health and Human Services Commission (HHSC)
Since 2004, we have been the contractor for Medicaid and CHIP-related audit services for HHSC. We have partnered with HHSC to assist in its mission to strengthen contract oversight by providing HHSC with professional audit services. Our services have helped ensure accurate and

relevant accountability and reporting by the external entities that provide services to HHSC Medicaid and CHIP programs, including MCOs. Our partnership with HHSC includes the development of a comprehensive monitoring program of the Texas Medicaid MCOs. This program includes:

- *Development of comprehensive risk assessments of each MCO that assess contract and operational risk over three major areas:*
  - ***Financial.*** *Are the costs being charged to the State in compliance with the federal acquisition regulation (FAR) and state rules and regulations?*
  - ***Service.*** *Are the services for which the State has contracted being provided in compliance with performance standards as set out in the contract?*
  - ***Business.*** *Are the business systems of the MCO, such as their information technology (IT) security systems, functioning effectively to meet all rules and regulations, as well as, contract standards?*

  These risk assessments provide the State with a unique management tool that can be used by the state program managers to identify and monitor contract compliance concerns. These risk assessments also serve as a basis for following up on the highest risk areas through conducting financial and performance audits.
- *Conducting performance audits of each of the MCOs on a rotating basis to provide the State with an independent assessment of the MCOs operational compliance with their contracts, covering the service and business risk areas identified in the comprehensive risk assessments. Using the risk assessments as a starting point, we work with the health plan managers to prioritize their concerns and develop objectives that will address those concerns. These performance audits have been instrumental in identifying deficiencies in self-reported performance data (such as encounter data); deficiencies in IT security systems that put personal health information at risk; development and coverage of provider networks; and the operations of call centers in handling such issues as customer complaints, along with feasible recommendations on how to address these deficiencies.*
- *Conducting financial examinations and agreed-upon procedures (AUPs) to assess the allowability of costs reported by MCOs. These examinations provide coverage of the financial risks identified in the risk assessments. Through these examinations, we have assisted the State in recouping millions of dollars in overcharges resulting from issues involving incorrect claims processing, reporting of reinsurance recoveries, allocation of unallowable costs, allocation of unallowable related-party expenditures, and overcharges for related-party services.*
- *Completed on-site information system and HIPAA-readiness reviews of seven MCOs for the state of Texas in December 2011 and January 2012. These reviews included performing a combination of desk review procedures and on-site assessments of information systems and facility security controls to determine whether the MCOs had implemented information system and Health Insurance Portability and Accountability Act (HIPAA) controls, as required under their contracts with the HHSC, and were ready to begin operations.*

Louisiana Department of Health (LDH)
Since 2012, Myers and Stauffer has worked closely with the Louisiana Department of Health and the state's managed care and care coordination networks participating in the Bayou Health program. As part of our contract, we:

- *Perform audits of MLR reports submitted by each MCO. This includes requesting supporting documentation from each MCO, trial balance, claim lag reports, and other claim and financial information; and performing analyses to ensure the definitions and assignments of medical and administration expenses are appropriate.*
- *Perform analyses of health plan submitted cost reports per the supplemental financial reporting guides. These quarterly reports were designed by the Department to assist with the monitoring of MLRs and administrative costs, and to aid with the development of capitation rates.*
- *Perform a bi-monthly reconciliation of the encounters being submitted by the health plans and their subcontractors to the Department's MMIS vendor, Molina, to ensure completeness and accuracy; work with Molina to identify issues with accurately storing and reporting health plan submitted encounter data; and recommend operational changes in order to enhance the reliability of the encounter data.*
- *Provide an analysis of the encounter processes and documentation utilized by the MMIS and/or the FAC. By utilizing information supplied by the MCOs to the FAC and the Department, the analysis determined the accuracy and effectiveness of the encounter processes and documentation utilized by MCOs and/or the fiscal agent contractor.*
- *Conduct analyses to measure the reliability and accuracy of encounter and member data used to establish capitation rates (i.e., inaccurate encounter and member data could lead to higher than necessary capitation rates).*
- *Assist the Department's actuarial vendor in reconciling and understanding the encounter data being used for capitation rate setting purposes.*

Mississippi Office of the Governor, Division of Medicaid (DOM)
Since August 2015, Myers and Stauffer has been performing financial reviews and analytical activities for the MississippiCAN and MississippiCHIP programs. Projects include encounter data validation and reconciliations (to include Protocol 4), capitation and rate reviews, medical loss and administrative expense reviews, TPL reviews, and health insurance providers' fee calculation review. Our services include:

- *Work with the FAC to identify issues with accurately storing and reporting health plan submitted encounter data, and recommended operational changes in order to enhance the reliability of the encounter data. This also includes an evaluation of the data used for risk adjustment.*
- *Evaluate denial rates among the CCOs to determine if claims are being inappropriately denied or if claims adjudication policies make it difficult for participating providers to receive accurate and timely payment.*

- *Review encounter data information and other inputs utilized in risk adjustment for rate setting.*
- *Review supporting TPL policies and procedures from each CCO.*
- *Provide recommendations and potential savings amounts to the DOM and each CCO.*
- *Review current tax law (federal and state) related to fees imposed to the CCO under Section 9010 of the Patient Protection and ACA.*
- *Conduct examinations of the Medicaid and CHIP MLR reports. Perform AUP analysis of the administrative expenses filed.*
- *Review of actual tax calculation owed/remitted to the federal government.*

Maryland Department of Health (MDH)

Since 2006, Myers and Stauffer has been contracted by the MDH to test the accuracy of the HealthChoice Financial Monitoring Report (HFMR) prepared by the seven MCOs contracted with the State under the Maryland HealthChoice program. The procedures include the following:

- *Reconciliation of amounts reported on the MCO's trial balance, audited financial statements, and annual statement to the HFMR.*
- *Haphazard selection of amounts reported on the regional and statewide HFMRs and verification of these amounts to supporting documentation, such as MCO system reports and queries.*
- *Random selection of claim transactions to determine whether the amount reported on the claim was recorded to the correct cell, service classification, region, and year on the HFMR.*
- *Review of amounts reported as IBNR on the annual report to the trial balance and lag reports. Verification of reported expenses per the HFMR to paid claims, plus IBNR for the year.*
- *Reviewing the methodology for reporting medical management expenses.*
- *Analysis of special delivery (kick) payments to ensure delivery-related claims were incurred by the MCO.*
- *Verification of pharmacy rebate payments.*
- *Determination that proper procedures were used to report non-plan services.*
- *Review of procedures and verification of amounts submitted for TPL recoveries.*

We were also contracted to perform procedures to verify investment income, administrative costs, and related-party costs. The procedures include reconciling these balances to the MCO's annual statement, audited financial statements, and trial balance. The procedures also included documenting the MCO's methodology for recording these transactions, as well as documenting the MCO's basis for allocating costs or revenues to the Medicaid program.

Nevada Division of Health Care Financing and Policy (DHCFP)
Since 2011, we have assisted the DHCFP with several aspects of their Medicaid managed care program including:

- *Performance audits. Focus areas included the effectiveness of compliance program, program integrity and fraud and abuse safeguards, TPL, and stop-loss.*
- *Administrative expense reviews.*
- *Encounter data validation.*
- *Process improvement review.*
- *MCO onboarding.*
- *MCO data and information strategic roadmap.*
- *Training.*

New Mexico Human Services Department, Medical Assistance Division (MAD)
Myers and Stauffer assisted the Department with monitoring and reporting as it relates to the Centennial Care Program. This engagement focused on the internal controls and processes related to claims adjudication, prior authorization, provider credentialing, and contract loading. In addition, claim payments and other transactions made for specified periods and service categories (particularly hospital claims) were tested and analyzed to determine if the payments or denials were made according to Centennial Care Program coverage and payment policies. Additional areas tested and analyzed on-site were complaints, appeals, and grievances; health plan compliance; program integrity; and subcontractor-delegated services monitoring. We are also recently concluded encounter data validation reviews under External Quality Review (EQR) Protocol 4. Through our work we:

- *Performed an analysis of the inpatient hospital claims data provided by each MCO, then prepared a summary on claims adjudication timeframes, claim denial rates, and reasons for the denials.*
- *Reviewed and documented the components of the MCO's claims processing/ reimbursement system and claim submission methods allowed by the MCOs, then documented any potential vulnerabilities, including weaknesses in their system that could lead to overpayments and underpayments.*
- *Analyzed a sample of paid and denied inpatient hospital claims from each MCO. The following procedures were performed:*
    - *Analyzed the claim exceptions/edits to determine if the claim should have been paid or denied.*
    - *Analyzed pricing data on the claim to determine if the claim was priced correctly in accordance with the provider or facility contract.*
    - *Reviewed individual hospital contract for reimbursement rates.*
    - *Tested certain intra-claim limits and audits.*

- *Determined whether the claim was paid accurately and timely or denied accurately and timely.*
- *Computed the dollar value of each mispayment, as applicable.*

- *Performed an analysis of the number of days between an authorization request and the date the authorization was approved or denied.*
- *Performed an analysis of the number of days required to complete provider credentialing.*
- *Performed an analysis of the number of days required to load provider contracts for behavioral health, long-term care, and hospital providers.*
- *Reviewed each MCOs' existing policies and procedures related to the reporting, investigation, and resolution of complaints, appeals, and grievances.*
- *Reviewed each MCOs' existing policies and procedures related to subcontractor oversight.*

Virginia Department of Medical Assistance Services (DMAS)
We have worked with DMAS for several years to test the accuracy and allowability of the administrative expenses reported by the Virginia MCOs in their annual reporting to the Bureau of Insurance. As part of this work, we also tested the allocation of expenses from other lines of business or related entities. We were also recently contracted by DMAS to conduct a review of MCO medical spend for related-party transactions to ensure that capitation rates do not cover spending above market value.

Colorado Department of Health Care Policy and Financing (HCPF)
We were contracted by the HCPF to assist with development of the financial reporting template used by their managed care program for calculating the MLR, and of the financial reporting template used to collect quarterly financial information from the Colorado Regional Care Collaborative Organizations. We worked in collaboration with HCPF to develop a risk-based annual monitoring plan to review their behavioral health organizations and MCOs. The annual reviews include:

- *Reconciliation of reported program costs to supporting general ledger and associated schedules.*
- *Review and limited testing of program medical and administrative cost for allowability and proper classification.*
- *Review of the monitoring and reporting of subcontractor costs.*

Washington State Auditor
Myers and Stauffer assisted the State Auditor with a Yellow Book performance audit of the Washington State Health Care Authority to assess the controls in place to monitor third-party contractors' compliance with contract requirements to implement programs to identify potential overpayments associated with medical claims under Washington's Medicaid managed care program. This audit encompassed detailed analytical data analysis and testing of medical and administrative costs reported by MCOs, testing of that data, and calculating the related impact of identified overpayments to the computation of capitated rates.

South Carolina Department of Health and Human Services (DHHS)
We were contracted by DHHS to test the accuracy and allowability of the administrative expenses reported by the four South Carolina MCOs in their annual reporting to the Bureau of Insurance. The procedures included the following:

- *Reconciliation of administrative expenses per the annual statement to the financial reports.*
- *Documenting our understanding of the administration expenses reported on the annual statement, including allocation of expenses from other lines of business or related entities, and reconciling and verifying financial data reported on the annual statement for administrative expenses.*
- *Verification and assessment of the business purpose and valuation of related-party transactions affecting administrative expenses.*

CMS: Examinations of Medicare Advantage Organizations and Prescription Drug Plans
We perform financial examinations of the MA/PDPs to provide assurance that Part C and Part D payments were proper, organizations' self-reported information used to determine payment amounts were valid and correct, and risk sharing calculations were in accordance with applicable regulations.

These financial audits consist of planning/risk assessment, medical and drug claim data mining, reviewing administrative/non-benefit expenses and allocations, reviewing medical and drug pricing calculations, reviewing drug rebate contracts and calculations, reviewing solvency, and reviewing the adequacy of their internal controls over payment disbursements for medical and drug benefit services.

CMS: Performance and Compliance Audits of Medicare Advantage Organizations and Prescription Drug Plans
We are also contracted by CMS to conduct performance and compliance audits of MA/PDPs. The current primary focus areas of the performance audits are formulary administration; coverage determinations, appeals, and grievances (CDAG); organizational determinations, appeals, grievances, and dismissals (ODAG); compliance plan effectiveness; and special needs plan (SNP) model of care.

In addition, we have provided CMS with technical and operational oversight and support, including:

- *Developing various audit protocols and audit guides.*
- *Conducting annual risk assessments of the plan sponsors.*
- *Low-income subsidy (LIS) readiness audits. These audits consist of a review of the health plan's enrollment and claims systems, and staff and training, as well as a review of their formulary benefit administration and compliance program. The purpose of the audits is to determine if the health plans are capable of processing the large influx of enrollees and if they have adequate internal controls in place to ensure they can then provide a level of service and properly administer the Medicare benefit after they are enrolled.*

- *Validating the adequacy of corrective actions performed to address prior deficiencies identified.*

Managed Care Consultation Experience

Through our successful work conducting MCO performance and contract compliance oversight for state Medicaid programs, Myers and Stauffer has gained considerable expertise with managed care. Our scope of comprehensive services helps ensure that MCOs are on track to achieve intended performance goals. We have a large national consulting practice focused exclusively on government health care programs. We bring a level of consulting expertise that is extraordinary, which uniquely qualifies us to provide managed care program oversight. We draw on the total resources of the firm when performing our consulting obligations. Often, issues currently being addressed in one state have previously been addressed in another state.

The combination of skills and expertise we bring to this project is truly unique. We possess a detailed understanding of West Virginia's reimbursement systems and environment. And not only do we have exceptional Medicare/Medicaid contract compliance audit and desk review knowledge and experience, but we also have equivalent knowledge and experience in the Medicaid consulting, data management, and vendor oversight areas.

We have consulted on a broad range of Medicaid contract performance and monitoring topics including:

- *Resource support, including subject matter expertise.*
- *Health plan contract development.*
- *Health plan and health plan system readiness reviews.*
- *Stakeholder outreach planning and implementation, including liaison to provider associations, legislative advocacy groups, or other outreach, as appropriate.*
- *Program risk assessment and evaluation.*
- *Assistance with development of reporting requirements and other program management tools, including network adequacy.*
- *Provisions for retention and submission of data.*
- *Provisions for state's right to audit.*
- *Provisions for addressing non-compliance.*
- *Provisions for addressing overpayments and excess profits.*
- *Data analysis and encounter testing.*
- *Performance audits to test for compliance with contract performance provisions.*
- *Follow-up audits to validate correction of issues.*
- *Improper payments made by MCOs to providers.*
- *Duplicate payments between benefit programs.*

- *Inappropriate payments to MCOs.*
- *Improper coding of data used to risk adjust payments.*

Specific References

On the following pages, we have included three client references that are most representative of the requirements for this engagement.

Georgia Department of Community Health

Care Management Organization Compliance

Scope of Project

Myers and Stauffer was engaged to assist the Georgia Department of Community Health (DCH) with its Georgia CMO analysis project. This project assesses the policies and procedures of the program, as well as oversight and monitoring of the Georgia CMOs which includes contract compliance; subcontractor oversight; encounter reconciliation and validation; performance testing; on-site audits; recommendations for process and contractual improvements; financial reconciliations; review of internal controls; MLR audits; and claim repricing.

CONTACT

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Atlanta, GA 30303

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TERM OF CONTRACT

2007 – Present

CONTRACT VALUE

$1,670,000 (Annually)

Services Provided

- Post-payment review of claims for accuracy and contract compliance.
- Monitoring and reporting of health plan compliance with contractual and regulatory provisions.
- On-site financial audits and performance audits.
- Bi-monthly reconciliation of the encounters being submitted by the health plans and their delegated vendors to the department's MMIS vendor, HP Enterprise Services, to ensure completeness and accuracy.
- Collaboration with HP to identify issues with accurately storing and reporting health plan submitted encounter data.
- Recommendations of operational changes in order to enhance the reliability of the encounter data.
- Assistance to the Department's actuarial vendor in reconciling and understanding the encounter data being used for capitation rate setting purposes.
- Reconciliation and testing of ACA required payment increases for compliance with state and federal statutes.
- Review of International Classification of Diseases (ICD)-10 readiness and identification of potential red flags to be addressed by the health plan and the Department.
- Global analysis of claim payment and denial trends and other care management performance related utilization trends.
- Testing for network adequacy and availability and perform analyses on care management provider directories and appointment wait times.

- Preparation of written and oral reports, including presentations to the Department of Community Health, the Board of Community Health, and legislative committees.

Maryland Department of Health

AUPs, Related Accounting, and Consulting Services for Managed Care Organizations

Scope of Project

Myers and Stauffer provides AUP and related accounting services to assure that MCOs' expenditures are in compliance with state and federal laws and regulations. Services include performing AUPs of financial and statistical data submitted to the Department by state-contracted MCOs.

Services Provided

- Developed a program of AUPs for MCOs that was approved by the Department.
- Determined that MCOs have implemented procedures and utilized financial, administrative, and internal control procedures to discharge their cost reporting responsibilities.
- Determined from a sampling of functional costs that the costs incurred and claimed are allowable.
- Recommended adjustments based on tests of reliability and allowability.
- Prepared individual MCO reports and a summary report for all plans.

CONTACT

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TERM OF CONTRACT

2006 – Present

CONTRACT VALUE

$1,009,844

Texas Health and Human Services Commission

Medicaid and CHIP MCO Attest Services

Scope of Project

Since 2004, Myers and Stauffer has been the contractor for Medicaid and the CHIP-related audit services for the HHSC. We have partnered with HHSC to assist in its mission to strengthen contract oversight by providing HHSC with professional audit services that have, in a timely manner, helped ensure accurate and relevant accountability and reporting by the external entities that provide services to HHSC Medicaid and CHIP programs, including MCOs. Our partnership with HHSC includes the development of a comprehensive monitoring program of the Texas Medicaid MCOs.

CONTACT

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TERM OF CONTRACT

2004 – Present

CONTRACT VALUE

$2,192,598 (Current Year)

Services Provided

- Development of comprehensive risk assessments of each MCO that assesses financial risks.
- Financial examinations and AUPs to assess the allowability of costs reported by MCOs; these examinations provide coverage of the financial risks identified in the risk assessments.
- Validation of the self-reported financial and accounting data of MCOs with respect to their business with HHSC and issue-related findings.
- Disseminate written opinions on each MCO's financial reporting and compliance with relevant terms of HHSC's Uniform Managed Care Contract (UMCC), HHSC's Uniform Managed Care Manual (UMCM), and FAR.
- Identification of areas within the UMCC and UMCM that may benefit from modification.
- Expertise with respect to financial reporting of MCO affiliate transactions.
- Information related to financial reporting best practices and experiences in the Medicaid managed care programs of other states.

Actuarial Services

Resumes of Key Staff (CRFQ Section 3.8)

On the following pages, please find the resume of our key actuarial staff member, as defined in the CRFQ. Please see *Appendix A: Resumes* for complete resumes of additional proposed non-key staff members.

Timothy Doyle, FSA, MAAA

Senior Actuary, Optumas

Summary

Mr. Doyle has more than 18 years of experience as a consulting actuary, specializing in providing program, strategy, and operational consulting services. He currently serves as the Senior Actuary for the Medicaid managed care programs in the states of Alabama, Arkansas, Kansas, Maryland, and North Dakota, overseeing the capitation rate development, signing the Actuarial Certifications, and supporting stakeholder communication efforts by presenting actuarial results in a way that can be understood by both experts and laymen. Per the specifications of CRFQ 0511 BMS1800000002, Mr. Doyle will be the Lead Actuary for the West Virginia BMS.

Mr. Doyle has also done work in Arizona, California, Colorado, Louisiana, Maine, New Hampshire, New Mexico, New York, North Carolina, Oregon, and Pennsylvania. The projects in these states spanned all types of populations and benefits. The types of projects included developing actuarially sound rates and rate ranges, 1915 and 1115 waiver assistance, developing per capita expenditure models, preparing costs and savings estimates for Medicaid expansion populations, and health care reform.

A facet of Mr. Doyle's experience that sets him apart from other actuaries is his work with contracted Medicaid managed care health plans. He has worked on both sides of the fence, helping states set rates for health plans and consulting for publicly-sponsored plans on effectively providing services under capitation rates from the state. This experience gives Mr. Doyle a unique perspective into provider relations; he knows what the plans are looking for and what they are likely to accept or reject. It is this experience that providers and state Medicaid plans are generally striving for the same goal: they each want to provide their constituents with the highest level of care while maintaining financial solvency. When an actuary has seen both sides of the managed care coin, it is much easier for them to understand what each party values. Mr. Doyle utilizes this experience to effectively communicate the methodology behind rate adjustments and the reason why each adjustment is fair and necessary. With his thorough and detailed communications, providers are able to see rate changes as essential changes to the rate structure, rather than the state attempting to save money by simply passing along unsubstantiated rate cuts to the health maintenance organization (HMOs).

Prior to joining Optumas in 2011, Mr. Doyle was a principal for Mercer, where he served as senior actuary for their government practice.

Education

B.A., Mathematics, Moorhead State University, 1994

Experience

18 years professional experience

Affiliations

American Academy of Actuaries
Society of Actuaries

Certifications

Fellow of the Society of Actuaries (FSA)
Member of the American Academy of Actuaries (MAAA)

Relevant Work Experience

Maryland HealthChoice Program via The Hilltop Institute (2010 – Present)

UPL Development

Scope of Work:

Optumas assists the Maryland Department of Health via subcontract with The Hilltop Institute to calculate actuarially sound capitation rates for the HealthChoice Medicaid managed care program.

Responsibilities:

- Serves as the Lead Actuary for Medicaid managed care rate setting, including developing the rate methodology in accordance with the Actuarial Standards of Practice (ASOP) covering Medicaid rate setting and rate development guidance from CMS, signing the rate certification letters submitted to CMS, and providing expert testimony and document in support of the actuarial soundness of the rates.
- Develop program change estimates in an actuarially sound manner.
- Develop budget models to allow state to forecast the impact of population, service, and program changes upon state expenditures.
- Analyzed potential changes in Medicaid managed care policy and procedures from an actuarial perspective to determine potential impact on risk pool and capitation paid.

New York Office for People with Developmental Disabilities (2009 – Present)

Resource Balancing Model

Scope of Work:

Optumas assists the New York Office for People with Developmental Disabilities with resource balancing modeling for their DD population.

Responsibilities:

- Serves as the Lead Actuary for rate development.
- Responsible for development of 1915b cost effectiveness analyses.
- Reviews the resource balancing model to ensure it matches payment to risk and enables proper individual resource allocation.

North Dakota Children's Health Insurance Program (2010 – Present)

Capitation Rate Development

Scope of Work:

Optumas assists the North Dakota Department of Human Services to calculate actuarially sound payment rates for the CHIP managed care program.

Responsibilities:

- Serves as the Lead Actuary for CHIP managed care rate setting, including developing the rate methodology in accordance with the ASOPs covering Medicaid rate setting and rate development guidance from CMS, signing the rate certification letters, and providing expert testimony and document in support of the actuarial soundness of the rates.
- Develops program changes estimates in an actuarially sound manner.
- Develops budget models to allow state to forecast the impact of population, service, and program changes upon state expenditures.
- Analyzed potential changes in CHIP managed care policy and procedures from an actuarial perspective to determine potential impact on risk pool and capitation paid.

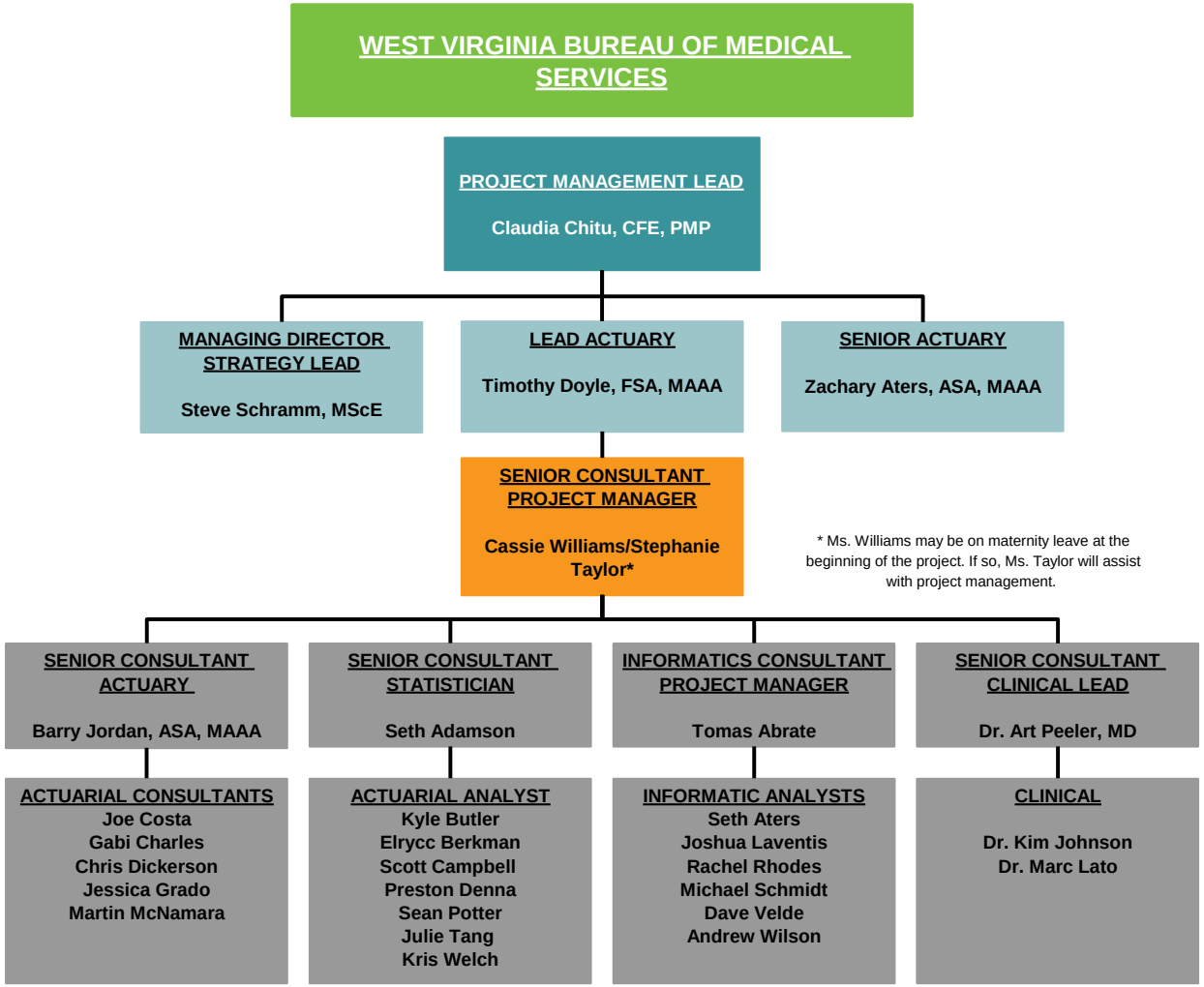
Staff Actuarial Resources (CRFQ Section 3.9)

Optumas has developed a dedicated team of nine main staff members, with additional support available from another 23 staff members, to meet the actuarial needs of BMS within agreed-upon timeframes. The Optumas team has sufficient capacity; there will be no need to hire any additional staff. BMS will have a team of seasoned professionals, the key members of which all have at least five years of Medicaid managed care rate setting experience.

The Lead Actuary, Mr. Timothy Doyle, is a Fellow in the Society of Actuaries (FSA) and a Member of the American Academy of Actuaries (MAAA), and has more than 18 years of experience with Medicaid managed care rate setting, greatly exceeding the minimum qualifications of the CRFQ. He may be requested on a full-time basis if warranted, per the CRFQ. Mr. Doyle will be supported by Mr. Steve Schramm, the managing director of Optumas, a health economist with more than 30 years of Medicaid managed care rate setting experience. Mr. Zachary Aters, an Associate in the Society of Actuaries (ASA) and MAAA, will serve as the Senior Actuary.

On the following page, please see an organizational chart of our proposed actuarial services staff. We assure BMS that the quality of staff will be maintained over the term of the contract agreement due to the depth of our experience with Medicaid agencies.

Actuarial Services Team Organizational Chart



References (CRFQ Section 3.10)

Actuarial Services Experience

Optumas has more than 11 years of extensive experience designing strategies to help purchasers identify, quantify, and balance the risk associated with health care reform. The team is experienced in providing actuarial services to public sector payers. Their actuarial experience consists of the following:

- *Actuarially sound capitation methodologies for existing programs in Alabama, Arizona, Colorado, Kansas, Maryland, Nebraska, New Mexico, North Dakota, Oregon, and Texas.*
- *Development of a comprehensive procurement process, including RFP writing, procurement and evaluation assistance, running bidder's conferences, answering questions, and developing bidder's libraries for prospective vendors (e.g., detailed and summary de-identified databooks and rating manuals).*
- *Comprehensive rate development for Medicaid (all populations and expansion and health reform populations and services).*
- *Partial rate development for shared risk arrangements with ACOs, IPAs, and PCCM/PCMH programs.*
- *Base data identification, homogenization, normalization, and organization.*
- *Data validation including:*
    - *Assessing the use of category of service and category of aid relative to benchmarks.*
    - *Statistical evaluation on the use of unit and other measures across MCOs or other data providers as units may be inconsistently used or used in some cases by some data providers but not by others.*
    - *Applying statistical techniques to perform various volume and dollar checks evaluating totals as well as trends over time to identify potential inconsistencies.*
    - *Performing frequency analysis across all fields, comparing datasets from previous submissions.*
    - *Completing referential integrity checks (RICs) to ensure that all encounters included in the base data were incurred by a member with valid Medicaid eligibility that coincided with the incurred date associated with the specific encounter.*
    - *Performing longitudinal checks (LCs) to support a review of data over time and identified data anomalies within any given month.*
    - *Re-pricing validations identifying comparable programs and/or waivers within that state or in comparable states, and identifying comparable services for appropriate rate matching.*
    - *Examining external data and information sources such as comparing actual reported dollar and other totals with budgets, internal proprietary and other benchmarks along with other external sources for consistency as needed.*

- *Development of sophisticated claims completion triangles, including IBNR and incurred but not paid (IBNP).*
- *Program and policy change analyses.*
- *Trend analysis to include retrospective, concurrent, and prospective by category of service, provider type, and geographic region for both utilization and unit cost.*
- *Provider reimbursement benchmarking to Medicaid fee schedule, other states' reimbursement, usual and customary, commercial insurance, and Medicare.*
- *Development of non-medical load (NML) models to project administrative costs by RFP responsibility, splitting out fixed and variable costs by total dollars and full-time equivalent (FTE).*
- *Capitation rate adjustment for individual cost adjustment factors, benefit, programmatic, and policy changes made after defined data are accumulated for analysis, certified match from public providers, encounter completion factors, financial experience of the MCO (including potential risk/rate differentials), cost and utilization trends, adjustments for historically-low utilization of a service, DSH payments, federally qualified health center/rural health clinic (FQHC/RHC) encounters, graduate medical education (GME), pharmacy rebates, post-pay recoveries, data smoothing/catastrophic claims, MLR, and Health Care Insurance Provider Fee(s) (HIPF).*
- *Review of supplemental payments to ensure they comport with federal requirements.*
- *Development of risk corridors and risk sharing program to mitigate targeted risk components assumed by the MCOs and the State.*
- *Write comprehensive certification letters documenting the rate development methodologies.*
- *Lead public presentations, including expert testimony for Legislative Oversight Committees on the rate development methodologies.*
- *Development of technical models designed to assist in rate development processes and other actuarial analyses that are often created to allow the client to see results dependent upon varying assumptions.*
- *Presentations, using an array of resources (PowerPoint, Visio, Excel, Tableau, Power BI), that present results in a manner that is tailored to and appropriate for the given audience.*
- Follow all applicable ASOP as promulgated by the Actuarial Standards Board, including but not limited to:
    - *ASOP 5 – Incurred Health and Disability Claim.*
    - *ASOP 23 – Data Quality.*
    - *ASOP 41 – Actuarial Communications.*
    - *ASOP 45 – The Use of Health Status Based Risk Adjustment Methodologies.*

- *ASOP 49 – Medicaid Managed Care Capitation Rate Development and Certification.*

- *Actuarial assistance for new programs/populations in Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Kansas, Maine, Maryland, Massachusetts, Montana, Nebraska, New Hampshire, Nevada, North Dakota, Ohio, Oregon, and Vermont.*
  - *Evaluate new program using Optumas' Four Determinants of Risk:*
    - *Program Design.*
    - *Target Population.*
    - *Covered Benefits.*
    - *Provider Network.*
  - *Estimate the number and type of enrollees using publicly available survey data and program information.*
  - *Develop appropriate analytic groupings to maximize both intra-cell homogeneity and inter-cell heterogeneity.*
  - *Design risk adjustment programs to enhance the viability and marketability of program initiatives for health and welfare programs.*
  - *Compare risk adjustment tools to determine the most appropriate for the state's health purchasing goals.*
  - *Present risk-adjustment results to MCOs and provider practices, explaining the methodology and the results and demonstrating how risk-adjustment results can be used on MCO and provider operations.*
  - *Determine available data for new population medical utilization, including uncompensated care reports, provider financial reports, non-Medicaid agency spending reports, or reference data for a similar population.*
  - *Apply all adjustment factors necessary to convert the medical utilization from the underlying program structure to the new program design.*
- *Budget modeling in Alabama, New York, North Dakota, Ohio, Oregon, and Vermont.*
  - *Assistance in preparing the Medicaid budget, including the managed care rate setting and identification of industry trends in price, utilization, and management of health care services.*
  - *Build budget models for states that match the general ledger system to track all Medicaid expenditures historically, and use that data to prospectively project future expenditures.*
  - *Evaluate proposed rates of increase in Medicaid expenditures against national and regional benchmarks by programs and population.*
- *Alternative payment methodologies in Alabama, California, Colorado, Kansas, and Oregon.*

- *Develop alternative payment methodologies for MCO, ACO, physician, FQHCs/RHCs, and other provider-based CMOs.*
- *Evaluate alternative payment methodologies for FQHCs, RHCs, MCOs, ACOs, and PCCM/PCMH programs to determine if they resulted in better quality, access, outcomes, or reduced rates of growth.*

- *Claims and encounter reporting requirements, specifications, and intake for Colorado, Maryland, Nebraska, New York, North Dakota, and Oregon.*
  - *Assisting states with encounter data improvement processes.*
  - *Providing secure data transfer using our secure file transfer protocol (SFTP) server host.*
  - *Analyzing state and/or health care plan or other stakeholder analyses from a technical perspective to ensure accuracy, identify any concerns, and suggest potential improvements to modeling.*
  - *Offering technical assistance and training to health care plans or other stakeholders through state clients on such issues as reporting requirements, including quality and financial reporting templates, data utilization analyses, administration, and operational/financial reviews.*
  - *Offering technical assistance and training to state staff on such issues as reporting requirements including quality and financial reporting templates, data utilization analyses, administration, and operational/financial reviews.*
- *UPL development for Alabama, California, Colorado, and Nebraska.*
  - *Set UPLs for PACE.*
  - *Develop hospital UPL methodologies to ensure reimbursement is consistent with federal guidelines.*
- *Assistance with 1915(b) and 1115 waiver submissions in Alabama, Arkansas, Colorado, Kansas, Maryland, Nebraska, and Vermont.*
  - *Submit 1915(b) waiver submission cost-effectiveness analyses for Alabama, Arkansas, Colorado, and Nebraska.*
    - *Acquire detailed data for the covered population and summarize the encounter data to be appropriate for capitation rebasing.*
    - *Collect any other data for payments made outside of the FFS or capitation systems to ensure that total risk is captured.*
    - *Collect financial reporting data from managed care contractors.*
    - *Review CMS Medicaid Eligibility Groups (MEGs) for applicability and relevance.*
    - *Adjust data for any retrospective/prospective program changes by program.*

- *Develop trends by category of service and population group using the detailed data, financial reports, national trend estimates, and actuarial experience with similar programs. Compare service trends by utilization per 1,000 and unit cost across multiple sources.*
- *Determine appropriate administrative expense funding.*
- *Develop the rates or cost effectiveness tests for each CMS-specific MEG.*
- *Provide any additional exhibits, such as a methodology document, presentation materials, etc.*

- *1115 waiver assistance for Alabama, Arkansas, Kansas, Massachusetts, New York, Oregon, and Vermont.*
  - *Write concept paper.*
  - *Develop program design strategy.*
  - *Perform budget neutrality calculations.*
  - *Lead public comment meetings.*
  - *Address questions from public comment sessions/period and CMS.*
  - *Lead CMS negotiations.*

- *MLTSS/HCBS Waiver Services in Alabama, Colorado, and Nebraska.*
  - *Develop cost savings model to estimate the move to a managed long-term care supports and services program.*
  - *Determine the potential diversion (move from nursing facility to the community) and deflection (delay the movement from nursing facility to community), and identify specific characteristics of individuals eligible to move and the rate of that movement for each.*
  - *Review HCBS spending to determine population acuity levels.*
  - *Analyze impact of LTSS management on population acuity.*
  - *Explore functional level of need analyses to create better LTSS predictive modeling capabilities.*

- *Strategy around new and innovative programs in Alabama, Arkansas, Colorado, Hawaii, Kansas, Maryland, Massachusetts, Nebraska, New York, Ohio, Oregon, and Vermont.*
  - *1115 waiver program design in Alabama, Arkansas, Kansas, Massachusetts, New York, Oregon, and Vermont.*
  - *SIM analysis for statewide health care reform for Colorado, Hawaii, and Maryland.*
  - *Establish global budgets using per capita caps in Oregon and Vermont.*
  - *Fully integrate physical and behavioral health in Hawaii and Nebraska.*

- *Design value-based payment programs in Alabama, Arkansas, Colorado, and Vermont to reward providers for improvements in access, quality, and outcomes.*

- *Establishing efficient pharmacy pricing for CMS and in Alabama, Colorado, Maryland, North Carolina, and Nebraska.*
  - *Compare pharmacy program among states to determine if state is meeting national best practices in pharmacy pricing, management, development of preferred drug list, formulary, etc.*
  - *Complete cost of dispensing surveys to determine appropriate reimbursement amounts for components of pharmacy reimbursement.*
  - *Analyze and project utilization of high cost breakthrough therapies such as Hepatitis C treatments and opioid usage.*

Specific References

On the following pages, we have included three client references that are most representative of the requirements for this engagement.

Maryland Department of Health (MDH)

Actuarial Services for Maryland Medicaid Managed Care Program

Scope of Project

Optumas serves as the state of Maryland's actuary of record and policy consultant, completing the rate certification letters submitted and approved by CMS, via a subcontract through with The Hilltop Institute, University of Maryland, Baltimore County for the MDH. They assist MDH/Hilltop in developing policy within their Medicaid program including:

- Certify approximately $4.4 billion of Medicaid managed care risk-adjusted capitation rates accepted by eight health plans.
- Certified rates for newly eligible Medicaid expansion enrollees.
- Certify to actuarially sound mid-year rate adjustments for each contract period.
- Present rates and rate development process, including trend, programmatic changes, and NML to health plans over the course of two in-person meetings.
- Forecasted change in population risk due to the economic slump and consequent influx of unemployed persons into Medicaid.
- Modeled durational claims patterns due to pent up demand of previously employed versus uninsured individuals.
- Estimated the impact of ad-hoc phenomena like H1N1 virus and blizzards on health plan experience.
- Facilitated discussions on the pharmacy rebate-related changes prompted by the ACA of 2010.

CONTACT

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TERM OF CONTRACT

2000 – 2010
2012 – Present

CONTRACT VALUE

$200,000 – $400,000
(Annually)

Services Provided

- Evaluate population risk by estimating the number and type of enrollees for new and existing programs based on marketplace offerings.
- Quantify changing risk profile of a population over time and reviewing the results for reasonableness.
- Design risk-adjusted programs to enhance the viability and marketability of managed care initiatives for health and welfare programs.

- Compare risk adjustments tools to determine the most appropriate for the state's health purchasing goals.
- Present risk-adjustment results to MCOs and provider practices, explaining the methodology and the results and demonstrating how risk-adjustment results can be used on MCO and provider operations.
- Design and develop MLR reporting structures consistent with the National Association of Insurance Commissioner (NAIC) guidelines, including writing the RFP/contract specifications delineating how they will be operationalized; the data specifications and the reporting template to be used; and overseeing the submission/adjudication process.
- Utilize actuarially sound capitation rate setting methodologies incorporating MLR standards as part of the comprehensive rate development strategy.
- Assess the appropriateness of MLR standards for particular populations and determine options for adjustment.
- Develop financial monitoring models for system/payment reform initiatives that include reporting templates and data submission processes to automatically populate the reporting tools.
- Calculate appropriate financial reserves for health plans and health systems based on assessing their operational risk – enrolled populations, covered benefits, and contracted networks.
- Work on program management analyses, including on-site operational and programmatic functionality reviews, to determine the potential financial savings available as part of the move to Medicaid managed care.

Alabama Medicaid Agency

Actuarial Services Contract for Alabama Medicaid Agency (AMA)

Scope of Project

Optumas serves as the state of Alabama's actuary of record and policy consultant for their Medicaid managed care programs and Medicaid program. Optumas consults AMA on their Regional Care Organizations (RCO) program (Medicaid), developing actuarially sound rates and 1115 waiver and developing the rate methodology and rate certification to be submitted to CMS.

Assist AMA in developing their new MLTSS program (called the Integrated Care Network [ICN] program) through:

- Developing an actuarially sound capitation rate setting methodology for provider-based RCOs and ICNs serving Alabama's managed care populations. Based actuarial adjustments and trending by actuarial components of FFS claims.
- Provider reimbursement benchmarking.
- Calculating and certifying that capitation rates paid to the RCOs (approximately $3 billion annually) and the ICNs (approximately $1.5 billion annually) are actuarially sound.
- Presenting at meetings to the RCOs to explain capitation rate development.

CONTACT

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Deputy Commissioner

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TERM OF CONTRACT

2012 – Present

CONTRACT VALUE

Approximately $900,000 (Annually)

Services Provided

- Develop models to generate rates and budgetary estimates for health care reform, uninsured initiatives, and expansion programs to inform health care program development, expansion, reform, and evaluation.
- Assist in the development of budget models to demonstrate the impact of managed care program rate changes, increases/decreases, and long-term projections.
- Train and lead state personnel in successful negotiation techniques with managed care providers.
- Acquire detailed data for the covered population, and summarize the encounter data to be appropriate for capitation rebasing.
- Collect any other data for payments made outside of the FFS or capitation systems to ensure that total risk is captured.
- Collect financial reporting data from managed care contractors.
- Develop appropriate rate cells to maximize both intra-cell homogeneity and inter-cell heterogeneity.

- Adjust data for any retrospective/prospective program changes by program.
- Review each program's risk adjustment methodology and adjust factors (if appropriate).
- Develop trends by category of service using the detailed data, financial reports, national trend estimates, and actuarial experience with similar programs. Compare service trends by utilization per 1,000 and unit cost across multiple sources.
- Determine appropriate NML (e.g., administration, profit, etc.) for rates. Compare health plan administration across plans.
- Develop the rates for each rating cohort and provide Actuarial Certification by program. The actuarial certification letter will include an appendix that crosswalks the CMS Rate Setting Checklist to the certification letter.
- Provide any additional exhibits, such as a methodology document, presentation materials, etc.
- Design and develop MLR reporting structures consistent with the NAIC guidelines, including writing the RFP/contract specifications delineating how they will be operationalized, the data specifications and the reporting template to be used, and overseeing the submission/adjudication process.
- Utilize actuarially sound capitation rate setting methodologies incorporating MLR standards as part of the comprehensive rate development strategy.
- Assess the appropriateness of MLR standards for particular populations and determine options for adjustment.
- Develop financial monitoring models for system/payment reform initiatives that include reporting templates and data submission processes to automatically populate the reporting tools.
- Calculate appropriate financial reserves for health plans and health systems based on assessing their operational risk – enrolled populations, covered benefits, and contracted networks.
- Work on program management analyses, including on-site operational and programmatic functionality reviews, to determine the potential financial savings available as part of the move to Medicaid managed care.

Colorado Department of Health Care Policy and Finance

Actuarial Assistance

Scope of Project

Optumas serves as the state of Colorado's actuary of record, certifying rates to CMS for all the Medicaid managed care programs including behavioral health organization (BHO), HMO-Denver Health, HMO-Prime, CHP+, PACE, and Kaiser Pilot Program. In addition, Optumas provides actuarial support for the Accountable Care Collaborative (ACC) program and assists HCPF in evaluating gaps in care and developing various APMs.

Develop actuarially sound capitation rate setting methodologies and accompanying certifications in accordance with CMS guidance and Medicaid- and health insurance-related ASOPs using actuarial adjustments for program changes, trending of encounters, financials and FFS claims, consideration of NML for the following Colorado Medicaid managed care programs: 1281 program, BHO program, CHIP, PACE, HMO program, and Partial PCP Program.

CONTACT

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TERM OF CONTRACT

2012 – Present

CONTRACT VALUE

Approximately $600,000 - $800,000 (Annually)

Services Provided

- Provider reimbursement benchmarking for special populations and programs, including the BHO, HMO-Denver Health, and HMO-Prime programs.
- Forecasted change in population risk due to the outside externalities like economic conditions and presence/absence of alternative insurance programs.
- Modeled durational claims patterns due to pent up demand of previously employed versus uninsured individuals.
- Estimated the impact of ad-hoc phenomena like Hepatitis C drug utilization, biologicals, and specialty injectables on health plan experience.
- Acquire detailed data for the covered population and summarize the encounter data to be appropriate for capitation rebasing.
- Collect any other data for payments made outside of the FFS or capitation systems to ensure that total risk is captured.
- Collect financial reporting data from managed care contractors.
- Develop appropriate rate cells to maximize both intra-cell homogeneity and inter-cell heterogeneity.

- Adjust data for any retrospective/prospective program changes by program.
- Review each program's risk adjustment methodology and adjust factors (if appropriate).
- Develop trends by category of service using the detailed data, financial reports, national trend estimates, and actuarial experience with similar programs. Compare service trends by utilization per 1,000 and unit cost across multiple sources.
- Determine appropriate NML (e.g., administration, profit, etc.) for rates.
- Compare health plan administration across plans.
- Develop the rates for each rating cohort and provide Actuarial Certification by program. The actuarial certification letter will include an appendix that crosswalks the CMS Rate Setting Checklist to the certification letter.
- Provide any additional exhibits, such as a methodology document, presentation materials, etc.
- Evaluate population risk by estimating the number and type of enrollees for new and existing programs based on marketplace offerings.
- Quantify changing risk profile of a population over time and reviewing the results for reasonableness.
- Design risk-adjusted programs to enhance the viability and marketability of managed care initiatives for health and welfare programs.
- Compare risk adjustments tools to determine the most appropriate for the state's health purchasing goals.
- Present risk adjustment results to MCOs and provider practices, explaining the methodology and the results and demonstrating how risk adjustment results can be used on MCO and provider operations.
- Design and develop MLR reporting structures consistent with the NAIC guidelines, including writing the RFP/contract specifications delineating how they will be operationalized, the data specifications and the reporting template to be used, and overseeing the submission/adjudication process.
- Utilize actuarially sound capitation rate setting methodologies incorporating MLR standards as part of the comprehensive rate development strategy.
- Assess the appropriateness of MLR standards for particular populations and determine options for adjustment.
- Design, develop, implement, and monitor risk corridor methodologies, including writing the RFP/contract specifications delineating how they will be operationalized, the data specifications, and the overseeing the submission/adjudication process.
- Work collaboratively with the State to assess the appropriateness of proposed/existing risk corridor payment structures and determining options for change.

Designations (CRFQ Section 3.11)

Our proposed Lead Actuary, Mr. Timothy Doyle, and Staff Actuaries, Mr. Barry Jordan and Mr. Zachary Aters, exceed the minimum requirement of at least five years of experience with pricing major medical health insurance products and maintain FSA and MAAA designations. Please see *Appendix B: Designations* for documentation.

Mandatory Contract Services Requirements and Deliverables (CRFQ Section 4.1)

Actuarial Services

Rate Development (CRFQ Section 4.1.1)

Managed Care Rate Development Approach (CRFQ Section 4.1.1.1)

The Myers and Stauffer Team has extensive experience in developing, setting, certifying, and/or reviewing actuarially sound rates. Optumas currently serves as the certifying actuaries for eight Medicaid managed care programs: Alabama, Arkansas, Colorado, Kansas, Maryland, Nebraska, North Dakota, and Oregon. Below, is a step-by-step description of our typical rate development process. This is followed by an example of our expertise in setting actuarially sound capitation rates for the Oregon Medicaid managed care program.

Detailed Medicaid Managed Care Rate Setting Approach

Optumas works collaboratively and transparently with each stakeholder (the state and its managed care entities) and follows a consistent process to developing actuarially sound rates. This rate development approach, which will easily translate to West Virginia's multi-faceted program, has led to success in achieving rate approval from CMS in states across the nation. This rate development process is characterized by three key components that are each customized to clients' particular needs:

- ***Process.*** *A comprehensive, transparent, collaborative, and actuarially sound process that meets and exceeds CMS and Office of the Actuary (OACT) rate development standards, no matter the population, covered services, or authorization vehicle (state plan, 1115, 1915 b/c, etc.).*
- ***Customization.*** *Spend the time necessary up front to understand the nuances of each states' managed care program(s) and, as a result, develop a customized rate development methodology for each population/services combination that ensures the state meets its managed care program goals for access, quality, and savings.*
- ***Documentation.*** *Develop rigorous and exhaustingly detailed documentation related to each rate development project that allows the State, the MCOs, and CMS/OACT to see, understand, review, critique, and provide input on our rate development methodology that speeds up state and MCO review/input process as well as greatly reduces the amount of time and questions needed by CMS/OACT for approval.*

Base Data – Identification, Review, and Validation

The first step in the rate development process is the identification of an appropriate base data set. Specifically, the data must contain experience for similar populations and services to those that will be covered under the managed care contract. The base data is a critical component of rate development, which is why the Myers and Stauffer Team will work closely with the State to determine the data source options that are available and the appropriateness of each option. The

data should reflect a recent time period to ensure the most reliable and representative information is incorporated into the process. The data should also reflect all medical-related costs for all populations and services included in the contract. The more complete, accurate, and recent the data, the more reflective of future experience the process will be, which, in addition to the various rating adjustments noted below, will result in capitation rates that reflect reasonable, appropriate, and attainable costs.

The Myers and Stauffer Team will collaborate with BMS to ensure the most appropriate data source(s) for the capitation rates being developed, including which sources and years of data will be used. Examples of data sources Optumas has used for clients include: FFS data, encounter data, eligibility/enrollment data, state Department of Insurance reports, quality reports, performance monitoring reports, VBP benchmarking reports, and financial statements.

After working with the State and MCOs to secure the appropriate base data, the next step is to actually collect this data. The Myers and Stauffer Team will work with the State to understand the processes available for data transfer. This typically includes data transfer through the Myers and Stauffer Team's SFTP site, or in some cases, a direct transfer of data via a secured, password protected, encrypted external hard drive.

After data is collected, the Myers and Stauffer Team will conduct a series of standard initial data processing protocols:

- ***Data Importing.*** *Data that consists of raw, detailed data (e.g., detailed enrollment file, detailed encounter/claims files, or detailed provider files), is collected and stored in Optumas' internal data warehouse.*
- ***Control Total Checks.*** *The Myers and Stauffer Team will collect control total summary files from the party transferring the data (usually the State), which contain information such as total record count, claim count, and dollar volume, contained in each file. This is then compared to summaries that Myers and Stauffer Team creates using the detailed data to ensure that no data truncation occurred between the time the data was pulled from its source (e.g., the State's MMIS data warehouse) to the time it gets collected and processed into Optumas' data warehouse. This is one of the first steps completed, so if any inconsistencies exist between control totals and the comparison summaries created by the Myers and Stauffer Team, the issue can be corrected early before any type of analytics are conducted.*
- ***Frequency Workbooks.*** *The Myers and Stauffer Team will create frequency workbooks which contain a list of each key field contained in the data set and the values populated in each field, as well as the number of occurrences of each value (e.g., the "Revenue Code" page of this workbook would contain a list of all revenue codes included in the data and the number of times each one occurs). This allows for review of the data elements in a streamlined manner and can quickly show if a certain data element is fully populated, often unpopulated, or populated with values that do not make sense (e.g., procedure codes showing up in a field that should reflect a date). This is an efficient tool that is used as part of the data validation, and is often referenced through the duration of a project.*

Once the initial steps outlined above are completed, the Myers and Stauffer team will then continue its validation phase through additional review and analytics to ensure that the data is valid and accurate. This process typically consists of the following:

- ***Review of Data over Time.*** *The Myers and Stauffer Team will conduct initial summaries to review key information such as membership, expenditures, and utilization over time. The goal of this step is to identify potential data gaps that could exist, any large fluctuation in spend from year to year, or large changes in enrollment. This gives early insight into additional considerations that may be needed, for example:*
    - *Supplemental data to fill data gaps.*
    - *Adjustments to smooth out missing or incomplete data (in lieu of supplemental data being available).*
    - *Consideration for valid changes that may have occurred in the program (large increase/decrease in costs or enrollment) that may translate into program change adjustments needed during rate development.*
- ***Review Data for Denied, Duplicate, Reversed, or Zero Paid Capitated Claims.*** *The Myers and Stauffer Team will review the data for additional items that need to be "scrubbed." In some cases, datasets include claims that were ultimately denied or reversed, and these should typically be omitted from the calculation of utilization when considering what would be covered by MCOs in the future. Duplicate claims or services should also be identified to the extent they exist in the data to ensure that services provided are not duplicated when counting expenditures and utilization. Additionally, there are instances where claims may be valid services, but due to a capitated arrangement for a certain provider, no financial amount is provided. These claims may be required to be re-priced at the Medicaid fee schedule or another benchmark fee schedule.*
- ***Comparisons of Encounters to Financials.*** *The Myers and Stauffer Team will work collaboratively with the State and its MCOs to validate the encounter data to the provided financial data after the steps noted above have been completed. This is a vital step in the process as it allows all parties to ensure that the data provided and the data used in the rate setting process are consistent. To the extent that differences exist, each party works together to validate whether the differences are appropriate. And if not, whether underreporting adjustments are necessary to ensure the base data includes all valid expenditures.*

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

Identification of Covered Populations and Services

Once the identified data sources have been collected and validated, the Myers and Stauffer Team works with each state to identify the covered populations and services, and to ensure that

the base data reflects only the populations and services specified in the managed care contract. This step includes identification of each type of population that is eligible, as well as an identification of the rating categories of eligibility (COE) and categories of service (COS) to be used in the rate development process.

Optumas then reviews COE groupings to ensure they represent the most appropriate and efficient grouping of risk. When creating COEs, they strive for inter-cell heterogeneity and intra-cell homogeneity, meaning each population group should be comprised of relatively similar members, but should be markedly different from all other rating categories. If BMS has a desire to revisit rating cohorts, a review of historical expenditure levels can be conducted and recommendations made as warranted.

A similar methodological concept is applied to group services into each rating COS. Once again, the goal is to identify services that represent a similar cost per unit provided, as well as service that might be expected to change similarly moving forward.

When the Myers and Stauffer Team begins work with a new client, we will spend time understanding the various nuances of each program, historical approaches to rating cohort categorization, and nuances between various regions and MCOs. We will meet with each state to understand the intricacies of the program. This will lead to the most effective rate development methodology and process. Because of the inherent risk in the program, we will do our due diligence to ensure the State is fully aware and informed of the differences in risk within a certain rating category that currently exists.

Base Data Adjustments

There are a number of traditional base data adjustments that may be necessary to ensure the base data is an accurate proxy for the contract period, including estimates for IBNR expenditures for the encounters and FFS base data. If necessary, data completion triangles will be built for both the encounter and FFS data or triangles previously completed by Medicaid will be used (if available and appropriate).

The Myers and Stauffer Team works with each state to identify additional adjustments that may be necessary. These may include the incorporation of non-encounterable costs, such as those related to APMs, critical access hospital (CAH) settlements, or other medical-related expenditures that are contractually required, but not submitted through the MMIS. Copayments may also need to be added back into the base data so the entire cost of the service will be appropriately projected to the contract period.

While the specific adjustments necessary vary by program, the key is that the Myers and Stauffer Team has multiple discussions with the State to understand what changes have occurred in their program, and evaluates the impact that each has by population and to the overall program.

Program Change Adjustments

Program change adjustments recognize the impact of eligibility or benefit changes occurring in or after the base period. CMS requires that program changes are accounted for in the development of actuarially sound rates. Program changes may consist of accounting for the financial impact of

adding a new population or service that was not previously covered under managed care, or may consist of changes in reimbursement levels or utilization limits for certain services that have historically been covered in managed care. The Myers and Stauffer Team will work with the State to determine which changes have occurred in its program and to ensure these adjustments are accounted for appropriately.

Another common program change is an update to provider reimbursement rates, such as an "x percent" change in reimbursement to all, or a specific subset of, services. Additionally, there may be a change in per diem rates for specific nursing facilities or hospitals. The key to the calculation of these program changes is that all historical data needs to be adjusted to current policy prior to projecting these costs into the future contract period.

In addition to the above program changes, TPL recoveries and other unspecified adjustments/payments that are not attributable to particular individuals or claims, but that reduce the State's overall Medicaid expenditures may have to be added or subtracted from the base data. This may be in the form of identifying the total percentage of spend these make of a specific service (or in aggregate), and then applying that percentage impact to the costs for that service within each population (e.g., if the expenditure in question is worth a plus three percent impact to all inpatient expenditures in the base data, then we would increase the inpatient expenditures for each population by three percent to account for this cost).

Additional considerations need to be made for other prospective programmatic changes, such as developing an impact to a program for the implementation of an integrated physical health and behavioral health program. While there is certainly opportunity for savings resulting from such an integration, the key is how the integration occurs. For example, if physical health and behavioral health services had been in a standalone program, and are newly integrated, there is room for savings; however, the key is that the integration needs to be completed at the actual provider level (meaning that doctors are coordinating care effectively), as opposed to just at the payer level (with little coordination between doctors). This is an important nuance, and the impact can only truly be evaluated through effective communication between the State, MCOs, and Actuaries, to ensure that the planned operational aspects of a program are consistent with the development of any financial impacts.

Trend Adjustment

Trend factors are applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors are used to project the costs from the base period to the future contract period. The Myers and Stauffer Team typically develops trends on an annualized basis and applies them by major category of service for the number of months from the midpoint of the base data period to the midpoint of the contract period.

While the purpose of trend development remains consistent for each program, there are various factors that require a flexible approach to developing trend. There are instances where the validity of detailed claims or encounter data is not at the level required to be able to develop a full-fledged historical trend development, and the data is heavily reliant upon summarized financial information. In this case, considerations need to be given to what is being experienced in other

programs, reflective of similar populations and services. Additional emerging national research and trends may be used in this case, as a method for informing anticipated growth in the program.

Optumas' preference, when data permits, is to array historical experience in such a way that costs and utilization can be arranged by month, population, service, and MCO/region if appropriate. This allows for multiple statistical analyses and three, six, and 12-month moving averages (MMA) to be reviewed to inform trend projections. Even with fully credible data, there are cases where certain services show steep increases or reductions historically, but may not be expected to perpetuate that trend in the future. Since trend is typically applied for multiple years' worth of projection, it is important to recognize that considerations outside of historical experience need to be made to appropriately project to future experience. An example of this is the recent growth in pharmaceutical costs in many programs. If only historical trend experience were to be used to project future contract periods without consideration for research and published growth estimates, historical growth may have been steady for multiple years, but research and publications suggested significant growth. If these sources were not given any consideration, projected pharmacy trend could have been drastically understated.

Optumas has been successful in documenting and substantiating its trend development process for each program in its correspondence with CMS/OACT. While there is not a cut-and-dry approach or formulaic approach to prospective trend development, and nuances exist between the exact approach used in various programs, the considerations are consistent at the core, and the use of historical data for the program itself, experience in other states in which Optumas develops rates, and national and published experience are all sources that are used in trend development within each program.

Non-Medical Loading (NML) Adjustments

NML measures the dollars associated with components such as administration, risk, contingencies, and profit, and are usually expressed as a percentage of the capitation rate. CMS' 2017 Medicaid Managed Care Rate Development Guide states that the non-benefit component must include reasonable, appropriate, and attainable expenses related to the following: administrative costs; care coordination and care management; provision for margin, taxes, fees, and assessments; and other material non-benefit costs.

Optumas utilizes several tools in our NML development:

- *Build the NML components by the categories required by CMS, listed above, by population. This requires a thorough understanding of the MCO requirements in the contract. Optumas meets with the State to assist in development.*
- *Guidance provided by the Society of Actuaries in their paper "Medicaid Managed Care Organizations: Considerations in Calculating Margin in Rate Setting." Key items to consider for margin include insurance risk, contribution to risk-based capital, income taxes, investment in IT infrastructure, investment in care management infrastructure, and contributions to owners/shareholders for MCOs that are for-profit.*
- *Per the Final Revised Medicaid Managed Care Rule, actuarially sound rates are set to achieve at least an 85 percent MLR. This threshold should be considered for smaller per*

member per month payments (PMPMs), such as children rate cells, to ensure an estimated 85 percent loss ratio may be achieved.

- *Benchmark developed figures against other states' financial cost reporting templates by population group both on a PMPM and percentage of premium basis.*

Substantiating Rate Development and Receiving CMS Approval

Optumas provides outstanding service in 20-plus Medicaid programs for various clients each year, including providing detailed substantiation as part of the rate certification. Optumas has received CMS approval for every program in which they developed rates. They provide CMS/OACT additional models/summaries upon request in order to address various questions surrounding specific aspects of rate development. Optumas has an outstanding relationship and reputation with CMS/OACT due to the rate development work completed in other programs. They have an open line of communication with the actuaries and policy members within CMS, which results in getting expedited resolutions to any issues identifies during the rate development process.

Optumas Rate Setting Example – Oregon's CCO Program

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

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

The use of these touch-points resulted in a very productive rate setting process, which allowed for CCOs to provide feedback. In some cases, the feedback was used in a way that was able to refine the process that Optumas and the State proposed, and in other cases, feedback was provided and rationale was given as to why no changes would be made. The ultimate outcome was a new rate development methodology. The discussions started with an in-depth comparison

of data that was reported by each CCO on its financial template (including all medically-related costs) as compared with MMIS encounter data; this opened the door for discussions around data quality and appropriate starting base data to use in rate development. After these initial discussions, analyses were conducted around regional differences in costs/population risks. This led to rating regions being defined (CCOs were grouped into four regions throughout the state), which allowed for a regional-based rate development methodology to be employed. This resulted in a credible population size being used as the base, with adjustments to reflect differences in risk (based on risk scores using the Chronic Illness and Disability Payment System [CDPS] + Rx tool) as well as differences in hospital reimbursement (diagnosis-related group [DRG] versus cost-based hospitals).

As noted above, this approach to transparency, stakeholder feedback, and periodic communication with CMS/OACT has ultimately led to CMS/OACT rate approval for the last three years, most recently for the rates effective January – December 2017 (CY17).

Capitation Rate Ranges (CRFQ Section 4.1.1.2)

Optumas currently develops actuarially sound rate ranges for the Alabama, Arkansas, Colorado, Kansas, Maryland, Nebraska, North Dakota, and Oregon. Based on guidance from CMS in the recent revisions to the Medicaid managed care rules (also known as the Mega-Rule) as well as CMS' annual Medicaid rate setting guidance, while actuaries are allowed to use rate ranges, ultimately each individual rate paid to an MCO must be certified as actuarially sound. Thus, states are still able to examine rate ranges and choose the point(s) that best match their individual constraints of cost, quality, and access. Rate ranges developed by Optumas are created by varying components of the rate development methodology such as the assumed savings, calculated trend, and/or non-medical assumptions. The rate ranges are typically calculated in a way to be applicable for all populations, services, and regions of the state.

In addition to providing the rate ranges to the state, we can also demonstrate how MCO organizations would potentially vary in cost, quality, and access at different points in the rate range. This allows the state to understand the trade-offs associated with any given point within the actuarially sound rate range.

Managed Care Rates at the Individual MCO Level (CRFQ Section 4.1.1.3)

Optumas works with each state to identify the appropriate populations and services included under the MCOs' contract for capitation payments, as well as whether the rate methodology includes MCO-specific rates based on risk stratification. These populations and services are then used to identify the capitation rate cells, or COE and risk adjustment methodology, to be used in the rate development process.

Optumas has previous experience using risk adjustment within the Colorado, Maryland, Nebraska, and Oregon programs. Their experience has been with a wide variety of risk adjustment models, including the CDPS, Medicaid Rx, CDPS + Rx, Clinical Risk Group (CRG), Adjusted Clinical Group (ACG), and Hierarchical Condition Category (HCC) to measure the relative acuity difference between the eligible populations compared to the populations enrolling in the programs. These tools can also be used to risk adjust rates for managed care entities, so that plans are appropriately reimbursed for the clinical risk of the population enrolled in their plan.

Health-based risk adjustment builds upon the concept of matching payment to risk by paying participating MCOs a capitation rate commensurate with the risk of their population compared to the populations within the other MCOs.

Most health care actuaries are familiar with various risk adjustment tools and have either used them directly or indirectly to assist with various risk assessment analyses. The application of the actual mechanics of risk adjustment are not what distinguishes Optumas from other actuarial firms. What makes Optumas unique is that they do not assume issues are already addressed within the risk score software model. Careful consideration and supporting analysis is given prior to applying risk scores within any program, even if the risk score methodology has been applied in the past. The diagram shown below shows some considerations along with associated questions:

- *Is the risk score tool being used appropriate for the available data?*
- *What populations should be included within the risk analysis? Is the decision supported by statistical correlation analyses?*
- *Is the application of the risk methodology consistent with the way in which the program is operationalized?*
- *Are the weights that are being used appropriate for the program and populations in question? Have they been updated to reflect current practice patterns?*
- *Is the risk adjustment software using recent drug mappings that reflect current practices surrounding types of drugs and related chronic conditions?*

In addition to the operational considerations and appropriateness of the tool, the Myers and Stauffer Team advocates for complete transparency surrounding all risk score analysis and output data.

Rate Setting Meeting Participation and Support (CRFQ Section 4.1.1.4)

Optumas excels at actuarial work and differentiates themselves as consultants in meetings, presentations, and level of transparency. Optumas has extensive experience with presenting final capitation rates via on-site meetings. They believe these meetings are a key component of the rate development process, ensuring all participating parties have a good understanding of the program and associated rate methodology.

The Myers and Stauffer Team is committed to attending as many face-to-face meetings in Charleston as deemed necessary by BMS. We are available to attend on-site meetings with BMS staff, MCO staff, CMS, and other stakeholders whenever necessary.

Face-to-face meetings are typically followed by a written Q&A session, where active spreadsheets are provided to our clients and the contracted MCOs. We believe transparency is key for stakeholder engagement. Our team will be available to provide additional substantiation of our methodology to BMS, MCOs, and CMS via a written narrative, conference calls, or face-to-face meetings. To the extent BMS would like to see more or less information, the Myers and Stauffer Team will update the deliverable format accordingly.

Databook development and presentation are great opportunities to improve the MCO rate setting process and program. Databooks are typically very familiar to MCOs since they contain summaries of the base data provided by the various contracted plans. Because of this, databook presentation provides the opportunity to educate the MCOs on data summarization approach and rate methodology. It also gives MCOs the opportunity to communicate about the use and purpose of their data and give feedback in a collaborative manner. In fact, if we are awarded this scope of work, the Myers and Stauffer Team would like to meet with the MCOs very early on to discuss what has and hasn't worked in the current program design and rate setting methodology. This can help build relationships and get MCOs invested in a productive partnership with BMS.

One of the ways we will ensure rates are appropriate is to build a collaborative process between ourselves, BMS, and the MCOs. We find it important to get in front of the MCOs and discuss the rate setting methodology, assumptions behind the methodology, and the implied impacts of those assumptions on the rates, the MCOs, BMS, the provider community, and the Medicaid population. Our presentations are meant to result in a meaningful conversation where each party leaves feeling as though progress has been made for a given process through a better understanding of the analyses performed and what makes the analyses appropriate. Open conversations and back and forth discussions between ourselves, BMS, and the MCOs are encouraged during these meetings, as well as through writing before and/or after the meetings. We will often provide meeting materials days in advance, giving the MCOs a chance to review and pose questions before an in-person discussion. This allows for more efficient in-person meetings that result in increased quality of work at a faster pace while building on the collaborative process.

Our presentation and meeting capabilities also consider the audience. We have the ability and experience to identify the level of detail needed for a given meeting depending on the audience. One of our strengths is our ability to present very detailed, complex analyses in a manner that is easily understandable at a high-level to a CEO or other leadership who may not be interested hearing about the "in the weeds" details. Conversely, we have experience discussing analyses and results at the detailed level with MCO data teams, analysts, actuaries, and CFOs.

Data Improvement Collaboration (CRFQ Section 4.1.1.5)

Data plays an important role in any actuarial analysis. The accuracy and validity of the actuarial analysis is dependent on data quality. Data frequently contains errors or is not fully complete, and it is the actuary's responsibility to identify such data issues and determine the appropriate use of the data in question. We will conduct a very rigorous data validation analysis on all datasets before they are used within any actuarial analyses. If a dataset is identified as having data quality issues, our team will work with the State and stakeholders to understand and correct the issue or to explore alternative datasets that can be used to inform the analysis. Alternative datasets can include internal data extracts from each MCO, completed templates from each MCO, or similar data from another time period.

The data validation analysis conducted by Optumas adheres to their own rigorous standards for accuracy, timeliness, and completeness, as well as being consistent with ASOP 23 – Data Quality. In order to be able to make this statement, Optumas invests extraordinary amounts of resources into data validation using a four-step process which is detailed in *Data Validation and Improvement Approach (CRFQ Section 4.1.1.12)*.

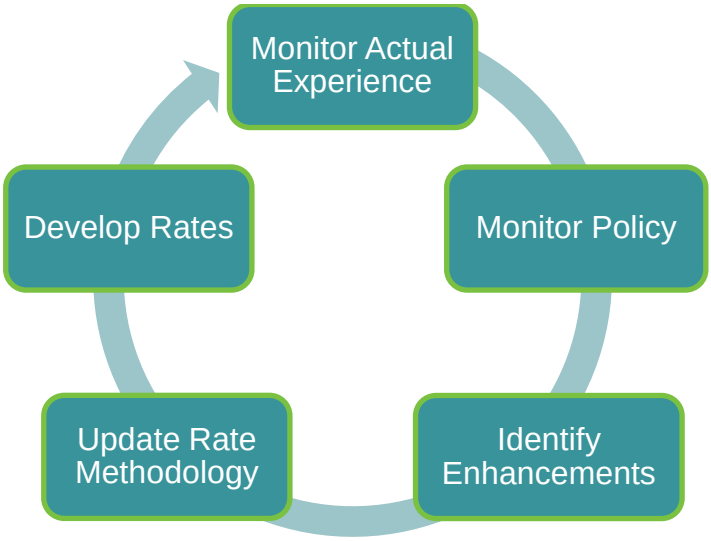
The Myers and Stauffer Team also collaborates with the state agency staff to improve the accuracy and efficiency of existing data sources used for rate development through our work validating encounter data, including the application of Protocol 4. In a number of states where we perform encounter data validation and report on the completeness and accuracy of the MCOs' submitted encounter data, we share the results of our analyses. This includes identifying incorrect and duplicate encounter payments, with the state's actuary, to assist in providing a more accurate representation of the services members are receiving and the payments made by MCOs and their delegated vendors to providers. For this project, the enhanced encounter data will be available for rate setting, and provided to program staff for program management. While working with our other state partners, this enhanced encounter has been effective in assisting key stakeholders in the decision making process and has assisted with quality improvement monitoring.

Reports and Calculations (CRFQ Section 4.1.1.6)

The Myers and Stauffer Team believes that transparency is critical to the success of any Medicaid managed care rate setting project. Thus, we provide all of our rate development in active format with all formulae and databases available for review. All datasets and any other documents are made available in active format. They are provided to the State with the necessary training so that the State rate setting team can utilize any of our models in their budget forecasting and financial modeling processes.

Rate Uniformity (CRFQ Section 4.1.1.7)

In reviewing rates to determine if payments are made consistently across all bureaus, the Myers and Stauffer Team will follow a five step process that we refer to as the Actuarial Cycle:



The purpose of the Actuarial Cycle is to lay a foundation for perpetual improvement/enhancement with regard to the actuarial risk assessment of each of the rate payment methodologies employed by the bureaus. Each of the five steps have a unique purpose and are described below:

1. ***Monitor Actual Experience.*** *The Myers and Stauffer Team will review actual experience via submitted encounter data as well as submitted financial reports or custom data submissions from the State or the MCOs. Using these data sources, we will compare projected expenditures (developed capitation rates) to the actual experience by rating cohort, category of service, and region. These comparisons will inform the actuary of any potential projection errors within the existing rate methodology and be used to make the appropriate adjustments to the payment rate methodology during the next rate cycle to ensure rate uniformity between/among the bureaus.*
2. ***Monitor Policy.*** *State policy surrounding their Medicaid program is constantly being debated, adapted, or adjusted by state leadership and the state Legislature. Therefore, it is important for the actuary to keep apprised of all current and potentially new policy so that appropriate adaptations can be made within each bureau's rate methodology to ensure the rates are as uniform as possible and appropriate. The Myers and Stauffer Team will keep in contact with BMS leadership so that all policy potentially impacting the Medicaid managed care programs is fully vetted from an actuarial perspective.*
3. ***Identify Enhancements.*** *Through the monitoring processes described above, we will identify areas within the existing rate methodologies that need to be enhanced to improve rate uniformity. These enhancements could include:*
    a. *Changes to existing rating cohorts.*
    b. *Changes to existing rating regions.*

c. *Enhancements to various trend projections or other projection factors.*

d. *Changes to the benefit package consistent with policy.*

e. *Changes to the managed care programs based on federal regulation.*

f. *Administrative load assumptions.*

g. *Financial and other reporting requirements.*

4. ***Update Rate Methodology**. The Myers and Stauffer Team will use the identified enhancements/changes to adjust the payment rates methodology to enhance rate uniformity. Any updates to the rate methodology will be fully vetted with BMS leadership as well as the participating MCOs. If needed, we will assist BMS in seeking guidance from CMS/OACT on interpretation of federal policy or compliance with federal policy.*

5. ***Develop Rates.** The rates will be developed using the updated rate methodology developed in step 4 above. Using the updated rate methodology allows for better aligned payment and risk within the BMS managed care programs. Consistent with standard actuarial principles, our actuaries will also incorporate all applicable Actuarial Standards of Practice and CMS/OACT guidance. As part of the rate development, we will produce robust substantiation for all aspects of the actuarial risk assessment, consistent with ASOP 41 – Actuarial Communications. This substantiation includes actuarial rate certification with all accompanied analyses and exhibits.*

The five step process allows both BMS and the Myers and Stauffer Team to constantly monitor and measure the rate uniformity of the BMS bureaus' programs and react quickly to ensure rate uniformity when appropriate.

Updating Capitation Rates (CRFQ Section 4.1.1.8)

The State's actuary is required to review and certify the rates at least annually to ensure the capitation payment matches the risk assumed by the MCO. Optumas has found it most effective to monitor the Medicaid managed care programs, where it is the Actuary of Record, on an ongoing, real-time basis. They receive regular monthly or quarterly data feeds and monitor them for retrospective changes in utilization, population mix, service mix, pricing, population demographics, and program changes. This allows for the most accurate, up-to-date dataset to model prospective changes in federal/state requirements.

The new federal MCO rule does allow the State some flexibility designed to reduce the time and expense associated with updating capitation rates within a contract year. If the change is no more than one and a half percent from the rates submitted by the certifying actuary and approved by CMS, the State does not have to seek CMS approval of the revised rates. The State's actuary still must meet the CMS documentation and substantiation requirements, but the need to seek CMS approval for minimal rate changes (no more than one and a half percent as noted above) has been eliminated.

Factors Impacting Rate Updates

Rate History Review

Reviewing historical changes to rates can help inform states on the drivers of Medicaid's program costs. Rates could be changing due to actions taken by MCOs, improved program efficiency, policy changes implemented by the State, or estimation error. Optumas routinely evaluates these changes for their clients, including current work on behalf of the Medicaid departments in Alabama, Arkansas, Colorado, Kansas, Maryland, Nebraska, North Dakota, and Oregon. Rate changes are generally conducted two different ways: comparing emerging experience to experience assumed under rate development; and comparing rate development assumptions to previous rate development projects. Both of these comparisons allow for determination if the rates are sufficient or inadequate, and also attribute changes in expenditure level to non-base data changes (e.g., program changes, projection error, etc.) or base data changes.

Program Changes

By evaluating emerging experience against capitation rate assumptions, the Myers and Stauffer Team will be able to determine the actual impact of program changes (e.g., changes to covered populations or services, reimbursement changes, benefit limit changes, etc.) and how that impact compares to what was assumed in the rate development process. Adjustments may be necessary to account for benefit ramp-in, but emerging data evaluation can refine state budget estimates and track how the MCOs implement Medicaid's policies. We will also look at annualized cost and utilization growth to determine the accuracy of assumed trend rates and the level of projection error occurring in the program. Through both of these analyses, profitability of the MCOs can be tracked and compared to what is expected under rate development. Additionally, any newly developed capitation rates will be compared to the previous rates; all changes are itemized. For example, if rates increase by three percent, we can show how much of the change is due to base data changes, public policy changes, changes to the trend rate, or other rate setting components. This itemized approach allows for a detailed review of the drivers of rate change and a better understanding of the impact of policy decisions on rate magnitudes.

Base Data Changes

Any changes that are not attributed to a specific program change or actual experience can remain as a base data change due to MCO operations. For example, Optumas just recently provided additional analytics to their clients in Colorado, Nebraska, and Oregon, further delving into these base data changes to determine what might have been caused by changes in health plan efficiency or the risk score of the enrolled population.

The Myers and Stauffer Team will conduct risk score analyses using nationally-recognized risk groupers to see what portion of base data changes are due to a change in the population's risk. We will identify episodes of care (EOC) and potentially avoidable complications. The combination of these two approaches can provide states with powerful conclusions. For example, if the population's risk is decreasing, but potentially avoidable complications are increasing, the state may want to consider implementing an efficiency adjustment to offset increases in health plan experience. Conversely, if complications are decreasing, the state has a way of monitoring and reporting the savings generated by the managed care program.

Trend

Optumas has wide-ranging experience developing trend estimates for multiple programs and clients in the past 10 years. Optumas works extensively in the Medicaid managed care environment, but also has experience with Medicare and commercial rate setting. Through this experience, Optumas has developed various trend development approaches that are adaptable to the intricacies of each program. The wide array of experience developing trends across different state and payer programs also gives Optumas a set of benchmark data that can be used to ensure consistency between the West Virginia medical assistance programs and national best practices.

Trend is typically one of the more debatable parts of capitation rate development because it incorporates a high level of actuarial judgement and opinion, rather than rote calculations. Optumas has experience explaining our trend calculations to managed care plans in Arkansas, California, Colorado, Kansas, Maine, Maryland, Nebraska, New Mexico, North Dakota, Ohio, Oregon, and Texas. Optumas has also supported trend calculations to CMS and OACT during rate review, and has always been able to receive rate approval without any edits or rate amendments.

Optumas' trend calculations have been successful and accurate due to their unique approach to trend development. They do not rely on models built for nationwide use or perform the same trend calculations for each of our clients. Instead, they treat each trend calculation as a new analysis independent from any work done before. This requires them to build a methodology for trend development that is specific to the program being analyzed, and utilizes the various data sources available for each project. This is a complex way to approach trend, as it requires meticulous review of all available information in order to construct a valid trend development methodology, however, Optumas feels strongly that it is the best way to proceed. The accuracy of their trends estimates, borne out by regular retrospective analyses to compare projected trends to actual trends, confirms empirically, that this is the most accurate way to approach trend calculations. Applying their ground-up approach to trend development allows for an analysis that fully incorporates the nuances and intricacies of BMS' various programs, and will create the most reliable projection estimates possible. Successful discussions with MCOs indicate that even if they might not fully agree with the trend rates, they accept and acknowledge the validity of Optumas' methodology. More importantly, Optumas' track record of approval from CMS and OACT indicates support for their approach, as all rate projects have been approved with the trends used on their initial certification submission.

Due to the customized nature of trend development, Optumas is unable to know how trends will be calculated for BMS without first conducting extensive data review.

Data Sources

Optumas has experience developing trend rates from detailed claim-level data, summarized data reports, and reference data. Regardless of the data source, the first step is thorough data validation and understanding to ensure trend development is based on full and complete data relevant to the program that is being projected. Data source understanding requires detailed knowledge of the populations, services, and program design (e.g., reimbursement levels and other policy decisions) underlying the data. This knowledge allows for known external influences

to be considered in trend development, and pure price and utilization trend to be isolated in calculations. If reference data must be used to account for a known issue with program-specific data, full understanding of the reference data is essential to ensure applicability to the program. With proper data understanding, reliable health care trend analyses can be completed from various data sets, and reference data can be reliably used to supplement or enhance program-specific data when necessary.

Example – Maryland HealthChoice Program Trend Data Sources
Once appropriate and sufficient data sources have been identified and validated, Optumas arrays the data by population, service, and month incurred. To demonstrate the specific data sources customized for the Maryland HealthChoice trend development, the table below shows the actual Maryland HealthChoice program trend data sources:

Source	Analysis Overview
MCO encounter data.	Encounter data across time was reviewed by plan, population, and service.
State policy on provider reimbursement changes.	The published unit cost changes were included directly within the rate development trend assumptions.
Hospital cost report data.	Maryland Medicaid trends were calculated for hospital (inpatient, outpatient ER, and outpatient non-ER) services from hospital cost reports.
Public sources of trend information.	National studies were reviewed from both the Medicaid and commercial marketplaces as well as published industry price indices.
Proprietary sources of trend information.	Optumas incorporated its experience with Medicaid FFS programs, managed care programs, and health plans in other states.

Maryland-specific sources (the first three items listed in the table above) are benchmarked against each other for reasonableness, both the data itself as well as the emerging trends. The last two items listed in the table above are either national studies or directly from other states, so they are primarily used for benchmark purposes. Once the data sources that could underlie trend calculations have been identified, Optumas proceeds to a series of calculations necessary to build trend projections from historical data.

Normalization
To properly develop health care trend analyses, it is necessary to normalize historical data for geographic region, population, service, and reimbursement mix. Normalization is done by bringing all months of data to be on the same basis with respect to membership distribution and public policy decisions. For example, if a state passes a two percent provider increase effective January 1, 2016, it is necessary to increase reimbursement for all data incurred prior to that date by two percent to control for the policy change. This allows for true, secular trend to be itemized and analyzed, and avoids double counting policy changes as trend.

In addition to program change normalization, it is important to mix-control for demographic information, such as age, sex, rating cohort, and geographic region. This is accomplished by using the demographic distribution of a single “snapshot” month to summarize all months of

service incurred data. This is necessary to ensure that changes in enrollment (e.g., a gradual transition to a population with an older average age) are not mistaken for service unit cost or utilization trend. By using a consistent demographic distribution to summarize data, secular trend rates can be analyzed and projected benefit costs are more accurate. Normalizing data for public policy changes and demographic differences is essential for valid trend development.

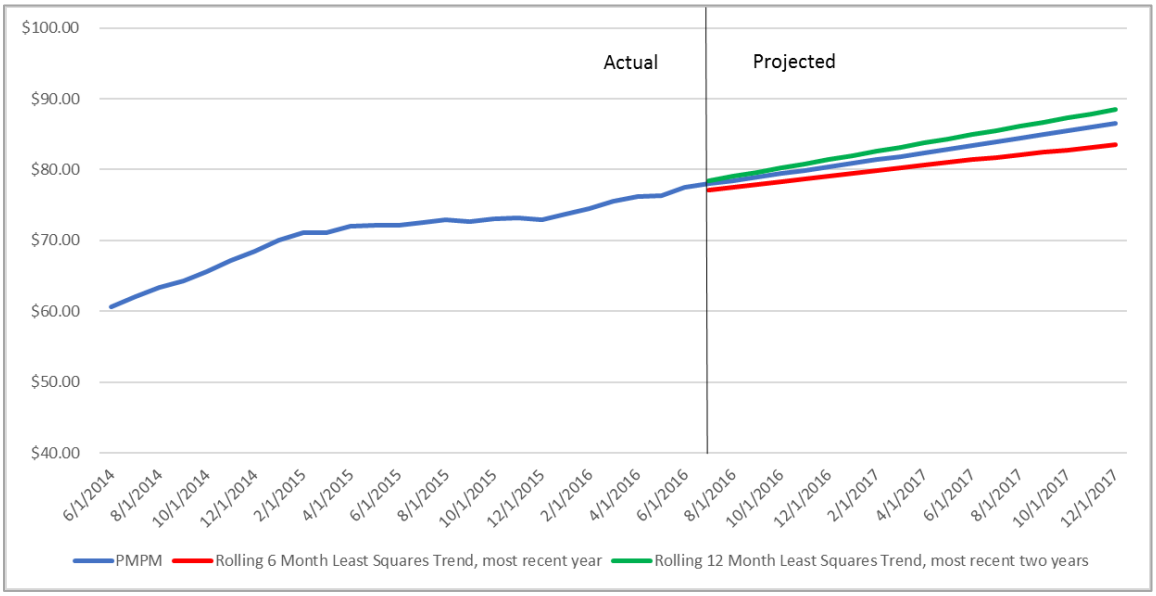
Trend Methods

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

The following graph shows a sample of Optumas' trend calculations. As emphasized through this response, a customized approach to trend development will be created based on each client's program design. This is one approach that was successful for a certain client, and the applicability of this would be analyzed for BMS before using a similar approach. In the graph below, the blue line shows the cost PMPM for a specific service and population. The graph below contains the following lines/figures:

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

For the specific project depicted in the graph, Optumas uses the trend estimates created by the green and red lines, in conjunction with our expertise and familiarity with reasonable benchmark trends, to create an assumed projection rate. This projection rate is then applied to actual data and graphed (as the blue line in the "Projected" portion of the graph) to ensure reasonableness and consistency with actual program experience. As the graph indicates, application of Optumas' chosen trend rate results in a reasonable estimate of future cost growth for the population and service currently being analyzed in the graph.



A final component of trend development that Optumas incorporates when approved by clients is transparent communication with participating MCOs. Trend development is a fairly subjective component of actuarially sound rate development, so occasionally it is a point of disagreement between the state and its contracted health plans. Optumas attempts to mitigate this by having frequent and transparent communication with stakeholders regarding the data that is used for trend, the primary calculation method employed, and the resulting trend selection. Even if these conversations end and each side still believes their approach is more appropriate, the discussion generally leads to an understanding of how the trend rates were calculated and why they are considered reasonable. These conversations are at the discretion of the state, but Optumas feels they are a very useful component of developing a successful managed care environment. This has been particularly useful in the Maryland HealthChoice program, where Optumas holds all-day meetings reviewing trend developments with the contracted health plans. All background information and details about trend development are covered through the course of these meetings. After the meetings are complete, the remainder of the rate setting process can continue without any lingering uncertainty about health care trend analyses.

Vendor Transition (CRFQ Section 4.1.1.9)

Optumas uses extensive project management tools to manage and document its rate development projects. This approach allows Optumas to be prepared to transition its data, methodologies, and documentation on any ongoing projects in just one to two weeks, well before the States' 30-day in advance requirement. Having been on the receiving end of contract transitions (most recently from Mercer in Alabama and Nebraska; from Deloitte in Colorado; from in-house/PwC in Oregon; and from Aon in Kansas), Optumas understands and appreciates the level of detail and documentation necessary to ensure a seamless transition. As a result, they have developed a comprehensive rate development methodology documentation process that not only encourages transparency between the State and it's contracted MCOs, but it also facilitates a clean, efficient transition among actuarial vendors.

Accurate Encounter, Claims, and Eligibility Data for Rate Setting (CRFQ Section 4.1.1.10)

The Myers and Stauffer Team has worked with encounter, claims, eligibility, and financial data from numerous state clients. When flaws in the encounter data process, eligibility reporting, claims adjudication, or financial reporting processes have been identified, we have been able to work with our clients to successfully resolve the issues. Based on our experience and knowledge, we are able to identify, report, and resolve data issues in a timely manner to ensure the integrity of the rate setting process.

Data Issue Resolution Example – Nebraska Department of Health and Human Services (DHHS)
Optumas has served as the actuaries for DHHS for five years, and during the course of their rate development work, they observed significant flaws with the encounter data submitted by the State's data vendor. To correct these flaws, they implemented a four-step plan that allowed for comprehensive review, evaluation, and improvement of the encounter system while maintaining progress on rate development project. This same four-step process would be applicable to encounters, claims, eligibility, and financial reporting.

Step 1: Supplemental Data
Despite the flaws in the encounter data system, it was essential to continue with rate development and produce actuarially sound capitation rates for the managed care program. Optumas met with DHHS and contracted health plans to see what data sources could be provided for rate setting as a stop-gap measure while encounter submissions were corrected. This conversation resulted in using financial statements, summarized data submitted via a customized rate development template, and supplemental MCO data submissions being utilized as the temporary base data for rate setting projects. This step was prioritized so all parties could be assured that progress would continue on rate setting projects and contractual obligations between the State and the health plans would be fulfilled. After this resolution was reached and rate development had a sound base data source, the data improvement process could be addressed and improved.

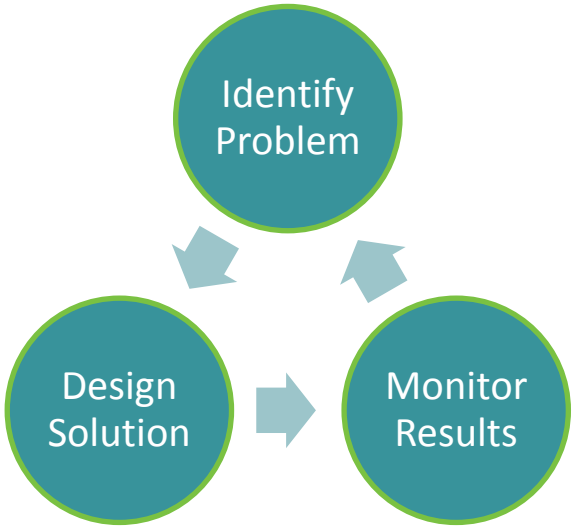
Step 2: Stakeholder Discussions
Optumas' experience as an actuarial firm with strong data analytics and IT systems allows them to solve unique data challenges.

In order to begin data improvement processes, Optumas met with the State, the State's data vendor, and the contracted health plans. The purpose of these discussions was to find the point in the process where data integrity was breaking down. Optumas was able to facilitate these discussions due to their dual role as a data vendor and an actuarial consulting firm. They are familiar with the challenges associated with receiving, standardizing, and warehousing data from multiple different sources, so they were able to understand the perspective of the data vendor. Additionally, they know the constraints in place under ASOP 23 on data integrity and quality for actuarially sound rate development, so they were able to effectively communicate the needs shared by us, the State, and the contracted health plans. With knowledge of both sides of data submission and data receipt, Optumas was able to facilitate an effective discussion that led to the creation of a targeted improvement process.

Step 3: Financial Incentive Structure to Improve Reporting
To help improve data quality, Optumas and the State discussed the use of a capitation rate withhold that was in place in the managed care program. Optumas and the State tied a portion of the withhold amount to data reporting metrics, providing a strong financial incentive to MCOs to submit timely and accurate data that meets the specifications of the data vendor.

Step 4: Data Vendor Process
For the final step in the process, Optumas worked with the data vendor to ensure they were able to properly store and transmit data. Optumas discussed data layouts, desired and available data elements, data variable definitions and crosswalks, and the timeliness of data extracts. Through this process, Optumas was able to develop a routine, repeatable data extract process that allowed for regular submissions of valid encounter data. Optumas now receives up-to-date and accurate encounter data for this client, and is able to utilize this information to provide timely analyses based on the most recent emerging program experience.

Continued Data Monitoring
Data improvement is not a stagnant process – it is constantly changing and evolving as systems, providers, health plans, and policies change. To stay on top of data collection and ensure a continuously reliable process is in place, Optumas employs a three-phase method. Optumas identifies problems, designs solutions, and monitors results. In the process of monitoring results new problems are identified and the process is repeated. By implementing this review cycle, Optumas can stay on top of changing data submissions processes and continuously ensure the state and their vendors are using and submitting valid data.



Additionally, as part of our managed care data review and monitoring work for a number of state clients, Myers and Stauffer evaluates the completeness and accuracy of encounters, financial, and member capitation data on a continuing basis. We reconcile the MCOs' encounters, as reported to the State's FAC, against the MCOs' financial data to identify both missing encounters and over-stated or duplicated payments. Through our analyses, we have identified issues such as MCO-reported encounter payments that have incorrectly included administrative fees. We have

made recommendations to address problems with missing or inaccurate encounter submissions that have involved changes to the MCOs' data submission processes, as well as changes to how the fiscal agent was processing and interpreting the encounter submissions.

Based on the results of our encounter data analyses, Myers and Stauffer notes adjustments to individual encounters, maintains a database of these adjustments, and shares this information with the state's actuary in the rate setting process to supplement and augment existing data. We also review the state's capitation payments to identify errors such as multiple member identification numbers for the same member. This can result in over-stated member rolls and duplicated capitation payments made to MCOs on behalf of a member, and we assist the state in making and monitoring these corrections to their member data. Performing these types of analyses, as part of a continued monitoring plan of the encounter, financial and member data being for rate setting, is a critical step to ensuring the accuracy and reliability of the rates produced.

State and Federal Reporting (CRFQ Section 4.1.1.11)

The Myers and Stauffer Team recognizes that any report is only as good as the State's ability to provide comprehensive technical documentation (substantiate, document, and explain the source data, homogenization, and results in a way that is easily understood to all stakeholders) demonstrating the completeness and accuracy of the report. Optumas has a stellar reputation of working with and providing technical assistance to all clients in support of state and federal reporting. The substantiation/documentation provided by Optumas goes beyond that required by Actuarial Standards of Practice 41 – Actuarial Communications and 42 CFR §438.6(c), as Optumas gives as much rigor and attention to reporting as to the actuarial analysis itself. The technical assistance around reporting and substantiation includes detailed substantiation/documentation of the process as well as documentation of the results of in-person meetings and conference calls with State staff and the fiscal agent, as necessary, to ensure the accuracy and completeness of the required state and federal reporting.

Data Validation and Improvement Approach (CRFQ Section 4.1.1.12)

In response to this section, Optumas has identified two key components necessary to ensure valid data underlies rate setting processes: 1) data validation; and 2) continued improvement in data collection. Each of these aspects of preparing data for rate setting work are described below.

Data Validation

Data plays an important role in any actuarial analysis. The accuracy and validity of the actuarial analysis is dependent on data quality. Data frequently contains errors or is not fully complete and it is the actuary's responsibility to identify such data issues and determine the appropriate use of the data in question. Optumas always conducts a very rigorous data validation analysis on all datasets before they are used within any Optumas actuarial analyses. When a dataset is identified as having data quality issues, Optumas works with the State and stakeholders to understand and correct the issue or to explore alternative datasets that can be used to inform the analysis. Alternative datasets can include internal data extracts from each MCO, completed templates from each MCO, or similar data from another time period.

The data validation analysis conducted by Optumas adheres to their own rigorous standards for accuracy, timeliness, and completeness as well as being consistent with ASOP 23 – Data Quality. In order to be able to make this statement, Optumas invests extraordinary amounts of resources into data validation using a four-step process:

1. ***Referential Integrity Checks.*** *Ensure that all encounters included in base data are incurred by a member with a valid capitation that coincided with the incurred date associated with the specific encounter.*
2. ***Volume Checks.*** *Check both volume of encounters and total expenditures by category of service and population by looking at utilization and expenditures longitudinally. This ensures that any gaps or spikes in the data are identified and addressed before creating the base data.*
3. ***Benchmark Comparison.*** *Compare summarized data to other base data summaries used in prior rate setting cycles as well as to the reported financial templates to ensure there were no missing encounters prior to rate development and also to identify unexplained/unanticipated changes in the reported data.*
4. ***Document Data Validation.*** *Include a section within each rate certification addressing the specific findings as a result of the analysis.*

To demonstrate a real-life example of this data validation process, below is an excerpt from a recently submitted (and approved by CMS) rate certification letter:

Excerpt from Actuarial Certification
To ensure compliance with ASOP 23 – Data Quality, Optumas conducted data validation analyses and benchmarked the data to the base data used for prior cycles of rate development as well as to the reported financials for the same time periods. The data validation analyses included:

- ***Referential Integrity Checks.*** *Ensured that all encounters included in base data were incurred by a member with a valid capitation that coincided with the incurred date associated with the specific encounter.*
- ***Volume Checks.*** *Checked both volume of encounters and total expenditures by category of service by looking at totals longitudinally. This ensured that any gaps or spikes in the data were identified and addressed before creating the base data.*
- ***Benchmark Comparison.*** *Compared summarized data to other base data summaries used in prior rate setting cycles for PRIME as well as the reported financial templates to ensure that there were no missing encounters prior to rate development.*

In particular, Section 3 of ASOP 23 is listed below in Figure 3, with a description of Optumas' adherence to the Standard of Practice:

Figure 1. ASOP 23 – Section 3. Analysis of Issues and Recommended Practices

ASOP 23 Section	Adherence
3.1 Overview	Based upon the data validation steps describes above, Optumas did not find data quality issues that would result in data limitations within the encounter data or the enrollment data used for rate setting.
3.2 Selection of Data	Optumas used the encounter data, which reflects their utilization and reimbursement as the base underlying rate development. Enrollment information was provided to calculate member months and determine utilization per thousand statistics. As seen within Figure 2 above, the aggregate PMPM for the program appears very consistent over time, and was considered an appropriate data set to use as the basis of rate setting.
3.3 Review of Data	Prior to rate setting, Optumas reviewed the data through the data validation analyses described above and found no inconsistencies that needed to be addressed prior to rate setting.
3.4 Use of Data	After review of the data, Optumas determined that the encounter data was appropriate to use as the basis of rate development. No enhancements outside of the necessary base data adjustments were required as part of rate development. No judgmental adjustments were made to the data, nor did Optumas have any reason to believe the data contained significant defects.
3.5 Reliance on Data Supplied by Others	As previously discussed, Optumas is relying upon actual encounter data experience for the November 1, 2014 to August 31, 2016 time period.
3.6 Reliance on Other Information Relevant to the Use of Data	N/A
3.7 Confidentiality	The encounter data contained confidential information and all information was handled consistent with Precept 9 of the Code of Professional Conduct.
3.8 Limitation of the Actuary's Responsibility	Optumas did not perform any of the following when reviewing the encounter data and enrollment information: ■ *Determine whether data or other information supplied by others are falsified or intentionally misleading.* ■ *Compile additional data solely for the purpose of searching for questionable or inconsistent data.* ■ *Perform an audit of the data.*

Continued Improvement in Data Collection

In addition to conducting a rigorous data validation analysis, the Myers and Stauffer Team will work with BMS and the MCOs to continually improve data collection from all data sources. A primary data source for Medicaid managed care programs is encounter data. Optumas has worked with encounter data from various state clients, and when flaws in the encounter data process have been identified, they have been able to work with their clients to resolve the issues. One example of this is their work with Nebraska's DHHS. Optumas has served as the actuaries for DHHS for five years. During the course of their rate development work, they have observed significant flaws with the encounter data submitted to us by the State's data vendor. To correct these flaws, they implemented a four-step plan that allowed for comprehensive review,

evaluation, and improvement of the encounter system while maintaining progress on rate development projects. For details on this four-step process, please reference *Accurate Encounter, Claims, and Eligibility Data for Rate Setting (CRFQ Section 4.1.1.10)*.

To stay on top of data collection and ensure a continuously reliable process is in place, Optumas employs a three-phase method. They identify problems, design solutions, and monitor results. In the process of monitoring results, new problems are identified and the process is repeated. By implementing this review cycle, Optumas can stay on top of changing data submissions processes and continuously ensure the state and their vendors are using and submitting valid data.

Directed Payment Program (CRFQ Section 4.1.1.13)

Business rules shaping the current health care landscape are rapidly changing. The final revised Medicaid managed care rule provides clarity around provider reimbursement rates, specifically around provider pass-through payments and value-based reimbursement. Pass-through or supplemental payments are a large component of provider reimbursement in many states, so correct interpretation of the final rule is very important. CMS released the final rule on pass-through payments in January 2017 and it provides states 10 years to phase out pass-through payments in hospitals and five years to phase out pass-through payments for physicians and nursing facilities.

Regarding value-based reimbursement, CMS' Medicaid and CHIP managed care final rule (also known as the final rule or Mega-Rule) has changed the Medicaid landscape. Throughout the Mega-Rule, there is a consistent theme around VBP, and CMS is very much in favor of new and creative payment methodologies. Given many states' budget struggles, this creates a significant opportunity for states to implement payment methodologies that ensure quality health care is consistently provided at the right time and through the right mode of care. The Myers and Stauffer Team has worked with several states to replace existing supplemental payment methodologies with quality based/delivery based reforms. This includes states implementing formal DSRIP plans as well as other DSRIP-like supplemental payment programs consistent with 42 CFR 438 et seq. For example, a transition to reimbursing providers for EOC or build quality incentives/pay-for-performance incentives based on successful EOC. Additionally, our tools will identify inappropriate and inefficient care, which can be used to ensure that states are paying for quality health care. To the extent that health plans are not currently efficient in their health care delivery, our tools will identify the inefficiency and allow states to remove those dollars from the base data, which will lower the capitation rates. Under this approach, states can ensure that they are receiving value for their health care expenditures.

With several tools at our disposal, the Myers and Stauffer Team is perfectly positioned to develop creative payment mechanisms in collaboration with BMS. For example, Optumas has already developed creative alternative payment mechanisms in California, Colorado, and Oregon. In Oregon's waiver, they developed a program called Gain Augmentation. Under this approach, CCOs that score high on both efficiency and quality will receive a higher profit load in their capitation rate (gain ranges from two percent to four percent, depending on score). Under this approach, CCOs are incented to transition into a more efficiently managed entity. In addition, Myers and Stauffer has extensive experience creating and developing unique data analysis tools

for many client engagements. We have developed analytical tools to review and monitor utilization stratified by demographics; managed care cohort groups; and different lines of business such as Medicaid managed care, CHIP managed care, Medicaid FFS, other waiver programs, etc. We have also compared encounter claims payments against capitation payments to estimate medical and administrative cost profiles at an individual, cohort, and MCO level. We will draw upon this experience and work with BMS to determine the best way to display the information needed to improve the quality of care and outreach.

Considerations for supplemental payment approaches include:

- *Discuss the goals of the payment approach with the State.*
- *Tailor payment approach based on the strengths of the provider community.*
- *Design the supplemental payment program to ensure it meets newly promulgated rules for directed payments.*
- *Discuss various tools available for creative reimbursement design. For example, access to an EOC tool. Under this approach, total costs of care across all providers are developed into one global payment. The tool also identifies potentially avoidable complications, which can help avoid unnecessary or inappropriate utilization.*
- *Discuss with MCOs potential payment methodologies to ensure they can be operationalized.*

Actuarial Analysis and Valuation (CRFQ Section 4.1.1.14)

In Optumas' experience working with state Medicaid programs, actuarial analysis and valuation of programmatic changes consists of two primary project types: standard impact projections (e.g., MCO rate estimates) and ad-hoc impact analyses. These two types of projections present different challenges and emphasize different analytic qualities within a firm, so Optumas has a different approach to successful completion of each type of projection. Additionally, while working on projections, Optumas has learned several lessons on how to deal with the typical (and not-so-typical) problems encountered within actuarial valuations. The challenges and potential solutions are discussed within this section.

Standard Impact Projections

Standard impact projections typically include rate projections updated on a regular (e.g., quarterly) basis to incorporate the most recent encounter and enrollment data. During each projection, while updating the rate estimates to include the most recent data, the Myers and Stauffer Team will discuss with BMS the appropriate use and application of each data source. Some data sources, such as enrollment data, can be fluidly incorporated to refine the estimate of total spend using the most recent enrollment magnitudes and mix of membership across region, rating cohort, and MCO. For example, the Myers and Stauffer Team will review eligibility data for completion, retroactive enrollment, and redetermination changes to ensure the membership data used is reasonable.

Budgeting Projection Example
Optumas developed an active, integrated budget model that ties to Alabama Medicaid's general ledger to allow the Medicaid CFO to see in real-time, the financial impact of proposed changes by the Legislature to the managed care program.

Data Source Use
Updated encounter data sources used in budget projections must be used cautiously. Encounter data sets and emerging experience can indicate the size of the future rate development base data and the future trend rates, but projections need to be careful not to overreact to a new data set that may be relatively small (and therefore volatile) compared to the program's history. When reviewing the most recent encounter data, the Myers and Stauffer Team will conduct standard analyses such as credibility analyses, IBNR completion factor development, and encounter underreporting analyses. For example, with the credibility analyses, we will enhance the value of the emerging data by looking at seasonality, claims volatility, and other factors. These factors can indicate if changes inherent in the most recent data represent true changes in the program cost levels or are random fluctuations. Fluctuations may be overwritten with changes in the opposite direction during the following quarter. A deeper dive into updated encounter data can ensure budget projections are stable and avoid unnecessary changes that are caused by data volatility rather than true shifts in the program expense level.

The data analyses conducted on encounter data can also indicate to BMS how the contracted MCOs are performing in a timelier manner when compared to retrospective financial reporting. Encounter quality and completion can be assessed regularly as part of this process, and any deficiencies can be brought to light shortly after they occur. This allows BMS to take corrective action with MCOs early, before data problems grow to a point where they affect future rate setting base data or CMS reporting.

The successful completion of this task will be indicated by the submission to BMS of updated cost estimates incorporating knowledge gleaned from the most recent encounter and eligibility data. The Myers and Stauffer Team envisions this deliverable will be an Excel spreadsheet showing the current MCO rates and enrollment magnitude by rate cell and region, along with any changes to projected rates and enrollment by the same dimensions. This spreadsheet will also itemize state and federal shares of expenditures, allowing BMS to see the direct impact to the state budget. We also plan on crafting a brief narrative to accompany the Excel spreadsheet, which will explain the reason for any changes and the aggregate impact of the updated data. All deliverables are subject to approval by BMS, and if certain pieces are more or less useful, they can be expanded or contracted as desired.

Ad-hoc Impact Projections
In addition to standard, planned impact projections based on standard changes in the MCO program, it is likely BMS will occasionally have ad-hoc impact questions. This could be estimating the impact of adding a new service, removing a service, implementing new cost sharing, or any number of proposed policy changes that are regularly under consideration during the Legislative sessions. Successful completion of these tasks will be a much more iterative process. As discussed below, Optumas has identified data receipt and policy communication as two key hurdles to clear to quickly and accurately complete ad-hoc budget projections. The deliverables

associated with these requests will likely mirror the MCO rate estimate budget forecast in the level of detail provided, with the actual content customized to purpose and ultimate end-user of the deliverable, and will consist of both an Excel spreadsheet and an accompanying narrative. Successful completion will be defined by BMS. When BMS feels the policy issue/consideration has been fully understood and implemented in the modeling and/or budget forecast produced by the Myers and Stauffer Team, only then will the task will be considered complete.

Data Receipt Protocol

From experience in almost two dozen states, to stay on top of changes to the projected Medicaid program budget (both Managed Care and FFS), we recommend that the BMS IT staff set up the Myers and Stauffer Team to receive regular, standard data extracts. In multiple states, Optumas has set up the ability to automatically receive bi-monthly, monthly, or quarterly data extracts. They work with each state to determine a standard data layout, and constructs a data repository-based on the data format each state is able to conveniently deliver. Optumas then sets up repeatable protocols that allow for rapid data intake and validation. This ensures that new datasets can be quickly imported and combined with historical information to create a full and complete data repository, without additional work or effort required by the state staff or the state's vendor. With the creation of a data repository, our team can quickly complete standard analyses related not only to the MCO capitation rates, but also other Medicaid program components, and therefore, queue up any specific cost/savings analysis requests BMS might desire. For example, requests as specific as the annual spend on certain DME services and as general as the most recent quarterly pharmacy trend can be fulfilled quickly to provide BMS with the most accurate information upon which to base budgetary decisions.

Cost/Savings Analyses of Policy Changes Communication

Another crucial aspect to effectively completing policy requests is regular communication between BMS and the Myers and Stauffer Team. We have found this is often successfully accomplished with a standing weekly call between the core BMS staff and the Myers and Stauffer Team members. A weekly touchpoint provides our team with the opportunity to hear from BMS about policy considerations and budgetary constraints before they become urgent needs, and allows us to vet the consequences of any proposed policy decisions with BMS. We can also hear concerns the MCOs have voiced to BMS, changes in member assignment algorithms, and numerous other operational or programmatic points that could impact MCO rate estimates. These regular conversations and the ability for the Myers and Stauffer Team to stay continuously plugged in to the challenges facing BMS creates a true partnership between BMS and the Myers and Stauffer Team. This will provide our team members with a fuller, more complete understanding of the nuances of the Medicaid program, including decisions made and analyses requested by BMS.

The Myers and Stauffer Team can combine the information learned from regular policy communications, with the power of a custom data repository, to analyze the budget impact of any and all program changes considered by BMS, because of similar experience for clients like Alabama, Nebraska, and Oregon. The Myers and Stauffer Team will be able to quickly summarize historical experience, compare it to recent data, develop membership and cost growth projections, and complete any other task necessary to accurately model budget forecasts. Combining this data knowledge and modeling expertise with the insight gained from regular policy

conversations will allow us to make sure all budget forecasts and MCO rate projections are consistent with BMS policy objectives and incorporate all program design nuances.

Frequent Budget Projection Challenges

In our experience with other state Medicaid programs, there are two common challenges related to budget forecasting. The first challenge is timelines. Frequent budget forecast requests are spurred by legislative sessions. Turnaround times can be very tight in order to get potential impacts in front of legislators and policy makers in time for it to influence budget discussions. The second challenge is proposed impacts. Occasionally, actuaries and state agencies can have a different perception of the cost or risk of certain policy changes, and that can lead to budget forecasts that do not line up with expectations. The Myers and Stauffer Team has encountered both of these challenges before, and has developed ways to work through them to create satisfactory products.

- ***Timelines.*** *The Myers and Stauffer Team is very nimble and able to react quickly to client requests. BMS will have a dedicated team of individuals that are focused on the success of Medicaid in West Virginia and driven to help BMS realize that success. Our motivated, attentive team will be able to accomplish tasks in short order to ensure that aggressive timelines that frequently accompany budget requests are met. Accuracy will not be sacrificed in order to meet deadlines. Our team has experience across the nation with Medicaid programs, and can tap into that expertise in order to make sure our methodology, approach, and results are well-reasoned and reliable. Finally, our dynamic will give BMS a direct connection to team members. While we have a main point of contact for each of our clients, we will also make our entire team available, at your disposal, and all team members will be able to contribute to the forecasting needs of BMS.*
    - ***Lesson Learned.*** *To ensure we are ready for tight timelines, we have worked with our clients to establish the framework for our budgeting assistance up front. In that manner, we are more focused on updating the data and examining the appropriateness of the results as opposed to feverishly building a model.*
- ***Difference in Impacts.*** *Occasionally, policy cost/savings analyses created by actuaries do not line up with a state's expectation; for example, the legislative projection of managed care savings could potentially be skewed towards the high end of a range of savings estimated in an attempt to demonstrate a balanced budget. Sometimes, the actuary values a proposed benefit at a higher cost than the State considered, and other times, a benefit cut is seen through a different cost lens by each organization. When this happens, it is crucial to talk through the differences. Actuaries have professional standards to uphold, and we will adhere to the precepts laid out by our profession. However, detailed conversations regarding policy changes and budget forecasts can reveal nuances that may impact the projected cost of a proposed benefit. For example, Optumas recently priced out the cost of adding a behavioral health service to a state's benefit package. Optumas conducted thorough research on the condition prevalence, treatment rate, and treatment cost to determine the budget impact of adding the benefit. When the results were presented to the state Medicaid agency, the state thought the cost was too high. After more discussions, it was revealed that the benefit was limited to*

certain geographic regions due to the limited number of qualified providers practicing in the state. Incorporating that information allowed Optumas and the state to get back on the same page regarding the potential benefit cost. When these differences of opinion arise, it can result in difficult conversations, as actuaries adhere to professional principles and states operate under budget constraints. However, one group giving in to the other without a truly open dialogue only hurts the entire program, as eventually costs will not line up with projections. In Optumas' experience, both groups working together through an open dialogue to understand why the difference in forecasted cost exists is crucial to setting up a reasonable budget forecast that will accurately reflect future experience.

- ***Lesson Learned.*** *All players bring valuable perspectives that need to be considered in the budget forecasting process. Rather than dismissing dissenting opinions or differing estimates, discussing, understanding, and reconciling those differences yields a better result for all involved.*

Managed Care Program Administration

Waivers (CRFQ Section 4.1.2)

Our national and individual staff experience working directly with states to review their waiver programs has given Myers and Stauffer great insight into Medicaid waivers and CMS' requirements. This knowledge will be valuable as we assist the State in managed care program administration and rate setting, and provide guidance to the State on preparing the necessary waiver documents to gain CMS approval. We will advise the BMS on the advantages and disadvantages of different authorities, as well as, innovation and lessons learned from our experience with other states.

Programs (CRFQ Section 4.1.2.1)

Myers and Stauffer has extensive experience supporting states in developing, implementing, and operationalizing programs using complex federal waiver authorities. We are at the forefront of industry best practices and innovation. We have worked closely with CMS on hundreds of hours of discussions and negotiations regarding state waivers and innovative program models. We have also worked to evaluate and improve waivers to better achieve the states' goals and objectives. Examples of our assistance with current and new program development and operations include, but are not limited to, the following:

- *Consulting on the planning and design of new and renewal waiver programs and applications.*
- *Preparing waiver cost effectiveness and budget neutrality analyses.*
- *Supporting state negotiations with CMS during the waiver renewal or initial application process.*
- *Stakeholder engagement involving key internal as well as external stakeholders, such as MCOs, providers, legislators, members, and consumer advocates. This experience includes compliance with the formal waiver public comment requirements.*
- *Policy analysis and support in critical policy decisions.*
- *Project management throughout planning, design, implementation, monitoring, and oversight phases.*
- *Consulting on program implementation strategies.*
- *Analysis of potential MMIS modifications required to support the waiver.*
- *MCO as well as client "go-live" readiness assessment prior to implementation of program changes.*
- *Development and implementation of comprehensive monitoring and oversight programs.*
- *Ensuring compliance with federal requirements and reporting under the waiver.*
- *Development and oversight of systems to prevent and/or detect FWA that may occur through the waiver.*

Waiver Applications (CRFQ Section 4.1.2.2)

CMS has done much to standardize the Medicaid 1915(b) waiver application process. However, technical requirements, approval timelines, CMS negotiations, and stakeholder processes, particularly for special populations can require a tremendous amount of communication, additional analysis, and revised planning. Myers and Stauffer's experience has enabled us to develop "best practices" to assist states in the drafting of waiver applications and supporting documents, and in navigating this often demanding process. We have expert knowledge of waiver applications and CMS' technical requirements. And we have developed specialized, but customizable, templates and tools for data collection and analysis necessary to support drafting waiver applications. Our experience includes collecting stakeholder information through key informant interviews, electronic surveys, and public hearings and comment forums for inclusion in application materials.

We are also adept at providing analysis necessary to complete waiver cost effectiveness calculations. In the case of renewal applications, we have provided detailed analysis in support of the existing waiver, including lessons learned and best practices, as well as any new features that are part of the renewal application.

Myers and Stauffer will support the Bureau throughout new waiver applications, amendments to the existing waiver, and the waiver renewal process. We will provide practical, well-researched, and data-supported solutions. We will assist with the timely drafting and completion of waiver applications while adhering to CMS' technical instructions. We have experience supporting our clients through the following waiver application and renewal activities.

- *Preparing necessary research on the front end to support the application and its features.*
- *Preparing, submitting, and archiving all waiver documents, communications, and supporting materials.*
- *Documenting program and policy changes considered throughout the approval process.*
- *Ensuring that waiver application language is consistent with how the program will continue through the renewal period or modifying the language accordingly.*
- *Working with staff to evaluate existing processes and operations, and to identify and document any significant, relevant process changes that may be needed to achieve efficiencies or improvements of benefit to the program.*
- *Identifying and analyzing any language that may be problematic to the approval process based on our experience with CMS or any new or existing federal requirements.*
- *Completing any population, geographic, stakeholder, or financial analysis necessary to inform and support policy decisions in the waiver/renewal.*
- *Developing clear and concise narrative describing any program changes or updates proposed for the waiver.*
- *Collaborating with State staff to determine appropriate waiver authority, target populations, delivery system models, financial arrangements and parameters, service offering, geographic focus areas, and provider roles and responsibilities.*

- *Conducting stakeholder meeting, surveys, and preparing stakeholder communications.*
- *Providing clear and concise narrative to support finalized policy decisions.*
- *Developing an approach outlining the State's quality monitoring and oversight strategy.*
- *Working with the State and stakeholders to develop quality metrics relevant to the waiver's objectives.*
- *Providing a monitoring plan and developing review protocols as necessary.*
- *Assisting the State staff in addressing any access standards and program operational questions and issues.*

Correspondence (CRFQ Section 4.1.2.3)

Myers and Stauffer has long-standing experience preparing written communications and reports for our state clients. We provide required communications and support, and we continuously work to improve communications and reports through an ongoing feedback loop. Based on our historical experience with states and CMS, written communications and reports may be in such forms as letters, emails, and documents for website posting, PowerPoint presentations for educational sessions and other meetings, and both detailed and summary reports. The intended audiences of these communications may include CMS, HHS-OIG, state officials, provider associations, providers, and other public stakeholders.

Our experience with developing correspondence for clients is extensive. We have developed a number of correspondence for our clients which includes status reports for CMS, public reporting, state executive-level reporting, and internal progress status reporting. We have developed and administered presentations in forums of all sizes on behalf of our clients. Written materials distributed electronically and in hard copy, and by web posting are also part of our resume. Myers and Stauffer has also developed bi-directional communication strategies and materials to communicate with a variety of stakeholders that includes electronic surveys and stakeholder emails. Further, we have developed and facilitated statewide Learning Collaborative forums on behalf of several of our clients.

In addition to assisting with the completion of the new and renewal waiver applications, Myers and Stauffer will support the State through the application process by developing correspondence to federal entities and other communications related to waivers as defined. This work may include:

- *Developing readily accessible language designed to appropriately increase transparency and minimize program questions from CMS.*
- *Preparing analysis, documentation, and narratives to help the State respond to CMS requests for additional information during the application or renewal negotiation process.*
- *Engaging with the State to develop, consider, and present to CMS any proposed changes to the waiver program, methods, or processes.*
- *Providing and presenting written communications through educational forums that may be held with the providers, partners, members, and other stakeholders.*

Myers and Stauffer's policy and practice is to conduct a strenuous internal quality review process of all written communications and reports generated. We follow the directive of the State regarding the level of review and approval of written communications before release to the intended audience.

Financial Analysis and Recommendations (CRFQ Section 4.1.2.4)

Myers and Stauffer is a seasoned evaluator of programs from both financial and operational perspectives. This work includes performing cost effectiveness and budget neutrality analyses, process evaluation, and consulting to bring best practice expertise to create efficiencies in regard to various waiver elements. We also have extensive experience assisting our clients with identifying and solving implementation opportunities and challenges.

Per the federal requirements and as necessary, Myers and Stauffer will conduct programmatic and financial analysis to determine the cost effectiveness and efficiency of each new or renewal 1915(b) waiver application. The analysis will be used to revise or fully develop Appendix D of the 1915(b) application, including combined qualitative and quantitative support. For both new and renewal waiver applications, we will start by considering the State's existing application elements and data. From there, we will determine whether there are changes to information or processes that may improve the current submission. If we determine that there are opportunities, we will work with the State to identify those changes, present them, and defend them to CMS as necessary, and implement the approved changes.

Annual Report (CRFQ Section 4.1.2.5)

Myers and Stauffer has significant experience developing qualitative and quantitative reports for our clients with waivers, including CMS required quarterly and annual reports.

In developing an annual report, Myers and Stauffer will take the following steps:

- *Ensure complete understanding of report audience and proposed use.*
- *With approval from the State, develop and complete a research and analysis plan which may include key informant interviews, surveys, or stakeholder meetings.*
- *Develop a draft outline for review with the State to ensure that the appropriate elements will be included in the report.*
- *Develop a draft report template, detailed with an outline of the data necessary to complete the report, for the State's consideration.*
- *Prepare a draft report by working closely with the State on revisions and clarifications.*
- *Complete the Myers and Stauffer internal quality process throughout the drafting cycle.*
- *Prepare a final report after full vetting within the State.*
- *Prepare any summaries or presentations necessary for State and stakeholder review of the report.*
- *Support the State in presentations of the final report and any required follow-up.*

Myers and Stauffer will work with the State and other stakeholders to gather qualitative and quantitative data necessary to complete the annual report. In addition, for state consideration, Myers and Stauffer can provide a comparative analysis of how certain waiver programs have progressed over a defined period of time.

1115 Waiver (CRFQ Section 4.1.2.6)

Myers and Stauffer will assist BMS with activities related to its 1115 waiver for Substance Use Disorder (SUD). This will include, but not be limited to, assisting with federal requirements and financial analysis as well as evaluating and maximizing the flexibility that may be available to the Bureau through the 1115 waiver authority.

Through an 1115 waiver, CMS has created a path to better identify individuals with SUD, increase access to care, increase provider capacity, deliver effective treatments for SUD, and use quality metrics to evaluate the success of these interventions. Myers and Stauffer will work with the State and CMS to ensure the success of BMS' 1115 waiver for SUD.

Because of our work with DSRIP states and other states employing managed care delivery systems, Myers and Stauffer has experience working directly with MCOs to facilitate state program reporting and administrative requirements. Specifically, we have experience assisting with various 1115 waiver activities, particularly those focusing on behavioral health needs including SUD. For instance, we have supported states by providing a learning community and technical assistance services through an 1115(a) DSRIP waiver focused on behavioral health and physical health integration, and by expanding SUD community treatment capabilities. In addition, we have supported a state with a successful Substance Abuse and Mental Health Services Administration (SAMHSA) planning grant award for CCBHCs. Subsequently, we supported that state in the successful development of the CMS demonstration application and the implementation of the project. We also support a number of state clients in the operational components of their 1115(a) waivers, including performing financial analysis and reporting. In addition to providing in-depth operational support, we have developed DSRIP Planning Protocols, Funding, and Mechanics Protocols (FMP) and assisted with amendments to the DSRIP waiver's Special Terms and Conditions (STCs). We also completed financial analysis and prepared monthly financial payment summaries; developed and maintained a data warehouse and information system used to collect quality metrics and financial data; and designed the financial audit approach for the waiver.

Myers and Stauffer will assist the BMS with activities related to an 1115 waiver for SUD, including, but not limited to, federal reporting requirements and financial analysis. This work may include:

- *Performing research and analysis of best practices related to SUD populations, trends, workforce development, and/or innovative treatment options.*
- *Assisting the State with strategic planning of administrative and operational functions.*
- *Identifying, adopting, and monitoring SUD-specific quality and outcome measures.*
- *Analyzing population health trends and assisting the State with determining options that reflect the State's unique health care objectives, culture, and values.*

- *Providing financial and monitoring reports to the State and CMS on a regular basis.*
- *Working with the MCO to ensure operational buy-in and participation, and to obtain and analyze MCO data.*
- *Developing budget neutrality analysis.*
- *Providing financial or population data and analysis to assist the State in discussions and negotiations with CMS, and to monitor waiver progress toward its intended goals.*
- *Assisting with the preparation and execution of a stakeholder engagement plan.*
- *Analyzing administrative and operational options, issues, and stakeholder feedback.*
- *Supporting the State in communications with CMS, including developing presentations, executive summaries, outlines, or supporting documentation.*

Analysis (CRFQ Section 4.1.3)

Impact Analyses and Support (CRFQ Section 4.1.3.1)

As a national firm, Myers and Stauffer closely monitors the activities of the federal health care regulatory environment regarding Medicaid and CHIP policy, innovation, federal funding, compliance, waivers, and other health care transformation initiatives. We maintain dialogue with CMS executives, state Medicaid officials, and industry leaders across the nation in order to provide our clients with a robust knowledge base, guidance, and assistance. Our professionals use this knowledge to routinely provide briefings, presentations, and webinars to aid our clients in navigating the complexities of federal regulations.

We are committed to providing reliable and timely analysis, presentations, and support to BMS. Our work products will include identifying and analyzing policy options, fiscal and programmatic impacts, and federal regulatory reviews. Our team has prepared and conducted numerous presentations for our state Medicaid clients. We have extensive experience in preparing reports and informational documents as well. Currently, we also develop work plans and prepare, organize, facilitate, and document meetings on behalf of many of our state clients; we are prepared to do the same for West Virginia.

Revisions (CRFQ Section 4.1.3.2)

Myers and Stauffer agrees to revise our analysis, as requested, based on future releases or revisions of information at the state or federal level within an agreed-upon timeframe with BMS.

Monitoring (CRFQ Section 4.1.3.3)

Myers and Stauffer will monitor federal regulations and requirements for potential changes and provide analysis on program impacts on an ongoing basis. We maintain dialogues with CMS executives, state Medicaid officials, and industry leaders across the nation, in order to provide our clients with guidance and assistance in a manner that other firms simply cannot match. We also closely monitor the activities of the state and national health care regulatory environment for items that may be relevant to West Virginia, BMS, and this engagement.

Program Integrity Analyst (CRFQ Section 4.1.3.4)

Myers and Stauffer will provide a full-time Program Integrity Analyst to assist with the oversight of managed care FWA reporting and improvement in recouping Medicaid funds. Given the increased state and federal scrutiny on managed care, it is incumbent upon states to have a strong approach to program integrity in a managed care environment, including adequate audit activities to identify and collect improper payments. Having robust oversight approach allows the state to comply with CMS program integrity expectations and improves the quality and efficiency of the MCO program.

As a firm, we offer extensive experience in program integrity. We have supported CMS in their program integrity oversight of Medicare Advantage and Part D plans for many years. In addition, we support multiple state agencies, program integrity divisions, and OIGs in states with large Medicaid managed care penetration rates such as Georgia, Indiana, and Iowa.

We are well-prepared to work with BMS staff and each MCO to evaluate their program integrity approach; help coordinate and perform activities such as audits, either in collaboration with MCOs or separate from MCO activities; review MCO program integrity reports; participate in meetings; and provide information, as necessary, to the State's MFCU. Please reference *Staffing* (*CRFQ Section 3.1)* for additional details.

Operations Plan (CRFQ Section 4.1.4)

The Myers and Stauffer Team will develop the Operations Plan within the first 30 calendar days of the contract. Our Operations Plan will begin with a dedicated staff that is both trained and knowledgeable in monitoring Medicaid managed care programs. Myers and Stauffer will manage this engagement from our Atlanta office, but will draw from our national pool of experts to assist with various aspects and phases. As a firm, we have assisted several states in monitoring their Medicaid managed care programs. These include Colorado, Georgia, Iowa, Louisiana, Maryland, Mississippi, Nevada, New Mexico, Texas, Virginia, and Washington. This knowledge and experience will be made available to program officials during the entire term of this contract to assist the State with addressing and resolving any program obstacles that may arise in the future.

Myers and Stauffer recognizes that each Medicaid managed care program is unique, and our approach is dependent on each state's specific program service areas and needs. Based on our experience, we have identified a team of professionals who are highly seasoned and eager to work with BMS to plan, develop, and implement a variety of approaches to monitor Medicaid MCOs. During the planning, development, and implementation stage, we will work in concert with BMS to identify the specific needs, scope of work, resource requirements, and project plan to ensure each engagement is successful and completed in a timely manner. The planning, development, and implementation stage takes the engagement from inception of an idea and identification of a concern or need of BMS, through to a defined engagement project with objectives, approach, budget, and timeline of project deliverables.

Since our project team consists of individuals who have provided managed care oversight services to several states, we will work with West Virginia to develop a mutually agreeable operational process to perform assigned tasks. Myers and Stauffer recognizes the importance of being a professional representative of our state Medicaid agency clients. We recognize Medicaid

programs are best served by having their engagements conducted professionally with as few disputes as possible. Our operational process has been developed with this understanding. The operational stage is where the services of a defined engagement project are performed.

As an initial task, senior management, along with Ms. Chitu, will conduct a project kick-off meeting with BMS to discuss project objectives, approach, and timelines. These informational meetings are conducted up front to ensure everyone is informed regarding the scope of the project, and to work out the logistics of conducting the engagement.

Our engagement teams include multiple levels of staff with a variety of specialties and experiences that are assigned to engagements based on the specific engagement objectives. Our teams have an established structure to ensure operational success and quality control for all engagement types. In addition to the engagement partner, Ms. Chitu, each team will have an assigned project manager who ensures ongoing activities are performed timely and meet the engagement objectives. The project managers keep Ms. Chitu and BMS aware of the project status on a regular basis. The engagement team structure will include staff to perform the work as well as adequate senior level staff and/or managers to coordinate day-to-day staff activities. The team's senior leaders are responsible for ensuring quality control and professional standards are adhered to in the performance and reporting of all engagements.

Development and Maintenance of Provider Enrollment and Managed Care Contracts and Agreements (CRFQ Section 4.1.4.1)

We will work with BMS staff to develop and maintain provider enrollment and managed care contracts and agreements. We will leverage our direct experience with other states to assist BMS, including recommendations for process improvements based on our analysis.

Contract Development (CRFQ Section 4.1.4.2)

Myers and Stauffer is accustomed to developing operations manual updates, proposed rule changes, contract modifications, SPAs, legislative language review, stakeholder correspondence, and all other documentation that is needed to comply with state and federal regulations. We clearly understand both the functions and timing to memorialize all policy changes and are committed to exceed BMS' performance and timeliness expectations. Myers and Stauffer will work with state staff to identify opportunities to strengthen and clarify the managed care contract. Our contract and policies and procedure review process is built from our experience working with other state Medicaid agencies. Through this process, we have developed a contract language repository, which identifies the best practices and benchmarks utilized by other Medicaid agencies across the country. As the contractor, our analysis includes:

- *Review of the contract (and amendments) between BMS and the MCO as well as any other guidance BMS provides to the MCOs.*
- *Policies and procedures related to claim adjudication and prior authorization.*
- *Appeals and grievances.*
- *Provider credentialing and provider contract loading.*

- *MCO policies and procedures related to subcontractor/vendor oversight and monitoring of health plan contractual compliance, and program integrity.*
- *Internal processes and procedures related to claims adjudication, including reimbursement system flow, provider rate files, claim pricing, and claim resolution (edits and audits).*
- *Policies and procedures related to hospital, behavioral health, and LTSS, including covered services, non-covered services, prior authorization, provider reimbursement, and claim processing and submission.*

Myers and Stauffer will provide recommendations to improve contract language, minimize program risks, and maximize the efficiency and value of the program. These recommendations can form the basis for longer-term improvement goals, corrective actions, and ongoing monitoring recommendations. We will continue to provide feedback and updates as new issues arise and additional edits are needed to these documents to address those issues.

Monitoring Contract Performance (CRFQ Section 4.1.4.3)

In recent rule-making activities, CMS has indicated its recognition of the importance of strong and effective oversight and monitoring of managed care plans to the overall success of the Medicaid managed care program. Myers and Stauffer is at the forefront of assisting state Medicaid programs with analysis, monitoring, and oversight of their managed care contractors, and can bring this direct experience to West Virginia by assigning staff that have already performed similar work in other states. We bring to this project an expert knowledge of industry practices related to managed care operations and approach each engagement with a proven framework that allows us to gain a full understanding of performance, compliance, and financial reporting aspects of each contract. This proven framework has led us to identify material areas of contractor non-compliance which has resulted in millions of dollars contractors have had to pay back to the State as well as the assessment of liquidated damages against the contractors.

Our scope of comprehensive services help ensure that MCOs are on track to achieve intended performance goals. The combination of skills and expertise we bring to this project are truly unique. We bring a level of expertise that is extraordinary, and draws on the total resources of the firm when performing our services. Not only do we have exceptional Medicare/Medicaid contract compliance knowledge and experience, we have equivalent knowledge and experience in the Medicaid consulting, data management, and vendor oversight areas. Often, issues currently being addressed in one state have previously been encountered and addressed in another state.

We have consulted on a broad range of contract analysis, performance, and monitoring topics including:

- *Health plan contract development.*
- *Health plan and health plan system readiness reviews.*
- *Stakeholder outreach planning and implementation, including liaison to provider associations, legislative advocacy groups, or other outreach, as appropriate.*
- *Program risk assessment and evaluation.*

- *Assistance with development of reporting requirements and other program management tools.*
- *Encounter data validation and reconciliation.*
- *MLR examinations.*
- *Monitoring of TPL payments and recoveries.*
- *Provisions for state's right to audit.*
- *Provisions for addressing non-compliance.*
- *Provisions for addressing overpayments and excess profits.*
- *Data analysis.*
- *Performance audits to test for compliance with contract performance provisions.*
- *Follow-up audits to validate correction of issues.*
- *Ensuring related-party transactions are reported in accordance with program requirements.*
- *Duplicate payments between benefit programs.*
- *Inappropriate payments to MCOs.*
- *Improper coding of data used to risk adjust payments.*
- *Resource support, including subject matter expertise.*

We are currently assisting several Medicaid programs and CMS with their monitoring efforts related to their managed care programs. These efforts are designed to assist our Medicaid and Medicare agency clients in realizing their goals and objectives for their managed care programs. Our experience also includes compliance audits of PBMs and TPAs.

MCO Performance Scorecards and Reports (CRFQ Section 4.1.4.4)

Myers and Stauffer has experience working with other state Medicaid agencies to provide similar information to stakeholders. We will develop quarterly performance scorecards for public distribution as well as an annual report on MCO performance and compliance with contract obligations. The performance scorecards will align with the monitoring requirements outlined in 42 CFR 438.66, and will feed into the annual requirements of subsection (e) specifically. Since the scorecards will be public facing, we suggest an internal detailed scorecard and a more consumer-friendly version designed to help beneficiaries select an MCO. We suggest conducting focus groups with members to understand what is important to them in selecting a health plan. Research indicates that users of report cards can usually only incorporate five or six categories into their decision making. We also recommend that prior to developing the scorecards, we assess current state monitoring/reporting, conduct a gap analysis, and determine overall compliance with various reporting requirements outlined in the managed care final rule (e.g., disclosure information regarding ownership and control, annual report of recoveries and overpayments, network adequacy report, etc.). The scorecards and annual report will be developed within 30 calendar days of the each of the applicable reporting period. The

performance scorecards will be updated, as needed, in subsequent periods with categories and measures that reflect new enrollee informational needs.

Program Readiness Document and Desk Reviews (CRFQ Section 4.1.4.5)

Myers and Stauffer has experience developing MCO readiness review programs for other state Medicaid agencies. We will prepare and propose a readiness tool for BMS' approval that will be applied during the review process, prior to conducting any readiness reviews. This tool will include a combination of off-site (desk review) and on-site activities. Myers and Stauffer proposes a readiness review tool that includes the activities as outlined below.

1. *Planning activities.*
    a. *Coordinate with BMS representation and MCOs.*
    b. *Pre-meeting with MCO.*
    c. *Create interview schedules.*
2. *Ensure call center operability.*
    a. *Perform desk reviews, policy retrieval, and review and analyze policy documentation.*
    b. *Participation in readiness review on-site interviews including call center demonstrations.*
    c. *Create interview transcription.*
    d. *Assess compliance using readiness review tool.*
3. *Systems readiness to process claims based on estimated threshold of claims and issue timely provider payments.*
    a. *Perform desk reviews, policy retrieval, and review and analyze policy documentation.*
    b. *Participation in readiness review on-site interviews including claims system demonstrations.*
    c. *System reviews and analyses.*
    d. *Create interview transcription.*
    e. *Assess compliance using readiness review tool.*
4. *Participation in readiness review interviews including encounter system demonstrations.*
    a. *Perform desk reviews, policy retrieval, and review and analyze policy documentation.*
    b. *System reviews and analyses.*
    c. *Create interview transcription.*
    d. *Assess compliance using readiness review tool.*

5. *Assess subcontractor compliance (PBM, vision, dental, etc.).*
    a. *Perform desk reviews, policy retrieval, and review and analyze policy documentation.*
    b. *Participation in readiness review remote interviews.*
    c. *Create interview transcription.*
    d. *Assess compliance using readiness review tool.*
6. *Assess other systems readiness.*
    a. *Coordination of benefits.*
    b. *Provider appeals.*
7. *Provider network adequacy.*
    a. *Interviews.*
    b. *Desk reviews.*
    c. *GeoAccess analysis, review, and development of findings.*
    d. *Systems reviews and analyses.*
    e. *Assess compliance using readiness review tool.*

Onboarding – MCO Command Center

The introduction of new MCOs, new populations, or new benefits creates significant risk to BMS in the form of network adequacy, continuity of care, as well as provider and member issues navigating this change. As such, Myers and Stauffer proposes to develop and support, along with BMS, a Command Center strategy for up to the first four weeks of the new MCO contract implementation. This will ensure an efficient and well-organized MCO implementation, promote continuity of care, decrease provider administrative burden, and foster robust stakeholder outreach. The Command Center will supplement the readiness reviews and will be responsible for monitoring MCO onboarding activities, resolving recipient and provider issues, and collecting and tracking pre-determined metrics from the MCOs. The Command Center Core team participants will be empowered with the responsibility and accountability to make decisions and take actions on behalf of their organization to address implementation issues. The Core Team will be responsible for attending all meetings/calls, resolving implementation and escalated issues, ensuring continuity of care, and producing all dashboards. Each MCO is required to submit daily dashboards tracking provider and recipient call center, claims, and prior authorization metrics. BMS will provide the dashboard template and instructions to the MCOs to ensure reporting consistency.

Evaluation of Network Adequacy (CRFQ Section 4.1.5)

Analyses and Monitoring (CRFQ Section 4.1.5.1)

The Myers and Stauffer Team has experience performing analysis, ongoing monitoring, and reporting of MCO provider networks for our state Medicaid agency client in Georgia. We will work with the state to develop an ongoing monitoring, analysis, and reporting plan for MCO provider

networks. Our approach will include an MCO quarterly network adequacy report that will compare each MCO's provider network against program standards and contract requirements to BMS in its goal to ensure access to services for its Medicaid managed care members that is at least equivalent to access under the traditional Medicaid program. As part of our analyses, we will work with the State and each of the MCO plans to properly identify and categorize each plan's network of providers, and the providers with open panels. We will also develop MCO-specific reports and maps detailing each plan's provider network in terms of specialty and location, including analyses for estimated travel times for PCPs, pharmacies, basic hospital services, tertiary services, etc. We will incorporate into our regional analysis, at the direction of BMS, exceptions to the expected travel times such as in situations where the standard travel times existing in the community at large are greater than program standards. These analyses may be performed on a regular or ad-hoc basis.

We actively license and use a GeoAccess software product to develop the analysis and have experience dividing plan networks by regions and by different access standards that state may employ, including urban, rural, and frontier, as appropriate for the contract. Finally, using the GeoAccess product, we will develop a standardized report template within the requested 10 calendar days.

In addition to these standard reports, Myers and Stauffer has experience developing ad-hoc reports designed to further test MCO provider networks. By utilizing techniques such as risk-based secret shopper calling, and following up on member complaints related to the MCOs' provider network, we are able to identify additional potential network deficiencies.

Work Plan and Timeline (CRFQ Section 4.1.5.2)

We will work with BMS to develop an operations plan that includes a work plan and timeline for the project.

Reporting Calendar (CRFQ Section 4.1.5.3)

We will work with BMS to develop a comprehensive reporting calendar for the program that complies with federal, state, and bureau-specific reporting requirements as defined by the managed care contract.

Compliance (CRFQ Section 4.1.5.4)

Myers and Stauffer will identify and comply with all federal and state Medicaid laws, regulations, and policies as outlined by CMS and BMS. In all of our client engagements, we are familiar with and routinely comply with relevant federal and state Medicaid laws, regulations, and policies.

EPSDT (CRFQ Section 4.1.5.5)

Myers and Stauffer will work with BMS and the MCOs to develop reports designed to identify gaps in Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services based on West Virginia's designated Periodicity Schedule, and to improve the efficiency, effectiveness, coordination, and quality of those services.

We understand the difficulty in ensuring that member populations receive EPSDT services in an appropriate timeframe. We have experience working with claims and clinical data to identify services performed and members that have gaps in care, as well as to ensure proper data collection and reporting of the CMS-416 EPSDT report. Our team includes individuals who have experience working with the EPSDT program in their capacity as former state Medicaid agency staff. Their experience covers:

- *Developing, implementing, and monitoring FFS policies and MCO contract requirements to ensure EPSDT services, as well as the EPSDT standard, are properly provided and applied by the provider.*
- *Incorporation of EPSDT-related measures in the MCO's Quality Assurance and Performance Improvement Projects (QAPIs).*
- *Leveraging the Child Core Set measure reporting as part of monitoring of the effectiveness of MCO EPSDT initiatives.*
- *Requiring all components of a well-child check up to be performed and documented on the claim for the well-child encounter claim to be included in the MCO's performance metrics.*
- *Linking EPSDT components to MCO incentive payment programs.*

Ad-hoc Reports (CRFQ Section 4.1.5.6)

Myers and Stauffer has significant experience developing ad-hoc reports for state Medicaid agencies. We excel at analyzing claims and encounters paid in FFS and in managed care programs, including how to identify and mitigate common pitfalls in submitted managed care claims payment information such as duplicate submissions, missing claims adjustments, and identifying data elements that a provider, the MCO, or the MMIS added to the claim, and how to handle these elements while developing reports.

This deep understanding of the data has allowed us to identify areas of risk for managed care programs. For example, we have worked with several states in identifying members enrolled more than one time. If a member is enrolled in more than one MCO, then there are multiple capitation payments being paid. These members can also show as having gaps in quality measures, even if they are receiving services through another identification card. Identifying and eliminating the duplicative members helps the state control cost, resulting in millions returned to the state, while improving the accuracy of quality measures and increasing program effectiveness.

Recently, a state Medicaid agency asked us to forecast the costs of a payment increase for several provider types, for both their managed care program as well as their FFS program. We were able to develop a report that accurately predicted the increased cost associated with the payment increase. During this engagement, we worked with the Medicaid agency to establish timelines and meet deadlines.

In another recent request, another state Medicaid agency asked us to compare medical utilization between multiple MCO plans, national benchmarks, and its own FFS program. As part of the

engagement, we were asked to compare healthcare effectiveness data and information set (HEDIS) benchmarks across plans and make recommendations to improve plan performance, accuracy, and quality.

Analysis Tool (CRFQ Section 4.1.5.7)

Myers and Stauffer focuses significant firm resources into our IT area. Our developers create unique data analysis tools for many of our engagements, which enables us to quickly and accurately provide our clients with valuable information. With more than 40 years of experience working with government health care programs, we understand the importance of data in supporting successful program management. To support BMS, we will implement collaborative analysis tools through IT solutions that manage and analyze large data sets and provide end users with easy to understand results. While protecting privacy, security, and confidentiality, Myers and Stauffer will manage and integrate new data sources, convert existing data into standardized formats, and make data easier to use and understand via application programming interfaces. We have extensive experience in analytics and informatics and will work with BMS to determine the best way to display the information needed to improve the quality of care and outreach.

Myers and Stauffer has experience developing analytical tools for clients. We have developed analytical tools to review and monitor utilization stratified by demographics, managed care cohort groups, and different lines of business such as Medicaid managed care, CHIP managed care, Medicaid FFS, other waiver programs, etc. We have compared encounter claims payments against capitation payments to estimate medical and administrative cost profiles at an individual, cohort, and MCO level. We have experience identifying gaps in care for members and systemic problems at a regional and plan level.

We will work with the State to develop a tool that meets its particular needs. We have experience using different software tools such as database packages like Microsoft SQL Server and visualization tools like Tableau and Microsoft Excel and can utilize these tools, among many others, in the development of our analysis tools.

Program and Regulatory Analyses (CRFQ Section 4.1.5.8)

Myers and Stauffer routinely works with state Medicaid agencies to develop analyses in response to legislative, federal, state, budgetary, provider, or advocacy requests. We routinely monitor changes and provide guidance to our clients. As a recent example, we provided a whitepaper to our clients on the managed care rule and followed up with a webinar covering important aspects of compliance issues associated with the rule. Our team includes professionals who have worked previously for federal, state, and budgetary agencies and understand how to craft responses that are clear and concise. We have supported state responses for federal requests such as OIG audits and CMS oversight and guidance. We have developed reports designed to be utilized by provider advocacy groups such as state hospital associations. We understand that data developed and utilized for this engagement is owned by the state and will provide data, analysis, and reporting as directed.

Strategy (CRFQ Section 4.1.5.9)

Myers and Stauffer will work with the State to develop a strategy for MCO contracting, including options for performance targets, use of incentives and/or penalties, modifications to program requirements, implementation and oversight of a managed care MLR, and other MCO strategies as requested.

Our team of professionals has deep expertise in Medicaid managed care program design, contracting, and operations, having previously served in executive or leadership positions within Medicaid agencies, CMS, MCOs, and providers. This experience will inform our strategy and recommendations. We have provided many of our state Medicaid agency clients with recommendations to improve their contracting strategy in the areas of monitoring and oversight, network adequacy, encounter data and reporting, liquidated damages and sanctions, program integrity, and MCO sub-contractor compliance. We are also contracted with multiple states to audit plan submitted MLRs.

In several states, we perform reconciliations of MCO encounter submissions to assess the completeness and accuracy of the submitted encounters. These states have completeness targets that are subject to contract-specified liquidated damages if the targets are not met.

Our firm also has extensive experience developing contracts to incentivize performance targets, and developing modifications to meet these standards based on state and federal requirements. We have worked with state clients that are moving from a volume driven reimbursement system to one that pays for quality and outcomes. Our team includes professionals who in their previous positions with the Georgia Medicaid agency worked to implement an MCO incentive payment for the Georgia Families Medicaid managed care program. Myers and Stauffer is also one of a small number of firms that has direct, hands-on experience assisting states with DSRIP programs. We currently support DSRIP programs in New Hampshire, New Jersey, Texas, and Washington.

Quality Assessment and Performance Improvement Strategy (CRFQ Section 4.1.5.10)

Nearly all services Myers and Stauffer provides to state Medicaid programs are designed to improve the quality of care and/or the efficiency of care delivery. Myers and Stauffer's in-depth knowledge of administration, operations, stakeholder engagement, and evaluation of government-sponsored health care programs, coupled with our staff experience, adds immeasurable value in the development of a comprehensive quality assessment and improvement strategy that complies with federal requirements, standards, and best practices, and supports the concerns and needs of enrollees, the MCOs, providers, and other stakeholders.

Myers and Stauffer will work closely with the State to develop a comprehensive strategy that complies with federal requirements, incorporates stakeholder input, and includes a robust monitoring and evaluation component to promote the quality and appropriateness of care. Based on our experience, we know that a successful quality improvement strategy occurs when there is effective planning and stakeholder engagement; well-organized coordination and support of common goals; strong data infrastructure and quality measurement methodology; and financial and payment methods that support quality goals.

Our experience in the area of quality assessment and performance improvement includes assisting states awarded funding under the CMS Center for Medicare and Medicaid Innovation (CMMI) SIM. This initiative provided funding to states that allowed for the development and testing of health care payment and delivery programs created to achieve better care at lower costs. We assisted Nevada with their SIM initiative where the deliverable was a State Health System Innovation Plan (SHSIP). Throughout the engagement, we supported the SIM project governance, task forces, and workgroups. Our services included project management, CMS quarterly progress reports, stakeholder engagement, and the development of plan options and recommendations for monitoring and evaluating the quality and appropriateness of health care services across the state. We also developed the Nevada SIM webpage, deployed an electronic stakeholder survey, and conducted stakeholder webinar updates.

Our approach to the development of a quality assessment and improvement strategy will include the following steps:

- *We will use the CMS Quality Strategy Toolkit for States to address all requirements and assure the strategy options and recommendations align with the State's goals and objectives. We will develop a preliminary draft strategy based on the Toolkit, information in the Mountain Health Trust contract, and discussion with the State, including placeholders for discussion and information gleaned from an internal workgroup as well as stakeholder input.*
- *We will support an internal workgroup to determine if and how the strategy might align with the HHS National Quality Strategy and the CMS Quality Strategy. As the overall strategy takes shape, we will continually consider impacts. Throughout development, should we identify issues, we will discuss with the State, and, when authorized, seek guidance through CMS' technical assistance.*
- *We will work with the State to meet timeframes for developing a draft for stakeholder input. We will to attend stakeholder input sessions and review stakeholder input received and recommend changes to the internal workgroup.*
- *We will finalize the quality assessment and performance improvement strategy for approval by the State and if required, submission to CMS. As requested, we will meet with the State and CMS, and work with the State to finalize the strategy. We will advise the State about the need for amendments or other recommendations based on final strategy components.*

We also recognize that at each step of the development process, stakeholder engagement can be the difference between success and failure. We have extensive experience with stakeholder engagement across numerous initiatives, including DSRIP, SIM, and CCBHCs, and in many states including Maine, New Hampshire, New Jersey, Nevada, Vermont, and Washington. Our experienced team will assist the State with identifying milestones throughout the project work plan where stakeholder involvement is most beneficial, and the most effective method of gathering stakeholder input. Methods may range from surveys to focus groups to town hall style meetings. Myers and Stauffer's experience supports stakeholder involvement in the early stages of the project to ensure transparency, gain stakeholder input that may shape the optimal solution, and promote a successful implementation. Our experience with Medicaid programs across the country

and our diverse resources can provide the State with the expertise that it needs to communicate with multiple stakeholders. However, we are mindful of the need to follow communication protocols established with our clients to ensure we are not sharing information outside of agreed-upon boundaries, and we will only communicate with external stakeholders at the direction and/or involvement of our client.

Meetings (CRFQ Section 4.1.5.11)

Myers and Stauffer routinely meets with states' managed care plans, at the direction of and in conjunction with our Medicaid agency client. We regularly present to different groups, including providers and MCOs at stakeholder meetings and industry conferences. We are happy participate in meetings in conjunction with BMS to support the activities outlined in this CRFQ.

Program Expansion (CRFQ Section 4.1.5.12)

Myers and Stauffer is uniquely qualified to assist BMS in preparing options and recommendations regarding MCO expansion, based on our comprehensive understanding of Medicaid programs and health care systems throughout the country. Based on our team's knowledge and experience, we are able to design custom solutions for program expansion, including the payment and delivery system options, to best meet the States' goals.

Our approach to assessing expansion options will include a review of West Virginia's experience with transitioning to managed care through review of the available data, literature review, and key informant interviews. We will also assist BMS staff with a review of the success of historical MCO quality improvement projects and provide suggestions regarding contractually required new short and longer term quality improvement projects that should be incorporated with a managed care expansion. Our recommendations will also consider the inclusion of PCMHs, Medicaid health homes, super-utilizer programs, and other features that the State may wish to include in an expanded MCO program.

We have extensive experience with state claims systems, CMS 64 reporting, CMS 21 reporting, and intergovernmental transfer of funds (IGT) and certified public expenditures (CPE) data. We also regularly work with state actuaries to establish financial modeling and rate setting for our state Medicaid clients. This experience will allow us to rapidly consume the data already compiled by the State to support this analysis. Additionally, we recommend that BMS continue to conduct public stakeholder meetings to discuss managed care model options and receive input about the geography of West Virginia's rural areas and how it impacts access to services.

In addition, we will assist BMS in developing options for program expansion, including preparation of documents, cost analysis, policy considerations, risks, issues, etc. We will assist the State in considering the federal funding authorities — including SPAs, Section 1115 or 1915 waiver authorities — that will be needed to pursue potential expansion. Finally, we will provide recommendations for compliance with the CMS Medicaid and CHIP managed care Proposed Rule (CMS-2390) under any potential MCO expansion option.

WV House Bill 4217 Reports (CRFQ Section 4.1.5.13)

Myers and Stauffer has experience reporting on the metrics specified in HB 4217 and can assist BMS in the development of the required annual report. Specifically, we have experience with many MCO claims processing and adjudication systems, such as Trizetto's Facets, and with encounter submission processes. We have reviewed the claims processing and encounter submission systems for at least two of West Virginia's current managed care plans as part of our work in other states under on-site performance and contract compliance reviews, as well as under EQR Protocol 4 analyses. We are also well-versed with several MCO integrated systems for maintaining provider and member information and provider payments. As part of MCO on-site reviews for one state, we review and report on many similar metrics using both encounter data and claims, and member and provider data from the plans. In assisting that state with their MCO readiness reviews, we developed dashboards for them that tracks member MCO enrollment including member MCO selection and auto-enrollment.

We believe this, in addition to our previously described work with network adequacy, makes us uniquely qualified to assist BMS with reporting on the following metrics:

- *Number of providers by MCO, type, specialty, and geographic area.*
- *Total and monthly averages, as applicable, of member enrollment by MCO, eligibility group, enrollment type (i.e., member selection of MCO or auto-enrollment).*
- *Metrics related to claims processing by MCO (or PBM) and provider type.*
    - *Clean claims percentages.*
    - *Average days to pay from claim receipt date and from claim adjudication date.*
    - *Number and rates of claim denials.*
    - *Payments to non-network providers.*
- *Summaries of members receiving outpatient emergency services, urgent care, and care in an inpatient facility setting.*
- *Total and average capitation payments per member to each MCO.*

Project Management System (CRFQ Section 4.1.6)

Myers and Stauffer will provide a web-based portal to capture, store, and display information for end-users to meet their unique, informational requirements. The system is configurable and customizable, and offers cost-effective, time-sensitive results. The portal supports user authentication with multi-level, roles-based access and views based on client-defined parameters. This offers display capabilities that can be targeted to present:

- *Key performance indicator dashboards.*
- *Detailed data for operational staff.*
- *Summarized data for executive staff.*
- *Public data to support transparency goals.*

Other features include interactive, “drill-down” functionalities with the ability to provide actionable analytics. Depending on the data and the requirements, reports can offer real-time, dynamic, or static, point-in-time data.

All Deliverables submitted by the MCOs (CRFQ Section 4.1.6.1)

Within the portal, a project management module will be made available for the purposes of tracking the MCO deliverables. The web portal framework is flexible and we will work with the State to configure the system in such a way to best meet their needs. Two-way communication of messages, files, and surveys is provided through the use of the portal.

MCO Policies and Procedures (CRFQ Section 4.1.6.2)

Within the portal, authorized users have the ability to upload and download documents. Using roles-based security, a “directory” to contain policy and procedure documents will be created, and users with appropriate clearance will be able to upload documents into this repository. Roles, defined by the client, can be configured to meet the needs of the client. For example, some users, such as an MCO, might be able to upload and even delete files, while others have “read only” access. In addition, folders can be organized into any configuration necessary as defined by the client. The flexibility and ease-of-use of this system will allow the client to organize this into a meaningful and useful repository.

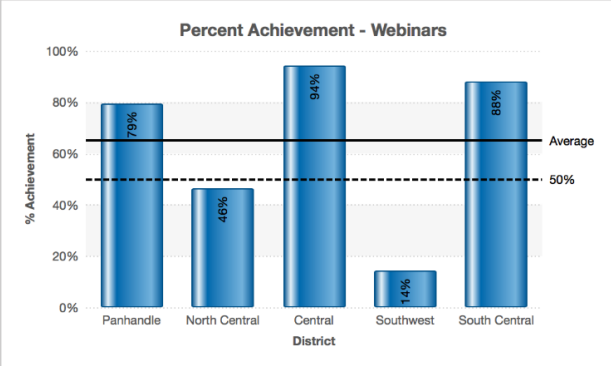
MCO Contracts (CRFQ Section 4.1.6.3)

The portal described above in *MCO Policies and Procedures (CRFQ Section 4.1.6.2)* would also apply to handling contract and amendment language. The system can be configured with different roles and permissions. The portal will contain the contract and amendment language and version history.

MCO Quality Metrics and Report Card (CRFQ Section 4.1.6.4)

Myers and Stauffer has extensive experience in analytics and informatics, especially around Medicaid data. We will work with the State to determine the best way to display the quality metrics and report card dashboards. We expect this to be a highly interactive and iterative process, which provides frequent feedback loops between Myers and Stauffer and the State during the design phase of the dashboards. The dashboards and reports can be displayed in a number of different ways, ranging from downloadable reports to interactive reports with graphs, charts with drill-down capabilities, and geospatial maps that are interactive. As an example, one might start with a map of the state, click down to a county level, and then produce a tabular report of all providers in that county that can be printed to a PDF report or downloaded as an Excel file. All of this data would be available through the web portal framework.

Examples of previous dashboards produced for other Medicaid programs follow.


Percent Achievement - Webinars
100%
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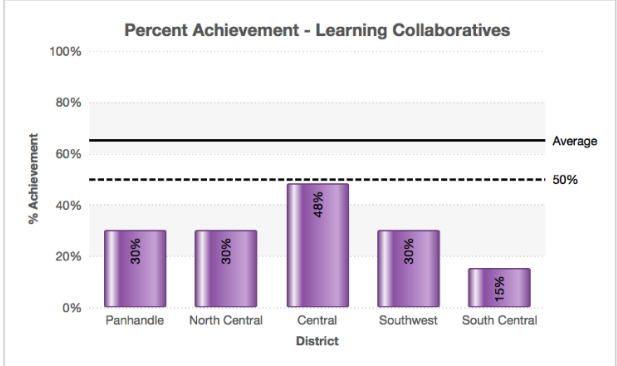
Southwest
South Central
District


Percent Achievement - Learning Collaboratives
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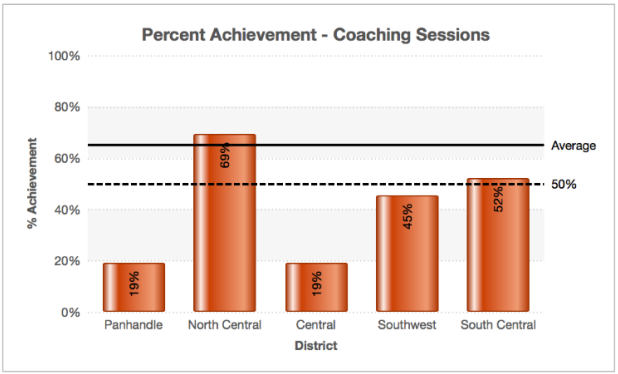
Percent Achievement - Coaching Sessions
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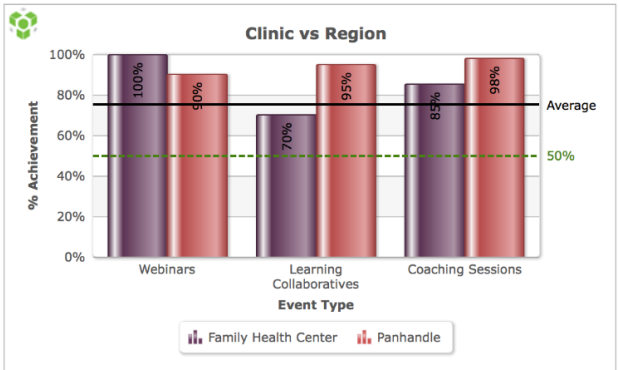
Clinic vs Region
100%
80%
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% Achievement
100%
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70%
95%
85%
98%
Average
50%
Webinars
Learning Collaboratives
Coaching Sessions
Event Type
Family Health Center
Panhandle


The Gauges below are expressed in Percentages
64.79
66.9
10.14
HgA1c
Lipid Panel
Retinal exam
59.86
8.45
Microalbumin
Flu Immunization

Network Adequacy and Readiness Reviews (CRFQ Section 4.1.6.5)

The portal will support the maintenance of network adequacy documents and readiness review materials. As these documents are updated, the current version will available while ensuring the historical information is accessible if needed.

Grievances and Appeals (CRFQ Section 4.1.6.6)

The portal will support the maintenance of reports and metrics associated with grievances and appeals. As these documents are updated, the current version will available while ensuring the historical information is accessible if needed. Reports can also be generated if it is necessary to track certain metrics around grievances and appeals.

Training (CRFQ Section 4.1.6.7)

Using a combination of on-site and web-based training, Myers and Stauffer will ensure the users of the system are well-versed and fully-trained on how to use the portal to meet the requirements of the project. In addition, we will work individually or in groups with anyone that needs extra training or has a need to learn more advanced functions (e.g., site administrators).

Hosting and User Access (CRFQ Section 4.1.6.8)

The web portal and all associated data will be hosted and stored by Myers and Stauffer in one of our secure, on-site data centers. The platform will support, at a minimum, 10 concurrent users. The platform is flexible, configurable, and scalable, allowing for any performance requirements that the client might have.

Ad-Hoc Services (CRFQ Section 4.1.7)

Changes under the ACA or Other Federal or State Health Care and/or Payment Provision Rules, Regulations, Laws, or Codes (CRFQ Section 4.1.7.1)

CMS periodically issues regulations and guidance to codify payment policies based on the ACA and other federal health care laws and regulations. State governments as well issue laws, rules, and regulations that impact the provider reimbursement. Myers and Stauffer regularly works with state Medicaid agencies to analyze the impact of these federal and state payment changes. For example, Georgia requested that Myers and Stauffer review the state compliance with the CMS final rule for Payment for Primary Care Services Furnished by Physicians. The final rule implemented section 1202 of the ACA, which required state Medicaid agencies provide at a minimum, a payment equal to the Medicare rates for calendar year 2013 and 2014 for primary care services that were performed by certain providers and for certain primary care services. Myers and Stauffer reviewed both MCO and FFS claims data to determine if the State and its MCOs complied with federal requirements by paying the correct providers the correct amount for eligible service codes.

We also routinely monitor federal and states changes that impact Medicaid payments. For example, the recent update to the Medicaid managed care rule (42 CFR 438) contained provisions that impact pass through payments via MCOs to providers. We reviewed and analyzed this provision and offered briefings, webinars, and other forms of assistance to guide our state clients in making accurate payments that complied with the federal rule.

Risk-adjusted Payment Model (CRFQ Section 4.1.7.2)

Optumas has a wide variety of experience using different risk adjustment tools such as CDPS, Medicaid Rx, CDPS + Rx, CRG, ACG, and HCC for Medicaid managed care programs and other related health programs. These tools have been critical to Optumas gaining insight into the risk of the population underlying our rate development for their various Medicaid managed care programs as well as determining the relative efficiency with which the contracted MCOs in those states operate. The key to implementing a successful risk adjustment methodology is transparency, with respect to both actuarial analyses and actuarial communication. Optumas has found that transparency at the stakeholder and state level facilitates understanding of the methodology from all levels. Having this understanding mitigates any anxiety that may stem from not understanding the mechanics related to the actuarial analyses, essentially getting rid of the "black box" approach to developing risk scores.

Optumas not only shares the risk analysis, but also shares the actual data that ran through the risk adjustment methodology, with consideration given to HIPAA and proprietary concerns of the managed care entities. Sharing this level of information, allows the managed care entities to get comfortable with the development of the risk score as well as the data quality related to the base data used as part of the analysis. Optumas has engaged in this level of transparency within the Colorado, Nebraska, and Oregon programs.

In addition to their own stringent internal requirements for accuracy and completeness, to assist with the transparency, Optumas also conducts all health-based risk analyses consistent with the guidance found within ASOP 45 – Use of Health Status Based Risk Adjustment Methodologies. This standard requires actuaries to explicitly consider important characteristics of the risk adjustment models and their use, rather than allowing actuaries to assume important issues are already addressed within any given risk adjustment software model. Consideration needs to be given to the uniqueness of each Medicaid program when using health-based risk tools. Optumas does not assume issues are already addressed within the software model.

The table below describes some of the key considerations that Optumas explores as part of each risk score analysis:

Source	Analysis Overview
Appropriate Risk Assessment Tool	There are many different risk assessment tools available. The actuary should ensure that the chosen tool is consistent with the available data. This ensures that the results are robust and that there is no bias due to gaps in the base data.
Data Needs	Ensuring that data is submitted consistently across all MCOs, such as number of reported diagnosis on each claim or completeness of National Drug Codes (NDCs). This level of consistently ensures that the results are not bias due to data reporting differences between MCOs.
Concurrent or Prospective Approach	The actuary should decide which approach is best for the program: ■ *Concurrent – risk assessment time period is same as the contract period or payment year.*

Source	Analysis Overview
	■ *Prospective – a calendar year of risk assessment is used to determine risk for subsequent calendar year.* *Note: Concurrent risk adjustment is more accurate than prospective risk adjustment but harder to administer.*
Aggregate or Individual Approach	Under an 'individual' approach, risk scores follow members during the rating period. An individual approach is typically used along with a prospective approach as described above. Under an 'aggregate' approach, risk-adjustment factors for each health plan are based on the enrollment in that health plan during the data collection period (e.g., July 2016 to June 2017). The aggregate approach assumes risk differences across health plans do not change rapidly and are stationary across time. The aggregate approach is typically associated with a concurrent approach as described above.
Durational Considerations	The actuary should explore the impact of duration on the associated risk scores and determine what level of duration should be used as a minimum threshold in order for the member to receive a risk score. For example, should three or six months be used as the threshold and how does the threshold impact credibility?
Non-Scored Members	Based upon any durational considerations, how will members that do not receive a risk score be handled within the methodology? The actuary needs to develop a methodology that makes sense with respect to how the program is operationalized.
Weights	Should state-specific weights be used or national weights? Both of these can be appropriate, depending on the data quality and maturity of the program in question.
Impacted Populations	Optumas conducts a correlation analysis that shows how well the developed risk score aligns with reported PMPMs for a given time period. Any populations showing inconsistent correlation may be considered to not be compatible with the chosen risk assessment tool.
Budget Neutral Application	Optumas ensures that the application of the risk adjustment scores is budget neutral to the overall program. This budget neutrality is also a requirement within the Medicaid final rule.

Payment Methodologies for Other Programs (CRFQ Section 4.1.7.3)

Risk-based managed care is the dominant delivery system in Medicaid today, with nearly 80 percent of beneficiaries enrolled in comprehensive MCOs, limited benefit MCOs, or PCCM programs. Though historically limited to children, pregnant women, and non-disabled parents and caretakers, many states are moving to implement statewide managed care for all Medicaid populations including persons receiving LTSS, both institutional and HCBS. The number of Medicaid beneficiaries using, or at risk of needing LTSS, who were enrolled in managed care programs covering LTSS, grew from approximately 916,000 in 2013, to more than 1.6 million in 2014.

Myers and Stauffer has provided rate setting services for LTSS and other programs not traditionally included in managed care, to states before, during, and after the transition to managed care. Our experience has given us valuable insight into rate setting considerations for LTSS and other programs in a managed care environment. We are well aware that moving these programs to managed care creates new challenges and opportunities. States must balance provider access and quality of care concerns with the need to empower managed care entities with enough control to effectively administer their plans. Those plans can also become valuable partners to help the State achieve specific LTSS and other program goals. To be most effective, the methodologies used to establish both capitation (plan) rates and service (provider) rates must be aligned.

In the future, as West Virginia considers transitioning its most vulnerable Medicaid beneficiaries into a managed care environment, it will be increasingly important that payment methodologies support Mountain Health Trust's emphasis on "effective organization, financing, and delivery of health care services as a means to improve Medicaid beneficiary access to care and enhance quality through the provision of coordinated services." Specific themes that should be taken into account to improve rate setting and risk adjustment methods include, but are not limited to:

- *Ensuring the accuracy and actuarial soundness of monthly capitation rates for LTSS enrollees. This requires collection of timely, accurate, and complete claims and encounter data; establishment of appropriate rate cells/categories; adjusting for enrollees with predictably higher utilization and costs; balancing institutional and HCBS targets, or incentivizing HCBS; and calculating appropriate spending levels for care management and care coordination.*
- *Recognizing that functional status may be a more reliable predictor of risk and costs for LTSS, as compared to claims and encounter data diagnoses used in traditional managed care programs. This requires use of reliable, consistent, and unbiased data (i.e., data subject to ongoing validation and auditing); linkages between member assessment data to encounter and/or claims data; and consistency in both form and use of functional assessment tools and data systems across programs, populations, and MCOs.*
- *Understanding the predictive power of specific variables that affect costs the most. This requires identification of functional status or individual member characteristics that drive cost and their differences across populations and programs; consideration of social determinants of health (e.g., socioeconomic status, education, physical environment, employment, social support networks, access to health care); and the availability and use of unpaid caregivers.*
- *Carefully considering the rationale and need for risk adjustment. This requires thorough understanding of individual markets within a state; assessing whether the number or type of MCOs and the competitiveness among them for enrollees justifies risk adjustment to ensure fair rates; garnering stakeholder support; and an evaluation of whether payment policies beyond capitation rates can be used to adjust for risk (e.g., reinsurance, stop-loss arrangements).*

Myers and Stauffer has considerable experience working with state clients to use various rate setting methods to establish payments rates for LTSS and other programs. We have helped

states craft reimbursement systems that address the diverse needs of complex populations and establish incentives to promote higher quality services and more cost-effective care for the most vulnerable Medicaid populations.

Iowa is one state where we have a long history of providing rate setting services. Our team has worked with the state of Iowa for nearly 15 years, providing professional accounting and consulting services to the Iowa Medicaid Enterprise (IME). The purpose of this engagement is to assist the State in determining reasonable reimbursement rates and cost settlements for services, as well as determining other calculations such as UPLs and supplemental payments. Services include, but are not limited to, rate setting, auditing, and cost settlement for various provider types (e.g., nursing facilities, intermediate care facilities for individuals with intellectual disabilities [ICF/ID], residential care facilities, home and community-based waiver providers, targeted case management, rehabilitation services, community mental health centers [CMHCs], FQHCs, HHAs, RHCs, psychiatric medical institutions for children [PMIC], CAHs, and general acute care hospitals); DSH; IGT and UPL calculations, and other revenue maximization; hospital payment rate setting, including outpatient and inpatient services; and budget analysis and consulting services related to IME's comprehensive managed care program.

Similarly, Myers and Stauffer has had a number of engagements with the state of Kansas dating back to the early 1980s. In these engagements, our staff calculates Medicaid per diem rates for nursing facilities and nursing facilities for mental health using facility-specific cost data. We provide the State with preliminary analysis of these costs and rates, and assist the State in developing a notice of proposed rates that describes their proposed rate methodology and lists proposed rates for each facility. Further, our team develops additional analyses to assist the State in evaluating comments on the proposed rates and to help them adjust the methodology for the final rates. We then prepare final rate lists for the State and their MCOs, and produce rate schedules for distribution to providers. We assist the State in preparing the notice of final rates and any related Medicaid SPAs.

Kansas and Iowa are two states that have transitioned LTSS and other programs to managed care within the last five years. Each state faced unique challenges before, during, and after its move to managed care. We assisted these states with rate setting concerns as they transitioned to managed care and we continue to provide each with ongoing rate setting services and support.

In addition to the growth in managed care, many states are experimenting with Medicaid APMs designed to incentivize providers for delivering high-quality, cost-effective care. These models may be implemented on top of existing FFS frameworks and/or within managed care programs by incorporating quality and performance incentives/penalties in managed care contracts, directing MCOs to implement VBP models or participate in multi-payer delivery system reform initiatives, and allowing MCOs to provide "value-added" services beyond what is covered under the Medicaid State Plan or MCO contract. The most commonly used APMs include shared savings, value-based payment, PCMHs, Medicaid health homes, ACOs, and bundled/EOC payments.

Through the incremental and persistent introduction of financial risks and rewards, APMs can provide health care professionals with the tools and flexibility to implement patient-centered solutions. Myers and Stauffer has considerable experience working with state clients to ensure

APM reforms synergize with broader efforts to transform health care delivery, and consider population health needs, utilization patterns, and the provider landscape. Our services include, but are not limited to:

- ***Identifying potential APMs.*** *This requires consideration of the provider environment and risk tolerance, as well as the state's internal capacity to administer the model; analysis of key design features of each model; assessment and solution building regarding the infrastructure required to administer and oversee the model; training of state staff; and draft APM design.*
- ***Conducting financial modeling.*** *This requires accounting for acuity of health conditions, provider case mix, geography, and other factors to accurately adjust performance metrics and expectations; forecasting the impact on state budgets and on commercial payers to assess return on investment and substantiate multi-payer alignment; and assessing alternative strategies and conduct realistic sensitivity analysis.*
- ***Conducting stakeholder engagement.*** *This requires integrating payers in design of APM strategies; involving provider groups in APM design to increase provider confidence in methodology, and to support efficient use of technology; and developing communication strategies for implementation and ongoing feedback.*
- ***Assessing health information technology (HIT) needs.*** *This requires assessment of data flows and identification of ways to leverage systems to enable the timely exchange of data to track performance and outcomes; establishing and maintaining performance dashboards; and integrating payers in design of strategies to support health system transformation through multi-payer alignment.*
- ***Developing and negotiating Medicaid SPAs and federal waivers.*** *This requires assessment and selection of authority that aligns with extant initiatives; assessment of alternatives for program funding and design; SPA/waiver drafting; facilitating public transparency process as necessary; and supporting discussions and negotiations with CMS.*
- ***Designing implementation strategies.*** *This requires consideration of state and federal requirements, operational needs, HIT infrastructure, reporting requirements, and informational needs; determination of whether a phased approach should be used for implementation; and analysis of resource needs to operate the APM (e.g., staffing, training, vendors, and technology).*

Myers and Stauffer has considerable experience working with state clients to design, develop, and support APMs. For example, as a subcontractor to the RELI Group, Myers and Stauffer assisted CMS in conducting a study and writing a report in accordance with Section 101(e)(7) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This study and report examined the applicability of the federal fraud prevention laws to items and services furnished under APMs, identified aspects of such APMs that were vulnerable to fraudulent and/or abusive activity, and examined the implications of waivers to such laws granted in support of such APMs, including under any potential expansion of such models.

Myers and Stauffer also assisted the state of Idaho in developing and implementing the PCMH model of care. The Idaho PCMH Transformation Team consisting of Myers and Stauffer, Briljent, LLC, and Health Management Associates (HMA) provides training and technical assistance in the PCMH model of care to practices and public health district (PHD) staff in order support the transformation of practices to PCMHs and creates a sustainable support system. As part of the transformational PCMH training and technical assistance program, Myers and Stauffer developed a payment system for incentives to practices that meet tiered PCMH requirements.

In addition, Myers and Stauffer has worked with New Jersey's DSRIP initiative since its inception in 2012. Our team represents the State in meetings and discussions with both CMS and the provider industry; developed waiver protocols and assisted the State in the amendments to the STCs; and designed the DSRIP application and audit approach that was approved by CMS to confirm DSRIP eligibility and to provide ongoing monitoring of performance through quarterly reporting procedures.

Lastly, Myers and Stauffer serves as independent assessor for the Texas DSRIP initiative. Our staff conducts periodic assessments of all 1,491 DSRIP projects in the state, totaling $11.4 billion in federal funding. Myers and Stauffer has developed a monitoring program that includes conducting a mid-point assessment to determine status of projects and provide recommendations to ensure success of projects; validating submitted data by performing providers that serve as the basis of their DSRIP payments; and identifying project risks and issues associated with variances from the approved plan and whether progress is measurable based on approved performance measures.

Programmatic Activities (CRFQ Section 4.1.7.4)

Myers and Stauffer has extensive expertise in supporting states with Medicaid program activities, including development of SPAs, contract amendments, and regulatory changes. We have consulted with states on the development of contracts and amendments for states for a variety of vendors, supported discussions with CMS about contract and programmatic approvals, and provided services related to state and federal regulatory changes and their implementation. We also regularly prepare or assist with federally-required materials and reports for state Medicaid programs, including SPAs, waiver documents, CMS 64 reports, and waiver reports, among others. Our team includes individuals who have worked directly for state Medicaid agencies, and had responsibility for managing, planning, development, and implementation of federal and state programmatic and policy initiatives. For any programmatic or policy initiative we support, we keep abreast of state and federal regulatory changes that are occurring, and raise considerations for the impacts to those initiatives.

Below, we provide a high-level summary of support for SPAs, contract amendments, and regulatory changes as examples of our support of Medicaid programmatic experience. For any request, we will work with the State to confirm the required level of support and timelines.

State Plan Amendments (SPAs)

Our team's deep knowledge of CMS SPA requirements, preprints and templates, understanding of CMS expectations, and the SPA approval process will ensure SPAs that we support are

properly developed, tracked, and submitted in accordance with state and federal requirements. Examples of support we anticipate providing may include:

- *Conduct research to inform planning, such as identifying similar requests made by other states to confirm the SPA is the correct federal authority, or to identify pending regulatory changes that may impact the requested amendment.*
- *Facilitate planning meetings to gain consensus on the amendment being requested, finalize the policy approach and follow up on next steps.*
- *Plan for meeting with CMS to discuss the amendment, including preparing talking points or other materials, attending the meeting, and helping to facilitate the discussion.*
- *Assist with the fiscal impact analysis for the CMS-179 form.*
- *Draft the SPA for State review and approval.*
- *Support drafting of public notices, support public hearings, and compiling public comments.*
- *Finalize the SPA for submission to CMS, and respond to CMS inquiries and negotiations.*
- *Transition the SPA into policy and implementation, and conduct post-implementation analysis.*

Contract Amendments

Myers and Stauffer is well-equipped to support the State in drafting Medicaid contracts and amendments, as our team members have extensive experience with state procurement and contracting processes, in addition to our programmatic expertise. For example, over the prior six months, we supported two states with implementation of new Medicaid MCO contracts. We facilitated workgroups and suggested contract amendments to incorporate improved programmatic monitoring and oversight and to bring the contracts into compliance with the updated Medicaid managed care regulations.

Examples of Medicaid contracts our team members have assisted to develop, include:

- MCOs.
- Enrollment brokers.
- EQR organizations.
- Credentialing verification organizations.
- Medical review and utilization review services.
- PBMs.
- Specialty pharmacy vendors.

We are well-versed on state procurement policies and regulations, and would consider those in any support we provide, noting for example, where proposed amendments may actually require procurement. For existing contracts, we also raise to clients when proposed requirements may result in need for revised federal authorities, whether it is a SPA or a waiver amendment.

Examples of support we anticipate providing may include:

- *Facilitate program design meetings to define and gain consensus on required programmatic changes and policy approach, including identifying key decision points, conducting research to inform the planning process, and developing options analyses.*

- *Conduct qualitative and quantitative analyses to inform decision-making, including a federal and state regulatory analysis.*
- *Identify impacted contracts and determine required processes to procure new or amend current contracts, and identify required federal authorities.*
- *Facilitate stakeholder input processes, including interviews, surveys, and public forums.*
- *Support the drafting of contract amendments, including language to clarify roles and responsibilities and required remedies for non-compliance. For new contracts, support the full procurement process.*
- *Support the contract approval process at the state and/or federal level, including response to CMS inquiries and supporting negotiations to finalize the contract.*
- *Support for preparation and completion of readiness reviews, if required.*
- *Define new reporting requirements and or needs for ongoing oversight and monitoring.*

Regulatory Changes

Staying abreast of state and federal regulatory changes is essential to the work we do across all states, and the assistance we provide is twofold:

- *Supporting Medicaid agencies to draft recommended regulatory language or reviewing potential regulatory changes to help draft comments. This may involve helping to draft summaries of impacts to the state's Medicaid program should legislation under consideration pass, or helping to facilitate meetings with legislators who have questions about potential impacts.*
- *Considering the impact state and federal regulatory changes have to existing Medicaid programs and policies, as well as to programs and initiatives that are in the planning stages. As noted in our support for development of SPAs and contract amendments, an important role for our team is to consistently understand and raise to our clients when regulatory changes will have an impact. This is particularly critical when considering new program design so that a state:*
    - *Does not head in a direction with the design only to find out later that components of the design are not allowed due to specific federal or state regulations.*
    - *Understands if the regulatory requirements or planned changes may require programmatic components that are administratively or cost prohibitive to the state to implement.*
    - *Understands federal authority and required reporting, as well as legislative reporting requirements.*

Examples of important regulations impacting Medicaid programs, include:

- 42 CFR Part 2.
- Final managed care rule.
- HCBS final rule.
- ACA.
- 21st Century Cures Act.
- Health Information Technology for Economic and Clinical health (HITECH) Act.
- State statutory changes.

In all of our work with the State, we will regularly raise the need for consideration and analysis of regulatory changes. We will support necessary programmatic changes to address the regulations, as needs are identified. We can also provide trainings to staff about the new regulations and impacts to the program and their responsibilities.

Analyze Proposed Adjustments to Provider Reimbursement Rates (CRFQ Section 4.1.7.5)

Myers and Stauffer has extensive experience with provider reimbursement analysis and claims adjudication systems review for both Medicaid FFS and MCO programs. At the state level, we work closely with 24 Medicaid agencies on rate setting projects that include nursing home, inpatient and outpatient hospital, durable medical equipment, and physician rate setting. Our reimbursement analysis includes an assessment of both fiscal and programmatic impacts to the state. We have used cost report data to perform analyses that provided helpful information to our clients, including assessing the budgetary impact of policy change. On our state clients' behalf, we work closely with MCOs to monitor adherence to contract definitions of accurate and timely payments. In addition to rate setting and capitation analysis, Myers and Stauffer has experience evaluating and testing inpatient DRG methodologies; reviewing reimbursement systems and contract set-up to identify potential vulnerabilities within the system that could lead to over-payments or underpayments; and assessing source inputs used in the development of actuarial rate ranges to identify risks that could impact the materiality of the rate changes. Providing these services for a large number of Medicaid programs requires us to continually assess the environment and understand differences from state to state. Relevant state clients for this area of expertise include Colorado, Georgia, Mississippi, and Texas.

Programmatic Activities (CRFQ Section 4.1.7.4) includes several rate setting examples.

Research and Recommend Approaches (CRFQ Section 4.1.7.6)

Myers and Stauffer's national experience provides our team with extensive insight into innovations and health reform efforts. We maintain an ongoing exchange of information with state Medicaid officials, CMS, and industry leaders across the nation, to provide our clients with guidance and assistance in a manner that only Myers and Stauffer can offer. We closely monitor the activities of the state and national health care regulatory environment regarding Medicaid policy, innovation, HIT, compliance, and program integrity matters to keep a current knowledge base of program policy, service innovations, operations, and regulatory requirements.

Many of our team members are former state Medicaid and CMS employees. We have a strong grasp of the federal and regulatory framework and how to conduct and interpret the results of our research. Additionally, we work to stay up-to-date on national trends, innovations, and best practices in health care delivery reform. In addition to our team's educational background and extensive professional experience, our team members regularly attend national conferences, webinars, and trainings, and are expected to be experts on policy areas so that teams are well diversified in their knowledge. We will be responsive to the State's requests for research analysis, and we will proactively provide recommendations when we think research would be beneficial to inform particular issues occurring within the program.

Our team members have experience in all areas of the work request: chronic care/disease management, pharmacy, eligibility and coverage, quality improvement, improved rural health delivery, and provider networks, among others. For example, we are supporting New Hampshire by providing Learning Collaborative forums and technical assistance to providers as they implement initiatives that incorporate many of these areas (e.g., workforce development, including in rural areas; behavioral health/disease management; access to care, etc.). This effort includes researching best practices and innovations, as well as identifying and working with local and national experts in a variety of areas. We have also supported multiple states with SIM planning, which included extensive research and stakeholder input across Medicaid and other health care delivery systems.

Our team members have also experience not limited to but including the following:

- *Designing, implementing, monitoring, and evaluating chronic care/disease management programs.*
- *Providing consultation on the design of pharmacy benefits, utilization management programs, pharmacy trend analysis and projections, use of 340B pharmacies, inclusion of MCO drugs and physician administered drugs into the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) drug rebate program, and rate setting.*
- *Developing MCO QAPI programs and designing programs that link performance and outcomes to MCO incentive payments.*
- *Designing programs and providing consulting services that analyze MCO network adequacy and offer solutions where appropriate and necessary, such as telemedicine and providers practicing at the top of their scope of practice.*
- *Researching evidence-based practices for incorporation into best practice models.*

For any topic, we would follow a similar research approach depending of the extent of a request. For example, this may include the following:

- *Target our research by:*
    - *Discussing the request with our internal experts to identify best practices and recommended approaches to consider across the nation.*
    - *Reviewing initiatives and innovations in Medicare and the commercial industry that may be applicable within a Medicaid environment.*
    - *Reviewing initiatives and innovations of health care providers.*
    - *Identifying states that are similar in geography, demographics, and programmatic features to West Virginia, and that may be most relevant for consideration.*
- *Conduct detailed electronic research.*
- *Recommend states or other entities to survey, develop survey questions, and facilitate the interview. Alternatively, administer a written survey via a web-based survey tool.*
- *Consider if a round table discussion among multiple individuals would be beneficial.*

- *Summarize research findings, including agreed-upon information based on the extent of the request. Information may include, summary by state or other entity, best practices, lessons learned, costs, and an options analysis that provides benefits and challenges of each identified approach and specific to West Virginia's program. These research findings would be presented to the agency in its desired format.*

Assistance (CRFQ Section 4.1.7.7)

Myers and Stauffer will provide assistance to DHHR in responding to various information requests from the Governor's office and legislative leadership. Our staff has years of experience working directly with Governor's offices, legislators, and legislative staff in many states. Included on our proposed team will be a former state Medicaid director, Governor's office and state agency budget and policy analysts, state auditors, and state Medicaid policy experts. Each of these positions previously had working relationships with the leadership in their state. Based on this experience, we understand what is necessary for state Medicaid agencies to provide timely notification and concise information and recommendations to state leadership concerning the complex issues that routinely impact Medicaid. Our staff is well-prepared to assist in the development of written correspondence, preparation of presentation materials, as well as attending and presenting at leadership meetings as requested. Specifically, our abilities include the development of legislative analysis, in-depth policy reviews, and policy and fiscal presentations. We have provided this support to our clients in Georgia, Mississippi, and Nevada.

Procurement Materials (CRFQ Section 4.1.7.8)

The Myers and Stauffer Team is highly-qualified to assist in the development of procurement materials related to services specified in this CRFQ. Our team knowledge and experience will inform the development of all necessary procurement materials in a thorough and concise manner.

Our staff previously served in state Medicaid executive and leadership positions where they participated in key procurements for Medicaid managed care, medical utilization, pharmacy benefits management, non-emergency transportation, consulting services, decision support system, MMIS, and others. Our team actuaries have also assisted in the procurement process including RFP writing, answering questions, and development of bidder's library materials for prospective vendors

Contract Award (CRFQ Section 5)

Contract Award/Pricing Page (CRFQ Section 5.1/2)

We have included our price estimate, using *Exhibit A Pricing Page*, separately through wvOASIS. Our pricing is based on our understanding of your request and our previous experience providing Medicaid managed care rate setting and Medicaid managed care program administration in numerous states.

Hourly Rates (CRFQ Section 5.3)

Myers and Stauffer understands and agrees to the specifications regarding hourly rates as described in *Section 5.3* of the CRFQ.

Ordering Procedures (CRFQ Section 5.4)

Myers and Stauffer understands and agrees to the ordering procedures as described in *Section 5.4* of the CRFQ.

During the life of the contract with each statement of work (SOW), we agree to provide resumes, licenses, credentials, and required experience of assigned staff. We acknowledge that BMS will indicate what additional criteria (if any) must be met for each project during the initial contact. In each SOW, we agree to provide the level of effort by staff required for each project stated in quantities of the prescribed hourly rates for approval prior to beginning work. We will submit a SOW which identifies the project services, outcomes, and deliverables (including deadlines) to support the request. We understand that DHHR must approve the SOW by issuance of an approved Delivery Order based on the quantity of hours prior to beginning work, and that quantities on the approved Delivery Order are not to be exceeded without approval of a modified Delivery Order.

We understand and acknowledge that Delivery Orders in excess of $25,000 shall require processing as a Centralized Delivery Order through the West Virginia State Purchasing Division, and that Delivery Orders of $25,000 or less will be processed as Agency Delivery Orders

Additional Information *(CRFQ Sections 6 – 11)*

Performance (CRFQ 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 Section 7)

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

Travel (CRFQ 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 may be 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 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 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 Section 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 10.1.2).*
- *Failure to comply with other specifications and requirements contained herein (CRFQ Section 10.1.3).*
- *Failure to comply with any laws, rules, and ordinances applicable to the contract services provided under this contract (CRFQ Section 10.1.4).*
- *Failure to remedy deficient performance upon request (CRFQ Section 10.1.5).*

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

- *Immediate cancellation of the contract (CRFQ Section 10.2.2).*
- *Immediate cancellation of one or more release orders issued under this contract (CRFQ Section 10.2.3).*
- *Any other remedies available in law or equity (CRFQ Section 10.2.4).*

Miscellaneous (CRFQ Section 11)

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

Contract Manager: Michael Johnson, CPA, CFE
Telephone Number: 404.524.0775 x 305
Toll-free Number: 866.758.3586
Fax Number: 404.524.0782
Email: mjohnson@mslc.com

Please note we have included all required CRFQ forms in *Appendix C: CRFQ Forms*.

Appendix A: Resumes

Michael Johnson, CPA, CFE

Member, Myers and Stauffer

Summary

Mr. Johnson, member with Myers and Stauffer, manages our Atlanta office. He has extensive experience working with state Medicaid clients on managed care initiatives and program integrity engagements, and currently serves as a partner-in-charge of our managed care engagement team.

During his career at Myers and Stauffer, Mr. Johnson has worked in all capacities on projects, including project director, project manager, and quality assurance. He provides high-level strategic input to assure successful completion of the project and the full satisfaction of the client.

Some of his accomplishments include the development of a strategy to reconcile MCO encounter claims back to financial records. With implementation of this strategy, the MCOs in several states have raised their completion rates and cleaned up erroneous encounters in the process. In addition, Mr. Johnson has worked with several states to implement many aspects of the recent CMS managed care regulation. This includes the development of a readiness review toolkit for health plans.

Education

B.B.A., Accounting, University of Georgia, 1994

Experience

23 years professional experience

Affiliations

American Institute of Certified Public Accountants
Association of Certified Fraud Examiners
Georgia Society of Certified Public Accountants
National Healthcare Anti-Fraud Association

Certifications

Certified Public Accountant
Certified Fraud Examiner

Relevant Work Experience

Georgia Department of Community Health (2008 – Present)
Care Management Organization (CMO) Compliance

Scope of Work:
Myers and Stauffer assists the DCH with providing oversight and monitoring of the Georgia Families CMOs.

Responsibilities:

- Assisted the Department in the oversight of their managed care program.
- Validated encounter data.
- Conduct on-site reviews at CMOs addressing contract compliance.
- Conduct readiness reviews.

Louisiana Department of Health (2015 – Present)

Managed Care Organization Oversight

Scope of Work:

Myers and Stauffer provides services to the Louisiana Department of Health for programmatic and financial reviews of MCOs.

Responsibilities:

- Assisted the Department in the oversight of their managed care program.
- Validated encounter data.
- Conduct MLR examinations.

U.S. Department of Justice (DOJ) (2014 – 2016)

Department of Justice Expert Support Services

Scope of Work:

Myers and Stauffer assisted the DOJ and state of Georgia in identifying and quantifying damages resulting from an alleged kickback arrangement.

Responsibilities:

- Assisted the DOJ in a successful case resulting in a large recovery.

Georgia Department of Community Health (2013 – Present)

Nursing Home Reimbursement Technical Assistance

Scope of Work:

Myers and Stauffer provides reimbursement consulting and case mix technical assistance.

Responsibilities:

- Worked with the Department to establish rates utilizing case mix for their long-term care providers.

Georgia Department of Community Health (2010 – Present)

Electronic Health Record (EHR) Auditing

Scope of Work:

Myers and Stauffer assists the department in planning, developing, implementing, operating, and auditing various functions of the Medicaid Incentive Program (MIP).

Responsibilities:

- Completed Audit Guide and stratification of providers into risk pools.
- Numerous eligible provider (EP) and eligible hospital (EH) audits completed.
- Some referrals to Program Integrity Unit as a result of review.
- Assists Department with pre-payment tasks.
- Assists the Department with their EHR incentive program.
- Directs a team that conducts the post-payment reviews of the incentive payments to ensure the payments are accurate and in compliance with federal and state rules.

Georgia Department of Community Health (2008 – Present)

Benefits Testing

Scope of Work:

Myers and Stauffer assists the DCH to evaluate the accuracy of benefit payments made through the Medicaid program and CHIP.

Responsibilities:

- Oversee the work and delivery of the annual report detailing errors and issues with payments made by the Department.

Georgia Department of Community Health (2013 – Present)

Hospital Reimbursement Technical Assistance

Scope of Work:

Georgia Medicaid engaged Myers and Stauffer to review their PPS for inpatient hospital services.

Responsibilities:

- Assisted the Department with certain technical hospital matters, including a review of hospital tax calculations.

Georgia Department of Community Health (2012 – Present)

Recovery Audit Contractor (RAC)

Scope of Work:

Myers and Stauffer provides RAC services to the DCH.

Responsibilities:

- Worked with the Department to oversee the federally mandated RAC program.
- Facilitated more than $30 million in recoveries back to the Department.

Louisiana Department of Health (2013 – 2016)

Recovery Audit Contractor

Scope of Work:

Myers and Stauffer assisted the department by enhancing overall program integrity efforts through the RAC program in accordance with federal and state laws.

Responsibilities:

- Worked with the Department to oversee the federally mandated RAC program.
- Facilitated millions in recoveries back to the Department.

Mississippi Division of Medicaid (2015 – Present)

Outsourced Financial Reviews Mississippi Coordinated Access Network (MississippiCAN)

Scope of Work:

Myers and Stauffer assists the division in a wide-ranging assessment of the CCOs' contract compliance. Under the contract, we perform encounter claim to cash disbursement journal reconciliations to assess completeness; assess encounter claim accuracy under CMS EQR Protocol 4; review capitation payments for payment accuracy and potential duplicated capitation payments; provide examination services of MLR report filings; and perform other compliance testing of other monthly monitoring tools, such as denials reporting and TPL collections, at the direction of the division.

Responsibilities:

- Assisted the Department in the oversight of their managed care program.
- Conduct MLR examinations.
- Review risk adjustment inputs.
- Assess compliance matters, including TPL, timely payment, denials, etc.

New Hampshire Department of Health and Human Services (2012 – Present)

Audit of Electronic Health Records

Scope of Work:

Myers and Stauffer conducted an audit of the Medicaid EHR incentive program for the New Hampshire Department of Health and Human Services.

Responsibilities:

- Assists the Department with their EHR incentive program.
- Directs a team that conducts the post-payment reviews of the incentive payments to ensure the payments are accurate and in compliance with federal and state rules.

New Mexico Human Services Department (2012 – 2014)

Fiscal Consulting

Scope of Work:

Myers and Stauffer was engaged to perform a thorough review of the current processes used to collect and report federal Medicaid expenditures.

Responsibilities:

- Assisted in reviewing the states federal claiming forms for accuracy.

New Mexico Human Services Department (2015 – Present)

Hospital Audit

Scope of Work:

Myers and Stauffer assists with the oversight of the MCOs.

Responsibilities:

- Assisted the Department in the oversight of their managed care program.
- Validated encounter data.
- Conduct on-site reviews at CMOs addressing contract compliance.

Presentations

"Data Mining Simplified," 2010 Indiana Society of CPAs Fraud Conference.

"Detecting Fraud, Abuse, and Errors in Fee-for-Service and Managed Care Programs," 25th Annual National Association of Medicaid Program Integrity Annual Conference.

"Identifying Improper Payments/Overpayments Using Data Mining," 27th Annual National Association of Medicaid Program Integrity Annual Conference.

"Applying Recovery Audit Contractor (RAC) Concepts to Medicaid Managed Care," 28th Annual National Association of Medicaid Program Integrity Annual Conference.

"Medicaid Managed Care: Helpful Hints for Effective Monitoring and Ensuring Compliance," 29th Annual National Association of Medicaid Program Integrity Annual Conference.

"Auditing Meaningful Use and Changes to Audit Approaches with Providers and Technology," Fifth Annual CMS Multi-State Medicaid HITECH Conference.

"Medicaid EHR Incentive Program Auditing: Best Practices and the CMS Toolkit," Fourth Annual CMS Multi-State Medicaid HITECH Conference.

Robert Bullen, CPA, CFE

Member, Myers and Stauffer

Summary

Mr. Bullen is a member (owner/partner) with Myers and Stauffer. He is one of two partners-in-charge of the firm's national managed care practice. Mr. Bullen has extensive experience relating exclusively to health care-related audit and compliance services, including overseeing audits of Medicaid MCOs, MAO/PDPs, and PBMs.

Mr. Bullen has been responsible for overseeing dozens of accounting, auditing, and consulting engagements during his career with Myers and Stauffer. He has worked in all capacities on projects, including project director, project manager, and quality assurance. He provides high-level strategic input on each project to ensure successful completion and the complete satisfaction of the client. He has directed projects from the development of the initial work plan through the report delivery.

Education

B.S., Accounting, University of Baltimore, 1983

Experience

34 years professional experience

Affiliations

American Institute of Certified Public Accountants
Association of Certified Fraud Examiners
Health Care Compliance Association
Maryland Association of Certified Public Accountants

Certifications

Certified Public Accountant
Certified Fraud Examiner

Relevant Work Experience

Nevada Department of Health and Human Services (2010 – Present)

Managed Care

Scope of Work:

Myers and Stauffer assists Nevada with oversight of MCOs to assure that financial and statistical information and encounter data is reported in compliance with state and federal laws and regulations.

Responsibilities:

- Assisted the State with the development of the review process related to performance audits and administrative expense audits of the Medicaid MCOs.
- Validation of encounter data submitted by the Nevada Medicaid MCOs utilizing CMS EQR Protocol 4.

U.S. Centers for Medicare & Medicaid Services (2010 – Present)

Audit, Oversight, and Technical/Operational Support

Scope of Work:

Myers and Stauffer provides audit, oversight, technical, and operational support of MA/PDP, PACE and other organizations related to the Part C and Part D Program.

Responsibilities:

- Consulted on the methodology used to conduct program audits of MAO/PDPs.
- Assisted CMS with the risk assessment utilized to select health plans for audit.
- Assisted CMS with the development of the audit protocols utilized to conduct the program audits.

U.S. Centers for Medicare & Medicaid Services (2006 – Present)

Medicare Advantage Financial Audits

Scope of Work:

Myers and Stauffer performs a thorough examination of the financial information reported to CMS to establish their capitation rates and of the relevant internal controls.

Responsibilities:

- Assisted with the development of the uniform examination process used to conduct one-third financial audits of MAO/PDPs.
- Assisted CMS with areas of innovation within our examination procedures that are above and beyond the statement of work requirements.
- Developed the Project Management Plan that establishes the methods and procedures used to complete the project including milestones, fieldwork and report dates, hours, and task descriptions, as well as assumptions and constraints.

Maryland Department of Health (1983 – 2006)

Auditing, Accounting, and Consulting Services

Scope of Work:

Myers and Stauffer provides nursing facility, hospital, residential treatment centers, ICF-alcoholic and state facility auditing, rate setting, and consulting services to ensure that medical assistance reimbursements are in compliance with state and federal laws and regulations.

Responsibilities:

- Assisted with the development of the audit process utilized to verify the accuracy of applications for trauma equipment grants, uncompensated care, on-call, and stand-by costs submitted by trauma physicians and trauma centers.
- Assisted the Department with the risk assessment utilized to select trauma physicians for review.
- Assisted the Department with the development of the review process related to the processing of the monthly invoices submitted by the regional health information exchange (HIE) serving Maryland.

Maryland Health Care Commission (2005 – Present)

Audit Services for several programs including Trauma Physician Services Fund and the Chesapeake Regional Information System for Our Patients (CRISP)

Scope of Work:

Myers and Stauffer performed an information technology-focused performance audit of the CRISP, the Maryland HIE, including performing comprehensive cybersecurity testing.

Responsibilities:

- Assisted with the development of the audit process utilized to verify the accuracy of applications for trauma equipment grants, uncompensated care, on-call, and stand-by costs submitted by trauma physicians and trauma centers.
- Assisted the Department with the risk assessment utilized to select trauma physicians for review.
- Assisted the Department with the development of the review process related to the processing of the monthly invoices submitted by the regional HIE serving Maryland.

Maryland Department of Health (2006)

Agreed-Upon Procedures, Related Accounting and Consulting Services for Managed Care Organizations

Scope of Work:
Myers and Stauffer provides AUPs and related accounting services to assure that MCOs' expenditures are in compliance with state and federal laws and regulations.

Responsibilities:

- Assisted with the development of the audit process utilized to verify the accuracy of applications for trauma equipment grants, uncompensated care, on-call, and stand-by costs submitted by trauma physicians and trauma centers.
- Assisted the Department with the risk assessment utilized to select trauma physicians for review.
- Assisted the Department with the development of the review process related to the processing of the monthly invoices submitted by the regional HIE serving Maryland.

Presentations

"Why Audit Managed Care Organizations?," Medicaid Integrity Institute: Emerging Trends in Managed Care Symposium, Columbia, South Carolina, 2012.

"Why Audit MCOs," National Association for Medicaid Program Integrity, Denver, Colorado, 2011.

Jerry Dubberly, PharmD

Principal, Myers and Stauffer

Summary

Dr. Dubberly, a principal with Myers and Stauffer, leads the Center of Quality Analytics, Design, and Payment within the firm. Since joining Myers and Stauffer in January of 2015, Dr. Dubberly has focused on the firm's integrated care model accounts, which include SIM, DSRIP, and CCBHC programs, and other consulting activities.

Prior to joining Myers and Stauffer, Dr. Dubberly served as Georgia's Medicaid director for over six years, where he was responsible for health care coverage for 1.9 million Georgians and an annual benefits budget of $10 billion. Prior to becoming Georgia's Medicaid director, he served as the deputy director of the Medical Assistance Policy Section, and for four years prior to that he was the director of pharmacy services. Dr. Dubberly brings a wide range of experience with Medicaid policy, state health care programs, and HIT.

Since joining Myers and Stauffer, he has directed the firm’s integrated care model work. He and his team provided consulting services for the onboarding of MCOs in Georgia and Nevada which included state and MCO readiness activities, MCO Command Center staffing, and MCO contract amendment recommendations. He led the development of the Nevada SHSIP project as a part of Nevada's SIM design award. This involved supporting Nevada stakeholders at all levels, including health care payers, providers and community advocates; developing a roadmap for delivery system and payment transformation; HIT solution building; and operational as well as fiscal sustainability planning. For the Nevada CCBHC planning grant, he served as subject matter expert to support the state efforts to establish CCBHCs drive integration of physical and behavioral health, and to establish innovative reimbursement models. Dr. Dubberly also led the team assisting American Samoa in the development of their SHSIP, which includes advising and consulting regarding population health improvement opportunities and strategies, and reviewing funding mechanisms to support the territory's innovation goals. His team is also responsible for the development of the Vermont SIM Sustainability Plan as well as the firm's DSRIP work in New Hampshire, New Jersey, Texas, and Washington.

Education

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

Experience

27 years professional experience

Affiliations

Academy of Managed Care Pharmacy
Georgia Academy of Managed Care Pharmacy
National Association of Medicaid Directors, Alumni

Certifications

Doctor of Pharmacy

Relevant Work Experience

Nevada Department of Health and Human Services (2017 – 2017)

Managed Care Organization Onboarding and Business Process Reengineering

Scope of Work:

Myers and Stauffer provides monitoring and oversight of activities performed by the MCOs.

Responsibilities:

- Served as partner-in-charge of this engagement and subject matter expert.
- Ensured proper staffing and quality of consulting services and work product delivered to the Department.

American Samoa Government (2015 – 2016)

SIM Model Development

Scope of Work:

Myers and Stauffer provided consulting services to assist in the development of the Department's SHSIP and all of its components.

Responsibilities:

- Served as the partner-in-charge of this engagement with ultimate internal accountability for the firm's performance and delivery of services.

Nevada Department of Health and Human Services (2015 – Present)

Certified Community Behavioral Health Clinic Planning Grant

Scope of Work:

Myers and Stauffer provided full service administrative and operational support for Nevada's CCBHC planning grant and supported the state in improving the behavioral health of Nevada's citizens.

Responsibilities:

- Advised on integration of physical and behavioral health, delivery system models, criteria for CCBHCs, and value based payment models within a CCBHC environment.

Nevada Department of Health and Human Services (2015 – 2016)

State Innovation Model (SIM)

Scope of Work:

Assisted State with the preparation of a SIM grant application and development of a DSRIP project.

Responsibilities:

- Led staff through activities including but not limited to: conducting stakeholder engagement; organizing and supporting workgroups and task force meetings; synthesizing stakeholder feedback; and sharing national best practices.
- Identified health care delivery system and payment alternatives; leveraged HIT; built consensus across multiple payers; was an active participant in CMS discussions and reporting; and developed an operational and fiscal sustainability plan.

New Hampshire Department of Health and Human Services (2016)

DSRIP Independent Assessor

Scope of Work:

As New Hampshire's contracted DSRIP independent assessor, Myers and Stauffer engaged in supporting IDNs that are regionally-based, able to leverage local resources, and are equipped to achieve DHHS' goal of improved access to – and quality of – both behavioral health services and the physical health services for those with behavioral health diagnoses.

Responsibilities:

- Served as the partner-in-charge of this engagement with ultimate internal accountability for the firm's performance and delivery of services.

New Hampshire Department of Health and Human Services (2017 – Present)

Delivery System Reform Incentive Program Learning Collaborative

Scope of Work:

Myers and Stauffer is providing professional services necessary to develop, operate and lead the Learning Collaborative – a required element of the Department of Health and Human Services' Building Capacity for Transformation, Section 1115 Medicaid Demonstration Waiver, #11-W-00301/1.

Responsibilities:

- Serves as the partner-in-charge of this engagement with ultimate internal accountability for the firm's performance and delivery of services.

New Hampshire Department of Health and Human Services (2015 – Present)

Health Information Technology Technical Assistance to Support Delivery System Reform Incentive Payments Program

Scope of Work:

For the duration of this project, Myers and Stauffer will conduct a HIT environmental assessment and a survey of statewide assets and IDN member organizations in order to show areas of need and gaps in the state's HIT infrastructure, facilitate for the monthly Demonstration HIT Taskforce, provide expert advisory services, and aid the IDNs to come to a consensus on statewide HIT implementation priorities and requirements.

Responsibilities:

- Consulting and coordinating the firm's integrated care team's efforts with the Myers and Stauffer HIT team.
- Coordination ensures DSRIP providers' business and programmatic needs and goals are supported by a strong HIT strategy to promote success.

New Jersey Department of Health (2015 – Present)

Delivery System Reform Incentive Payment Program Support and Consulting

Scope of Work:

Myers and Stauffer has been leading New Jersey's DSRIP initiative since its inception in October 2012. We have represented the state in hundreds of hours of meetings and discussions with both CMS and the provider industry. We have had the lead role in developing the Planning Protocol, Funding and Mechanics Protocol, and assisted the State in the amendments to the STCs of the 1115 waiver. Additionally, we spearheaded the New Jersey DSRIP Quality and Measures subcommittee tasked with developing the menu of hospital quality projects to support achievement of the demonstration goals. Myers and Stauffer designed the DSRIP application and audit approach that was approved by CMS to confirm DSRIP eligibility and to provide ongoing monitoring of performance through quarterly reporting procedures. We conduct these required reviews to confirm milestone achievement and submit findings for state and CMS approval for incentive award payment.

Responsibilities:

- Serves as the partner-in-charge of this engagement with ultimate internal accountability for the firm's performance and delivery of services.

Vermont Department of Vermont Health Access (2016 – 2017)

Vermont Health Care Innovation Project (VHCIP)/SIM Sustainability Plan

Scope of Work:

Myers and Stauffer supported the Department's efforts to conduct and facilitate stakeholder meetings, key informant interviews, and review projects and efforts implemented as part of the state's SIM project. We

drafted the SIM Sustainability Plan to help the state identify innovation elements of SIM that should be continued after the end of the project. This work included a review of the operational and fiscal sustainability components.

Responsibilities:

- Serves as the partner-in-charge of this engagement with ultimate internal accountability for the firm's performance and delivery of services.

Presentations

"Health Care Reform Medicaid Agency Impact Highlights," AMCP 23rd Annual Meeting and Showcase. Minneapolis, Minnesota, 2011.

"Managed Medicaid: How Medicaid Programs Are Navigating the Managed Medicaid Trends," American Drug Utilization Review Society Symposium, Scottsdale, Arizona, 2013.

"Rx Innovations and Challenges," Association of Medicaid Directors Fall Conference, Arlington, Virginia, 2011.

"Panel Discussion: Program Enhancements and Changes Underway within State Programs," CBI's 9th Annual Medicaid Rebates Conference, Orlando, Florida, 2007.

"*Working with Purchasers& Payers to Increase Access, Utilization & Quality of Preventive Services Forum*," Centers for Disease Control and Prevention, Atlanta, Georgia, 2015.

"MACRA and Healthcare Payment Transformation," Georgia AMCP Winter Symposium, Atlanta, Georgia, 2017.

"Cost Control in Mental Health Medications," International Society for Pharmacoeconomic and Outcomes Research (ISPOR) 12th Annual International Meeting, Arlington, Virginia, 2007.

"J Code Status Update," IRR's 12th Annual Summit on the Medicaid Drug Rebate Program, Chicago, Illinois, 2007.

"DRA Impact on the States: AMP Data and NDC Capture," IRR's 12th Annual Summit on the Medicaid Drug Rebate Program, Chicago, Illinois, 2007.

"Compliance Techniques and Step by Step Instructions for State Medicaid Professionals to Improve Processes under the DRA," IRR's 12th Annual Summit on the Medicaid Drug Rebate Program, Chicago, Illinois, 2007.

"A Deeper Dive into Requirements of the New Managed Care Rule," Myers and Stauffer national webinar, Atlanta, Georgia, 2016.

"Health Care Transformation and the Changing Tides of Medicaid Program Integrity," National Association for Medicaid Program Integrity, Baltimore, Maryland, 2016.

"*A Medicaid Director's View of Program Integrity in Managed Care*," National Association for Medicaid Program Integrity, New Orleans, Louisiana, 2015.

"*New Medicines: Opportunities and Challenges*," National Council of State Legislatures Legislative Summit, Seattle, Washington, 2015.

"Medicaid Director Panel Discussion," National Governors Association Health Reform Meeting, Stowe, Vermont, 2010.

"*Everything You Wanted to Know About Medicaid but Were Afraid to Ask.* (Medicaid Waivers and Long Term Support Services component)," National Home and Community Based Services Conference, Washington D.C., 2015.

"*The Importance of Program Integrity in Home and Community Based Services*," National Home and Community Based Services Conference, Washington D.C., 2015.

"Fourteenth Annual Rosalynn Carter Georgia Mental Health Forum," Stakeholder Group Forum, Atlanta, Georgia, 2009.

Bobby Courtney, MPH, JD

Senior Manager, Myers and Stauffer

Summary

A recent addition to Myers and Stauffer, Mr. Courtney specializes in public health law and policy, and has over 18 years of experience working in the health care industry. He is a senior manager and provides a broad range of consulting services, including issues related to Medicaid waivers, managed care, LTSS, as well as federal health care regulations and policies. Mr. Courtney's work spans across the firm's service areas and he currently serves as a project manager for the firm's New Hampshire DSRIP engagement. In this role, he is responsible for communications with state and industry leadership, and provides oversight of the DSRIP Learning Collaboratives and technical assistance provided to the program's IDNs.

Prior to joining Myers and Stauffer, Mr. Courtney served as a senior consultant with SVC, Inc., an Indianapolis-based health policy firm. In this role, he counseled clients on a variety of matters including Medicaid waivers, managed care, statutory and regulatory compliance, as well as public health program design and implementation. He has developed, and supported states in the negotiation of federal health care waivers, including facilitation of the public notice and comment process. He has also supported states to review existing waiver programs for compliance and areas of improvement and efficiency. Most recently, he worked with the state of Iowa to secure federal approval for implementation of the Iowa Health Link managed care program, which required development and negotiation of a series of §1115, §1915(b), and §1915(c) waivers. In addition, Mr. Courtney was the primary author for the recently published Indiana Governor's Task Force on Drug Enforcement, Treatment, and Prevention Final Report, a statewide effort to evaluate existing resources, identify gaps and best practices, and provide recommendations to address the state's current opioid epidemic.

Mr. Courtney's past work history also includes serving in the role of chief executive officer at MESH, Inc., a nationally recognized, health care coalition in Indianapolis, Indiana. While at MESH, Bobby acted as the primary spokesperson for the organization, collaborated with government and private entity clients to ensure effective service delivery, and served as executive leader for the National Healthcare Coalition Resource Center. Prior to MESH, Mr. Courtney served as a strategic planning specialist at OSF Saint Francis Medical Center, a teaching hospital for the University of Illinois College of Medicine in Peoria, Illinois. While at OSF, he partnered with executive leadership to develop facility and service line strategic plans, and to ensure compliance with state Certificate of Need regulations.

Education

J.D., Health Law, Indiana University, 2012
M.P.H., Health Policy, Indiana University, 2012
M.A., English, Bradley University, 2001
B.A., Philosophy, University of Illinois, 1999

Experience

18 years professional experience

Affiliations

American Bar Association
American Health Lawyers Association
American Public Health Association
Indiana Bar Association
Indianapolis Bar Association

Certifications

Juris Doctor
Master in Public Health

Relevant Work Experience

Nevada Department of Health and Human Services (2017 – Present)

Medicaid Consulting

Scope of Work:

Myers and Stauffer performs consulting services for the Division of Health Care Financing and Policy (DHCFP) to ensure compliance with Medicaid and Medicare regulations, principles and policies and to assist the agency with the implementation or development of new Medicaid programs or policies.

Responsibilities:

- Serve as subject matter expert and presenter for annual DHCFP staff training.

New Hampshire Department of Health and Human Services (2017 – Present)

Delivery System Reform Incentive Program Learning Collaborative

Scope of Work:

Myers and Stauffer is providing professional services necessary to develop, operate and lead the Learning Collaborative – a required element of the Department of Health and Human Services' Building Capacity for Transformation, Section 1115 Medicaid Demonstration Waiver, #11-W-00301/1.

Responsibilities:

- Serve as a project manager for the engagement.
- Responsible for primary communications with state and industry leadership.
- Provide oversight of the DSRIP Learning Collaboratives and technical assistance provided to the program's IDNs.

Presentations

"Long Term Care Payment Forum," Myers and Stauffer, 2016.

"Legal Issues in Coalition Development and Response," National Healthcare Coalition Resource Center Annual Conference, 2013.

"Crisis Standards of Care: Clinical and Legal Aspects in Disaster Response," Public Health Preparedness Summit, 2012.

"Crisis Standards of Care – Challenges & Opportunities," Indiana State Bar Association Health Law Symposium, 2011.

Venesa Day, MPA

Senior Manager, Myers and Stauffer

Summary

Ms. Day has more than 15 years' experience working in health care policy, including experience ensuring state and provider compliance with federal financial requirements. For Myers and Stauffer, she recently completed a project identifying and documenting potential FWA risks and vulnerabilities for several CMS APMs, including CPC+, MSSP, CEC, and IAH. In addition, she worked with CMS program offices to identify potential mitigation strategies for risks and vulnerabilities. She also worked with the state of Vermont to develop its SIM sustainability plan. As lead writer and researcher for the Vermont SIM sustainability plan, she completed research and analysis used to inform stakeholder inputs throughout the writing process, guided the State in identifying project requirements for sustainability, and facilitated the process by which the Vermont health care community gained consensus on SIM projects to sustain.

Currently, Ms. Day is working as an Innovation Agent with the state of New Hampshire DSRIP program. In this role, she is assisting the State in developing a statewide Learning Collaborative, as well as providing technical assistance in areas relevant to APMs, behavioral and physical health integration, SUD, and care coordination.

Prior to coming to Myers and Stauffer, she worked in the Medicare and Medicaid Coordinated Care Office (MMCO) of CMS where she led the Duals Managed FFS Financial (MFFS) Alignment Demonstration team. As the team lead, she headed the development of the demonstration's monitoring and state compliance strategy. She established shared savings payment parameters for the demonstration, ensuring policy coordination across Medicare and Medicaid, as well as with other shared savings programs including Pioneer ACO, MSSP ACO, Independence IAH, and SIM.

She also worked in the Medicaid Financial Management Group of CMS as a subject matter expert on Medicaid institutional reimbursement policy, including Medicaid DSH, UPL, GME, and related funding. She served as the financial policy subject matter expert for several Medicaid financial management reviews and related disallowance processes. Ms. Day also provided financial policy analysis for state 1115(a) waiver programs, where she consulted with the Children and Adults Health Programs Group to ensure that waiver provisions did not violate applicable financial policy requirements related to efficiency, economy, and quality of care. In addition, she participated in the development, evaluation, review, and implementation of program operations and policies related to institutional reimbursement and state financing policies that impact the federal Medicaid program – including legislative analysis for the Medicaid program, uninsured, HIT, H1N1, fiscal integrity, and health care reform initiatives.

Education

M.P.A., American University, 2003
B.A., Political Science, Morgan State University, 1999

Experience

18 years professional experience

Certifications

Master of Public Administration

Relevant Work Experience

New Hampshire Department of Health and Human Services (2017 – Present)

Delivery System Reform Incentive Program Learning Collaborative

Scope of Work:

Myers and Stauffer is providing professional services necessary to develop, operate, and lead the Learning Collaborative – a required element of the Department of Health and Human Services' Building Capacity for Transformation, Section 1115 Medicaid Demonstration Waiver, #11-W-00301/1.

Responsibilities:

- Provided technical assistance and best practice research on a number of topics including incentives for MAT providers, re-entry program principles, critical time intervention principles and implementation, behavioral/physical health integration, and integrated care workforce position descriptions.
- Coordinated with the state, IDNs, and regional partners to deliver targeted statewide and regional Learning Collaboratives tailored to meet the learning needs of the partners around integrated health and APMs.
- Provided integration and process information to assist IDNs in meeting implementation goals.

Centers for Medicare & Medicaid Services (CMS) (2016 – Present)

Center for Program Integrity (CPI) Medicare Access and CHIP Reauthorization Act (MACRA)

Scope of Work:

As a subcontractor to the RELI Group, Myers and Stauffer identified, studied, and reported the risks and vulnerabilities of alternate payment models for CMS.

Responsibilities:

- Provided APM policy and process background to assist researchers in identifying potential vulnerabilities.
- Identified potential APM vulnerabilities within designated models.
- Provided support for the vulnerabilities identified, and worked with CMS and the RELI partners to determine reasonable mitigation options.
- Coordinated and compiled research related to designated APMs, and worked with RELI and CMS to develop a narrative reports outlining select APM risks, vulnerabilities, and potential mitigation options related to APM FWA.

Vermont Department of Vermont Health Access (2016 – 2017)

Vermont Health Care Innovation Project (VHCIP)/SIM Sustainability Plan

Scope of Work:

Myers and Stauffer supported the Department's efforts to conduct and facilitate stakeholder meetings, key informant interviews, and review projects and efforts implemented as part of the state's SIM project. We drafted the SIM Sustainability Plan to help the state identify innovation elements of SIM that should be continued after the end of the project. This work included a review of the operational and fiscal sustainability components.

Responsibilities:

- Compiled and coordinated industry research around sustainability and sustainability in health care programs.
- Developed a sustainability framework which ultimately became the outline and guide for the plan development.

- Compiled and coordinated research pertaining to Vermont Medicaid, SIM, ACOs, programs, and stakeholder organizations for inclusion and consideration in the sustainability plan.
- Conducted key informant interviews and convened stakeholder meetings to gather input on program sustainability.
- Outline State priorities and goals related to sustainability, as well as to manage stakeholder anxieties around broader system changes and the move to the Vermont all-payer model.
- Helped draft the SIM sustainability plan according to CMS specifications. This included an initial draft, updates based on changes in policy and direction, as well as stakeholder feedback.
- Worked to ensure that the SIM sustainability plan incorporated concepts from related state projects – ensuring that the document minimized the continuance of silos detrimental to cross-state efforts.
- Facilitated stakeholder meetings, assisting the state and stakeholders in identifying the appropriate framework for sustainability.

Presentations

"Medicare Access and CHIP Reauthorization Act (MACRA)," MSLC – Integrated Care Model Team, Indianapolis, Indiana, 2016.

"Medicare Access and CHIP Reauthorization Act (MACRA) – APM," MSLC - Atlanta RO, Atlanta, Georgia, 2016.

"Medicare Access and CHIP Reauthorization Act (MACRA) – MIPS," MSLC - Benefits/Program Integrity Team, Indianapolis, Indiana, 2016.

"Nevada Annual Training SAMHSA," Nevada State Staff, Reno, Nevada, 2017.

"Nevada Annual Training Health Homes for SMI," Nevada State Staff, Reno, Nevada, 2017.

"Integrated Care Delivery 101," New Hampshire DSRIP Learning Collaborative, Concord, New Hampshire, 2017.

"Plan Do Study Act, Info-Fresher," New Hampshire DSRIP IDN 2 All Partner Meeting, Concord, New Hampshire, 2017.

Kerry Illg

Manager, Myers and Stauffer

Summary

Mr. Illg has extensive experience providing health care auditing, accounting, and consulting services. As a manager with Myers and Stauffer, he oversees the production of MDS case mix reports and MDS reviews. He has experience performing desk reviews of provider financial reports, resulting in changes to their Medicaid long-term care rates. Mr. Illg also has experience planning and leading on-site reviews of provider financial reports to determine compliance with Medicaid rate setting criteria.

Mr. Illg has worked in the MDS department of Myers and Stauffer since 2012. As part of his duties as a manager of the MDS department, he oversees the production of detailed facility case mix reports for six state clients. He performs detailed quality assurance reviews and analysis on MDS summary data for each state's quarterly reports. He also oversees the MDS help desk. The MDS help desk answers provider questions related to the MDS case mix reports and MDS reviews.

During his time at Myers and Stauffer, he has been heavily involved in developing and maintaining a web-based system for distributing reports to providers in multiple states. Mr. Illg has also been very involved in developing MDS reporting and review programs for multiple state clients. This process involves coordination with client contacts, IT development staff, and the state provider community. He performs detail level reviews to assure accuracy of the MDS reporting data.

Education

B.S.B.A., Accounting, Ball State University, 2006

Experience

11 years professional experience

Relevant Work Experience

Indiana Family & Social Services Administration (2015 – Present)

MDS Case Mix Reviews

Scope of Work:

Myers and Stauffer conducts periodic case mix reviews at long-term care facilities designated by OMPP.

Responsibilities:

- Worked with internal staff to develop a process for electronic review of MDS assessment data. This process has involved working with clinical experts and IT developers to develop a risk-based sample selection process.
- Oversee the support functions and provide quality review for post review reporting and implementation of reviewed data into the case mix reports utilized in establishing provider reimbursement rates.

Louisiana Department of Health (2012 – Present)

Case Mix Reimbursement System

Scope of Work:

Myers and Stauffer is assisting in the development and operation of a case mix reimbursement system for nursing facilities participating in the Louisiana Medicaid program.

Responsibilities:

- Performed quality reviews and analysis of MDS data reported on a quarterly basis.

- Oversee the support functions and provide quality review for post review reporting and implementation of reviewed data into the case mix reports utilized in establishing provider reimbursement rates.

Mississippi Division of Medicaid (2014 – Present)

Minimum Data Set (MDS) Data Collection, Management, and Processing System

Scope of Work:

Myers and Stauffer produced resource utilization groups (RUG-IV) CMIs used for Medicaid rate setting along with providing electronic review system and data for performing MDS reviews.

Responsibilities:

- Responsible for quality assurance reviews of the MDS case mix reports.
- Coordinated with the client and IT development staff to establish an electronic process for reviewing MDS assessment data specific to the needs of the client.

North Carolina Department of Health and Human Services (2012 – Present)

Minimum Data Set Validation Reviews

Scope of Work:

Myers and Stauffer conducts on-site field reviews for approximately 400 long-term care facilities to determine whether the clinical documentation supports the resident's resource utilization classification.

Responsibilities:

- Performed quality reviews and analysis of MDS data reported on a quarterly basis.
- Oversee the support functions and provide quality review for post review reporting and implementation of reviewed data into the case mix reports utilized in establishing provider reimbursement rates.
- Coordinate with the client to provide analysis and modeling of rates based on proposed changes in the MDS reimbursement methodology and MDS validation review process.

Oklahoma Health Care Authority (2016 – Present)

Nursing Facilities Supplemental Payment Program

Scope of Work:

Myers and Stauffer provides state plan consultation, prepares Medicare RUG UPL calculations, determines nursing facility supplemental payments, and prepares materials for and assists with correspondence with CMS.

Responsibilities:

- Working with the client to establish a supplemental payment program utilizing MDS assessment information.
- Obtaining MDS data and developing a reporting process that RUGs assessment information and determines Medicaid population for calculation of the payment.
- Working with the client to develop the payment process and agreements with participating providers.

Kelly McNamara, CFE

Manager, Myers and Stauffer

Summary

Ms. McNamara, a manager with Myers and Stauffer, has extensive experience with government health care programs including contract administration and compliance monitoring. Ms. McNamara has completed engagements related to the performance of MCOs under contract with states of Georgia, Louisiana, Mississippi, and New Mexico. Areas of focus include corporate and contract compliance, subcontractor oversight, program integrity oversight, and encounter submissions and payment systems.

Prior to joining Myers and Stauffer, Ms. McNamara was a research and data analysis manager for the Georgia DCH, Georgia Board for Physician Workforce. Ms. McNamara led data collection and analysis efforts related to the physician workforce; streamlined contract administration, reporting, and compliance; and formulated policy recommendations. She was also a principle management analyst and performance auditor participating in efficiency and effectiveness reviews of government health care programs to include evaluation; identification of best practices; analyzing processes, workflow, and outcomes; and prepared reports detailing findings/recommendations for state agency and legislative leadership.

Education

M.B.A., Kennesaw State University, 1998
B.B.A., Kennesaw State University, 1993

Experience

23 years professional experience

Affiliations

Association of Certified Fraud Examiners

Certifications

Certified Fraud Examiner

Relevant Work Experience

Georgia Department of Community Health (DCH) (2012 – 2015)

Care Management Organization (CMO) Compliance

Scope of Work:

Myers and Stauffer assisted the DCH with providing oversight and monitoring of the Georgia Families CMOs.

Responsibilities:

- Analyzed programmatic, financial, and claims information from the MCOs to determine compliance with state contract requirements.
- Evaluated MCO performance in the areas of corporate and contract compliance; subcontractor oversight; encounter submissions and payment systems; and program integrity oversight.
- Participated in on-site interviews with state and MCO representatives to obtain an understanding of policies, procedures, and internal controls.
- Performed policy analysis and identified best practices for the state client's consideration.
- Evaluated network adequacy based on established standards and performed an analysis of timely network access.
- Developed findings and recommendations.
- Generated written and oral reports.

Louisiana Department of Health (2015)

Louisiana Behavioral Encounter Reconciliation

Scope of Work:

Myers and Stauffer provided accounting and auditing services to support operation of the Louisiana Behavioral Health Partnership (LBHP) to minimize the Department's risk in the areas of member care and administration, data quality, and financial management. Myers and Stauffer also assisted the Department with accomplishing its goal of ensuring that LBHP members are receiving high-quality coordinated care at the lowest cost.

Responsibilities:

- Consulted with the state and participated in CMS EQR Protocol 4 activities related to validation of encounter data.
- Participated in on-site interviews; developed findings and recommendations; and helped prepare final report on the completeness and accuracy of encounter data.

Mississippi Division of Medicaid (2015 – Present)

Outsourced Financial Reviews Mississippi Coordinated Access Network (MississippiCAN)

Scope of Work:

Myers and Stauffer assists the division in a wide-ranging assessment of the CCOs' contract compliance. Under the contract, we perform encounter claim to cash disbursement journal reconciliations to assess completeness; assess encounter claim accuracy under CMS EQR Protocol 4; review capitation payments for payment accuracy and potential duplicated capitation payments; provide examination services of MLR report filings; and perform other compliance testing of other monthly monitoring tools, such as denials reporting and TPL collections, at the direction of the division.

Responsibilities:

- Assisted with the preparation of the proposal and work plan to guide MississippiCAN and MississippiCHIP financial reviews.
- Worked with the State to monitor and measure the performance of the MCOs.
- Led on-site interviews with State and MCO representatives to obtain an understanding of policies, procedures, and processes related to CMS' EQR Protocol 4 validation of encounter data activities.
- Coordinated and participated in monthly client status meetings to discuss issues identified in the bi-monthly encounter reconciliation reports; progress of the MCOs in addressing encounter data related issues; and, ongoing action items.
- Worked with the State to review each MCOs' treatment of claims for TPL including cost avoidance strategies, recovery procedures, and reporting to the State.

New Mexico Human Services Department (2015 – 2016)

Audit Agent

Scope of Work:

Myers and Stauffer performed examinations and reviews of hospitals, HHAs, and long-term care institutional facilities (nursing facilities and intermediate care facilities) that participate in the New Mexico Medicaid program.

Responsibilities:

- Evaluated MCO performance in the areas of claims adjudication, prior authorization, provider credentialing and contract loading, and other areas as requested by the client.
- Performed policy analysis and identified best practices for the state client's consideration.
- Participated in on-site interviews; developed findings and recommendations; and led the preparation of the final written reports.

Nickie Turner, CFE

Senior Analyst, Myers and Stauffer

Summary

Ms. Turner, a senior analyst with Myers and Stauffer, has extensive experience with government health care programs, including contract administration and compliance monitoring. Ms. Turner has completed engagements related to the performance of MCOs under contract with states of Georgia and New Mexico. Areas of focus include corporate and contract compliance, subcontractor oversight, program integrity oversight, and encounter submissions and payment systems.

Prior to joining Myers and Stauffer, Ms. Turner spent seven years with Affiliated Computer Services, Incorporated (ACS), the previous fiscal agent for Georgia Medicaid. As a Medicaid claims specialist/provider services representative, Ms. Turner managed a 20-county territory assessing and addressing the needs of providers. She provided on-site training to Georgia Medicaid providers across claim submission and resolution, billing, member issues, and policy-related issues. She conducted provider trainings and workshops for up to 250 attendees; hosted web-based provider trainings and meetings via WebEx; promoted ACS proprietary software and use of Georgia Health Partnership's website including website training; and liaised between ACS, provider community, Medicaid fiscal agent, and client, the DCH. Ms. Turner also has five years of experience as a patient account representative and insurance collections agent for a large medical oncology practice having several offices located around metropolitan Atlanta.

Education

M.B.A, Health Services Administration, Strayer University, 2011
B.S.B.A., Marketing, Auburn University, 1990

Experience

19 years professional experience

Affiliations

Association of Certified Fraud Examiners

Certifications

Certified Fraud Examiner

Relevant Work Experience

Georgia Department of Community Health (2011 – Present)

Care Management Organization Compliance

Scope of Work:

Myers and Stauffer assists the DCH with providing oversight and monitoring of the Georgia Families CMOs.

Responsibilities:

- Analyzed CMO claims, financial, and other program information to determine compliance with state contract requirements and identify best practices for the state client's consideration.
- Evaluated CMO performance in the areas of corporate and contract compliance, program integrity oversight, subcontractor oversight, and encounter submissions and payment systems.

- Participated in on-site interviews with State and CMO representatives to acquire an understanding of CMO policies, procedures, and internal controls.
- Evaluated network adequacy and performed an analysis of timely network access based on established standards.
- Developed findings and recommendations.
- Generated written reports.

New Mexico Human Services Department (2015 – Present)

Medicaid Audit Agent for Managed Care Organizations

Scope of Work:

Myers and Stauffer performs examinations and reviews of hospitals, behavioral health, and LTSS providers that participate in the New Mexico Medicaid program.

Responsibilities:

- Evaluated MCO performance in the areas of claims adjudication, prior authorization, provider credentialing and contract loading, and other areas as requested by the client.
- Performed policy analysis and identified best practices for the state client's consideration.
- Participated in on-site interviews with the state and MCOs.
- Developed findings and recommendations based on information obtained during the interviews and policy analysis.
- Participated in the preparation of the final written reports.

Georgia Department of Community Health (2011 – Present)

Estimation Project/Benefits Testing

Scope of Work:

Myers and Stauffer assists the DCH to evaluate the accuracy of benefit payments made through the Medicaid program and CHIP.

Responsibilities:

- Tested and re-priced paid claims to identify claims that may not have been paid in accordance with Georgia Medicaid and CHIP coverage and payment policies.
- Identified payments that should not have been made (e.g., duplicate payments or for ineligible members or providers).
- Identified other amounts that should have been paid but were not paid.
- Identified and/or quantified payment errors in the universe of paid claims for selected categories of service.

Georgia Department of Community Health (2011 – Present)

Recovery Audit Contractor

Scope of Work:

Myers and Stauffer provides RAC services to the DCH.

Responsibilities:

- Performed post-payment reviews of FFS claims during a five-year lookback.
- Identified and/or quantified Medicaid overpayments or payments due to providers.
- Participated in repricing of Neonatal Intensive Care Unit (NICU) claims as a result of clinical review and leveling.

Matthew Smith, CFE

Senior Accountant, Myers and Stauffer

Summary

Mr. Smith, a senior accountant with Myers and Stauffer, has approximately five years' experience performing MIC audits for CMS. Mr. Smith has performed audits across 12 states for Medicaid providers, including West Virginia Medicaid for hospice audits. These engagements are responsible for detecting FWA, and they involve provider types such as hospitals, physicians, hospices, HHAs, dentists, and orthotics and prosthetics. He is responsible for assisting coordination and performing complex Medicaid audits to ensure compliance with federal laws and regulations, CMS requirements and guidance, and state laws, regulations, and standards. In addition, he is an active member of the ACFE.

Education

B.S., Accounting, University of Baltimore, 2012
M.S., Health Care Administration, University of Maryland University College, 2017

Experience

Five years professional experience

Affiliations

Association of Certified Fraud Examiners

Certifications

Certified Fraud Examiner

Relevant Work Experience

Centers for Medicare & Medicaid Services (CMS) (2012 – Present)

Medicaid Integrity Contractor Audits

Scope of Work:

Myers and Stauffer provides audit management, subject matter expertise, and audit staff to support Health Integrity, the MIC with CMS.

Responsibilities:

- Perform focused and comprehensive audits in the field or at the desk.
- Prepare audit plans to address audit issues.
- Gather necessary citations to document audit findings.
- Coordinate audit activities with appropriate staff to ensure findings are well-founded.
- Prepare work papers timely and places them in the appropriate files.
- Led a team of staff members on field audits.
- Prepare audit reports in a timely and professional manner.
- Perform research regarding Medicare and Medicaid guidelines, to be well-versed about rules, regulations, and policies that will be needed to meet the audit objectives.
- Identify potential fraud independently and refers matters of fraud to the CMS Medicaid Integrity Group (MIG) and law enforcement as prescribed.

Maryland Office of the Attorney General (2012)

Medicaid Fraud Control Unit

Scope of Work:
The MFCU is responsible for prosecuting both Medicaid fraud and the abuse and neglect of vulnerable adults. In addition the unit provides education regarding the prevention of abuse and neglect as well as training on how to detect, report, and investigate such offenses.

Responsibilities:

- Performed audit engagements on various type of operational and financial audits.
- Reconciled bank statements to the general ledger, creating cash flow statements, and investigating unusual deposits and expenditure variances while using programs such as Excel and Lexis.
- Participated in conference calls and court cases for Medicaid fraud.

Presentations

"Hospice General Inpatient Care Audit," Health Integrity Annual MIC Training, 2016.

Steve Schramm, MSCE

Managing Director, Optumas

Summary

Mr. Schramm has over 30 years of experience in the public health arena. He founded Optumas to be a leader in the health strategy and reform market, and actively pursues new opportunities to implement cutting edge health care initiatives. He also assists with development of models to generate rates and budgetary estimates for health care reform, uninsured initiatives, and expansion programs to inform health care program development, expansion, reform, and evaluation. Per the specifications of CRFQ 0511 BMS1800000002, Mr. Schramm will be the Strategy Lead supporting Mr. Timothy Doyle as the Lead Actuary for the West Virginia BMS.

Mr. Schramm has assisted in designing and utilizing actuarially sound capitation rate setting methodologies for a variety of health care providers serving publicly-funded populations and specializes in providing program, strategy and operational consulting services. He currently serves as the lead strategist for the states of Alabama, Arkansas, Kansas, Maryland, North Dakota, and Oregon. Mr. Schramm manages the calculations of various benefits and program changes including reviewing them for reasonableness, and evaluates and compares various program criteria and rate assumptions. Mr. Schramm oversees the capitation rate development and supports stakeholder communication efforts by presenting actuarial results in a way that can be understood by both experts and laymen.

Mr. Schramm has also done work in Arizona, California, Colorado, Louisiana, Maine, New Hampshire, New Mexico, New York, North Carolina, Oregon, and Pennsylvania. The projects in these states spanned all types of populations as well as benefits. The types of projects included developing actuarially sound rates and rate ranges, 1915 and 1115 waiver assistance, developing per capita expenditure models, preparing costs and savings estimates for Medicaid expansion populations, and health care reform.

Mr. Schramm has overseen capitation rate development in over 20 states, and has been on the cutting edge of health care reform projects. He helped set up the Low-Income Health Program in California and was instrumental behind the design and implementation of Arkansas' Private Option Medicaid Expansion program. Mr. Schramm has an innovative and creative mind, capable of keeping his clients ahead of the health care curve.

Education

B.S., Economics, Arizona State University
M.S., Health Economics, London School of Economics

Experience

30 years professional experience

Seth Adamson

Senior Actuarial Consultant, Optumas

Summary

Mr. Adamson has seven years of experience with Medicaid managed care rate setting and other actuarial analyses pertaining to public health programs. He is currently a senior actuarial consultant at Optumas. He has completed his exams to earn the Associate designation in the Society of Actuaries' and is in the process of completing the final requirements to be recognized as an ASA. Per the specifications of CRFQ 0511 BMS1800000002, Mr. Adamson will be part of the Staff Actuarial Resources (RFP Section 3.9) for the West Virginia BMS.

Mr. Adamson's Medicaid managed care experience includes physical health capitation rates, mental health/substance abuse capitation rates, PACE UPL development, case rate development, and rate development for populations/services with limited Medicaid data. This work includes detailed statistical analysis, such as Monte Carlo simulations and full credibility testing, to understand the variability and volatility of the data being used which can then inform the appropriate actuarial adjustments for accurate rate development.

Mr. Adamson also has experience with Medicaid Rx in risk adjusted rate development. He has applied these risk tools to Medicaid TANF and disabled populations to assess the relative risk of enrollees by health plan and geographic region. Mr. Adamson has also been on the plan side of risk adjustment in Medicaid and provider side of risk adjustment for Medicare ACOs, and has helped plans and providers understand their risk score, how to improve their risk metrics, and potential weaknesses in risk adjustment. This experience gives him valuable insight when applying risk adjustment tools, as he has been on the other side of the table and can anticipate plan reaction to various approaches to risk adjustment.

An important role in performing detailed statistical analysis is the ability to convey the results to a wide variety of audiences, and Mr. Adamson has performed this role many times. He has presented actuarial analyses to stakeholders and key personnel involved in the rate development process, including members of the state Medicaid team and managed care plan CEOs, CFOs and senior actuaries. He has been commended on his ability to relay detailed analytics in a way that is understandable for all audiences, both through presentations and actuarial methodology reports.

Education

B.S., Mathematics, Arizona State University

Experience

Seven years professional experience

Cassie Williams

Project Manager, Optumas

Summary

Ms. Williams is currently pursuing her ASA designation while working as a project manager at Optumas. She has over five years of experience working on the development of capitation rates for Medicaid managed care programs. Her main responsibilities at Optumas include project management, data analytics, rate model development, and client communication. Per the specifications of CRFQ 0511 BMS1800000002, Ms. Williams will be part of the Staff Actuarial Resources (RFP Section 3.9) for the West Virginia BMS.

During Ms. Williams' time at Optumas, she has worked on a wide variety of Medicaid projects, including mental health capitation rate development, physical health rate development, and integrated care rate development. Ms. Williams has worked as a project manager for the following Medicaid managed care programs: Colorado Behavioral Health Program, Colorado 1281 Program, Nebraska Behavioral Health Program, Nebraska Heritage Health Program, and Nebraska Dental Program.

Ms. Williams' main responsibilities on these projects have included analyzing detailed data sets, building actuarial models to assist in capitation rate development, and presenting results to the client. Ms. Williams has experience preparing capitation rate development model spreadsheets that accommodate a variety of program components, actuarial adjustments, and trend. Ms. Williams is familiar with harmonizing detailed, service-level FFS and encounter data for validation and accuracy to help form the base of capitation rate development. Ms. Williams is responsible for developing rate adjustments and trend figures by reviewing available data, including plan encounter data, plan financial reports, and supplementary data sources.

In addition to data analytics and capitation rate development, Ms. Williams has extensive experience with project management responsibilities and stakeholder communication. She is responsible for creating detailed project plans that outline the responsible entity and due date for each of the key activities in the rate development process. Ms. Williams has participated and presented during in-person rate development meetings. She has experience discussing rate results with the plans' actuary on behalf of the State, to resolve disconnects between state assumptions and plan expectations. In addition, Ms. Williams has experience organizing and producing detailed Actuarial Certifications and methodology narratives for Medicaid managed care programs, allowing the rate reviewer and all stakeholders to better understand the program and the actuarial analyses underlying the rate development.

Education

B.S., Applied Mathematics, Arizona State University

Experience

Five years professional experience

Tomas Abrate

Project Manager and Informatics Consultant, Optumas

Summary

Mr. Abrate has five years of experience with project management for Medicaid managed care rate setting and public health programs. He currently serves as a project manager/informatics consultant at Optumas. He has extensive experience with stakeholder and resource management, setting and meeting deadlines, and managing working parties. Per the specifications of CRFQ 0511 BMS1800000002, Mr. Abrate will be part of the Staff Actuarial Resources (RFP Section 3.9) for the West Virginia BMS.

Mr. Abrate has worked with a diverse number of clients across multiple states and programs. For the New York Office for People with Developmental Disabilities, Mr. Abrate serves as the project manager as Optumas develops resource balancing modeling for their developmentally disabled population. In addition to his project management role, he has performed analyses of the existing reimbursement system, identifying gaps in the methodology and highlighting opportunities for changes. For the new resource balancing model, Mr. Abrate is responsible for the development and testing of a case mix stratification model and then applying this model to enable proper individual resource allocation. For the North Dakota CHIP Capitation Rate Development project, he is managing the Optumas teams as they evaluate the accuracy of benefit payments made through the CHIP program. His responsibilities include providing research and analysis, conducting policy research, and analyzing adjudication policy and procedures. For the Colorado PACE UPL development, he is part of the Optumas team that is working with the Colorado DHCPF to evaluate the UPLs for the PACE program.

As part these actuarial projects, Mr. Abrate has conducted various health care analytics while managing and overseeing teams. His main responsibilities include data processing and harmonizing, performing ancillary actuarial analyses, and managing client communication and expectations. In past projects, Mr. Abrate has produced detailed project timelines, Gantt charts, project trackers, and several other strategic project management tools at the request of his clients. He has also participated in numerous stakeholder meetings and has demonstrated the ability to clearly and concisely communicate information while tailoring to his audience. Additionally, he has experience communicating the results of analytics via presentation and written methodology reports.

Mr. Abrate has demonstrated the ability to keep projects moving toward successful completion in face of aggressive schedules and is committed to creating an efficient and effective project timeline for his clients. Through his knowledge of fundamental project management processes, methodologies, tools, and techniques, Mr. Abrate ensures that the Optumas rate development projects are completed on-target and on-time.

Education

B.S., Management Consulting, University of Notre Dame

Experience

Five years professional experience

Dr. Art Pelberg

Chief Medical Officer and Senior Consultant – Clinical Lead, Optumas

Summary

Dr. Pelberg is a senior consultant, clinical lead, and chief medical officer at Optumas. He has over 35 years of experience in Medicaid managed care program operation and capitation rate methodologies, having run Medicaid managed care plans in seven states. His main responsibilities at Optumas include reviewing capitation rate development model spreadsheets for clinical appropriateness and reviewing claims data to estimate the impact of various benefits and program changes. Per the specifications of CRFQ 0511 BMS1800000002, Dr. Pelberg will be part of the Staff Actuarial Resources (RFP Section 3.9) for the West Virginia BMS.

During Dr. Pelberg's time at Optumas, he has worked on a wide variety of Medicaid projects, including mental health capitation rate development, physical health rate development, and integrated care rate development. Dr. Pelberg has worked as clinical lead for the following Medicaid managed care programs: Alabama RCO program, Alabama ICN program, Kansas KanCare program, Maryland HealthChoice program, and Nebraska Heritage Health.

Dr. Pelberg's main responsibilities on these projects have included the design, development, and implementation of innovative Medicaid managed care programs for a variety of services and populations. Dr. Pelberg has experience providing expert witness testimony on the design and development of innovative health purchasing strategies and on determining savings from insuring previously uninsured and under-insured individuals. Dr. Pelberg is responsible for coordinating the relationship between various state agencies and public participants involved in system reform.

In addition to program design and development, Dr. Pelberg has extensive experience with project management responsibilities and stakeholder communication. He is responsible for presenting to key health care reform stakeholders tasked with designing system/payment reform initiatives, including governors, legislators, provider organizations, community groups, and consumer forums on the impact of care. Dr. Pelberg has participated and presented during in-person rate development meetings.

Dr. Pelberg also has extensive experience quantifying the clinical interventions necessary to change risk profiles of a population over time, and reviewing the changing risk profile of a population over time and considering clinical interventions.

Education

Doctorate of Medicine, Temple University

Experience

35 years professional experience

Stephanie Taylor

Project Manager and Senior Actuarial Consultant, Optumas

Summary

Ms. Taylor is currently pursuing her ASA designation while working as a project manager and senior actuarial consultant at Optumas. She has over two years of experience working on the development of capitation rates for Medicaid managed care programs. Her main responsibilities at Optumas include project management, data analytics, rate model development, and client communication. Stephanie has completed four of the five exams for the Society of Actuaries Associate designation. Per the specifications of CRFQ 0511 BMS1800000002, Ms. Taylor will be part of the Staff Actuarial Resources (RFP Section 3.9) for the West Virginia BMS.

Ms. Taylor has experience overseeing Optumas teams preparing capitation rate development model spreadsheets that accommodate a variety of program components, actuarial adjustments, and trend, as well as developing them herself. Ms. Taylor has worked extensively with detailed, service-level FFS and encounter data that help form the base of capitation rate development. Her responsibilities also include developing trend figures by reviewing multiple data sources, including national data on trends in Medicaid managed care programs, plan encounter data, plan financial reports, and other states' trend experience.

Ms. Taylor also has extensive experience with project management responsibilities. On several of her rate setting projects, she is responsible for creating detailed project plans that outline the responsible entity and due date for each of the key activities in the rate development process. Ms. Taylor has extensive experience organizing and producing Actuarial Certifications for Medicaid managed care programs. The detail within both the methodologies and Certifications allow the rate reviewer and all stakeholders to better understand the program and the actuarial analyses underlying Optumas' capitation rate development process.

Education

B.S., Mathematics, Arizona State University

Experience

Two years professional experience

Relevant Work Experience

Ms. Taylor has worked as an actuarial analyst on the following State Medicaid managed care rate development projects:

- *Colorado RMHP PRIME Program.*
- *Colorado PCP Partial Capitation Program.*
- *Nebraska Physical Health Program.*
- *Nebraska Heritage Health Program.*
- *Nebraska Dental Program.*
- *Nebraska PACE UPL Development.*

Her responsibilities on these projects have included:

- *Creating capitation rate development model spreadsheets that account for program changes, actuarial adjustments, and medical trends.*
- *Calculating the impact of various prospective and retrospective program and benefit changes.*
- *Performing encounter/claims data validation analyses including referential integrity and volume checks.*
- *Analyze quarterly and annual financial data and benchmark claims/encounter data against financial reports.*
- *Calculation of MLR and risk corridor recoupments.*
- *Presenting to MCOs to explain capitation rate development.*

Zachary Aters, ASA, MAAA

Senior Actuary, Optumas

Summary

Mr. Aters has over 15 years of experience developing capitation rates, assessing risk, and providing strategy consulting within Medicaid managed care programs. He currently serves as the senior actuary and client lead for the Medicaid managed care programs in the states of Colorado and Oregon. He provides direct oversight to the capitation rate development, signing the Actuarial Certifications, and works directly with the state legislature and state leadership to inform policy and further health care transformation. Per the specifications of CRFQ 0511 BMS1800000002, Mr. Aters will be part of the Staff Actuarial Resources (RFP Section 3.9) for the West Virginia BMS, and is available as a Co-Lead Actuary should the workload require an additional Lead Actuary.

Mr. Aters has worked on a variety of engagements throughout his career. Recently, Mr. Aters has focused his efforts on assisting Oregon with 1115 waiver approval and developing a CCO rate methodology that complies with the new manage care rule, as well as assisting Colorado with creating methodologies that measure efficiency and quality of care across their Accountable Care Collaborative (ACC) and managed care programs. Mr. Aters has worked with multiple states including California, Colorado, Delaware, Kansas, Nebraska, New Mexico, North Dakota, Ohio, and Oregon. The programs with these states have been integrated care programs such as Kancare (Kansas), Heritage Health (Nebraska), CCOs (Oregon), as well as standalone physical health and behavioral health programs. In addition, Mr. Aters has extensive experience in assessing risk and developing capitation rates for MLTSS programs in Delaware, Kansas, and New Mexico. Mr. Aters has assisted states in developing rate methodologies that support APMs, measuring efficiency and quality.

Mr. Aters is an active member of the Society of Actuaries, regularly participating in annual meetings by presenting new and creative concepts surrounding Medicaid risk assessment. Mr. Aters was recently invited to participate on a Society of Actuaries health council and was elected a member of the marketing council.

Prior to joining Optumas in 2011, Mr. Aters was a senior associate actuary for Mercer, where he served as client lead and senior actuary for their government practice.

Education

B.B.A., Mathematics, Indiana University Southeast

Experience

15 years professional experience

Affiliations

American Academy of Actuaries
Society of Actuaries

Certifications

Fellow of the Society of Actuaries (FSA)
Member of the American Academy of Actuaries (MAAA)

Barry Jordan, ASA, MAAA

Actuary, Optumas

Summary

Mr. Jordan is an ASA, and a MAAA and has more than five years of experience working with Optumas as a consultant and actuary. He has actuarial experience with health care work (Medicaid, Medicare, Exchange) in over 10 states, and has certified managed care rates for various state Medicaid programs, including physical health, behavioral health, and integrated care, as well as PACE UPLs. Per the specifications of CRFQ 0511 BMS1800000002, Mr. Jordan will be part of the Staff Actuarial Resources for the West Virginia BMS.

Mr. Jordan has worked with a variety of clients in multiple states, focused primarily on work within state Medicaid programs. This has included development of Medicaid managed care capitation rates, savings projections related to SIM initiatives, state Medicaid program-wide projections, development of Medicare Advantage and Health Insurance Exchange bids, and stakeholder communication.

Within each of the actuarial projects Mr. Jordan has been involved, he has directly conducted, or overseen, the development of various health care analytics, and use of commonly-used industry tools. This includes various levels of detailed data analytics such as FFS and encounter data processing and harmonizing as well as development of trend forecasts, impact of programmatic/policy changes, and the use of risk adjustment and reimbursement analyses within the Medicaid rate setting context.

Mr. Jordan has experience leading actuarial teams, and working with various types of health care data, and conducting health care analytics. However, one of the primary keys to successfully implementing this work into a valuable product, is the effective communication of this work to clients and stakeholders. Mr. Jordan has experience communicating at various levels. This often includes strategizing with state clients via daily or weekly touchpoints. Additionally, he has experience communicating the results of analytics and rate development to Medicaid directors, MCO actuaries, and executives via presentation and written methodology reports. His experience also includes presentations to members at legislative hearings.

Education

B.B.A., Mathematics, Northern Arizona University

Experience

Five years professional experience

Affiliations

American Academy of Actuaries
Society of Actuaries

Certifications

Fellow of the Society of Actuaries (FSA)
Member of the American Academy of Actuaries (MAAA)

Appendix B: Designations


AMERICAN ACADEMY OF ACTUARIES

This is to certify that

Timothy Michael Doyle

having met the education and experience requirements for admission is hereby enrolled as a

MEMBER OF THE AMERICAN ACADEMY OF ACTUARIES

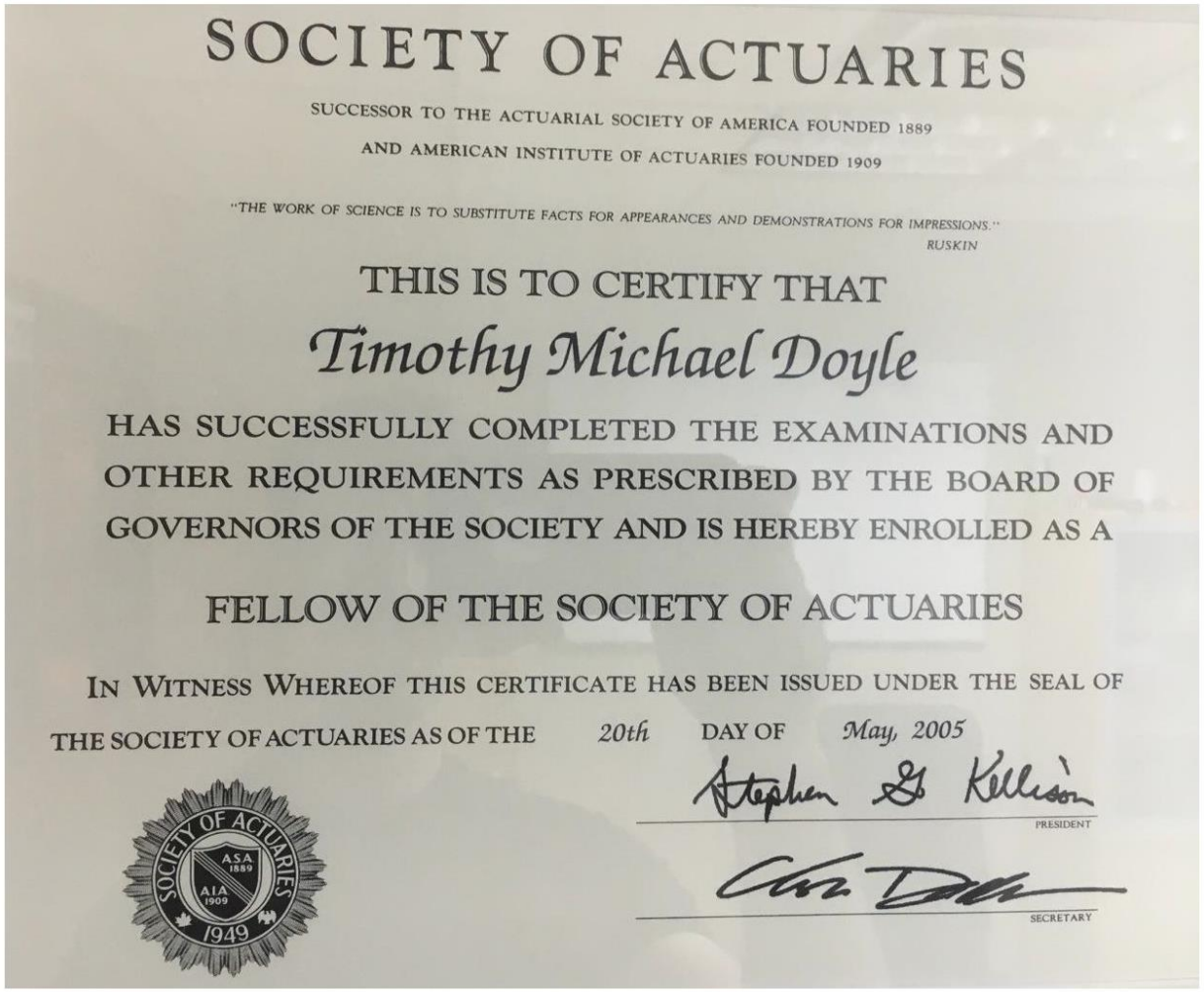
in witness whereof this certificate has been issued under the seal of the American Academy of Actuaries

August 30, 2002

PRESIDENT

AMERICAN ACADEMY OF ACTUARIES 1965

SECRETARY/TREASURER



SOCIETY OF ACTUARIES

SUCCESSOR TO THE ACTUARIAL SOCIETY OF AMERICA FOUNDED 1889
AND AMERICAN INSTITUTE OF ACTUARIES FOUNDED 1909

"THE WORK OF SCIENCE IS TO SUBSTITUTE FACTS FOR APPEARANCES AND DEMONSTRATIONS FOR IMPRESSIONS."
RUSKIN

THIS IS TO CERTIFY THAT

Timothy Michael Doyle

HAS SUCCESSFULLY COMPLETED THE EXAMINATIONS AND OTHER REQUIREMENTS AS PRESCRIBED BY THE BOARD OF GOVERNORS OF THE SOCIETY AND IS HEREBY ENROLLED AS A

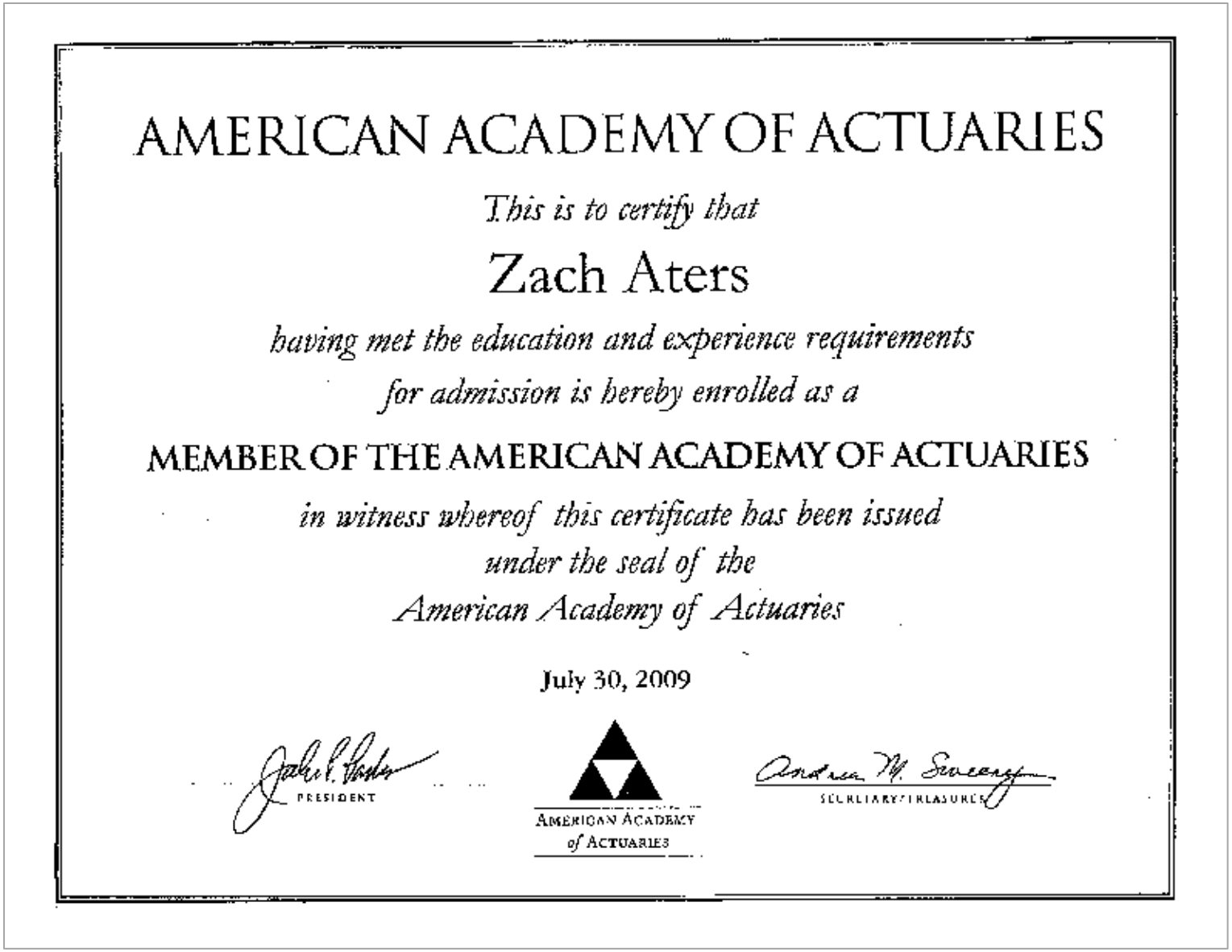
FELLOW OF THE SOCIETY OF ACTUARIES

IN WITNESS WHEREOF THIS CERTIFICATE HAS BEEN ISSUED UNDER THE SEAL OF THE SOCIETY OF ACTUARIES AS OF THE *20th* DAY OF *May, 2005*

Stephen G Kellison
PRESIDENT

SECRETARY

SOCIETY OF ACTUARIES ASA 1889 AIA 1909 1949



AMERICAN ACADEMY OF ACTUARIES

This is to certify that

Zach Aters

having met the education and experience requirements
for admission is hereby enrolled as a

MEMBER OF THE AMERICAN ACADEMY OF ACTUARIES

in witness whereof this certificate has been issued
under the seal of the
American Academy of Actuaries

July 30, 2009

PRESIDENT

AMERICAN ACADEMY of ACTUARIES

SECRETARY/TREASURER

SOCIETY OF ACTUARIES

SUCCESSOR TO THE ACTUARIAL SOCIETY OF AMERICA FOUNDED 1889

AND AMERICAN INSTITUTE OF ACTUARIES FOUNDED 1909

"THE WORK OF SCIENCE IS TO SUBSTITUTE FACTS FOR APPEARANCES AND DEMONSTRATIONS FOR IMPRESSIONS."
RUSKIN

THIS IS TO CERTIFY THAT

Zachary Christian Aters

HAS SUCCESSFULLY COMPLETED THE EXAMINATIONS AND OTHER REQUIREMENTS AS PRESCRIBED BY THE BOARD OF DIRECTORS OF THE SOCIETY AND IS HEREBY ENROLLED AS AN

ASSOCIATE OF THE SOCIETY OF ACTUARIES

IN WITNESS WHEREOF THIS CERTIFICATE HAS BEEN ISSUED UNDER THE SEAL OF THE SOCIETY OF ACTUARIES AS OF THE *31st* DAY OF *July, 2009*

PRESIDENT

SECRETARY

AMERICAN ACADEMY of ACTUARIES
Objective. Independent. Effective.™

This is to certify that

Barry Jordan Jr.

having met the admission requirements
for membership is hereby enrolled as a*

MEMBER OF THE AMERICAN ACADEMY *of* ACTUARIES

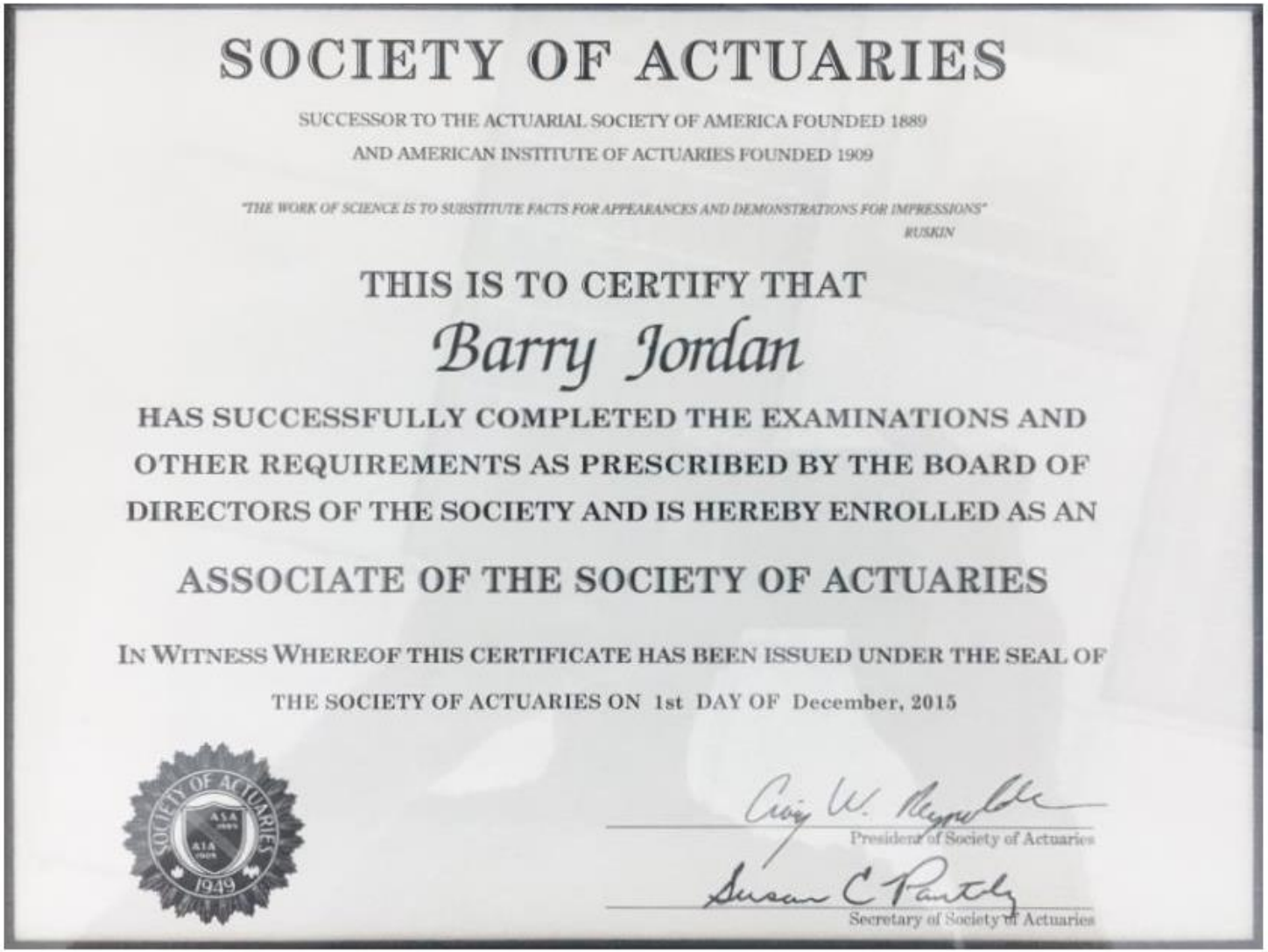
in witness whereof this certificate has been issued
under the seal of the
American Academy of Actuaries

January 13, 2016

Tom Wildsmith
PRESIDENT

SECRETARY-TREASURER

*Continued enrollment and entitlement to use the MAAA designation requires continuing annual membership in the Academy



SOCIETY OF ACTUARIES

SUCCESSOR TO THE ACTUARIAL SOCIETY OF AMERICA FOUNDED 1889
AND AMERICAN INSTITUTE OF ACTUARIES FOUNDED 1909

"THE WORK OF SCIENCE IS TO SUBSTITUTE FACTS FOR APPEARANCES AND DEMONSTRATIONS FOR IMPRESSIONS"
RUSKIN

THIS IS TO CERTIFY THAT

Barry Jordan

HAS SUCCESSFULLY COMPLETED THE EXAMINATIONS AND OTHER REQUIREMENTS AS PRESCRIBED BY THE BOARD OF DIRECTORS OF THE SOCIETY AND IS HEREBY ENROLLED AS AN

ASSOCIATE OF THE SOCIETY OF ACTUARIES

IN WITNESS WHEREOF THIS CERTIFICATE HAS BEEN ISSUED UNDER THE SEAL OF THE SOCIETY OF ACTUARIES ON 1st DAY OF December, 2015

President of Society of Actuaries

Secretary of Society of Actuaries

Appendix C: CRFQ Forms

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFQ 0511 BMS1800000002

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)

[✓]	Addendum No. 1	[✓]	Addendum No. 6
[✓]	Addendum No. 2	[✓]	Addendum No. 7
[✓]	Addendum No. 3	[ ]	Addendum No. 8
[✓]	Addendum No. 4	[ ]	Addendum No. 9
[✓]	Addendum No. 5	[ ]	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 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

10/30/2017
Date

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

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

Pursuant to W. Va. Code § 6D-1-2, a state agency may not enter into a contract, or a series of related contracts, that has/have an actual or estimated value of $100,000 or more until the business entity submits to the contracting state agency a Disclosure of Interested Parties to the applicable contract. In addition, the business entity awarded a contract is obligated to submit a supplemental Disclosure of Interested Parties reflecting any new or differing interested parties to the contract within 30 days following the completion or termination of the applicable contract.

For purposes of complying with these requirements, the following definitions apply:

"Business entity" means any entity recognized by law through which business is conducted, including a sole proprietorship, partnership or corporation.

"Interested party" or *"Interested parties"* means:

(1) A business entity performing work or service pursuant to, or in furtherance of, the applicable contract, including specifically sub-contractors;
(2) the person(s) who have an ownership interest equal to or greater than 25% in the business entity performing work or service pursuant to, or in furtherance of, the applicable contract. (This subdivision does not apply to a publicly traded company); and
(3) the person or business entity, if any, that served as a compensated broker or intermediary to actively facilitate the applicable contract or negotiated the terms of the applicable contract with the state agency. (This subdivision does not apply to persons or business entities performing legal services related to the negotiation or drafting of the applicable contract.)

"State agency" means a board, commission, office, department or other agency in the executive, judicial or legislative branch of state government, including publicly funded institutions of higher education: Provided, that for purposes of W. Va. Code § 6D-1-2, the West Virginia Investment Management Board shall not be deemed a state agency nor subject to the requirements of that provision.

The contracting business entity must complete this form and submit it to the contracting state agency prior to contract award and to complete another form within 30 days of contract completion or termination.

This form was created by the State of West Virginia Ethics Commission, 210 Brooks Street, Suite 300, Charleston, WV 25301-1804. Telephone: (304)558-0664; fax: (304)558-2169; e-mail: ethics@wv.gov; website: www.ethics.wv.gov.

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

Contracting business entity: Myers and Stauffer LC

Address: 133 Peachtree St. NE, Ste 3150 Atlanta, GA 30303

Contracting business entity's authorized agent: Corp Service Co

Address: 209 W. Washington St. Charleston, WV 25302

Number or title of contract: Medicaid Managed Care Rate Setting and Program Administration

Type or description of contract: Medicaid Managed Care Rate Setting and Program Administration

Governmental agency awarding contract: West Virginia Department of Health and Human Resources/Department of Administration

Names of each Interested Party to the contract known or reasonably anticipated by the contracting business entity *(attach additional pages if necessary)*:

Myers and Stauffer LC - Prime Contractor , Optumas - Subcontractor

Keenan Buoy, Kevin Londeen (Myers and Stauffer, Owners)

Signature: Michael D Johnson Date Signed: 10/5/2017

☐ Check here if this is a Supplemental Disclosure.

Verification

State of Georgia, County of Fulton:

I, MICHAEL D JOHNSON, the authorized agent of the contracting business entity listed above, being duly sworn, acknowledges that the Disclosure herein is being made under oath and under the penalty of perjury.

Taken, sworn to and subscribed before me this 5th day of October, 2017.

BERNICE L GEIER NOTARY PUBLIC My Comm. Expires Aug 8, 2021 PAULDING COUNTY STATE OF GEORGIA

Notary Public's Signature

To be completed by State Agency:

Date Received by State Agency: _____

Date submitted to Ethics Commission: _____

Governmental agency submitting Disclosure: _____

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

CONSTRUCTION CONTRACTS: Under W. Va. Code § 5-22-1(i), the contracting public entity shall not award a construction contract to any bidder that is known to be in default on any monetary obligation owed to the state or a political subdivision of the state, including, but not limited to, obligations related to payroll taxes, property taxes, sales and use taxes, fire service fees, or other fines or fees.

ALL OTHER CONTRACTS: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that: (1) for construction contracts, the vendor is not in default on any monetary obligation owed to the state or a political subdivision of the state, and (2) for all other contracts, that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: Myers and Stauffer LC

Authorized Signature: _____ Date: 10/5/2017

State of Georgia

County of Fulton, to-wit:

Taken, subscribed, and sworn to before me this 5th day of October, 2017.

My Commission expires Aug. 8th, 2021.

AFFIX SEAL HERE

BERNICE L GEIER
NOTARY PUBLIC
My Comm. Expires
Aug 8, 2021
PAULDING COUNTY
STATE OF GEORGIA

NOTARY PUBLIC _____

Purchasing Affidavit (Revised 07/07/2017)

WV-10
Approved / Revised
12/16/15

State of West Virginia

VENDOR PREFERENCE CERTIFICATE

Certification and application is hereby made for Preference in accordance with ***West Virginia Code***, §5A-3-37. (Does not apply to construction contracts). ***West Virginia Code***, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the ***West Virginia Code***. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Vendor Preference, if applicable.

1. **Application is made for 2.5% vendor preference for the reason checked:**
☐ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

☐ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification;

☐ Bidder is a resident vendor partnership, association, or corporation with at least eighty percent of ownership interest of bidder held by another entity that meets the applicable four year residency requirement; **or,**

☐ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

2. **Application is made for 2.5% vendor preference for the reason checked:**
☐ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

3. **Application is made for 2.5% vendor preference for the reason checked:**
☐ Bidder is a nonresident vendor that employs a minimum of one hundred state residents, or a nonresident vendor which has an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia and employs a minimum of one hundred state residents, and for purposes of producing or distributing the commodities or completing the project which is the subject of the bidder's bid and continuously over the entire term of the project, on average at least seventy-five percent of the bidder's employees or the bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years and the vendor's bid; **or,**

4. **Application is made for 5% vendor preference for the reason checked:**
☐ Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or,**

5. **Application is made for 3.5% vendor preference who is a veteran for the reason checked:**
☐ Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

6. **Application is made for 3.5% vendor preference who is a veteran for the reason checked:**
☐ Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

7. **Application is made for preference as a non-resident small, women- and minority-owned business, in accordance with *West Virginia Code* §5A-3-59 and *West Virginia Code of State Rules*.**
☐ Bidder has been or expects to be approved prior to contract award by the Purchasing Division as a certified small, women- and minority-owned business.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) rescind the contract or purchase order; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: Myers and Stauffer LC **Signed:** [signature]

Date: 10/3/2017 **Title:** Member

**Check any combination of preference consideration(s) indicated above, which you are entitled to receive.*

MYERS AND STAUFFER LC
1977 - 2017
CERTIFIED PUBLIC ACCOUNTANTS

STATE OF WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Medicaid Managed Care Rate Setting and Medicaid Managed Care Program Administration

CRFQ 0511 BMS1800000002

October 31, 2017

Price Proposal

MYERS AND STAUFFER LC
133 PEACHTREE ST NE, STE 3150
ATLANTA, GA 30303
866.758.3586
WWW.MSLC.COM

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

Contract Award/Pricing Page *(RFQ Sections 5.1/2)*

We have included our price estimate, using *Exhibit A: Pricing Page*, on the following pages. Our pricing is based on our understanding of your request and our previous experience conducting managed care services in numerous states. In addition, we have included the cover sheet with pricing from Addendum 7.

CENTRALIZED REQUEST FOR QUOTATION
CRFQ 0511 BMS1800000002
Medicaid Managed Care Rate Setting and Medicaid Managed Care Program Administration

Attachment 1: Exhibit A Pricing Page

Please reference **Exhibit A: Pricing Page** to complete the bid information.

The contract shall be awarded to the vendor with the lowest total cost bid meeting all of the specifications.

Vendor Name:	Myers and Stauffer LC
Remit to Address:	133 Peachtree St. NE. Ste 3150 Atlanta, GA 30303
Phone #:	866.758.3586
Vendor Fax #:	404.524.0782
Email Address:	MJohnson@mslc.com
Signature:	 Date: 10/30/2017

17

Exhibit A: Pricing Page
Section Actuarial Services
Section Managed Care Oversight
Section Ad Hoc Services

Vendor should complete highlighted cells; formulas built into cells will calculate total costs.

Section A: Mandatory Services

Actuarial Services will be billed on an hourly basis for services as they are needed. Vendors should provide the hourly rate for the below staffing levels.

Actuarial Services*

Staff by Level	# of Hours (total)	Cost Per Hour	Total Cost
Lead Actuary	2,080	$ 198.00	$ 411,840.00
Staff Actuaries (4)	8,320	$ 198.00	$ 1,647,360.00
Technical Support Staff (non-actuary)	2,080	$ 198.00	$ 411,840.00
Clerical Support Staff	2,080	$ 198.00	$ 411,840.00

*hours are estimated on a per year (2080 hours) basis and subject to change. The hourly rate established for each position will carry forward throughout the life of the contract, including any optional renewals and extenstion awarded. Vendor is responsible for all travel costs.

Managed Care Program Oversight will be billed on a fixed annual amount divided into 12 equal monthly installments and is all-inclusive of all services outlines within that section of the RFQ.
Vendor should provide the annual cost in the highlighted box below for Managed Care Program Oversight.

Managed Care Program Oversight

Total Cost (Annual)	$ 1,725,000.00

Ad hoc services may be rendered for various services. Vendor shall provide an estimated rate that would cover any of the potential services outlined within the Ad Hoc section of the RFQ.

Section B: Ad Hoc Services:

Staff	# of Hours Per Year	Cost Per Hour	Total Cost
Managed Care Oversight Projects	5,000	$ 165.00	$ 825,000.00
Actuarial Services Projects	5,000	$ 198.00	$ 990,000.00

Total Project Cost (Sum of Actuarial Services Cost, Managed Care Oversight Cost and Ad Hoc Cost):
$ 6,422,880.00

Notes:

1.) Total Project Cost will be used for purposes of bid evaluation.
2.) Contract services will be paid monthly in arrears.
3.) Payment for Ad Hoc Services will be based on an approved Statement of Work .
4.) All amounts bid shall include all general and administrative expenses, including travel, training and supplies necessary to provide the services required in this solicitation.
5.) Total Project Cost shall be calculated as Total Cost of Mandatory Services (Section A) + Total Cost of Ad Hoc Services (Section B)
6.) Hours in Ad Hoc section are for bid purposes only and are not to be considered an annual project cap.

Myers and Stauffer LC
(Company)

Michael Johnson, Member
(Representative, Name, Title)

404-524-0775/404-524-0782
(Contact Phone/Fax Number)

October 31, 2017
(Date)

Purchasing Divison 2019 Washington Street East Post Office Box 50130 Charleston, WV 25305-0130	**State of West Virginia** **Request for Quotation** **27 — Miscellaneous**

Proc Folder: 360501

Doc Description: Medicaid Managed Care Rate Setting/Program Admin-Addendum #7

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2017-10-23	2017-10-31 13:30:00	CRFQ 0511 BMS1800000002	8

BID RECEIVING LOCATION

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

VENDOR

Vendor Name, Address and Telephone Number:
Myers and Stauffer LC
133 Peachtree St. NE, 3150
Atlanta, GA 30303
866.758.3586

FOR INFORMATION CONTACT THE BUYER

April Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X  **FEIN #** 48-1164042 **DATE** 10/30/2017

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

Page : 1 FORM ID : WV-PRC-CRFQ-001

ADDITIONAL INFORMAITON:

Addendum #7 is issued to:

1) add the following commodity lines:

Technical Support Staff (Non-Actuary) $198 X per hour X 2,080 hours

Clerical Support Staff $198 per hours X 2,080 hours

Ad Hoc Services Actuarial Services Projects $198 per hours X 5,000 hours

2) modify Commodity Line Item #4 to:

Ad Hoc Services Managed Care Oversight Projects to 5,000 hours.

No other changes.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Lead Actuary Services		2,080 Hours (Total)	$198.00/Hour	$411,840.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :

Lead Actuary Services
$198 per hour x 2,080 hours

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Staff Actuary Services		8,320 Hours (Total)	$198.00/Hour	$1,647,360.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :

Staff Actuary Services
$198 per hour x 8,320 hours

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INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	Managed Care Program Oversight Services				$1,725,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :
Managed Care Program Oversight Services Annual Cost

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	Ad Hoc Services Managed Care Oversight Projects		5,000 Hours Per Year	$165.00/Hour	$825,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :
Ad Hoc Services Managed Care Oversight Projects
$165 per hour x 5,000 hours

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
5	Technical Support Staff (Non-Actuary)		2,080 Hours (Total)	$198.00/Hour	$411,840.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :
Technical Support Staff (Non-Actuary) $198per hour X 2,080 hours

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
6	Clerical Support Staff		2,080 Hours (Total)	$198.00/Hour	$411,840.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :
Clerical Support Staff $198per hours X 2,080 hours

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
7	Ad Hoc Services Actuarial Services Projects		5,000 Hours Per Year	$198.00/Hour	$990,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :
Ad Hoc Services Actuarial Services Projects $198per hours X 5,000 hours

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2017-09-19
2	Questions Due	2017-09-22

	Document Phase	Document Description	Page 5
BMS1800000002	Final	Medicaid Managed Care Rate Setting/Program Admin-Addendum #7	of 5

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions