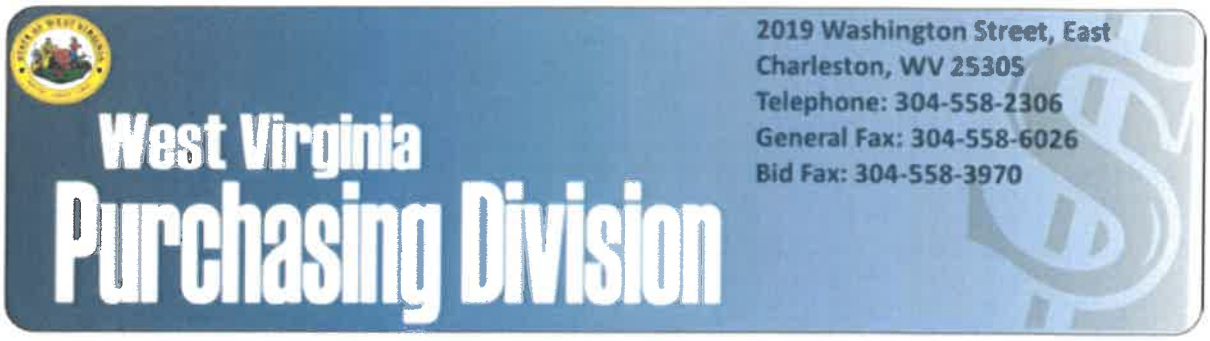
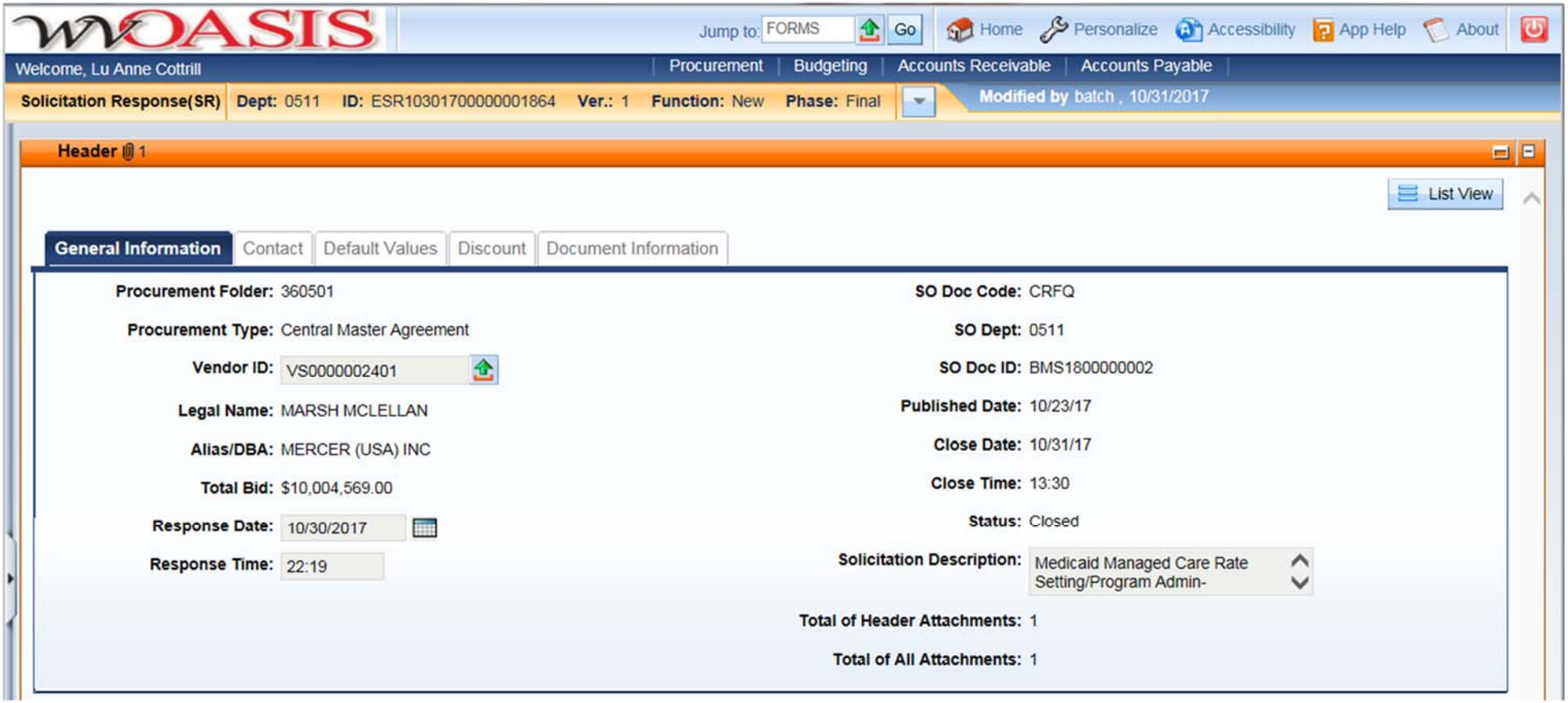


The following documentation is an electronically-submitted vendor response to an advertised solicitation from the *West Virginia Purchasing Bulletin* within the Vendor Self-Service portal at ***wvOASIS.gov***. As part of the State of West Virginia's procurement process, and to maintain the transparency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


wvOASIS
Jump to: FORMS Go
Home
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Welcome, Lu Anne Cottrill
Procurement
Budgeting
Accounts Receivable
Accounts Payable
Solicitation Response(SR) Dept: 0511 ID: ESR10301700000001864 Ver.: 1 Function: New Phase: Final
Modified by batch , 10/31/2017
Header 1
List View
General Information
Contact
Default Values
Discount
Document Information
Procurement Folder: 360501
Procurement Type: Central Master Agreement
Vendor ID: VS0000002401
Legal Name: MARSH MCLELLAN
Alias/DBA: MERCER (USA) INC
Total Bid: $10,004,569.00
Response Date: 10/30/2017
Response Time: 22:19
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: 1
Total of All Attachments: 1

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 ESR10301700000001864	1

VENDOR

VS0000002401

MARSH MCLELLAN

MERCER (USA) INC

Solicitation Number: CRFQ 0511 BMS1800000002

Total Bid : $10,004,569.00 **Response Date:** 2017-10-30 **Response Time:** 22:19:46

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				$624,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :

Lead Actuary Services
$ per hour x 2,080 hours

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
2	Staff Actuary Services				$2,340,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :

Staff Actuary Services
$ per hour x 8,320 hours

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
3	Managed Care Program Oversight Services				$4,059,469.00

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				$1,222,750.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
5	Technical Support Staff (Non-Actuary)				$447,200.00

Comm Code	Manufacturer	Specification	Model #
93151507			

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
6	Clerical Support Staff				$104,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
7	Ad Hoc Services Actuarial Services Projects				$1,207,150.00

Comm Code	Manufacturer	Specification	Model #
93151507			

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

Ryan Johnson, MPA
Principal

Government Human Services Consulting
2325 E Camelback Road, Suite 600
Phoenix, AZ 85016
+1 602 522 8576
Ryan.Johnson@mercer.com
www.mercer-government.mercer.com

October 30, 2017

April Battle
Buyer File 22
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

Submitted online via
wvOASIS

Subject: Mercer Response to Solicitation No. CRFQ 0511 BMS1800000002 for Medicaid Managed Care Rate Setting and Program Administration

Dear Ms. Battle,

Mercer Health & Benefits LLC (Mercer) is pleased to respond to Solicitation No. CRFQ 0511 BMS1800000002 for Medicaid Managed Care Rate Setting and Program Administration.

This response attests to Mercer's ability to meet all mandatory requirements of the procurement. Specifically, the documentation in our response addresses the following mandatory requirements:

- **The Vendor(s) must have a minimum of 10 years of experience in providing Managed Care program administration and oversight and a minimum of 10 years of experience in developing Managed Care rates for state Medicaid agencies**

Mercer has more than 30 years of experience providing services like those requested in the CRFQ. In that time, we have provided actuarial and related managed care program administration consulting on issues related to Medicaid, Children's Health Insurance Program (CHIP), and other state health programs for more than 35 states and territories. We hold active contracts with 29 states and territories providing services similar to those requested in this CRFQ. We are currently the actuary of record, performing actuarial services similar or larger in size and scope to those requested in this CRFQ, for a total of 13 states and the District of Columbia. Our relationships with the majority of our clients have been long term, attesting to their satisfaction with our services and faith in us as a trusted advisor. For example, we have been under contract performing services for more than 12 years for our five largest clients (California, Massachusetts, New Jersey, New York, and Pennsylvania). At least five of our state Medicaid clients have contracted with us for more than 20 years. Additional information regarding our experience is provided in Section 1 – Qualifications of this response.

- **The vendor shall provide the following staff for Managed Care Program Oversight: Project Management Lead, On-Site Program Management/Policy Analyst, one (1) Senior Consultant, two (2) Junior Consultants, three (3) Research Analysts, Support/Clerical Staff, and an on-site Program Integrity Analyst.**

Mercer proposes the following staff for Managed Care Program Administration and Oversight, all of whom exceed the educational and experiential requirements:

MANAGED CARE PROGRAM ADMINISTRATION AND OVERSIGHT			
Position	**Name**	**Degree**	**Years of Experience**
Project Management Lead	Sara Drake, MPH, MBA	Master's	10+
On-site Program Management/ Policy Analyst	Allen Gibson*	Bachelor's	15+
On-site Program Integrity Analyst	Holly Ekstrand*	Bachelor's	7+
Senior Consultants	Kim Donica Heather Huff, MA Nicole Kaufman, JD, LL.M Laurie Klanchar, RN, MSN, CRNP Jessica Osborne Michele Walker, MSG, MPA Rachel Wright, RN, MSN, PHN	Bachelor's Master's JD, LL.M Master's Bachelor's Master's Master's	30+ 24+ 8+ 28+ 12+ 24+ 13+
Junior Consultants	Jonathan Myers, MS Son Yong Pak, CPHQ, CPC Maija Welton	Master's Bachelor's Bachelor's	5+ 10+ 11+
Research Analysts	James Moore Madison Surdyke, PMP Alec Zuber, MPA	Bachelor's Bachelor's Master's	2+ 3+ 10+
Support Staff	TBD	TBD	TBD

*Subcontractor

Additional information regarding our experience is provided in Section 2 – Required Staffing of this response. Resumes are provided in Appendix A.

- **The vendor, and its subcontractor if used, must provide resumes of key staff that will assist on this project with its bid submission. Key staff for this project shall be defined as the Lead Actuary, which the State may request be available on a full-time basis if warranted.**

- **In addition, the vendor must make available an adequate number of additional staff actuarial resources to meet the deliverables assigned by the State in the agreed upon timeframe between the State and vendor.**

We propose the following staff for Managed Care Actuarial Services, all of whom exceed the professional actuarial designation, educational, and experiential requirements:

MANAGED CARE ACTUARIAL SERVICES			
Position	**Name**	**Actuarial Designation**	**Years of Experience**
Lead Actuary	Katherine Long, FSA, MAAA	FSA, MAAA	9+
Actuaries	Lisa Deyer, ASA, MAAA James Matthisen, ASA, MAAA Brandon Odell, FSA, MAAA Adam Sery, FSA, MAAA	ASA, MAAA ASA, MAAA FSA, MAAA FSA, MAAA	11+ 32+ 4+ 13+
Actuarial Analysts	Christina Coleman James Moore Madison Surdyke, PMP	N/A N/A N/A	2+ 2+ 3+
Support Staff	TBD	TBD	TBD

Mercer recognizes and agrees that the Department may request Katherine Long, FSA, MAAA, as the Lead Actuary, be available on a full-time basis if warranted. Mercer also recognizes and agrees that the Department reserves the right to request replacement staff if it believes its needs are not being adequately met. Further, Mercer recognizes and agrees that we will make available an adequate number of additional staff of actuarial resources to meet the deliverables assigned by the Department in the agreed upon timeframe between the Department and Mercer.

Additional information regarding our experience is provided in Section 2 – Required Staffing of this response. Resumes are provided in Appendix A.

- **The vendor shall provide references from three individual states for Managed Care Program Oversight services for a state Medicaid agency. The references must be for work performed within the last ten years and must not include a reference from the West Virginia Department of Health and Human Resources. These documents shall be included with the bid response.**

Mercer provides references in Section 3 – References. Contact and service information as required from the answers to questions is provided.

- **Required signature and other forms.**

Mercer provides the required forms in Section 4 – Required Forms. We include any signature forms required by the CRFQ, as well as a copy of our Proof of Registration required by the West Virginia Purchasing Division. As allowed in answers to questions, we also provide our requested exceptions to the terms and conditions in red-line format.

- **Pricing.**

Mercer uploaded our pricing into the wvOASIS system along with this response document. Mercer reproduces the pricing information in Section 5 – Pricing. In addition, we provide Attachment 1 from the CRFQ in Section 5.

As a Principal with Mercer, I am authorized to bind Mercer into contract. I have completed and signed the Designated Contact form and provided it on the following page. Should you have any questions regarding our submission, please do not hesitate to contact me by telephone at +1 602 522 8576 or by email at Ryan.Johnson@mercer.com.

Sincerely,

Ryan Johnson, MPA
Principal

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.

Ryan Johnson, Principal
(Name, Title)

Ryan Johnson, MPA, Principal
(Printed Name and Title)

2325 E. Camelback Road, Suite 600, Phoenix, AZ 85016
(Address)

Phone = +1 602 522 8576; Fax = +1 602 522 6499
(Phone Number) / (Fax Number)

Ryan.Johnson@mercer.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.

Mercer Health & Benefits LLC
(Company)

(Authorized Signature) (Representative Name, Title)

Ryan Johnson, MPA, Principal
(Printed Name and Title of Authorized Representative)

October 30, 2017
(Date)

Phone = +1 602 522 8576; Fax = +1 602 522 6499
(Phone Number) / (Fax Number)

CONTENTS

1

QUALIFICATIONS

3. QUALIFICATIONS: Vendor, its employees, or its subcontractor, if requirements are inherently limited to individuals rather than corporate entities, shall have the following minimum qualifications. This Section is divided into Managed Care Program Administration and Actuarial Services.

The Vendor(s) must have a minimum of 10 years of experience in providing Managed Care program administration and oversight and a minimum of 10 years of experience in developing Managed Care rates for state Medicaid agencies. Vendor(s) shall have experience with at least three (3) individual state Medicaid programs for each service type: managed care program administration and actuarial services. Experience for each service is permitted to have occurred concurrently and within the same state, so long as three (3) individual state examples are provided.

Introduction

Mercer has more than 30 years of experience providing services like those requested in the CRFQ. Based on our unrivaled national Medicaid Managed Care, actuarial, and related consulting experience, Mercer will demonstrate throughout our proposal the superior value, quality, and talent we intend to bring to bear to support the work covered under this CRFQ.

Mercer has more than 30 years of experience providing services like those requested in the CRFQ.

Mercer's qualifications to carry out the scope of work requested through this CRFQ are derived from the 30+ years of directly related experience our specialized government health care consulting practice has in providing actuarial and related managed care program administration consulting services to our state Medicaid clients.

Beginning in 1985, a group of consultants within Mercer began working with publicly-funded health care programs across the country, developing actuarially sound Medicaid Managed Care capitation rates and helping states design, develop, and implement innovative solutions to improve quality of care while saving state general fund dollars. In 1992, after seven years of working to meet the specialized needs of publicly-sponsored health care programs, primarily Medicaid, Mercer formally established a separate specialty consulting practice – Mercer Government Human Services Consulting. Since that time, we have provided actuarial and related managed care program administration consulting on issues related to Medicaid, CHIP, and other state health programs for more than 35 states and territories.

Mercer has been providing actuarial rate setting and complementary consulting services for Medicaid agencies since 1985.

Today, Mercer's Government specialty practice boasts a staff of more than 280 dedicated professionals with expertise and experience in all facets of Medicaid program financing and administration. Our dedicated government staff includes:

- 45 credentialed actuaries
- 50+ actuarial students
- Five certified public accountants (CPAs)
- Seven pharmacists
- More than a dozen clinicians (medical doctor, psychologists, nurses, social workers, etc.)
- Five pharmacists

Our full-time, in-house staff includes:

- **280 professionals**
- **45 actuaries**
- **50+ actuarial students**
- **Five CPAs**
- **Seven former CMS staff**
- **More than a dozen clinicians**
- **Five pharmacists**

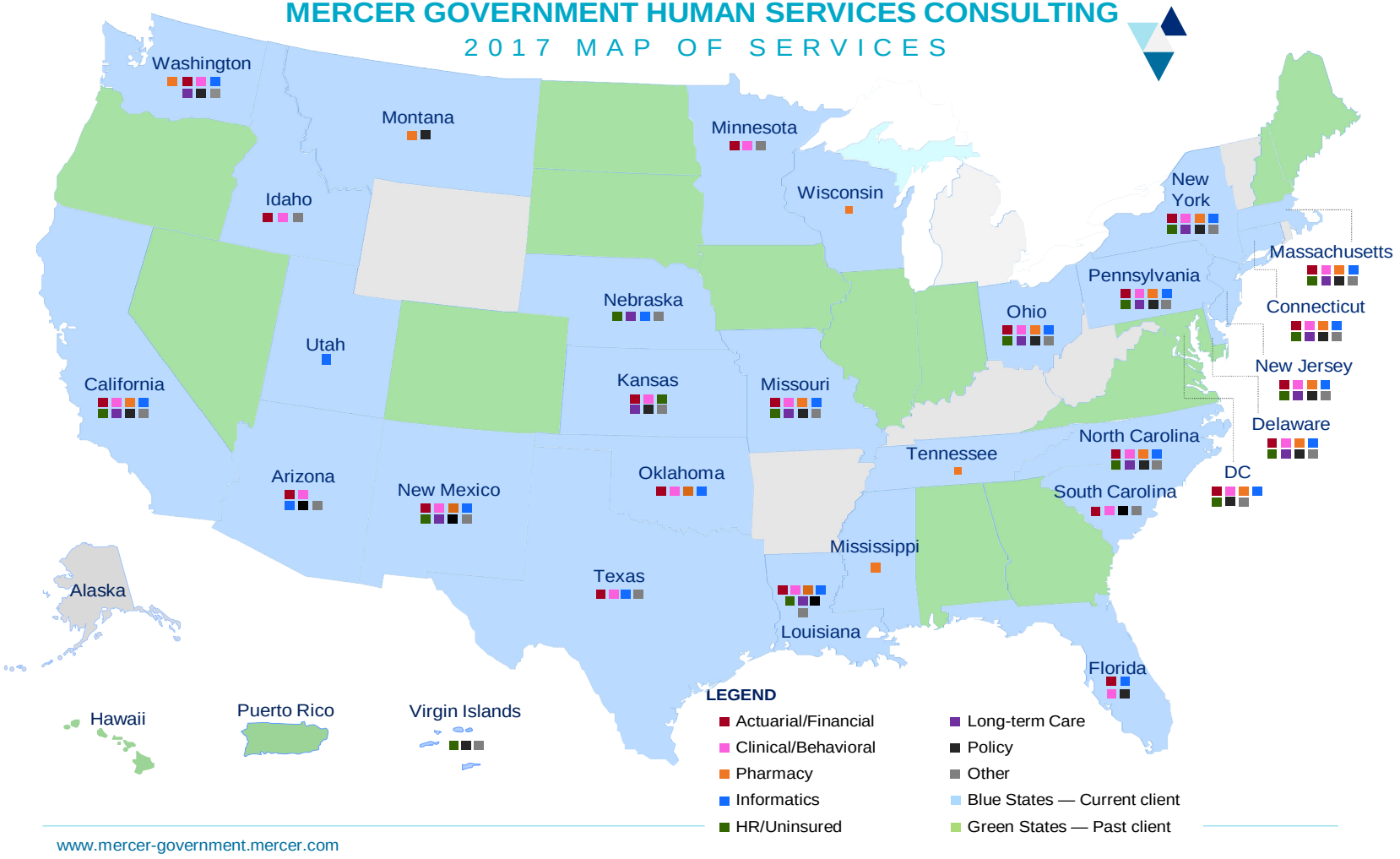
In addition, our other staff expertise and experience includes Medicaid administration, operations, oversight, Federal health care policy, an ability to easily work with large data set/information management, pharmacy policy analysis and reimbursement, clinical quality, behavioral health, actuarial/financial analyses, and project management. Accordingly, you will find that our proposed team is comprised of consultants who have hands-on experience helping state Medicaid/CHIP agencies manage, monitor, and administer managed care programs that cover all varieties of populations (e.g., children, low income adults, “expansion” adults, aged and disabled individuals, Medicaid/Medicare dual eligibles, individuals with intellectual and/or developmental disabilities and specialty populations such as individuals with HIV/AIDS or serious behavioral health conditions). In addition, our experience includes knowledge of the full gamut of Medicaid/CHIP services (i.e., acute care, pharmacy, long-term services and supports {LTSS}), as well as all types of and geographic areas (e.g., urban, suburban, rural, and remote). Please see more specific details on our proposed staffing plan and staff qualifications in Section 2 – Required Staffing, of this response.

Our relationships with the majority of our clients have been long term, attesting to their satisfaction with our services and faith in us as a trusted advisor. For example, we have been under contract performing services for more than 12 years for our five largest clients (California, Massachusetts, New Jersey, New York, and Pennsylvania). In fact, at least five of our state Medicaid clients have contracted with us for more than 20 years.

The longevity of our relationships with our Medicaid clients speaks directly to the value we bring as a trusted partner. Our relationship with our five largest clients is a dozen years or more.

Furthermore, we hold 14 contracts with state government health purchasers valued at more than $1 million annually. Our success in simultaneously managing these large contracts, along with our 15 other state/territory clients, speaks directly to our ability to properly staff and manage large, complex projects like the scope of work in this West Virginia CRFQ.

The map on the following page demonstrates the geographic diversity of our clients while simultaneously providing a snapshot of the services we provide to each of them.


MERCER GOVERNMENT HUMAN SERVICES CONSULTING
2017 MAP OF SERVICES
Washington
Montana
Minnesota
Idaho
Wisconsin
New York
Massachusetts
Pennsylvania
Nebraska
Ohio
Connecticut
Utah
New Jersey
California
Kansas
Missouri
Delaware
North Carolina
Tennessee
Arizona
Oklahoma
DC
New Mexico
South Carolina
Mississippi
Texas
Alaska
Louisiana
Florida
Hawaii
Puerto Rico
Virgin Islands
LEGEND
Actuarial/Financial
Clinical/Behavioral
Pharmacy
Informatics
HR/Uninsured
Long-term Care
Policy
Other
Blue States — Current client
Green States — Past client
www.mercer-government.mercer.com

Mercer's Qualifications – Managed Care Program Administration and Oversight

First and foremost, our understanding of the scope of work covered under this CRFQ is informed by our experience. As a firm, we possess 30+ years of experience assisting our clients with implementing, administering, and evaluating their Medicaid Managed Care programs. In fact, our very first client for our Mercer Government specialty practice was the first state to implement Medicaid Managed Care, the Arizona Health Care Cost Containment System (AHCCCS). We have been helping states manage their Medicaid programs ever since. AHCCCS remains a client to this day.

For more than 30 years Mercer has been providing Medicaid Managed Care consulting services to state Medicaid agencies.

We have worked with more than 35 states and territories and hold active contracts with 29. Recognizing the need for a comprehensive approach to help states achieve their Medicaid Managed Care program goals, we organize our Government specialty practice into five sectors including:

- Clinical/Behavioral Health services
- Pharmacy services
- Actuarial services
- Informatics
- Policy and Operations

While cross-sector teams are the norm for our projects, the sectors most involved in managed care administration and oversight are our Policy and Operations sector and our Clinical and Behavioral Health sector. Each is described more fully below.

Policy and Operations

Mercer team members bring vast policy and operational experience, including leadership at the state and Federal levels, and understand the barriers and opportunities faced by those involved in systemic change. Mercer has extensive experience in the design, implementation, and operation of many state and integrated programs, including those related to behavioral health, pharmacy, clinical, and LTSS. We have helped states successfully build programs within managed care and other service delivery models and have assisted them in their efforts to plan strategically and gain input from key stakeholders. With a cadre of former Federal and state officials, Mercer brings unparalleled knowledge of rules and policymaking from the national level, providing invaluable content and context for our clients. This level of expertise is bolstered significantly through the additional resources Mercer brings to the table, including individuals with expertise in actuarial, clinical, behavioral health, pharmacy, and information planning.

We combine high-level strategic consulting with practical solutions to help states transform and manage their Medicaid and CHIP Programs.

Mercer Government specialty practice's policy and operations team includes professionals that provide assistance regarding:

- Strategic planning (program design and Federal authorities)
- Medicaid program comprehensive design and redesign, including waiver development
- Negotiation strategy with state and Federal agencies
- Procurement assistance
- Policy and procedure development
- Medicaid Managed Care and actuarial analysis
- Network adequacy monitoring and assessment
- Behavioral health program redesign
- Home- and community-based services (HCBS) program design
- Accountable care organizations (ACOs) and shared savings
- Programs and demonstrations to serve dual eligibles
- Emerging models for LTSS
- State operations, including developing workflows, informational notices to providers, reporting templates, and program evaluations
- Reviews of state and health plan readiness with new program implementation
- Affordable Care Act (ACA) options and implementation (health care reform strategy)

In addition, Mercer has specialized expertise in policy guidance on Medicaid-specific issues such as:

- Federal funding mechanisms including Medicaid Waivers
- Health care reform provisions
- Health insurance exchange planning
- Managed care contracting

- Behavioral health
- LTSS (community and institutional)
- Pharmacy
- Regulatory issues
- Federally Qualified Health Centers (FQHCs)
- Medicaid eligibility
- Provider tax issues
- Independent assessments
- Stakeholder meetings and focus groups
- Family planning

Clinical and Behavioral Health

Our clinical and behavioral health team helps government agencies design, implement, and monitor programs that enhance the quality of care for covered populations while reducing their financial and operational burden.

Mercer has developed innovative tools to assess the performance of managed care organizations (MCOs), managed behavioral health care organizations, specialty health care companies, and alternative delivery models (enhanced Primary Care Case Management and ACOs). The tools address the areas of access to care, quality improvement, provider management, member services, grievances and appeals, and care management, including utilization review, case management, and chronic care management.

Mercer Government specialty practice's clinical and behavioral health team includes psychiatrists, psychologists, psychiatric nurses, social workers, substance use disorder professionals, pharmacists, and former Centers for Medicare & Medicaid Services (CMS) policy specialists that provide assistance regarding:

- Quality strategy development
- External quality review (EQR)
- On-site MCO/Contractor compliance reviews and reports
- Clinical practice program development and implementation
- Disease/chronic care management program implementation, independent assessment, and evaluation
- Long-term care strategy and integration
- Corrective action plan design, review, and monitoring
- Medical home design and implementation
- Early and Periodic Screening, Diagnosis, and Testing (EPSDT) and outreach and evaluation strategies
- Performance improvement and monitoring strategies including evaluations focused on access, continuity of care, and care management; development and implementation of performance measures; and outcome measurement and reporting
- Provider performance improvement including provider quality-performance monitoring and reporting and provider and pay-for-performance reimbursement strategies
- Procurement/vendor selection
- Contract negotiations
- Waiver and state plan amendment (SPA)

Matching the right resources to a specific project is the cornerstone of our success. We offer the following three managed care administration and oversight projects to confirm our qualifications. We have multiple other examples we can provide if desired.

*In September 2016, Mercer began providing the **Kansas** Department of Health and Environment (KDHE) with consultation and technical assistance to explore and develop standards to implement and operationalize its Medicaid Managed Care program known as KanCare. The work includes conferring and providing guidance to state staff, developing overview documents, developing the program's Request for Proposals (RFPs), including the evaluation process for each proposal, as well as assisting KDHE in conducting readiness reviews and other related activities for KDHE's selected MCOs. The readiness review assistance includes the development, implementation, and utilization of a readiness review tool, completion of a thorough review of the MCOs across a variety of functional areas to assess their readiness and reporting back to KDHE on such findings. The RFP should be published by the end of the year.*

Project Deliverables:

- *Actuarial analysis*
- *Data collection*
- *KanCare RFP*
- *Managed care improvement strategies*
- *Policy development*
- *Project management*
- *Readiness review assessment and reports*
- *RFP evaluation tool*
- *Statistical analysis*
- *Technical assistance and support*

*The Healthy **Louisiana** Program is the State's primary Medicaid Managed Care program. Healthy Louisiana covers integrated behavioral health, medical, pharmacy and non-emergency medical transportation (NEMT) for Children and Families, CHIP children and Disabled Children and Adults. It also provides behavioral health and NEMT for the majority of other Medicaid eligible individuals, even if those individuals do not receive any other services through managed care. Beginning July 2016, Mercer assisted in the design, development, and implementation of a Medicaid expansion. Mercer assisted in the program design and development from 2008 until implementation in 2012. The original managed care program (Bayou Health) included both a full risk component and a shared savings component, and Mercer assisted in the operational implementation for both, including the eventual application of risk adjustment. Specifically, Mercer has provided:*

Program Design and Policy/Waiver Development:

- *Ongoing assistance with the interpretation and implementation of various Federal requirements, including the Medicaid Managed Care Final Rule.*
- *Assistance in program design and 1915(b) waiver development for integration of behavioral health services into Healthy Louisiana and mandatory managed care participation.*
- *Assistance with the drafting of the SPA initially authorizing managed care services.*
- *Reviewing and assisting with the development of managed care provider agreements and operational guides.*
- *Assistance with the CMS negotiations pertaining to the shared savings methodology for the Bayou Health Shared Savings program and waivers for the Louisiana Bayou Health Program (LBHP) and the Greater New Orleans Community Health Connection.*
- *Drafting 1915(b)(c) and 1115 waivers for the LBHP.*
- *Assistance in the development of a child's coordinated system of care for mental health services, including development of SPA.*
- *Assistance with workgroup management related to the managed behavioral health program.*
- *Assistance with the review of State rules regarding managed care implementation.*
- *Assisting in program design and waiver development for a planned Medicaid Managed LTSS (MLTSS) program (not implemented).*

Procurement:

- *Assistance in development of the RFP for the Bayou Health program.*
- *Drafting the RFP for the LBHP.*

*The **Virginia** Joint Legislative Audit & Review Commission (JLARC) retained Mercer from December 2015 to December 2016 to conduct an extensive review of Virginia Medicaid Program (all populations and programs). The 2015 Virginia General Assembly, through House Joint Resolution No. 637, directed JLARC to study the Commonwealth's Medicaid program. The study mandate specifically directed JLARC to examine processes used to determine eligibility, whether the most appropriate services are provided in a cost-effective manner, and to review evidence-based practices and strategies that have been successfully adopted in other states and could be used in the Commonwealth. To assist with the review, JLARC contracted with Mercer to conduct research into specific areas (Task Areas) of interest in order to identify key drivers of cost growth including:*

- *Task Area 1 – Managed Care Cost and Oversight*
- *Task Area 2 – Increasing Enrollment of Disabled Beneficiaries*
- *Task Area 3 – Service Utilization of High-Cost Beneficiaries*
- *Task Area 4 – Long-Term Care Services*
- *Task Area 5 – Community-Based Mental Health Resources*

Mercer measured the cost effectiveness of specific aspects of Virginia's Medicaid program, compared current Virginia Medicaid practices against those of other states, and identified specific practices that could be used to reduce costs while maintaining or improving the quality of care.

For detail on each Task Area, including approach(es) to the research, background information, methodology, task specific findings, and task specific recommendations, please see Appendix A for the report from Mercer titled JLARC Task Summary Report *dated August 15, 2016. This summary was distilled from the full 558-page detailed report provided to JLARC on August 12, 2016. JLARC, in turn, used Mercer's full report to generate public information documents on Managing Spending in Virginia's Medicaid Program including:*

- *Managing Spending in Virginia's Medicaid Program – Report to the Governor and the General Assembly of Virginia (2016) (http://jlarc.virginia.gov/pdfs/reports/Rpt489.pdf)*
- *Summary: Managing Spending in Virginia's Medicaid Program (http://jlarc.virginia.gov/pdfs/summary/Rpt489Sum.pdf)*
- *Recommendations: Managing Spending in Virginia's Medicaid Program (http://jlarc.virginia.gov/pdfs/summary/Rpt489Rec.pdf)*

The latter two are provided as Appendix B and Appendix C.

Waiver Support

The scope of work in the CRFQ identifies specific assistance requested for Waiver support. Mercer offers the following narrative as a summary for meeting the requirements of Waiver support.

Mercer has a wealth of experience and knowledge in assisting states in making policy decisions that are innovative while remaining compliant with Federal and state statutes and regulations. Mercer prides itself on our understanding of CMS policies and regulations. In order to provide exceptional services to our clients, we constantly monitor, track, and analyze CMS publications regarding policies, regulations, and other guidance and implications for state programs. We also have several staff who are former CMS employees and, as such, have first-hand knowledge of the inner workings of CMS. As a result, we have a heightened appreciation of CMS' expectations – we know the right questions to ask and the appropriate timing to engage CMS. This is the added value Mercer provides to our clients and we have been doing so for many years. In light of the potential for dramatic changes in Medicaid at the Federal level and the continually evolving regulatory environment, we believe our experience in this area makes us a uniquely valued partner for upcoming anticipated (and any unexpected) policy changes.

The expertise and background of our staff has allowed us to assist our clients with a wide range of health policy issues. Whether it is providing technical assistance to you as you transition a new policy change into an implemented reality, analyzing the impact of Federal policy changes, or guiding you through the advantages and disadvantages of any necessary Federal authorities to achieve the overarching goals for your Medicaid program, our approach to policy consulting is tailored to you, depending on your specific needs and timing.

As it pertains specifically to the scope of work under this CRFQ, Mercer has extensive experience with 1915(b), 1915(b)/(c), and 1115 waiver financial tests including assistance to the following states for the activities described:

- **Louisiana**. CMS strategy, actuarial, and policy assistance for Louisiana's concurrent Section 1932(a)/1915(b)/1915(c) Healthy Louisiana Medicaid Managed Care program. Assistance included program design, drafting waiver applications (including the cost-effectiveness and cost-neutrality tests and the 1915(b)(3) waiver savings proposals), and Federal waiver negotiations for the initial waiver approvals, amendments and renewals.

- **New Mexico.** Prior to their 1115 Centennial Care Waiver, Mercer developed cost effectiveness for renewals and mid-waiver amendments for their 1915(b) physical health and behavioral health programs, as well as their 1915(b)/(c) coordination of long-term services program.

- **North Carolina**. Actuarial support for the 1915(b)/(c) waivers authorizing the Local Managed Entity-MCO managed care program, including cost projections for the 1915(b) and 1915(c) waivers and consultation on general waiver questions.

- **Ohio.** Development of the MyCare MLTSS demonstration for dual eligibles, which included support for program design and development of the state's 1915(b)/(c) waiver authority and assistance with CMS negotiations.

- **Pennsylvania.** Developing cost effectiveness for the pending 1915(b)/(c) MLTSS waiver program. Mercer has also provided technical assistance over time on the Commonwealth's

Health Choices 1915(b) waiver that provides physical and behavioral health services.

- **Independent Assessor.** Mercer has been the 1915(b) waiver Independent Assessment contractor responsible for assessing the waiver cost-effectiveness projections and reporting for Montana, Ohio, and Texas.

Based on our experience and the specific expertise of the personnel we propose to staff this project with, we are confident we will be able to efficiently and effectively assist the Department of Health and Human Resources (DHHR) in the preparation and amendment of your 1915(b) Waiver Cost Effectiveness projections. Furthermore, Mercer is well-positioned to support DHHR in other waiver activities, if needed, beyond the completion of the 1915(b) cost effectiveness analysis including, among other things:

- Drafting, negotiating, and assisting in the renewal of Waivers
- Drafting SPAs
- Exploring value-based payment (VBP) arrangements
- Drafting managed care contracts
- Updating state regulations based on programmatic changes
- Completing MCO readiness reviews
- Assisting with Federal claiming issues

Mercer's Qualifications – Actuarial Services

As noted previously, Mercer's Government specialty practice is organized into five sectors. The largest is our actuarial sector with 45 credentialed health care actuaries and another 50 professionals in process to become credentialed actuaries. Mercer has been conducting actuarial rate development, certification and related services for Medicaid clients since 1985. With the increased emphasis CMS is placing on actuarial expertise, Mercer is well positioned to assist clients on a variety of topics ranging from traditional capitated rate setting and certification to program development and compliance with new health care delivery models. Mercer Government specialty practice's actuarial team employs professionals that provide assistance regarding:

- Capitation rate development and certification for full-risk Medicaid managed care:
  - Acute care (all populations – children and adults, expansion populations and seniors and persons with disabilities, including dual eligible members)
  - Long-term care and LTSS
  - Behavioral health
  - Developmentally disabled
  - Children with special health care needs
- Cost-effectiveness and budget neutrality analysis for 1915(b), 1915(c), and 1115 waivers
- Health home reimbursement analysis
- ACO shared-savings target development
- Financial analysis related to duals integration projects involving Medicaid and Medicare funding
- Cost evaluation of expansion populations, including the expansion of Medicaid coverage under the ACA
- Focused data-driven efficiency studies related to health plan management of emergency room utilization and potentially preventative inpatient admissions, as well as management of pharmacy

- Health plan reviews for compliance and efficiency benchmarking
- Technical assistance sessions, including contract/rate negotiations with health plans
- Primary Care Case Management program enhancement strategy
- Identification of efficient provider networks
- Ad-hoc analyses of any nature involving health care eligibility, claims/encounter, or financial data

Mercer's Government specialty practice employs more than 280 professionals all dedicated to publicly-funded health care consulting. Among them are 45 credentialed health care actuaries and more than 50 actuarial students.

Our actuarial sector includes 45 credentialed health care actuaries and more than 50 actuarial students. They are supported by a staff of more than 185 others, from CPAs to clinicians.

Mercer's Government specialty practice's current Medicaid portfolio of clients is comprised of 29 states and territories; with the majority (22) of these contracts having a rate-setting component. Among these current clients are 11 of the 14 largest state Medicaid agencies (by Medicaid spending). We are currently the actuary of record, performing actuarial services similar or larger in size and scope to those requested in this CRFQ, for a total of 13 states and the District of Columbia. As the table below illustrates, there is significant variability in the size of the programs for which we are the actuary of record. In aggregate, these 13 states plus the District of Columbia cover more than 23 million individuals through Medicaid MCOs and spend in excess of $100 billion annually on Medicaid MCO capitation – figures that dwarf the totals of all other firms operating in this space.

Of the 14 largest state Medicaid agencies (by Medicaid spending), Mercer holds a contract with 11 of them.

	Medicaid/CHIP Totals[1]	
Mercer State Client	**March 2017 Enrollment**	**FY 2016 Spending**
California	12,376,741	$81,963,494,431
Connecticut	771,588	$7,886,642,781
Delaware	244,571	$1,888,440,200
DC	271,511	$2,773,098,123
Louisiana	1,447,315	$8,637,261,244
Massachusetts	1,662,576	$17,121,704,904
Missouri	977,708	$9,904,675,663
New Jersey	1,801,538	$14,546,679,583
New Mexico	787,110	$5,364,140,357
New York	6,443,857	$62,858,761,866
North Carolina	2,087,729	$12,382,079,896
Oklahoma	810,816	$4,813,304,816

[1] Source: http://www.kff.org/state-category/medicaid-chip/

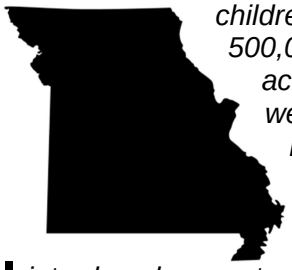
	Medicaid/CHIP Totals[1]	
Mercer State Client	**March 2017 Enrollment**	**FY 2016 Spending**
Pennsylvania	2,951,646	$27,562,165,896
Washington	1,814,997	$10,935,089,585
Total	**34,449,703**	**$268,637,539,345**

We have extensive and current relevant experience providing actuarial services to calculate actuarially sound, risk-adjusted capitation rates for managed care programs for low-income newborns, adolescents, pregnant women, the frail elderly, and disabled persons covered by Medicaid. Our experience includes development of actuarially sound risk-adjusted capitation rates for Medicaid, CHIP, Program for the All-Inclusive Care of the Elderly (PACE), and dual eligible populations across multiple state Medicaid programs.

Our actuarial work includes evaluating and improving data, developing and certifying capitation rates, performing risk adjustment, preparing databooks and robust information sharing packages for CMS and other stakeholders, estimating fiscal (and other) impacts of new programmatic changes arising at both the state and Federal level, and providing comprehensive support with the wavier/waiver renewal process.

Three noteworthy rate-setting projects we have completed recently are presented beginning on the following page.

Missouri's *MO HealthNet Managed Care program covers acute care services for Temporary Assistance For Needy Families (TANF) children and adults, pregnant women, foster care children, and CHIP children. As of January 2017, the program enrolled over 500,000 members, and capitation topped $1.5 billion annually. As Missouri's actuary since managed care was implemented in the East Region in 1993, we have worked with Missouri for more than 20 years to evolve its rate-setting methodology as the managed care program has matured over that time. In particular, Mercer has worked in partnership with Missouri to transition to use encounter data as a primary data source in capitation rate development. Additionally, Mercer has implemented risk adjustment, introduced new rate cells including a Neonatal Intensive Care Unit payment and added efficiency adjustments into capitation rate development to help Missouri improve upon its goal of value-based purchasing. Most recently, Mercer assisted in the design and implementation of a performance withhold program, which was established through the use of a withhold applied to the capitation payments made to the health plan to provide incentives for assuring health plan compliance with contract requirements.*



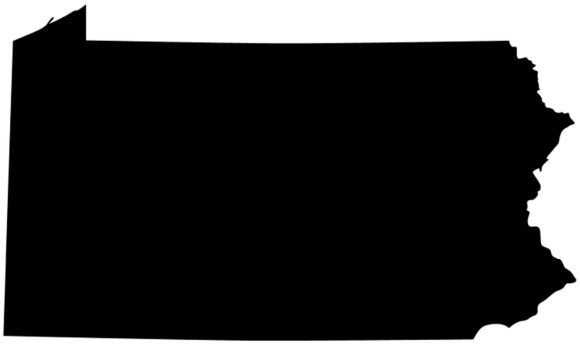
One significant project that demonstrated our ability to help Missouri achieve its goals was to assist with the implementation of statewide managed care. Effective May 1, 2017, Missouri moved its Medicaid program to a statewide basis that resulted in expanding coverage geographically for the current eligibility groups from 54 counties to 115 counties. Missouri's goals with the expansion were to improve access to needed services and the quality of health care services for eligible populations, while controlling the program's rate of cost increase. As Missouri's actuary throughout this change, Mercer's most important responsibilities have included developing actuarially sound capitation rates for each region and working collaboratively with Missouri to design the health plan contract. With the expansion of managed care, enrollment has increased to approximately 730,000 currently. The rate structure, risk mechanisms, and contract Mercer has worked in partnership with Missouri to design and implement over time have allowed Missouri to foster overall program stability through this change.

Mercer also works with the State to provide financial and policy consulting to a variety of other MO HealthNet programs such as the State-administered pharmacy program, the NEMT Program, the Certified Community Behavioral Health Clinics program, the Chronic Care Improvement Program (disease management focus), and the Health Home programs. Additionally, Mercer supports the State in managing their State Plan, 1915(b), and 1115 waiver authorities for their various Medicaid programs.

*The **New Jersey** Medicaid Managed Care program has provided health care coverage to most state Medicaid recipients since 1995, and Mercer has served as New Jersey's contracted actuarial firm supporting the Medicaid Managed Care program and rate development since that time. New Jersey's acute care program currently covers children, parents/caretakers, adults without dependent children, pregnant women, and people who are aged, blind and disabled, including those dually eligible for Medicare. Individuals served through New Jersey's CHIP are also covered under the same managed care contract. The majority of MCOs offer Medicare Advantage D-SNP products and are the only D-SNP carriers in New Jersey serving dual-eligible Medicaid members. Services covered for the above populations include hospital and physician services, prescription drugs, dental care, LTSS, rehabilitative nursing home care, and other health care needs depending on what program a person is eligible for. The State expects to serve an average of 1,638,347 enrollees and over $7.6 billion in total capitation in the acute managed care program during State Fiscal Year 2018.*

Mercer's work with the State of New Jersey extends beyond actuarial rate development and also includes program monitoring, risk adjustment, and waiver support. These responsibilities include assisting the State with design and maintenance of program-specific MCO financial reports and managing a web-based reporting application for MCOs to use when submitting those reports. The financial submissions are reviewed in conjunction with encounter data on a quarterly basis to facilitate ongoing monitoring. Mercer also produces a Strategic Analysis Report that provides the State with a quarterly snapshot of the program performance, cost and utilization of services, and MCO benchmarking among other key statistics. Implementation and management of health-based risk adjustment for all acute care populations, including duals, has helped to ensure appropriate capitation among MCOs. The State regularly turns to Mercer for support as new needs arise, such as the recent development of a new cost-based prospective payment system for certified community behavioral health clinics, implementation of an All Patient Refined-Diagnosis Related Groups prospective inpatient payment system, and beginning discussions about driving more VBP concepts into the program. Mercer has also assisted in the development of Section 1115 waivers, including New Jersey's successful 1115 Comprehensive waiver bid, which laid the groundwork for the ultimate goal of changing New Jersey's health care delivery landscape to ensure a more community and person-centered continuum of care.

*The **Pennsylvania** Department of Human Service's (Department) physical health risk-based managed care program is known as HealthChoices (HC) and was originally implemented in the late 1990s. The HC program currently operates statewide. In general, the HC physical health program provides the majority of physical health services to Medicaid-eligible populations, including: inpatient, physician, pharmacy and other services (e.g., dental, vision, outpatient, etc.). The HC physical health program currently includes Medicaid-eligible populations such as; children up to and including age 20 years old, adults up to and including age 64 at or below 138% of the Federal poverty limit, pregnant women, some women with breast and/or cervical cancer, adults aged 65 and older, and people with disabilities, including blindness as determined under Social Security rules. Currently, dual eligibles (i.e., individuals with Medicare Part A and/or Part B) under age 21 are also enrolled in the HC program. Current HC physical health enrollment is approximately 2.2 million with corresponding revenue payments of about $13 billion annually.*



Mercer has been setting actuarially sound capitation rates for the Department for over 20 years. During this span as Pennsylvania's consulting actuary, our breadth of services has grown significantly beyond our core role of actuarial capitation rate setting. As an extension of our rate-setting work, Mercer also assisted Pennsylvania with implementation of risk adjustment and has calculated risk-adjusted rate factors for the physical health program for over 15 years. Part of our role with risk adjustment includes continuously monitoring the latest in risk-adjustment techniques and refining the process periodically as necessary to react to the changing environment and remain on the forefront of risk adjustment. Mercer has also assisted the Department with evaluating numerous policy and budget initiatives, including but not limited to, statewide expansion of HC, implementation and evaluation of the ACA Medicaid expansion, and most recently Mercer has worked closely with the Department to summarize and analyze impacts of the Medicaid Managed Care Final Rule on Department operations. As part of this effort, Mercer has led a number of compliance planning and strategy sessions with the Department to develop action plans for the various implementation stages. Mercer has also been working with the Department to evaluate impacts on the physical health program related to the pending implementation of the new comprehensive MLTSS program known as Community HealthChoices (CHC), as well as developing actuarially sound capitation rates for the CHC program.

In Summary

Mercer has worked with states at every level of managed care implementation – from established, traditional programs to those that have undertaken massive transformation. The Mercer advantage is that we provide actuarial support customized for each of our clients resulting in program stability, enhanced quality of care, better program management, and cost savings.

As your partner, data capabilities, information, communication, guidance, actuarial soundness, and responsiveness are all critical components of what DHHR can expect from Mercer to support its vulnerable populations.

The Mercer difference:

- **Our corporate and staff experience goes well beyond just actuarial services.**
- **Our multi-state national resources.**
- **Our Medicaid-specific knowledge.**
- **Our insight into the Medicaid data.**
- **Our ability to provide cutting edge, customized services starting with a seamless and timely transition.**

2

REQUIRED STAFFING

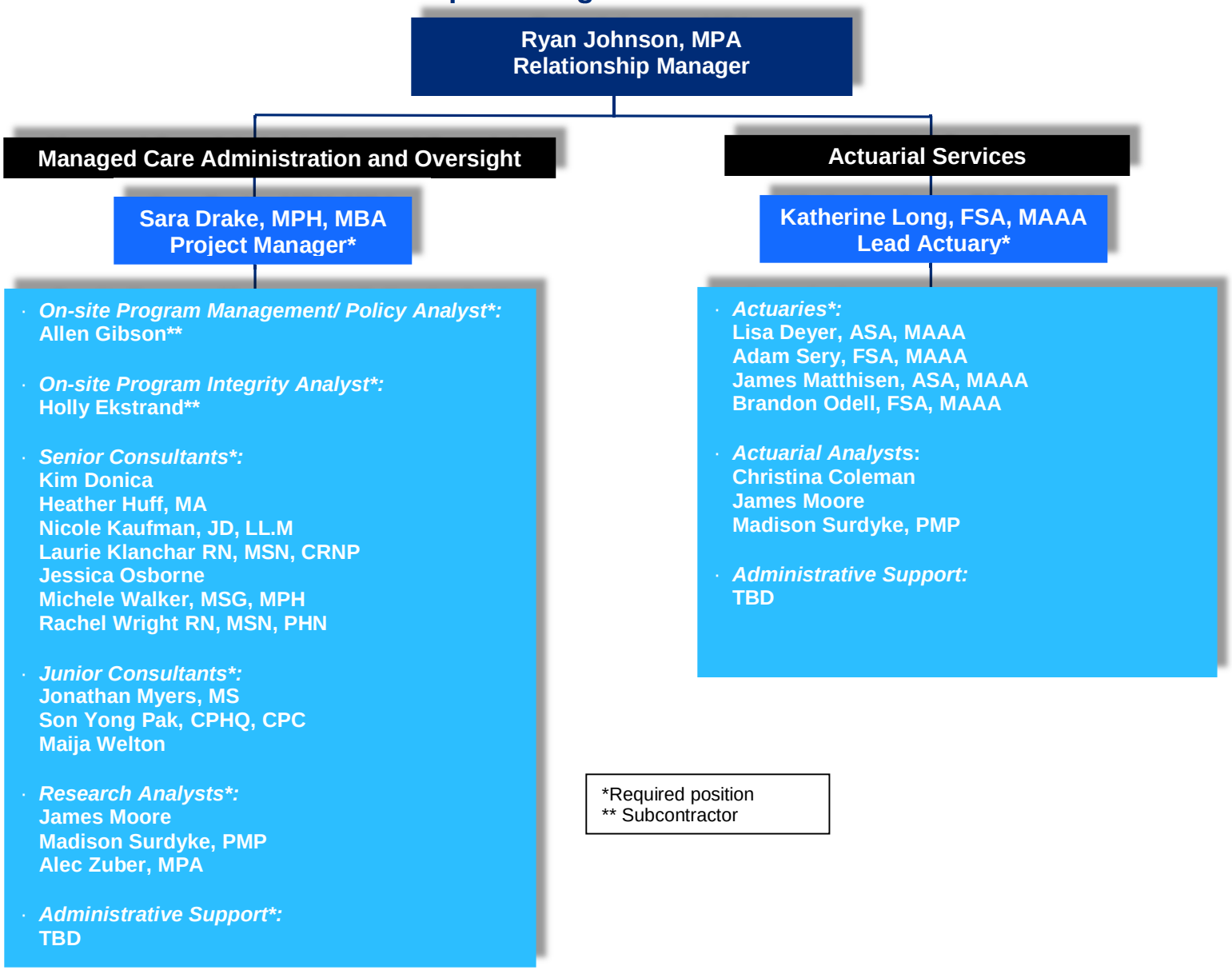
Mercer provides an organization chart for both components of the requested services, managed care program administration and oversight and actuarial services, to aid the reviewer in identifying how the entire project fits together. Following the organizational chart, Mercer identifies specific staff for each component.

Although not a required position, Mercer believes strongly in the need for a senior level single point-of-contact. In addition to the individuals responsible for the day-to-day success of the project – the Project Manager (Sara Drake, MPH, MBA) for Managed Care Oversight and Administration and the Lead Actuary (Katherine Long, FSA, MAAA) for Managed Care Actuarial Services – Mercer proposes Ryan Johnson, MPA as the Client Leader for this engagement.

Ryan is a Principal in our Phoenix office and will be Mercer's overall contract manager for this engagement. In over 15 years with Mercer, Ryan has consulted on Medicaid issues in over 10 different states including Connecticut, the District of Columbia, Massachusetts, and New Jersey. Ryan leads teams of consultants, clinicians, actuaries, analysts, and accountants to ensure Mercer brings the best strategies and solutions. Moreover, having been a part of numerous acute care, long-term care, and uninsured/Medicaid expansion project teams, he is experienced in working with a broad spectrum of Medicaid populations and services. For example, Ryan has served as the overall Contract Manager for Mercer's work with the state of Connecticut for nearly six years. In this role, he has led many large-scale consulting projects including modernizing the states hospital payment system, integrating Medicare/Medicaid dually eligible populations, and establishing a shared savings program based on a patient-centered medical home model under the state's state innovation model initiative. Ryan has assisted many states with strategic planning, stakeholder collaboration, complex reimbursement design, and health plan negotiations.

Ryan is also a risk adjustment subject matter expert and currently leads Mercer's efforts nationally within its Government speciality practice. He has nearly 15 years of experience implementing and maintaining risk adjustment payment systems for over a dozen states. In fact, Ryan led the initial implementation of health-based risk adjustment in California, the District of Columbia, Florida, Massachusetts, Missouri, Ohio, New Jersey, and North Carolina. Ryan's experience includes the development of a customized long-term care risk-adjustment model in New Jersey based on functional assessment data. He is a well-known expert in the field and regularly presents at national conferences on emerging topics.

Proposed Organizational Chart



Managed Care Program Administration and Oversight

3.1 As outlined in Exhibit A, Pricing Page, the vendor shall provide the following staff for Managed Care Program Oversight: Project Management Lead, On-Site Program Management/Policy Analyst, one (1) Senior Consultant, two (2) Junior Consultants, three (3) Research Analysts, Support/Clerical Staff, and an on-site Program Integrity Analyst.

Mercer proposes the following required staff for managed care program administration and oversight:

MANAGED CARE PROGRAM ADMINISTRATION AND OVERSIGHT			
Position	**Name**	**Degree**	**Years of Experience**
Project Management Lead	Sara Drake, MPH, MBA	Master's	10+
On-site Program Management/ Policy Analyst	Allen Gibson*	Bachelor's	15+
On-site Program Integrity Analyst	Holly Ekstrand*	Bachelor's	7+
Senior Consultants	Kim Donica Heather Huff, MA Nicole Kaufman, JD, LL.M Laurie Klanchar, RN, MSN, CRNP Jessica Osborne Michele Walker, MSG, MPA Rachel Wright, RN, MSN, PHN	Bachelor's Master's JD, LL.M Master's Bachelor's Master's Master's	30+ 24+ 8+ 28+ 12+ 24+ 13+
Junior Consultants	Jonathan Myers, MS Son Yong Pak, CPHQ, CPC Maija Welton	Master's Bachelor's Bachelor's	5+ 10+ 11+
Research Analysts	James Moore Madison Surdyke, PMP Alec Zuber, MPA	Bachelor's Bachelor's Master's	2+ 3+ 10+
Support Staff	TBD	TBD	TBD

*Subcontractor

3.2 The vendor, and its subcontractor if used, must provide resumes of key staff that will assist on this project with its bid submission. Key staff for this project shall be defined as the Project Management Lead, On-Site Program Management/Policy Analyst, and Program Integrity Analyst. The Department reserves the right to review and approve initial hiring of key staff and to request replacement staff if felt that needs are not being adequately met.

Resumes for all proposed staff are provided in Appendix A including resumes for the Project Management Lead (Sara Drake, MPH, MBA), subcontracted On-Site Program Management/Policy Analyst (Allen Gibson), and subcontracted Program Integrity Analyst (Holly Ekstrand). A brief narrative of each proposed key staff is provided below following the summary table.

MANAGED CARE PROGRAM ADMINISTRATION AND OVERSIGHT			
Position	**Name**	**Degree**	**Years of Experience**
Project Management Lead	Sara Drake, MPH, MBA	Master's	10+
On-site Program Management/ Policy Analyst	Allen Gibson	Bachelor's	15+
On-site Program Integrity Analyst	Holly Ekstrand	Bachelor's	7+

Sara Drake, MPH, MBA is proposed as Mercer's Project Management Lead. Sara has Master's degrees in Business and Public Health from the University of California Berkeley and has over 10 years of experience working in public and private health care programs. Sara served as the Deputy Director of Health Care Purchasing and Service Delivery at the Minnesota Department of Human Services (DHS) until early 2017 where she worked closely with the Medicaid Director to lead a team of state and vendor staff to successfully conduct a statewide competitive bid managed care procurement for the families and children population enrolled in Medicaid and MinnesotaCare, Minnesota's Basic Health Plan. Sara's team successfully transitioned over 300,000 enrollees to new managed care plans with minimal disruption to patients and providers. In her time at DHS, Sara provided oversight and leadership to health care benefit policy and rate teams, managed care contracting and compliance, and the pharmacy benefit team. Since joining Mercer, Sara has worked closely with actuarial teams to conduct managed care efficiency analyses and provide clinical support in the areas of pharmacy and other health care services. Her resume is provided in Appendix A.

Allen Gibson is proposed as Mercer's subcontracted On-site Program Management/Policy Analyst. Allen has a Bachelor's degree and over 15 years of professional experience. He has an established history of meeting and exceeding departmental and client goals. Most recently, Allen was Project Manager at Maximus and prior to that served as Independent Consultant for CVS Health where he led and completed several management projects including clinical pharmacy call center optimization and a business process improvement project.

Holly Ekstrand is proposed as Mercer's subcontracted On-site Program Integrity Analyst. Holly has a Bachelor's degree and more than seven years of professional experience. In her most recent role Holly served as a Program Integrity Analyst at AdvanceMed Corp. in Nashville, TN. In that role, Holly utilized data analysis techniques to detect aberrancies in Medicare claims data, reviewed information contained in standard claims processing system files to determine provider billing patterns and to detect potential fraudulent or abusive billing practices, and conducted independent investigations resulting from the discovery of situations that potentially involve fraud or abuse.

Mercer recognizes and agrees that the Department reserves the right to review and approve initial hiring of key staff and to request replacement staff if felt that needs are not being adequately met.

3.3 All consultant and research analyst staff must hold at least a Bachelor's degree and have at least two (2) years' experience working with State Medicaid programs.

The proposed consultant and research analyst staff have a Bachelor's or Master's degree and significantly more than two years of experience as noted in the table below. A brief narrative of

each proposed consultant and research analyst is provided following the summary table and resumes are provided in Appendix A.

MANAGED CARE PROGRAM ADMINISTRATION AND OVERSIGHT			
Position	**Name**	**Degree**	**Years of Experience**
Senior Consultants	Kim Donica Heather Huff, MA Nicole Kaufman, JD, LL.M Laurie Klanchar, RN, MSN, CRNP Jessica Osborne Michele Walker, MSG, MPA Rachel Wright, RN, MSN, PHN	Bachelor's Master's JD, LL.M Master's Bachelor's Master's Master's	30+ 24+ 8+ 28+ 12+ 24+ 13+
Junior Consultants	Jonathan Myers, MS Son Yong Pak, CPHQ, CPC Maija Welton	Master's Bachelor's Bachelor's	5+ 10+ 11+
Research Analysts	James Moore Madison Surdyke, PMP Alec Zuber, MPA	Bachelor's Bachelor's Master's	2+ 3+ 10+
Support Staff	TBD	TBD	TBD

Kim Donica is proposed as a Senior Consultant. Kim has a Bachelor's degree in Social Work and more than 30 years of experience. Kim has extensive LTSS clinical and program experience, as well as experience in the development of innovative HCBS initiatives. Kim has helped develop and implement managed care programs in Ohio and has helped develop programs in Florida and Kansas under various CMS authorities (1915(b) and 1115).

Heather Huff, MA is proposed as a Senior Consultant. Heather has a Master's degree and more than 24 years of experience. Heather has served as Project Manager for EQR projects, led clinical quality, clinical efficiency and behavioral health projects for Medicaid/CHIP and long-term care populations. Heather has led performance based contracting, compliance, quality measurement, and management activities for a number of states. Her knowledge of nationally recognized performance measures, accuracy with data analysis, ability to translate data into actionable steps, and project management skills result in exceptional deliverables for client projects.

Nicole Kaufman, JD, LL.M is proposed as a Senior Consultant. Nicole has a JD and LL.M in health law and more than eight years of experience with Medicaid. Prior to joining Mercer in 2016, Nicole was the technical director for Medicaid Managed Care policy at CMS and, in that role, served as a primary author of the Medicaid Managed Care Proposed (2015) and Final Rules (2016). Nicole also specialized in the negotiation of complex section 1115 demonstration projects that involved delivery system integration and delivery system reform incentive payment programs. Since joining Mercer as a Senior Associate, Nicole has worked with several states to revisit, evaluate, and modify Medicaid and CHIP managed care Federal authorities, contracts, procurement documents, policies, and rate-setting practices for compliance with the new Federal regulatory framework.

Laurie Klanchar, RN, MSN, CRNP is proposed as a Senior Consultant. Laurie has a Master's degree in Nursing and more than 28 years of experience. Laurie has extensive Medicaid and

Commercial managed care experience largely focused in the areas of quality management, care management, and operations.

Jessica Osborne is proposed as a Senior Consultant. Jessica has a Bachelor's degree and more than a dozen years of Medicaid Managed Care experience. Jessica has worked with states and their Medicaid health plans in almost all facets of managed care. Jessica has designed RFPs and contracts, led competitive procurement activities, designed and conducted large scale readiness review, led internal and external stakeholder groups, driven program design decisions, drafted SPAs, and negotiated their approval by CMS. Jessica understands operations, policy making, training, and implementation. Jessica's strengths are building consensus and implementing program changes.

Michele Walker, MSG, MPA is proposed as a Senior Consultant. Michele has a Master's degree in Gerontology and Public Administration and more than 24 years of experience. Michele held senior positions for over 17 years within the US Department of Health and Human Services (DHHS), including CMS. Michele has been with Mercer for over six years and has been working on the design and implementation of managed care programs and statewide Medicaid managed long-term care programs. Michele has also worked with many states in preparing and negotiating 1915(b), 1915(c), 1915(b)/(c) concurrent, and 1115 waivers and 1932(a) SPAs. In addition, Michele has been advising clients on changes in Federal laws, regulations and policy in the area of health care reform, managed care, state funding mechanisms, managed care rate setting, fee-for-service (FFS) rate-setting, PACE, long-term care and dual eligibles.

Rachel Wright, RN, MSN, PHN is proposed as a Senior Consultant. Rachel has a Master's degree in Nursing and more than 13 years of experience. Rachel is a former Medicaid Quality Bureau Chief with clinical and operational knowledge. She has experience as an EQR for CMS compliance reviews, as well as health plan and provider audits, desk, and readiness reviews. Rachel has experience with developing and monitoring performance measures. She developed network adequacy studies and reports and led a state workgroup through the process for developing network standards in compliance with the new CMS Final Rule.

Jonathan Myers, MS, Son Yong Pak, CPHQ, CPC, and **Maija Welton** are proposed as Mercer's Junior Consultants.

Jonathan Myers, MS has a Master's of science degree and more than five years of experience conducting policy/operational analyses and monitoring activities for state clients. He has significant project management experience and subject matter expertise conducting statewide analyses, program compliance reviews, MCO procurements, and readiness reviews. He also has conducted multiple state evaluations of Federal compliance of program integrity programs, behavioral health regulations and has supported numerous clients in evaluating and building operational efficiencies in managed care oversight activities.

Son Yong Pak, CPHQ, CPC has over 20 years of experience in Medicaid Managed Care administration and oversight having worked in both a Medicaid agency and MCOs in various capacities. In Son Yong's various roles in MCOs, she was responsible for providing operations oversight and regulatory compliance, overseeing the EPSDT program to include member and provider education and outreach, developing quality improvement work plans to increase performance measures and performing compliance audits.

Maija Welton has a Bachelor's degree in economics and more than 11 years of experience. Maija has approximately three years working with state Medicaid Managed Care programs, much of which has focused on Federal regulatory compliance. She has worked with Delaware, Missouri, New Jersey, and Pennsylvania specifically on Medicaid Managed Care regulatory compliance, which has included contract updates and policy and procedure documents to operationalize regulatory changes.

James Moore, Madison Surdyke, PMP, and **Alec Zuber, MPA** are proposed as Mercer's Research Analysts.

James has a Bachelor's degree in Mathematics and has been at Mercer over two and a half years. While at Mercer, James has worked on Louisiana's managed care project team, assisted in two 1115 waivers, conducted revenue/expenditure reconciliations for New Mexico. In his role, he has performed detailed encounter and claims validations, evaluation, and impact estimation of program changes and general analyses for rate setting.

Madison has a Bachelor's degree, more than three years of experience, and is a designated Project Management Professional (PMP). Madison combines her experience in project management and data analysis to assist in Mercer's Medicaid Managed Care projects.

Alec has a Master's degree in Public Administration and more than 10 years of Medicaid Managed Care experience. Alec began his career as a Support Coordinator for the state of Utah's Division of Services for People with Disabilities—the local Intellectual Disabilities and Related Conditions 1915(c) Medicaid Waiver authority. There he gained certification as a Qualified Intellectual Disabilities Professional and worked to coordinate needs-based service access for Medicaid recipients living with intellectual and development disabilities, as well as acquired and traumatic brain injuries. Most recently, Alec has worked as an actuarial analyst supporting Medicaid Managed Care rate-setting for several major state clients. During this time Alec has supported project work involving: projection of the state of New Jersey's Managed Care eligibility, pricing of New Jersey's non-medical long-term care services care management rates, clinical efficiencies adjustments for the state of New Jersey, and monitoring and analysis of the state of New York's Managed Care pharmacy benefit related encounter experience.

Mercer has deep bench strength from which to draw analytic research. Once we understand your specific needs, we will assign additional research analysts as needed to the project. We commit that each will meet the minimum educational and experiential requirements.

3.4 The vendor must assign a Project Management Lead who will be responsible for ensuring project deliverables are met and communication is maintained with all parties. The Project Management Lead must have at least five (5) years of experience with projects of similar size and complexity within Medicaid.

Mercer proposes **Sara Drake, MPH, MBA** as the Project Management Lead. A brief narrative of Sara's experience was provided in response to Section 3.2 and is reproduced here. Sara has Master's degrees in Business and Public Health from the University of California Berkeley and has over 10 years of experience working in public and private health care programs. Sara served as the Deputy Director of Health Care Purchasing and Service Delivery at the Minnesota DHS until early 2017 where she worked closely with the Medicaid Director to lead a team of state and vendor staff to successfully conduct a statewide competitive bid managed care procurement for the families and children population enrolled in Medicaid and MinnesotaCare, Minnesota's BHP. Sara's team successfully transitioned over 300,000 enrollees to new

managed care plans with minimal disruption to patients and providers. In her time at DHS, Sara provided oversight and leadership to health care benefit policy and rate teams, managed care contracting and compliance, and the pharmacy benefit team. Since joining Mercer, Sara has worked closely with actuarial teams to conduct managed care efficiency analyses and provide clinical support in the areas of pharmacy and other health care services. Her resume is provided in Appendix A.

3.5 The vendor shall provide an on-site Program Integrity Analyst with at least three (3) years of experience in reviewing Medicaid fraud, waste and abuse cases and issuing recovery notices.

Mercer proposes **Holly Ekstrand** as the On-site Program Integrity Analyst. Holly has more than seven years of experience with projects of similar size and complexity. A brief narrative of Holly's experience in reviewing Medicaid fraud, waste, and abuse cases and issuing recovery notices was provided in response to Section 3.2 and is reiterated below:

Holly Ekstrand is proposed as Mercer's subcontracted On-site Program Integrity Analyst. Holly has a Bachelor's degree and more than seven years of professional experience. In her most recent role Holly served as a Program Integrity Analyst at AdvanceMed Corp. in Nashville, TN. In that role, Holly utilized data analysis techniques to detect aberrancies in Medicare claims data, reviewed information contained in standard claims processing system files to determine provider billing patterns and to detect potential fraudulent or abusive billing practices, and conducted independent investigations resulting from the discovery of situations that potentially involve fraud or abuse.

Her resume is provided in Appendix A.

3.6 The vendor must provide an on-site Project Management/Policy Analyst with at least three (3) years of experience in Medicaid Managed Care. Analyst should have at least a Bachelor's degree in a field relevant to the services being rendered, such as Health Care Administration, Finance, Hospital Administration, Public Health, etc.

Mercer proposes **Allen Gibson** as Mercer's subcontracted On-site Project Management/Policy Analyst. Allen has more than 15 years of experience with similar projects. He has a Bachelor's degree. A brief narrative of Allen's experience in Medicaid Managed Care was provided in response to
Section 3.2 and is reiterated here:

Allen Gibson is proposed as Mercer's subcontracted On-site Program Management/Policy Analyst. Allen has a bachelor's degree and over 15 years of professional experience. He has an established history of meeting and exceeding departmental and client goals. Most recently, Allen was Project Manager at Maximus and prior to that served as Independent Consultant for CVS Health where he led and completed several management projects including clinical pharmacy call center optimization and a business process improvement project.

His resume is provided in Appendix A.

3.7 The vendor shall provide references from three individual states for Managed Care Program Oversight services for a state Medicaid agency. The references must be for work performed within the last ten years and must not include a reference from

the West Virginia Department of Health and Human Resources. These documents shall be included with the bid response.

Mercer references for managed care program administration and oversight are provided in Section 3 of our response.

Actuarial Services

3.8 The vendor, and its subcontractor if used, must provide resumes of key staff that will assist on this project with its bid submission. Key staff for this project shall be defined as the Lead Actuary, which the State may request be available on a full-time basis if warranted. The Department reserves the right to request replacement staff if felt that needs are not being adequately met.

Mercer proposes the following required staff for the actuarial services component of the project:

MANAGED CARE ACTUARIAL SERVICES			
Position	**Name**	**Actuarial Designation**	**Years of Experience**
Lead Actuary	Katherine Long, FSA, MAAA	FSA, MAAA	9+
Actuaries	Lisa Deyer, ASA, MAAA James Matthisen, ASA, MAAA Brandon Odell, FSA, MAAA Adam Sery, FSA, MAAA	ASA, MAAA ASA, MAAA FSA, MAAA FSA, MAAA	11+ 32+ 4+ 13+
Actuarial Analysts	Christina Coleman James Moore Madison Surdyke, PMP	N/A N/A N/A	2+ 2+ 3+
Support Staff	TBD	TBD	TBD

Mercer proposes **Katherine Long, FSA, MAAA** as the Lead Actuary. A brief narrative of Katherine's experience is provided below. Her resume is provided in Appendix A.

Katherine is a Fellow in the Society of Actuaries (FSA) and a Member of the American Academy of Actuaries (MAAA). Katherine has more than nine years of professional experience, including experience as an Actuary leading a variety of Medicaid projects. Katherine provides actuarial consulting services to develop capitation rates reflective of the efficient managed care environments expected by state clients and supports her clients during negotiations with contractors and CMS. Katherine's experience includes capitation rate development and actuarial support on various projects for Florida, New Mexico, New York, and Pennsylvania. She has direct experience developing capitation rates for a broad spectrum of Medicaid populations and services, including acute care, behavioral health, and extensive experience with MLTSS programs, including Duals Demonstrations and PACE upper payment limits (UPL).

Most recently, Katherine has supported New York through a dramatic program redesign for their four distinct MLTSS programs. This included providing strategic consulting as the programs tripled in enrollment and identifying opportunities to streamline the capitation rate process to ensure process efficiency and alignment across each program. She has also recently been an

integral part of the team supporting New Mexico's competitive MCO procurement, including advising on available approaches, messaging strategy, bidder's conference support and cost scoring. As the Lead Actuary, Katherine will partner with the Department to understand their program goals and will strive to provide actuarial services that align with these goals.

Mercer recognizes and agrees that the Department may request Katherine be available on a full-time basis if warranted. Mercer also recognizes and agrees that the Department reserves the right to request replacement staff if felt that its needs are not being adequately met.

3.9 In addition, the vendor must make available an adequate number of additional staff actuarial resources to meet the deliverables assigned by the State in the agreed upon timeframe between the State and vendor.

Mercer recognizes and agrees that we will make available an adequate number of additional staff of actuarial resources to meet the deliverables assigned by the Department in the agreed upon timeframe between the Department and Mercer.

Mercer proposes the following additional actuarial resources:

Lisa Deyer, ASA, MAAA is proposed as a Staff Actuary. Lisa is an Associate in the Society of Actuaries (ASA) and an MAAA. Lisa has more than 11 years of professional experience, including experience leading actuarial teams across several Medicaid projects. Lisa provides actuarial consulting services to develop and certify capitation rates reflective of the efficient managed care environments expected by state clients and supports her clients with robust documentation, as well as during negotiations with contractors and CMS. Lisa's experience includes capitation rate development and actuarial support on various projects for the state of New York and the Commonwealth of Pennsylvania. She has direct experience developing capitation rates for acute care populations in Medicaid programs including but not limited to HIV special needs populations and the adult expansion populations. Lisa also has experience reviewing and supporting CHIP rates. Lisa has supported New York through a Medicaid Redesign Program which included significant benefit and population changes to the acute care managed care programs. She has also worked significantly on pharmacy components related to rate setting and budgetary items including analysis of encounter data, programmatic changes, and efficiency adjustments.

James Matthisen, ASA, MAAA is proposed as a Staff Actuary. James is an ASA and an MAAA. James has more than 32 years of experience as an actuary working on Medicaid projects. He has deep experience with programs for government employees, Medicaid, and other low income and uninsured population groups. He has special expertise in health status risk assessment and adjustment, fee schedule development, and VBP. James is frequently involved in projects involving significant data sets, groupers of various types, and complex analytics.

Brandon Odell, FSA, MAAA is proposed as a Staff Actuary. Brandon is an FSA and an MAAA. Brandon has more than four years of experience as an actuary working on Medicaid projects. During his time at Mercer, Brandon has consulted on Medicaid issues in eight states including Louisiana, New Mexico, and New York. He has led the development and certification of actuarially sound capitation rates and benchmarks for multiple programs. He has extensive experience in financial reporting and analysis of Medicaid Managed Care programs.

Adam Sery, FSA, MAAA is proposed as a Staff Actuary. Adam is an FSA and an MAAA. Adam has more than 13 years of experience as an actuary working on Medicaid projects. He has consulted on Medicaid issues in seven different states, including Delaware, Louisiana, Minnesota, Missouri, New York, Ohio, and Pennsylvania. This experience includes Medicaid Managed Care capitation rate development for three of these states and consulting on behavioral health issues or HCBS populations in other states. Adam's experience includes evaluation or incorporation of FFS populations into managed care. Adam is well-versed on leading discussions on behalf of state Medicaid programs with MCOs, as well as other stakeholders, including advocacy groups and associations focused on disabled populations and populations with mental health or substance abuse issues.

Mercer has identified **actuarial analysts** as **Christina Coleman, James Moore, and Madison Surdyke, PMP**. Each holds a college degree and has more than two years of experience. With more than 280 staff, Mercer has deep bench strength from which to draw analytic support. Once we understand your specific needs, we will assign additional analysts as needed to the project.

Resumes for all staff are included in Appendix A.

3.10 The vendor shall provide three individual state references for actuarial services for a state Medicaid agency. The references must be for work performed within the last ten years and must not include a reference from the West Virginia Department of Health and Human Resources. These documents shall be submitted with the bid response.

Mercer references for actuarial services are provided in Section 3 of our response.

3.11 The Lead Actuary and Staff Actuaries shall be Fellows of the Society of Actuaries (FSA) and/or Members of the American Academy of Actuaries. All actuarial staff must have at least five (5) years of experience with pricing major medical health insurance products

The Lead Actuary (**Katherine Long, FSA, MAAA**) is a Fellow of the Society of Actuaries (FSA) and a Member of the American Academy of Actuaries. Staff Actuaries (**Lisa Deyer, ASA, MAAA** and **James Matthisen, ASA, MAAA**) are Associates of the Society of Actuaries (ASA) and Members of the American Academy of Actuaries. Staff Actuaries (**Liz Larson, FSA, MAAA** and **Brandon Odell, FSA, MAAA**) are Fellows of the Society of Actuaries (FSA) and Members of the American Academy of Actuaries. All proposed actuarial staff have at least five years of experience with pricing major medical health insurance products.

Resumes are provided in Appendix A.

3

REFERENCES

3.7 The vendor shall provide references from three individual states for Managed Care Program Oversight services for a state Medicaid agency. The references must be for work performed within the last ten years and must not include a reference from the West Virginia Department of Health and Human Resources. These documents shall be included with the bid response.

3.10 The vendor shall provide three individual state references for actuarial services for a state Medicaid agency. The references must be for work performed within the last ten years and must not include a reference from the West Virginia Department of Health and Human Resources. These documents shall be submitted with the bid response.

Mercer offers three references for managed care program administration and oversight and three references for actuarial services below:

References – Managed Care Program Administration and Oversight

Mercer offers the following references related to managed care program oversight:

Reference #1 – Managed Care Program Administration and Oversight

Delaware Department of Health and Human Services	
Contact Name:	Steve Groff Director, Division of Medicaid & Medical Assistance
Address:	Box 906, Lewis Building 1901 N. DuPont Highway New Castle, DE 19720
Telephone:	+1 302 255 9663
Email Address:	stephen.groff@state.de.us
Contract Period:	2008 – Present
Scope of Services:	In addition to being the actuary of record, Mercer has worked with the State on its managed care administration and oversight including: • Mercer provides financial/accounting services to support the State in reviewing the financial statements (e.g., income statements, balance sheet, profitability statements) submitted quarterly and annually by the risk-based MCOs including making annual updates/revisions to the State's managed care financial reporting requirements. • As part of our ongoing actuarial work, Mercer provides managed care program oversight support in the area of encounter data. Mercer uses encounter data in both actuarial rate development and in doing the periodic

Delaware Department of Health and Human Services	
	diagnostic-based risk adjustment. This work involves monitoring MCO encounter data submissions, producing data volume reports, resolving outstanding data issues and working collaboratively with the State's MMIS vendor to improve the quality and completeness of encounter data. • In 2013/2014, Mercer undertook a project to completely modernize/update the State's entire Medicaid/CHIP managed care contract in support of a re-procurement of the program with new managed care contracts taking effect January 1, 2015. • Our team provides extensive health care policy support in support of the managed care program including technical assistance and project management support in helping the State come into compliance with the Medicaid/CHIP Managed Care Final Rule and related federal regulations including strategic advice on issues related to Institutions for Mental Diseases (IMDs). Our health policy specialists have also developed 1115 waiver strategy and supporting documents on behalf of the State including a managed LTSS concept paper, 1115 waiver amendment and 1115 waiver extension. • Facilitated an on-site strategy meeting to evaluate the various methods available to the State to refine the way in which behavioral health/substance abuse services are delivered and financed. As a byproduct of this strategy session, Mercer continues to work with the State to implement and monitor a new payment methodology and provider fees for Assertive Community Treatment services and Group Home services along with a 1915(i) community based waiver application targeted at adults with serious and persistent mental illness. Presently, Mercer is undertaking a behavioral health landscape review to assess strengths and weaknesses of the current delivery system. • Mercer is currently the External Quality Review Organization (EQRO) for the State's managed Medicaid/CHIP and long-term services and supports (MLTSS) program. Responsibilities under this contract include development of written Quality Management Strategy, completion of EQR compliance reviews and reporting, validation of performance improvement projects, validation of the health plans' performance measures as well as development and technical assistance in the maintenance of the State's Quality and Care Management Monitoring Report (QCMMR). The QCMMR acts as the states early warning system as part of its management and oversight operations. Mercer has also conducted many optional activities under the EQRO contract including conducting focused studies on fidelity to practice guidelines for childhood overweight and obesity management and evaluating potential over-/under-utilization of home and community based services post MLTSS implementation, conducting surveys to support development of the State's HCBS Transition Plan and providing technical assistance to the managed care contractors on numerous topics including network adequacy, care coordination and case management and rapid-cycle process improvement. • Mercer is the key consultant supporting Delaware in becoming one of the first states to receive a final CMS approval of their HCBS Statewide Transition Plan.

Reference #2 – Managed Care Program Administration and Oversight

New Mexico Human Services Department	
Contact Name:	Nancy Smith Leslie Medicaid Director
Address:	2025 South Pacheco Santa Fe, NM
Telephone:	+1 505 827 7704
Email Address:	nancy.smith-leslie@state.nm.us
Contract Period:	1997 – Present
Scope of Services:	Mercer works with the State of New Mexico, Human Services Department (HSD), Medical Assistance Division on several projects. Services include or have included: • Assisted HSD with the design, implementation and ongoing monitoring of the Centennial Care program including: - 1115 waiver application and budget neutrality - Develop materials and facilitate discussions with stakeholders - Managed care contract development and procurement - Managed care plan readiness reviews - Assisted HSD develop administrative rules and managed care policy - Assisted HSD develop and implement Health Home pilot • Assisted HSD identify and address the changes to contracts and policy impacted by the 2016 Medicaid Managed Care rule. • Developed quarterly encounter and financial dashboards for use by HSD in committee meetings. • Assisted HSD develop 1915(b) waiver cost effectiveness for the physical and behavioral health programs. • Assisted HSD develop the Section 1915(b)/(c) waiver cost effectiveness for the long-term care program. • Assisted HSD develop the CHIPRA waiver for their adult expansion program. • Identification of clinical efficiency opportunities within the managed care programs. • Assisted HSD develop value-based purchasing strategy and implement in managed care.

Reference #3 – Managed Care Program Administration and Oversight

Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services	
Contact Name:	Terry L. Mardis Acting Director, Bureau of Financial Management and Administration
Address:	Office of Mental Health and Substance Abuse Services Commonwealth Tower, 12th Floor P.O. Box 2675 Harrisburg, PA 17105
Telephone:	+1 717 772 7358
Email Address:	tmardis@pa.gov

Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services	
Contract Period:	1995 – Present
Scope of Services:	In addition to being the actuary of record for both the physical and behavioral health programs, Mercer provides extensive clinical and policy service including: • Mercer provides extensive policy assistance to the Department, including the impact of the CMS Medicaid Managed Care Final Rule. This assistance includes communication with the MCOs of Final Rule implications, implementation of minimum loss rate tracking and calculation, and quantification of the regulations related to Federal match on admissions to the Institute for Mental Diseases. • Mercer provides policy and financial analysis support to the Department with waiver applications and renewals, and helps explore waiver options for various initiatives. • Mercer provides policy, clinical, and financial support to the Department on compliance with the Mental Health Parity and Addiction Equity Act. • Mercer assisted the Department with its Certified Community Behavioral Health Clinics demonstration grant, quantifying the impact, providing clinical support, and helping write the actual application. After CMS selected the Commonwealth as a grant winner, Mercer continues to assist the Commonwealth with the financial side of implementing the initiative. • Mercer provides policy, clinical and financial implications support to the Department for complex program changes, such as changes to coverage of Applied Behavioral Analysis services and physical health/behavioral health integration initiatives. Project deliverables have included: • 1115 and 1915(b) waiver design/renewal • Competitive bidding/rate negotiations with MCOs Encounter data reporting • Financial reporting and data housing • Managed care cost efficiency analyses • Policy development • Provider outcome analysis • Web-based data collection site • Strategy development • Policy assistance with regulatory changes

References – Actuarial Services

Mercer offers the following references related to actuarial services:

Reference #1 – Actuarial Services

Delaware Department of Health and Human Services	
Contact Name:	Steve Groff Director, Division of Medicaid & Medical Assistance
Address:	Box 906, Lewis Building 1901 N. DuPont Highway New Castle, DE 19720
Telephone:	+1 302 255 9663

Delaware Department of Health and Human Services	
Email Address:	stephen.groff@state.de.us
Contract Period:	2008 – Present
Scope of Services:	As Delaware's actuary, Mercer performs numerous tasks for the State's Medicaid/CHIP managed care program including: • Actuarially-sound capitation rates for TANF, Supplemental Security Income, Title XXI, Kids, Adults and Pregnant Women • Actuarially-sound capitation rates for nursing facility/HCBS populations receiving Medicaid LTSS including Medicare/Medicaid dual eligible populations • Actuarially-sound capitation rates for pre-ACA and post-ACA adult expansion populations • Numerous CMS actuarial rate certifications • Rate development presentations to the MCOs and financial rate negotiation support to the State • Calculation of risk sharing/risk pool premiums for targeted issues Depending upon the rating period, Mercer's rate-setting methodology has used FFS, encounter data and/or financial data for the base of the rate development and the process includes many steps such as data modeling, policy/program change adjustments, trend analyses, managed care administration/gain and risk adjustment. Previous policy changes accounted for the Health Insurance Providers Fee payment, pharmacy carve-in, nursing facility mandated fee changes, MLTSS expansion, ACA Section 1202 physician fee increase, and alternative benefit package for adult expansion populations. Mercer also analyzes family planning expenses, in lieu of services for Institutions for Mental Disease, ACA Section 4106 preventive services, institutional FFS UPL issues and provides provider/premium tax strategic advice. Mercer's actuaries, pharmacists, data consultants, and Medicaid/health policy experts collaborate to offer the State trusted advice and options. Together with the State staff, Mercer researched, developed, and successfully implemented diagnostic-based risk-adjustment into the capitated MCO program using the CDPS+Rx risk adjustment model. This required numerous policy and strategic planning discussions with State staff and meetings with the MCOs to explain the process and related policies. In support of the risk adjustment process, Mercer collects and processes person-level encounter, FFS data, and eligibility data provided by the State. In addition to diagnostic-based risk adjustment, Mercer worked with the State to implement a pharmacy risk sharing arrangement related to Hepatitis C, cystic fibrosis and hemophiliac drug treatments, a high dollar under age risk pool arrangement, as well as evaluate differences in the MCOs' provider network composition that contribute to differences in risk not otherwise accounted for in other adjustments. Mercer also supports Delaware's PACE with development of the UPLs/amounts otherwise paid, as well as PACE policy support.

Reference #2 – Actuarial Services

New Mexico Human Services Department	
Contact Name:	Nancy Smith Leslie Medicaid Director
Address:	2025 South Pacheco Santa Fe, NM
Telephone:	+1 505 827 7704
Email Address:	nancy.smith-leslie@state.nm.us
Contract Period:	1997 – Present
Scope of Services:	Mercer works with the State of New Mexico, Human Services Department (HSD), Medical Assistance Division on several projects. Services include or have included: • Develop capitation rates for their Medicaid Managed Care programs that include: physical health, behavioral health, LTSS, and Medicaid expansion adults • Assist HSD in annual and mid-year capitation rate payment change discussions with each MCO • Implemented risk-adjusted rates for calendar year 2017 for physical health and expansion adults • Perform analysis of managed care plans' encounter and financial data for completeness and accuracy and incorporating the data into the development of rates • Developed quarterly and annual financial reporting templates and instructions for Medicaid Managed Care plans • Assist HSD assess the impact of numerous programmatic changes, which includes making financial impact estimates and addressing operational and implementation effects • Assist HSD with MCO reconciliations and risk-corridor evaluations

Reference #3 – Actuarial Services

Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services (OMHSAS)	
Contact Name:	Terry L. Mardis Acting Director, Bureau of Financial Management and Administration
Address:	Office of Mental Health and Substance Abuse Services Commonwealth Tower, 12th Floor P.O. Box 2675 Harrisburg, PA 17105
Telephone:	+1 717 772 7358
Email Address:	tmardis@pa.gov
Contract Period:	1995 – Present
Scope of Services:	Mercer's actuarial services for Pennsylvania include: • Mercer establishes behavioral health capitation rate ranges for the mandatory managed care program (HealthChoices). Mercer assists with

Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services (OMHSAS)	
	policy development, financial analyses, program monitoring, and data collection. • Mercer develops behavioral health capitation rates, negotiates capitation payments with MCOs, produces data and rate summaries for MCOs and related entities, and assists in the waiver submission/renewal process. Mercer develops behavioral health capitation rates for Pennsylvania using a variety of data sources including MCO encounter data, MCO financial reports, and ad hoc data sources such as provider surveys. Mercer has written numerous CMS actuarial rate certification reports and all behavioral health rates have been approved by CMS/Office of the Actuary after thorough review. • Mercer incorporates efficiency analyses/adjustments directly into capitation rate setting such as analyzing hospital readmission rates and cost effectiveness of alternative payment arrangements. Mercer analyzes crossover impact with joint physical and behavioral health integration programs as well as the financial impact to the behavioral health managed care program as a result of the Commonwealth's mandatory MLTSS program. • Mercer assists with the analysis of program changes, including incorporation of clinical feedback as appropriate. A sample of recent changes included the acuity and rate of enrollment of the Medicaid expansion population, quantifying the impact of mandated third party insurer payments for certain eligible individuals and services, and analyzing the financial impact of new provider payment policies, including for FQHCs and a state initiative related to centers of excellence in dealing with the opioid epidemic. Project deliverables have included: • 1115 and 1915(b) waiver design/renewal • Actuarially-sound behavioral health capitation rates • CMS rate certification report • CMS negotiation • Competitive bidding/rate negotiations with MCOs Encounter data reporting • Financial reporting and data housing • Managed care cost efficiency analyses • Provider outcome analyses • Web-based data collection site • Strategy development • Policy assistance with regulatory changes

4

REQUIRED FORMS

Mercer Health & Benefits LLC (Mercer) provides the following forms related to Centralized Request for Quotation (CRFQ) 0511 BMS1800000002 for Medicaid Managed Care Rate Setting/Medicaid Managed Care Program Administration for the West Virginia Department of Health and Human Resources (Department or DHHR) Bureau for Medical Services (BMS):

- Signed Cover Pages
- Addendum Acknowledgement Page for Addendums 1 – 7
- Disclosure of Interested Parties to Contracts
- Purchasing Affidavit
- Vendor Preference Certificate
- Proof of Registration – West Virginia Purchasing Division
- Requested Exceptions to the Terms and Conditions

Proc Folder: 360501

Doc Description: RFQ for Medicaid Managed Care Rate Setting/Program Admin

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2017-09-06	2017-10-05 13:30:00	CRFQ 0511 BMS1800000002	1

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:

Mercer Health & Benefits LLC
Contact: Ryan Johnson, Principal
2325 E. Camelback Road, Suite 600
Phoenix, AZ 85016
+1 602 522 8576

FOR INFORMATION CONTACT THE BUYER

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

Signature X **FEIN # 34-2015463** **DATE October 30, 2017**

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

Proc Folder: 360501

Doc Description: Medicaid Managed Care Rate Setting/Program Admin-Addendum #1

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2017-09-19	2017-10-05 13:30:00	CRFQ 0511 BMS1800000002	2

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:

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Signature X **FEIN # 34-2015463** **DATE October 30, 2017**

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

Proc Folder: 360501

Doc Description: Medicaid Managed Care Rate Setting/Program Admin-Addendum #2

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2017-09-22	2017-10-12 13:30:00	CRFQ 0511 BMS1800000002	3

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:

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Phoenix, AZ 85016
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Signature X **FEIN # 34-301-5463** **DATE October 30, 2017**

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

Proc Folder: 360501

Doc Description: Medicaid Managed Care Rate Setting/Program Admin-Addendum #3

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2017-10-06	2017-10-12 13:30:00	CRFQ 0511 BMS1800000002	4

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:

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+1 602 522 8576

FOR INFORMATION CONTACT THE BUYER

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

Signature X **FEIN # 34-2015463** **DATE October 30, 2017**

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

Proc Folder: 360501

Doc Description: Medicaid Managed Care Rate Setting/Program Admin-Addendum #4

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2017-10-06	2017-10-24 13:30:00	CRFQ 0511 BMS1800000002	5

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:

Mercer Health & Benefits LLC
Contact: Ryan Johnson, Principal
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Phoenix, AZ 85016
+1 602 522 8576

FOR INFORMATION CONTACT THE BUYER

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

Signature X **FEIN # 334-2015463 DATE October 30, 2017**

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

Proc Folder: 360501

Doc Description: Medicaid Managed Care Rate Setting/Program Admin-Addendum #5

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2017-10-18	2017-10-31 13:30:00	CRFQ 0511 BMS1800000002	6

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:

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FOR INFORMATION CONTACT THE BUYER

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Signature X **FEIN # 34-2015463** **DATE October 30, 2017**

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

Proc Folder: 360501

Doc Description: Medicaid Managed Care Rate Setting/Program Admin-Addendum #6

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2017-10-20	2017-10-31 13:30:00	CRFQ 0511 BMS1800000002	7

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:

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Phoenix, AZ 85016
+1 602 522 8576

FOR INFORMATION CONTACT THE BUYER

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

Signature X **FEIN # 342015463** **DATE October 30, 2017**

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

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:

Mercer Health & Benefits LLC
Contact: Ryan Johnson, Principal
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Phoenix, AZ 85016
+1 602 522 8576

FOR INFORMATION CONTACT THE BUYER

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

Signature X **FEIN # 34-2015463** **DATE October 30, 2017**

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

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)

[X] Addendum 1	[X] Addendum 6
[X] Addendum 2	[X] Addendum 7
[X] Addendum 3	[ ] Addendum 8
[X] Addendum 4	[ ] Addendum 9
[X] Addendum 5	[ ] Addendum 10

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

Mercer Health & Benefits LLC
Company

Authorized Signature

October 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.

Disclosure of Interested Parties to Contracts

Contracting business entity: Mercer Health & Benefits LLC

Address: 2325 E. Camelback Road, Suite 600, Phoenix, AZ 85016

Contracting business entity's authorized agent: Ryan Johnson, MPA, Principal

Address: 2325 E. Camelback Road, Suite 600, Phoenix, AZ 85016

Number or title of contract: CRFQ 0511 BMS1800000002

Type or description of contract: Managed Care Admin/Actuarial Services

Governmental agency awarding contract: Dept. of Health & Human Resources

Names of each Interested Party to the contract known or reasonably anticipated by the contracting business entity *(attach additional pages if necessary)*:

Allen Gibson (subcontractor)

Holly Ekstrand (subcontractor)

Signature: _____ Date Signed: October 30, 2017

☐ Check here if this is a Supplemental Disclosure.

Verification

State of Arizona, County of Maricopa:

I, Francine Tarnow, 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 30th day of October, 2017.

FRANCINE F TARNOW
NOTARY PUBLIC, ARIZONA
MARICOPA COUNTY
My Commission Expires
July 31, 2020

_____
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: Mercer Health & Benefits LLC

Authorized Signature: _____ Date: October 30, 2017

State of Arizona

County of Maricopa, to-wit:

Taken, subscribed, and sworn to before me this 30th day of October, 2017.

My Commission expires _____, 20___.

AFFIX SEAL HERE

FRANCINE F TARNOW
NOTARY PUBLIC, ARIZONA
MARICOPA COUNTY
My Commission Expires
July 31, 2020

NOTARY PUBLIC _____

Purchasing Affidavit (Revised 07/07/2017)

Approved / Revised
12/16/15

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: Mercer Health & Benefits LLC **Signed:**

Date: October 30, 2017 **Title:** Principal

**Check any combination of preference consideration(s) indicated above, which you are entitled to receive.*

WV Oasis

Transaction Number: 20170919107802

Status: CompletedOk

Amount: $125.00

Company Name: Mercer Health & Benefits LLC

Name: Terri Goens

Address: 3036 E. Sierra Street

Phoenix AZ 85028

Phone: 6025226527

e-Mail: terri.goens@mercer.com

Card Holder: Terri Goens

Card Type: American Express

Card: xxxxxxxxxxx1005

"Your bank statement will show WV Treasury for this transaction

GENERAL TERMS AND CONDITIONS:

1. CONTRACTUAL AGREEMENT: Issuance of a Award Document signed by the Purchasing Division Director, or his designee, and approved as to form by the Attorney General's office constitutes acceptance of this Contract made by and between the State of West Virginia and the Vendor. Vendor's signature on its bid signifies Vendor's agreement to be bound by and accept the terms and conditions contained in this Contract **as modified by its bid**.

2. DEFINITIONS: As used in this Solicitation/Contract, the following terms shall have the meanings attributed to them below. Additional definitions may be found in the specifications included with this Solicitation/Contract.

2.1. "Agency" or **"Agencies"** means the agency, board, commission, or other entity of the State of West Virginia that is identified on the first page of the Solicitation or any other public entity seeking to procure goods or services under this Contract.

2.2. "Bid" or **"Proposal"** means the vendors submitted response to this solicitation.

2.3. "Contract" means the binding agreement that is entered into between the State and the Vendor to provide the goods or services requested in the Solicitation.

2.4. "Director" means the Director of the West Virginia Department of Administration, Purchasing Division.

2.5. "Purchasing Division" means the West Virginia Department of Administration, Purchasing Division.

2.6. "Award Document" means the document signed by the Agency and the Purchasing Division, and approved as to form by the Attorney General, that identifies the Vendor as the contract holder.

2.7. "Solicitation" means the official notice of an opportunity to supply the State with goods or services that is published by the Purchasing Division.

2.8. "State" means the State of West Virginia and/or any of its agencies, commissions, boards, etc. as context requires.

2.9. "Vendor" or **"Vendors"** means any entity submitting a bid in response to the Solicitation, the entity that has been selected as the lowest responsible bidder, or the entity that has been awarded the Contract as context requires.

3. CONTRACT TERM; RENEWAL; EXTENSION: The term of this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below:

× **Term Contract**

Initial Contract Term: This Contract becomes effective on __award__ and extends for a period of one (1) _____.year(s).

Renewal Term: This Contract may be renewed upon the mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). Any request for renewal should be submitted to the Purchasing Division thirty (30) days prior to the expiration date of the initial contract term or appropriate renewal term. A Contract renewal shall be in accordance with the terms and conditions of the original contract. Renewal of this Contract is limited to three successive one (1) year periods or multiple renewal periods of less than one year, provided that the multiple renewal periods do not exceed thirty-six (36) months in total. Automatic renewal of this Contract is prohibited. Notwithstanding the foregoing, Purchasing Division approval is not required on agency delegated or exempt purchases. Attorney General approval may be required for vendor terms and conditions.

Delivery Order Limitations: In the event that this contract permits delivery orders, a delivery order may only be issued during the time this Contract is in effect. Any delivery order issued within one year of the expiration of this Contract shall be effective for one year from the date the delivery order is issued. No delivery order may be extended beyond one year after this Contract has expired.

¨ **Fixed Period Contract:** This Contract becomes effective upon Vendor's receipt of the notice to proceed and must be completed within _____ days.

¨ **Fixed Period Contract with Renewals:** This Contract becomes effective upon Vendor's receipt of the notice to proceed and part of the Contract more fully described in the attached specifications must be completed within _____ days.

Upon completion, the vendor agrees that maintenance, monitoring, or warranty services will be provided for one year thereafter with an additional successive one year renewal periods or multiple renewal periods of less than one year provided that the multiple renewal periods do not exceed _____ months in total. Automatic renewal of this Contract is prohibited.

¨ **One Time Purchase:** The term of this Contract shall run from the issuance of the Award Document until all of the goods contracted for have been delivered, but in no event will this Contract extend for more than one fiscal year.

¨ **Other:** See attached.

4. NOTICE TO PROCEED: Vendor shall begin performance of this Contract immediately upon ~~receiving notice to proceed~~ **Vendor and the Agency having executed the Contract** unless otherwise instructed by the Agency. ~~Unless otherwise specified, the fully executed Award Document will be considered notice to proceed.~~

5. QUANTITIES: The quantities required under this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below.

¨ **Open End Contract:** Quantities listed in this Solicitation are approximations only, based on estimates supplied by the Agency. It is understood and agreed that the Contract shall cover the quantities actually ordered for delivery during the term of the Contract, whether more or less than the quantities shown.

× **Service:** The scope of the service to be provided will be more clearly defined in the specifications included herewith.

¨ **Combined Service and Goods:** The scope of the service and deliverable goods to be provided will be more clearly defined in the specifications included herewith.

¨ **One Time Purchase:** This Contract is for the purchase of a set quantity of goods that are identified in the specifications included herewith. Once those items have been delivered, no additional goods may be procured under this Contract without an appropriate change order approved by the Vendor, Agency, Purchasing Division, and Attorney General's office.

6. EMERGENCY PURCHASES: The Purchasing Division Director may authorize the Agency to purchase goods or services in the open market that Vendor would otherwise provide under this Contract if those goods or services are for immediate or expedited delivery in an emergency. Emergencies shall include, but are not limited to, delays in transportation or an unanticipated increase in the volume of work. An emergency purchase in the open market, approved by the Purchasing Division Director, shall not constitute of breach of this Contract and shall not entitle the Vendor to any form of compensation or damages. This provision does not excuse the State from fulfilling its obligations under a One Time Purchase contract.

7. REQUIRED DOCUMENTS: All of the items checked below must be provided to the Purchasing Division by the Vendor as specified below.

¨ **BID BOND (Construction Only):** Pursuant to the requirements contained in W.Va. Code§ 5-22-1(c), All Vendors submitting a bid on a construction project shall furnish a valid bid bond in the amount of five percent (5%) of the total amount of the bid protecting the State of West Virginia. The bid bond must be submitted with the bid.

¨ **PERFORMANCE BOND:** The apparent successful Vendor shall provide a performance bond in the amount of_____. The performance bond must be received by the Purchasing Division prior to Contract award. On construction contracts, the performance bond must be 100% of the Contract value.

¨ **LABOR/MATERIAL PAYMENT BOND:** The apparent successful Vendor shall provide a labor/material payment bond in the amount of 100% of the Contract value. The labor/material payment bond must be delivered to the Purchasing Division prior to Contract award.

In lieu of the Bid Bond, Performance Bond, and Labor/Material Payment Bond, the Vendor may provide certified checks, cashier's checks, or irrevocable letters of credit. Any certified check, cashier's check, or irrevocable letter of credit provided in lieu of a bond must be of the same amount and delivered on the same schedule as the bond it replaces. A letter of credit submitted in lieu of a performance and labor/material payment bond will only be allowed for projects under $100,000. Personal or business checks are not acceptable. Notwithstanding the foregoing, West Virginia Code§ 5-22-1 (d) mandates that a vendor provide a performance and labor/material payment bond for construction projects. Accordingly, substitutions for the performance and labor/material payment bonds for construction projects is not permitted.

¨ **MAINTENANCE BOND:** The apparent successful Vendor shall provide a two (2) year maintenance bond covering the roofing system. The maintenance bond must be issued and delivered to the Purchasing Division prior to Contract award.

x **LICENSE(S) *I* CERTIFICATIONS *I* PERMITS:** In addition to anything required under the

Section entitled Licensing, of the General Terms and Conditions, the apparent successful Vendor shall furnish proof of the following licenses, certifications, and/or permits prior to Contract award, in a form acceptable to the Purchasing Division.

þ Fellows of the Society of Actuaries
Member of the American Academy of Actuaries

The apparent successful Vendor shall also furnish proof of any additional licenses or certifications contained in the specifications prior to Contract award regardless of whether or not that requirement is listed above.

8. INSURANCE: The apparent successful Vendor shall furnish proof of the insurance identified by a checkmark below prior to Contract award. Subsequent to contract award, and prior to the insurance expiration date, Vendor shall provide the Agency with proof that the insurance mandated herein has been continued. Vendor must also provide Agency with ~~immediate~~ **prompt** notice of any changes in its insurance policies mandated herein, including but not limited to, policy cancelation, policy reduction, or change in insurers. The insurance coverages identified below must be maintained throughout the life of this contract. The apparent successful Vendor shall also furnish proof of any additional insurance requirements contained in the specifications prior to Contract award regardless of whether or not that insurance requirement is listed in this section.

Vendor must maintain:

x **Commercial General Liability Insurance** in at least an amount of:
1,000,000.00 per occurrence

x **Automobile Liability Insurance** in at least an amount of: 1,000,000.00 per occurrence

x **Professional/Malpractice/Errors and Omission Insurance** in at least an amount of:
10,000,000,.00 per ~~occurrence~~**claim**

x **Commercial Crime and Third Party Fidelity Insurance** in an amount of:
5,000,000.00 per ~~occurrence~~**loss**

¨ **Cyber Liability Insurance** in an amount of: _____

¨ **Builders Risk Insurance** in an amount equal to 100% of the amount of the Contract.

9. WORKERS' COMPENSATION INSURANCE: The apparent successful Vendor shall comply with laws relating to workers compensation, shall maintain workers' compensation insurance when required, and shall furnish proof of workers' compensation insurance upon request.

10. LITIGATION BOND: The Director reserves the right to require any Vendor that files a protest of an award to submit a litigation bond in the amount equal to one percent of the lowest bid submitted or $5,000, whichever is greater. The entire amount of the bond shall be forfeited if the hearing officer determines that the protest was filed for frivolous or improper purpose, including but not limited to, the purpose of harassing, causing unnecessary delay, or needless expense for the Agency. All litigation bonds shall be made payable to the Purchasing Division. In lieu of a bond, the

protester may submit a cashier's check or certified check payable to the Purchasing Division. Cashier's or certified checks will be deposited with and held by the State Treasurer's office. If it is determined that the protest has not been filed for frivolous or improper purpose, the bond or deposit shall be returned in its entirety.

11. LIQUIDATED DAMAGES: Vendor shall pay liquidated damages in the amount of N/A
for N/A
This clause shall in no way be considered exclusive and shall not limit the State or Agency's right to pursue any other available remedy.

12. ACCEPTANCE: Vendor's signature on its bid, or on the certification and signature page, constitutes an offer to the State that cannot be unilaterally withdrawn, signifies that the product or service proposed by vendor meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise indicated, and signifies acceptance of the terms and conditions contained in the Solicitation **as modified by its bid** unless otherwise indicated.

13. PRICING: The pricing set forth herein is firm for the life of the Contract, unless specified elsewhere within this Solicitation/Contract by the State. A Vendor's inclusion of price adjustment provisions in its bid, without an express authorization from the State in the Solicitation to do so, may result in bid disqualification.

14. PAYMENT: Payment in advance is prohibited under this Contract. Payment may only be made after the delivery and acceptance of goods or services. The Vendor shall submit invoices, in arrears. **Vendor's invoices should be paid within 30 days of receipt.**

15. PURCHASING CARD ACCEPTANCE: The State of West Virginia currently utilizes a Purchasing Card program, administered under contract by a banking institution, to process payment for goods and services. The Vendor must accept the State of West Virginia's Purchasing Card for payment of all orders under this Contract unless the box below is checked.

¨ Vendor is not required to accept the State of West Virginia's Purchasing Card as payment for all goods and services.

16. TAXES: The Vendor shall pay any applicable sales, use, personal property or any other taxes arising out of this Contract and the transactions contemplated thereby. The State of West Virginia is exempt from federal and state taxes and will not pay or reimburse such taxes.

17. ADDITIONAL FEES: Vendor is not permitted to charge additional fees or assess additional charges that were not either expressly provided for in the solicitation published by the State of West Virginia or included in the unit price or lump sum bid amount that Vendor is required by the solicitation to provide. Including such fees or charges as notes to the solicitation may result in rejection of vendor's bid. Requesting such fees or charges be paid after the contract has been awarded may result in cancellation of the contract.

18. FUNDING: This Contract shall continue for the term stated herein, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise made available, this Contract becomes void and of no effect beginning on July 1 of the fiscal year for which funding has not been appropriated or otherwise made

available. **The Agency shall promptly inform Vendor if such funding has not been approved.**

19. CANCELLATION: The Purchasing Division Director reserves the right to cancel this Contract immediately upon **30 days** written notice to the vendor if the materials or workmanship supplied do not conform to the specifications contained in the Contract **and Vendor has failed to cure such deficiencies in such 30 day period**. The Purchasing Division Director may also cancel any purchase or Contract upon 30 days written notice to the Vendor in accordance with West Virginia Code of State Rules§ 148-l-6.l.e.

20. TIME: Time is of the essence with regard to all matters of time and performance in this Contract.

21. APPLICABLE LAW: This Contract is governed by and interpreted under West Virginia law without giving effect to its choice of law principles. Any information provided in specification manuals, or any other source, verbal or written, which contradicts or violates the West Virginia Constitution, West Virginia Code or West Virginia Code of State Rules is void and of no effect.

22. COMPLIANCE WITH LAWS: Vendor shall comply with all applicable federal, state, and local laws, regulations and ordinances **in its performance of the Services hereunder**. By submitting a bid, Vendor acknowledges that it has reviewed, understands, and will comply with all applicable laws, regulations, and ordinances.

23. ARBITRATION: Any references made to arbitration contained in this Contract, Vendor's bid, or in any American Institute of Architects documents pertaining to this Contract are hereby deleted, void, and of no effect.

24. MODIFICATIONS: This writing is the parties' final expression of intent. Notwithstanding anything contained in this Contract to the contrary no modification of this Contract shall be binding without mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). Any change to existing contracts that adds work or changes contract cost, and were not included in the original contract, must be approved by the Purchasing Division and the Attorney General's Office (as to form) prior to the implementation of the change or commencement of work affected by the change.

25. WAIVER: The failure of either party to insist upon a strict performance of any of the terms or provision of this Contract, or to exercise any option, right, or remedy herein contained, shall not be construed as a waiver or a relinquishment for the future of such term, provision, option, right, or remedy, but the same shall continue in full force and effect. Any waiver must be expressly stated in writing and signed by the waiving party.

26. SUBSEQUENT FORMS: The terms and conditions contained in this Contract shall supersede any and all subsequent terms and conditions which may appear on any form documents submitted by Vendor to the Agency or Purchasing Division such as price lists, order forms, invoices, sales agreements, or maintenance agreements, and includes internet websites or other electronic documents. Acceptance or use of Vendor's forms does not constitute acceptance of the terms and conditions contained thereon.

27. ASSIGNMENT: Neither this Contract nor any monies due, or to become due hereunder, may be assigned by the Vendor without the express written consent of the Agency, the Purchasing Division, the Attorney General's office (as to form only), and any other government agency or office that may be required to approve such assignments. Notwithstanding the foregoing, Purchasing Division approval may or may not be required on certain agency delegated or exempt purchases.

28. WARRANTY: The Vendor expressly warrants that the goods and/or services covered by this Contract will~~: (a)~~ conform **in all material respects** to the specifications, drawings, samples, or other description furnished or specified by the Agency~~; (b) be merchantable and fit for the purpose intended; and (c) be free from defect in material and workmanship~~. **Except as specifically stated in the Agreement, Vendor does not make any representations or warranties, express or implied, regarding any matter, including the merchantability, suitability, originality, title, fitness for a particular purpose or results to be derived from the use of the Services provided under the Contract.**

29. STATE EMPLOYEES: State employees are not permitted to utilize this Contract for personal use and the Vendor is prohibited from permitting or facilitating the same.

30. BANKRUPTCY: In the event the Vendor files for bankruptcy protection, the State of West Virginia may deem this Contract null and void, and terminate this Contract without notice.

31. PRIVACY, SECURITY, AND CONFIDENTIALITY: The Vendor agrees that it will not disclose to anyone, directly or indirectly, any such personally identifiable information or other confidential information gained from the Agency, unless the individual who is the subject of the information consents to the disclosure in writing or the disclosure is made pursuant to the Agency's policies, procedures, and rules. Vendor further agrees to comply with the Confidentiality Policies and Information Security Accountability Requirements, set forth in http://www.state.wv.us/admin/purchase/privacy/default.html. **The obligations under this paragraph shall be reciprocal. Notwithstanding anything to the contrary in this Agreement, but subject to the confidentiality obligations set forth in this Section, Vendor may (i) retain copies of confidential information that is required to be retained by law or regulation, (ii) retain copies of its work product that contain confidential information for archival purposes or to defend its work product and (iii) in accordance with legal, disaster recovery and records retention requirements, store such copies and derivative works in an archival format (e.g. tape backups), which may not be returned or destroyed.**

32. YOUR SUBMISSION IS A PUBLIC DOCUMENT: Vendor's entire response to the Solicitation and the resulting Contract are public documents. As public documents, they will be disclosed to the public following the bid/proposal opening or award of the contract, as required by the competitive bidding laws of West Virginia Code§§ SA-3-1 et seq., 5-22-1 et seq., and 50-1-1 et seq. and the Freedom of Information Act West Virginia Code§§ 29B-1-1 et seq.

DO NOT SUBMIT MATERIAL YOU CONSIDER TO BE CONFIDENTIAL, A TRADE SECRET, OR OTHERWISE NOT SUBJECT TO PUBLIC DISCLOSURE.

Submission of any bid, proposal, or other document to the Purchasing Division constitutes your

explicit consent to the subsequent public disclosure of the bid, proposal, or document. The Purchasing Division will disclose any document labeled "confidential," "proprietary," "trade secret," "private," or labeled with any other claim against public disclosure of the documents, to include any "trade secrets" as defined by West Virginia Code§ 47-22-1 et seq. All submissions are subject to public disclosure without notice.

33. LICENSING: In accordance with West Virginia Code of State Rules§ 148-1-6.1.e, Vendor must be licensed and in good standing in accordance with any and all state and local laws and requirements by any state or local agency of West Virginia, including, but not limited to, the West Virginia Secretary of State's Office, the West Virginia Tax Department, West Virginia Insurance Commission, or any other state agency or political subdivision. Upon request, the Vendor must provide all necessary releases to obtain information to enable the Purchasing Division Director or the Agency to verify that the Vendor is licensed and in good standing with the above entities.

34. ANTITRUST: In submitting a bid to, signing a contract with, or accepting a Award Document from any agency of the State of West Virginia, the Vendor agrees to convey, sell, assign, or transfer to the State of West Virginia all rights, title, and interest in and to all causes of action it may now or hereafter acquire under the antitrust laws of the United States and the State of West Virginia for price fixing and/or unreasonable restraints of trade relating to the particular commodities or services purchased or acquired by the State of West Virginia. Such assignment shall be made and become effective at the time the purchasing agency tenders the initial payment to Vendor.

35. VENDOR CERTIFICATIONS: By signing its bid or entering into this Contract, Vendor certifies (1) that its bid or offer was made without prior understanding, agreement, or connection with any corporation, firm, limited liability company, partnership, person or entity submitting a bid or offer for the same material, supplies, equipment or services; (2) that its bid or offer is in all respects fair and without collusion or fraud; (3) that this Contract is accepted or entered into without any prior understanding, agreement, or connection to any other entity that could be considered a violation of law; and (4) that it has reviewed this Solicitation in its entirety; understands the requirements, terms and conditions, and other information contained herein.

Vendor's signature on its bid or offer also affirms that neither it nor its representatives have any interest, nor shall acquire any interest, direct or indirect, which would compromise the performance of its services hereunder. Any such interests shall be promptly presented in detail to the Agency. The individual signing this bid or offer on behalf of Vendor certifies that he or she is authorized by the Vendor to execute this bid or offer or any documents related thereto on Vendor's behalf; that he or she is authorized to bind the Vendor in a contractual relationship; and that, to the best of his or her knowledge, the Vendor has properly registered with any State agency that may require registration.

36. VENDOR RELATIONSHIP: The relationship of the Vendor to the State shall be that of an independent contractor and no principal-agent relationship or employer-employee relationship is contemplated or created by this Contract. The Vendor as an independent contractor is solely liable for the acts and omissions of its employees and agents. Vendor shall be responsible for selecting, supervising, and compensating any and all individuals employed pursuant to the terms of this Solicitation and resulting contract. Neither the Vendor, nor any employees or subcontractors of the Vendor, shall be deemed to be employees of the State for any purpose whatsoever. Vendor shall be exclusively responsible for payment of employees and contractors for all wages and salaries, taxes, withholding payments, penalties, fees, fringe benefits, professional liability insurance premiums, contributions to insurance and pension, or other deferred compensation plans, including but not limited to, Workers' Compensation and Social Security obligations, licensing fees, etc. and the filing

of all necessary documents, forms, and returns pertinent to all of the foregoing.

Vendor shall hold harmless the State, and shall provide the State and Agency with a defense against any and all claims including, but not limited to, the foregoing payments, withholdings, contributions, taxes, Social Security taxes, and employer income tax returns.

37. INDEMNIFICATION: The Vendor agrees to indemnify, defend, and hold harmless the State and the Agency, their officers, and employees from and against: (1) Any claims or losses **in connection with a third party claim to the extent directly arising out of Vendor's negligent acts or omissions or bad faith conduct** ~~for services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies~~ in connection with **Vendor's** ~~the~~ performance of **its obligations under** the Contract; (2) Any claims or losses **in connection with a third party claim to the extent directly** resulting **or Consultant's breach of its representations and warranties under the Agreement**~~to any person or entity injured or damaged by the Vendor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under the Contract in a manner not authorized by the Contract, or by Federal or State statutes or regulations~~; and (3) Any failure of the Vendor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws. **Vendor shall have no responsibility for any losses, liabilities or damages to the extent they are attributable to the acts or omissions of an indemnified person or any third party other than Vendor's subcontractors.**

38. PURCHASING AFFIDAVIT: In accordance with West Virginia Code§ 5-22-l(i), the contracting public entity shall not award a contract for a construction project 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. Accordingly, prior to contract award, Vendors are required to sign, notarize, and submit the Purchasing Affidavit to the Purchasing Division affirming under oath that it is not in default on any monetary obligation owed to the state or a political subdivision of the state.

39. ADDITIONAL AGENCY AND LOCAL GOVERNMENT USE: This Contract may be utilized by other agencies, spending units, and political subdivisions of the State of West Virginia; county, municipal, and other local government bodies; and school districts ("Other Government Entities"). Any extension of this Contract to the aforementioned Other Government Entities must be on the same prices, terms, and conditions as those offered and agreed to in this Contract, provided that such extension is in compliance with the applicable laws, rules, and ordinances of the Other Government Entity. If the Vendor does not wish to extend the prices, terms, and conditions of its bid and subsequent contract to the Other Government Entities, the Vendor must clearly indicate such refusal in its bid. A refusal to extend this Contract to the Other Government Entities shall not impact or influence the award of this Contract in any manner.

40. CONFLICT OF INTEREST: ~~Vendor, its officers or members or employees, shall not presently have or acquire an interest, direct or indirect, which would conflict with or compromise the performance of its obligations hereunder. Vendor shall periodically inquire of its officers, members and employees to ensure that a conflict of interest does not arise. Any conflict of interest discovered shall be promptly presented in detail to the Agency.~~ **It is Vendor's practice to serve multiple clients within industries, including those with potentially opposing interests.**

Accordingly, Vendor may have served, may currently be serving or may in the future serve other clients whose interests may be adverse to those of the Agency. In all such situations, Vendor is committed to maintaining the confidentiality of each client's information and will abide by non-disclosure procedures (such as firewall protocols and other safeguards) to ensure that all confidences are protected.

41. REPORTS: Vendor shall provide the Agency and/or the Purchasing Division with the following reports identified by a checked box below:

x Such reports as the Agency and/or the Purchasing Division may request. Requested reports may include, but are not limited to, quantities purchased, agencies utilizing the contract, total contract expenditures by agency, etc.

¨ Quarterly reports detailing the total quantity of purchases in units and dollars, along with a listing of purchases by agency. Quarterly reports should be delivered to the Purchasing Division via email at purchasing.requisitions@wv.gov.

42. BACKGROUND CHECK: In accordance with W.Va. Code§ 15-2D-3, the Director of the Division of Protective Services shall require any service provider whose employees are regularly employed on the grounds or in the buildings of the Capitol complex or who have access to sensitive or critical information to submit to a fingerprint-based state and federal background inquiry through the state repository. The service provider is responsible for any costs associated with the fingerprint-based state and federal background inquiry.

After the contract for such services has been approved, but before any such employees are permitted to be on the grounds or in the buildings of the Capitol complex or have access to sensitive or critical information, the service provider shall submit a list of all persons who will be physically present and working at the Capitol complex to the Director of the Division of Protective Services for purposes of verifying compliance with this provision. The State reserves the right to prohibit a service provider's employees from accessing sensitive or critical information or to be present at the Capitol complex based upon results addressed from a criminal background check.

Service providers should contact the West Virginia Division of Protective Services by phone at (304) 558-9911 for more information.

43. PREFERENCE FOR USE OF DOMESTIC STEEL PRODUCTS: Except when authorized by the Director of the Purchasing Division pursuant toW. Va. Code§ SA-3-56, no contractor may use or supply steel products for a State Contract Project other than those steel products made in the United States. A contractor who uses steel products in violation of this section may be subject to civil penalties pursuant toW. Va. Code§ SA-3-56. As used in this section:

a. "State Contract Project" means any erection or construction of, or any addition to, alteration of or other improvement to any building or structure, including, but not limited to, roads or highways, or the installation of any heating or cooling or ventilating plants or other equipment, or the supply of and materials for such projects, pursuant to a contract with the State of West Virginia for which bids were solicited on or after June 6, 2001.
b. "Steel Products" means products rolled, formed, shaped, drawn, extruded, forged, cast, fabricated or otherwise similarly processed, or processed by a combination of two or more or such operations, from steel made by the open heath, basic oxygen, electric furnace, Bessemer or other steel making

process. The Purchasing Division Director may, in writing, authorize the use of foreign steel products if:

c. The cost for each contract item used does not exceed one tenth of one percent (.1%) of the total contract cost or two thousand five hundred dollars ($2,500.00), whichever is greater. For the purposes of this section, the cost is the value of the steel product as delivered to the project; or

d. The Director of the Purchasing Division determines that specified steel materials are not produced in the United States in sufficient quantity or otherwise are not reasonably available to meet contract requirements.

44. PREFERENCE FOR USE OF DOMESTIC ALUMINUM, GLASS, AND STEEL: In Accordance with W.Va. Code§ 5-19-1 et seq., and W.Va. CSR § 148-10-1 et seq., for every contract or subcontract, subject to the limitations contained herein, for the construction, reconstruction, alteration, repair, improvement or maintenance of public works or for the purchase of any item of machinery or equipment to be used at sites of public works, only domestic aluminum, glass or steel products shall be supplied unless the spending officer determines, in writing, after the receipt of offers or bids, (1) that the cost of domestic aluminum, glass or steel products is unreasonable or inconsistent with the public interest of the State of West Virginia, (2) that domestic aluminum, glass or steel products are not produced in sufficient quantities to meet the contract requirements, or (3) the available domestic aluminum, glass, or steel do not meet the contract specifications. This provision only applies to public works contracts awarded in an amount more than fifty thousand dollars ($50,000) or public works contracts that require more than ten thousand pounds of steel products.

The cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than twenty percent (20%) of the bid or offered price for foreign made aluminum, glass, or steel products. If the domestic aluminum, glass or steel products to be supplied or produced in a "substantial labor surplus area", as defined by the United States Department of Labor, the cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than thirty percent (30%) of the bid or offered price for foreign made aluminum, glass, or steel products. This preference shall be applied to an item of machinery or equipment, as indicated above, when the item is a single unit of equipment or machinery manufactured primarily of aluminum, glass or steel, is part of a public works contract and has the sole purpose or of being a permanent part of a single public works project. This provision does not apply to equipment or machinery purchased by a spending unit for use by that spending unit and not as part of a single public works project.

All bids and offers including domestic aluminum, glass or steel products that exceed bid or offer prices including foreign aluminum, glass or steel products after application of the preferences provided in this provision may be reduced to a price equal to or lower than the lowest bid or offer price for foreign aluminum, glass or steel products plus the applicable preference. If the reduced bid or offer prices are made in writing and supersede the prior bid or offer prices, all bids or offers, including the reduced bid or offer prices, will be reevaluated in accordance with this rule.

45. INTERESTED PARTY SUPPLEMENTAL DISCLOSURE: W.Va. Code§ 6D-1-2 requires that for contracts with an actual or estimated value of at least $100,000, the vendor must submit to the Agency a supplemental disclosure of interested parties reflecting any new or differing interested parties to the contract, which were not included in the original pre- award interested party disclosure, within 30 days following the completion or termination of the contract. A copy of that form is included with this solicitation or can be obtained from the WV

Ethics Commission. "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; 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: Provided, That subdivision (2) shall be inapplicable if a business entity is a publicly traded company: Provided, however, That subdivision (3) shall not include persons or business entities performing legal services related to the negotiation or drafting of the applicable contract. The Agency shall submit a copy of the disclosure to the Ethics Commission within 15 days after receiving the supplemental disclosure of interested parties.

46. LIMITATION OF LIABILITY: A. The aggregate liability of Vendor, its affiliates and any officer, director or employee of Vendor's and our Affiliates ("Vendor Parties") to the State, its officers, directors or employees and any third party (including any benefit plan, its fiduciaries or any plan sponsor) for any and all Losses arising out of or relating to the provision of any Services at any time by any of the Vendor Parties shall not exceed one times the compensation for the Services giving rise to such Loss. Vendor shall have no liability for the acts or omissions of any third party (other than its subcontractors).

B. In no event shall either party or its affiliates be liable in connection with this Contract or the Services to the other Party, its Affiliates or any third party for any loss of profit or incidental, consequential, special, indirect, punitive or similar damages. The provisions of this Section shall apply to the fullest extent permitted by law. Nothing in this Section limiting the liability of a party shall apply to any liability that has been finally determined by a court to have been caused by the fraud of such party.

C. For purposes of this Contract "Loss" means damages, claims, liabilities, losses, awards, judgments, penalties, third party claims, interest, costs and expenses, including reasonable attorneys' fees, whether arising under any legal theory including, but not limited to claims sounding in tort (such as for negligence, misrepresentation or otherwise), contract (whether express or implied), by statute, or otherwise, claims seeking any kind of damages and claims seeking to apply any standard of liability such as negligence, statutory violation or otherwise. For the avoidance of doubt, multiple claims arising out of or based upon the same act, error or omission, or series of continuous, interrelated or repeated acts, errors or omissions shall be considered a single Loss.

47. OWNERSHIP OF DELIVERABLES: Deliverables created or developed by Vendor specifically and exclusively for the Agency pursuant to this Contract shall be considered 'work made for hire' and exclusively owned by the Agency (collectively, "Work"). Notwithstanding anything to the contrary in this Contract, Vendor shall retain all patent, copyright and other intellectual property rights in the methodologies, methods of analysis, ideas, concepts, know-how, models, tools, techniques, skills, knowledge and experience owned or possessed by Vendor before the commencement of, or acquired by Vendor during or after, the performance of the Services (collectively, "Intellectual Property"). To the extent that any of Intellectual Property is embodied in any of the Work, Vendor will grant to the Agency a non-exclusive, non-transferable, royalty-free license to use the Intellectual Property for its internal use, but solely in connection with and to the extent necessary for use of the Work as contemplated by this Contract; provided that and so long as the Agency is not in breach of this Contract or

otherwise misusing the Intellectual Property. Unless Vendor provides its prior written consent, the Agency will not use, or disclose to any third party, Vendor advice or Work other than as mutually contemplated by the parties when Vendor first was retained to provide such advice or Work or as required by law.

48. SEVERABILITY: It is the intent of the parties that the provisions of this Contract shall be enforced to the fullest extent permitted by applicable law. To the extent that the terms set forth in this Contract or any word, phrase, clause or sentence is found to be illegal or unenforceable for any reason, such word, phrase, clause or sentence shall be modified, deleted or interpreted in such a manner so as to afford the party for whose benefit it was intended the fullest benefit commensurate with making this Contract as modified, enforceable and the balance of this Contract shall not be affected thereby, the balance being construed as severable and independent.

49. WAIVER OF JURY TRIAL: IN THE EVENT OF A DISPUTE BETWEEN US ARISING OUT OF OR RELATING TO THIS AGREEMENT, WE EACH AGREE TO WAIVE AND NOT DEMAND A TRIAL BY JURY.

50. NO THIRD PARTY BENEFICIARIES: Neither the Agreement nor the provision of the Services is intended to confer any right or benefit on any third party. The provision of Services under this Agreement cannot reasonably be relied upon by any third party.

51. PROVISON OF INFORMATION AND DIRECTION: The Agency will provide all necessary and reasonably requested information, direction and cooperation to enable Vendor to provide the Services, and any direction (whether verbal or written) shall be effective if contained expressly in the applicable specifications or if received (whether verbally or in writing) from a person known to Vendor or reasonably believed by Vendor to be authorized to act on the Agency's behalf. Vendor shall be permitted to use all information and data supplied by or on behalf of the Agency without having independently verified the accuracy or completeness of it.

52. PERSONAL INFORMATION. Each party and its respective affiliates will comply with our respective obligations arising from data protection and privacy laws in effect from time to time to the extent applicable to the Agreement and the Services.

5

PRICING

Mercer uploaded our pricing into the wvOASIS system along with this response document. Mercer also provides the pricing information in this section. In addition, we provide Attachment 1 from the CRFQ in this section.

CENTRALIZED REQUEST FOR QUOTATION CRFQ 0511 BMS1800000002
Medicaid Managed Care Rate Setting and Medicaid Managed Care Program Administration

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Attachment 1: Exhibit A Pricing Page

Please reference Exhibit A: l) 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: Mercer Health & Benefits LLC

Remit to Address: 2325 E. Camelback Road, Suite 600, Phoenix, AZ 85016

Phone#: +1 602 522 8576

Vendor Fax#: +1 602 522 6499

Email Address: Ryan.Johnson@mercer.com

Signature:  Date: 10/30/17

Exhibit A: Pricing Page - CRFQ 0511 BMS1800000002
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	$ 300.00	$ 624,000.00
Staff Actuaries (4)	8,320	$ 281.25	$ 2,340,000.00
Technical Support Staff (non-actuary)	2,080	$ 215.00	$ 447,200.00
Clerical Support Staff	2,080	$ 50.00	$ 104,000.00

*hours are estimated on a per year (2,080 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 extention 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 outlined 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)	$ 4,059,469.00

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	$ 244.55	$ 1,222,750.00
Actuarial Services Projects	5,000	$ 241.43	$ 1,207,150.00

Total Project Cost (Sum of Actuarial Services Cost, Managed Care Oversight Cost and Ad Hoc Cost):
$ 10,004,569.00

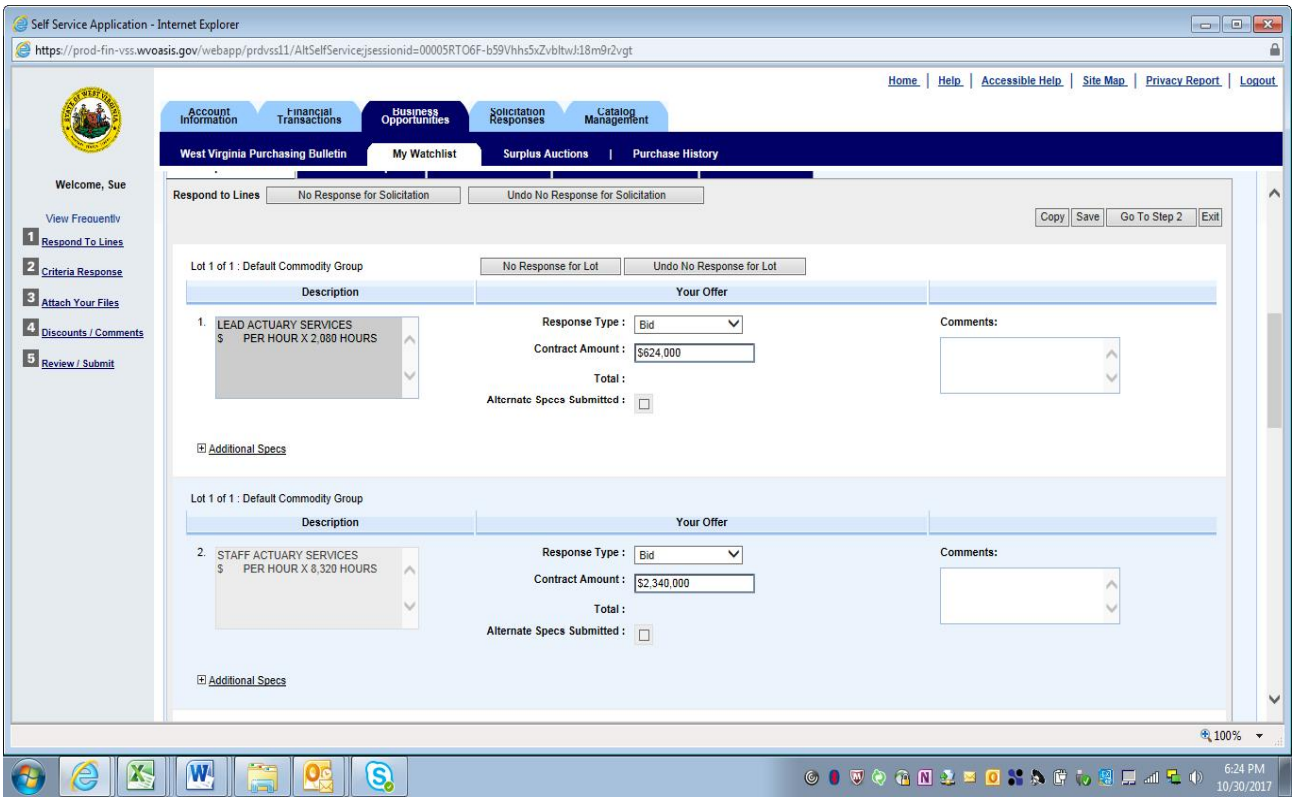
Notes:
1.) Total Project Cost will be used for purposes of bid evaluation.
2.) Contract services will be paid monthly in arrears.
3.) Payment for Ad Hoc Services will be based on an approved Statement of Work .
4.) All amounts bid shall include all general and administrative expenses, including travel, 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.

Mercer Health & Benefits LLC
(Company)

Ryan Johnson, Principal
(Representative, Name, Title)

+1 602 522 8576
(Contact Phone/Fax Number)

October 30, 2017
(Date)


Self Service Application - Internet Explorer
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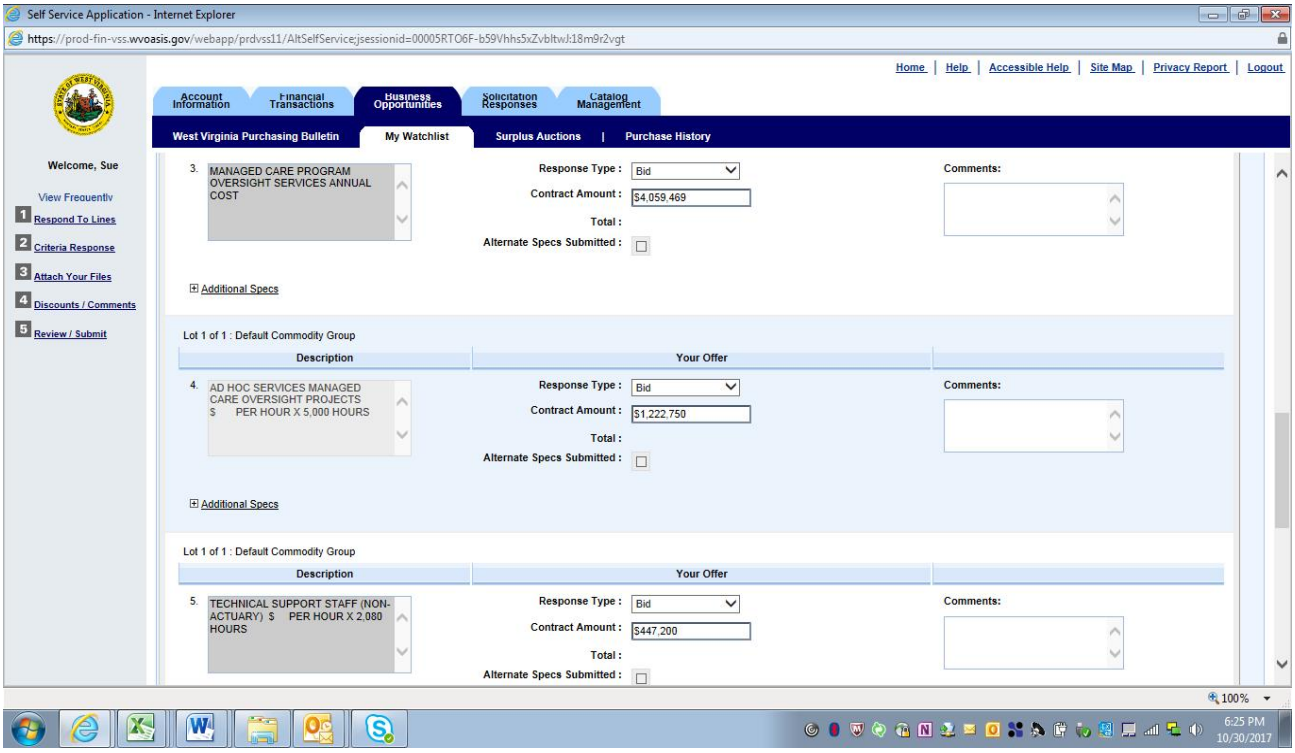
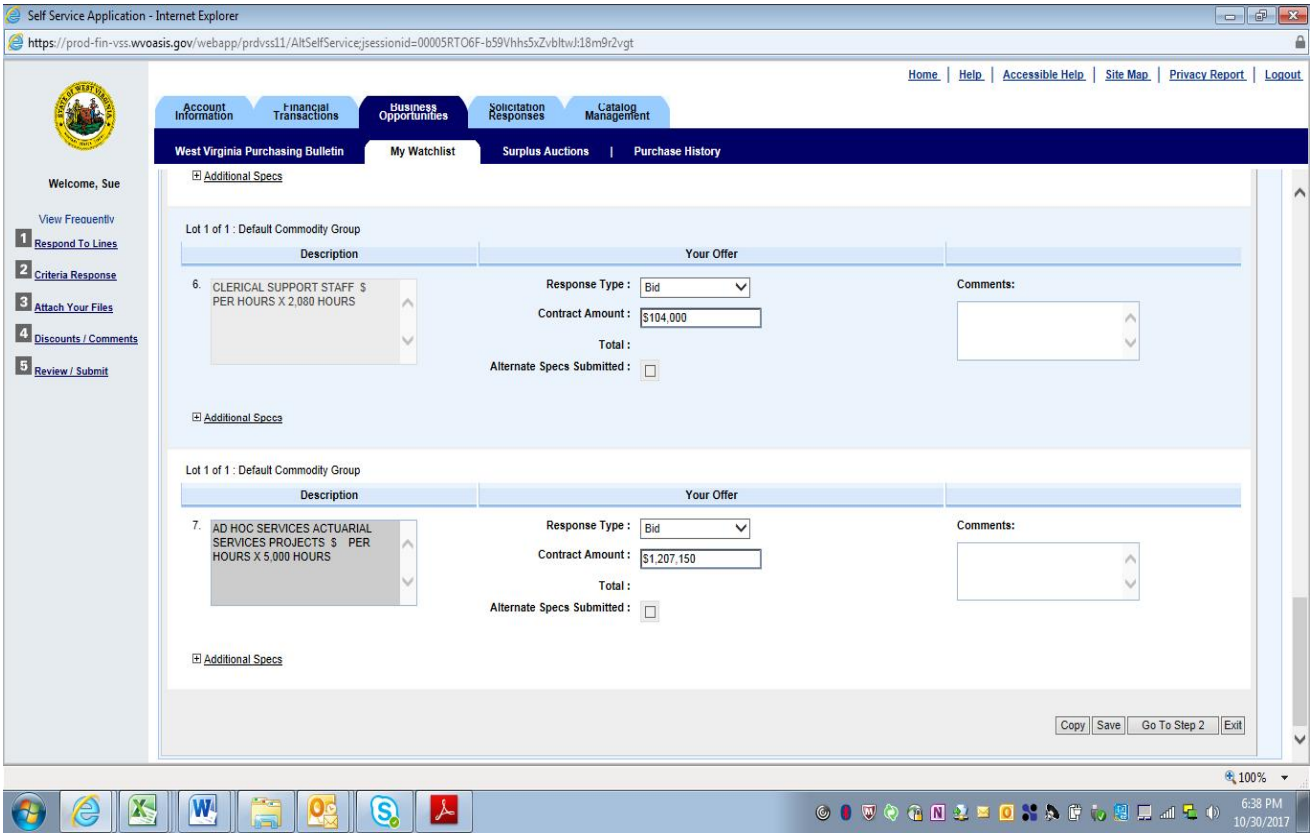
Home | Help | Accessible Help | Site Map | Privacy Report | Logout
Account Information
Financial Transactions
Business Opportunities
Solicitation Responses
Catalog Management
West Virginia Purchasing Bulletin
My Watchlist
Surplus Auctions
Purchase History
Welcome, Sue
View Frequently
1 Respond To Lines
2 Criteria Response
3 Attach Your Files
4 Discounts / Comments
5 Review / Submit
Respond to Lines
No Response for Solicitation
Undo No Response for Solicitation
Copy
Save
Go To Step 2
Exit
Lot 1 of 1 : Default Commodity Group
No Response for Lot
Undo No Response for Lot
Description
Your Offer
1. LEAD ACTUARY SERVICES $ PER HOUR X 2,080 HOURS
Response Type : Bid
Contract Amount : $624,000
Total :
Alternate Specs Submitted :
Comments:
Additional Specs
Lot 1 of 1 : Default Commodity Group
Description
Your Offer
2. STAFF ACTUARY SERVICES $ PER HOUR X 8,320 HOURS
Response Type : Bid
Contract Amount : $2,340,000
Total :
Alternate Specs Submitted :
Comments:
Additional Specs
100%
6:24 PM
10/30/2017


Self Service Application - Internet Explorer
https://prod-fin-vss.wvoasis.gov/webapp/prdvss11/AltSelfService;jsessionid=00005RTO6F-b59Vhhs5xZvbltwJ:18m9r2vgt
Home | Help | Accessible Help | Site Map | Privacy Report | Logout
Account Information
Financial Transactions
Business Opportunities
Solicitation Responses
Catalog Management
West Virginia Purchasing Bulletin
My Watchlist
Surplus Auctions
Purchase History
Welcome, Sue
View Frequently
1 Respond To Lines
2 Criteria Response
3 Attach Your Files
4 Discounts / Comments
5 Review / Submit
3. MANAGED CARE PROGRAM OVERSIGHT SERVICES ANNUAL COST
Response Type : Bid
Contract Amount : $4,059,469
Total :
Alternate Specs Submitted :
Comments:
Additional Specs
Lot 1 of 1 : Default Commodity Group
Description
Your Offer
4. AD HOC SERVICES MANAGED CARE OVERSIGHT PROJECTS $ PER HOUR X 5,000 HOURS
Response Type : Bid
Contract Amount : $1,222,750
Total :
Alternate Specs Submitted :
Comments:
Additional Specs
Lot 1 of 1 : Default Commodity Group
Description
Your Offer
5. TECHNICAL SUPPORT STAFF (NON-ACTUARY) $ PER HOUR X 2,080 HOURS
Response Type : Bid
Contract Amount : $447,200
Total :
Alternate Specs Submitted :
Comments:
100%
6:25 PM
10/30/2017


Self Service Application - Internet Explorer
https://prod-fin-vss.wvoasis.gov/webapp/prdvss11/AltSelfService;jsessionid=00005RTO6F-b59Vhhs5xZvbltwJ:18m9r2vgt
Home | Help | Accessible Help | Site Map | Privacy Report | Logout
Account Information
Financial Transactions
Business Opportunities
Solicitation Responses
Catalog Management
West Virginia Purchasing Bulletin
My Watchlist
Surplus Auctions
Purchase History
Welcome, Sue
View Frequently
1 Respond To Lines
2 Criteria Response
3 Attach Your Files
4 Discounts / Comments
5 Review / Submit
Additional Specs
Lot 1 of 1 : Default Commodity Group
Description
Your Offer
6. CLERICAL SUPPORT STAFF $ PER HOURS X 2,080 HOURS
Response Type : Bid
Contract Amount : $104,000
Total :
Alternate Specs Submitted :
Comments:
Additional Specs
Lot 1 of 1 : Default Commodity Group
Description
Your Offer
7. AD HOC SERVICES ACTUARIAL SERVICES PROJECTS $ PER HOURS X 5,000 HOURS
Response Type : Bid
Contract Amount : $1,207,150
Total :
Alternate Specs Submitted :
Comments:
Additional Specs
Copy
Save
Go To Step 2
Exit
100%
6:38 PM
10/30/2017

APPENDICES

A

STAFF BIOGRAPHIES

MERCER
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Ryan Johnson, MPA
Role: Client Leader

QUALIFICATIONS

Ryan has been consulting in the healthcare arena since 2001. He is a client relationship manager for the State of Connecticut and State of Utah. His responsibility in this role is to manage the overall client engagements within some of Mercer's largest clients. Ryan leads teams of consultants, clinicians, actuaries, analysts, and accountants to ensure that Mercer is bringing the best strategies and solutions.

Ryan's background in healthcare policy, finance, and administration has allowed him to consult to Medicaid programs across the country. In fact, Ryan led the initial implementation of health-based risk adjustment in California, Florida, Massachusetts, Missouri, Ohio, New Jersey, North Carolina, and the District of Columbia. He currently leads Mercer's risk adjustment efforts nationally within our GHSC practice and has nearly 15 years of experience implementing and maintaining risk adjustment payment systems for over a dozen states.

Ryan Johnson, MPA
Principal

EDUCATION
Master's degree, Public Administration
Brigham Young University

Bachelor's degree, Health Sciences
Brigham Young University

EXPERIENCE
15 years
Professional experience working in government healthcare consulting

CORE COMPETENCIES
Managed care rate setting and finance

Risk adjustment

Financial performance measurement

Data analytics and reporting

EXPERIENCE

Ryan uses his broad analytical and leadership skills to complete client projects related to reimbursement strategies, delivery system reform, and health-based risk assessment. He has managed large teams in providing a broad array of strategic, financial, and analytical support to Medicaid programs including Connecticut, Massachusetts, and New Jersey. His project work includes:

- Developing strategic plans, collaborating with stakeholders, and presenting results.
- Designing complex reimbursement strategies and negotiating payment structures with state vendors.
- Leading value-based payment efforts to implement a shared savings program for patient-centered medical home within a multi-payer State Innovation Model (SIM) implementation
- Directed the implementation of inpatient APR-DRG and outpatient APC hospital reimbursement systems.
- Nearly 15 years of experience using ACG, DxCG (HCC), CDPS, CDPS+Rx, and Medicaid Rx grouper models to adjust capitation rates and assess population risk.
- Risk adjustment model recalibration with one of the first states to use health plan reported encounter data for cost weight development
- Key architect of custom risk adjustment model for use in a managed long-term care setting
- Implementing risk adjustment techniques within Medicaid/Medicare dually eligible pilot demonstrations, bundled primary care rates, and other shared savings arrangements.

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PROPOSED STAFF

MEDICAID MANAGED CARE
PROGRAM ADMINISTRATION AND OVERSIGHT

Resumes for the following staff (in this order) are provided in this section.

MANAGED CARE PROGRAM ADMINISTRATION AND OVERSIGHT			
Position	**Name**	**Degree**	**Years of Experience**
Project Management Lead	Sara Drake, MPH, MBA	Master's	10+
On-site Program Management/ Policy Analyst	Allen Gibson*	Bachelor's	15+
On-site Program Integrity Analyst	Holly Ekstrand*	Bachelor's	7+
Senior Consultants	Kim Donica Heather Huff, MA Nicole Kaufman, JD, LL.M Laurie Klanchar, RN, MSN, CRNP Jessica Osborne Michele Walker, MSG, MPA Rachel Wright, RN, MSN, PHN	Bachelor's Master's JD, LL.M Master's Bachelor's Master's Master's	30+ 24+ 8+ 28+ 12+ 24+ 13+
Junior Consultants	Jonathan Myers, MS Son Yong Pak, CPHQ, CPC Maija Welton	Master's Bachelor's Bachelor's	5+ 10+ 11+
Research Analysts	James Moore Madison Surdyke, PMP Alec Zuber, MPA	Bachelor's Bachelor's Master's	2+ 3+ 10+
Support Staff	TBD	TBD	TBD

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Sara Drake, RPh, MPH, MBA
Role: Project Management Lead

QUALIFICATIONS

Sara's experiences across the pharmacy, government, and health care landscapes allow her to assist Mercer clients in evaluation, research, analysis, and implementation of both new and existing policy options for managing Medicaid benefits in both the managed care and fee-for-service (FFS) environment.

EXPERIENCE

Prior to joining Mercer, Sara worked for the Minnesota Department of Human Services where she served in a dual role as the Deputy Director of Health Care Purchasing and Service Delivery and Pharmacy Program Manager. Prior to her role in state government, Sara's experiences included management consulting, nonprofit health plan, inpatient hospital pharmacy, and retail pharmacy. At Mercer, Sara has worked to identify inefficiencies in managed care pharmacy claims experience and has provided policy support to several State Medicaid programs.

Examples of Sara's more recent experience and accomplishments include:

- Statewide competitive bid managed care procurement
- Stakeholder engagement, communication, and operations planning leading to successful transition of 300,000+ members into new managed care plans
- Development and implementation of uniform pharmacy policy work group which implemented policies for high cost high impact prescription drugs across managed care and FFS
- Stakeholder engagement and design of a new payment methodology for Federally Qualified Health Centers (FQHC)
- Design and implementation of cost sharing methodology for basic health plan (BHP) enrollees.
- Implementation of the nation's first standard 340B reimbursement methodology.
- Management and continuous improvement of a Medicaid medication therapy management (MTM) program.

Sara Drake, RPh, MPH, MBA
Principal

EDUCATION

Master's in Business Administration, University of California at Berkeley

Master's in Public Health with an emphasis on health policy management, University of California at Berkeley

Bachelor's of Science in Pharmacy, University of Wisconsin-Madison

EXPERIENCE

19 years professional experience

Former state Medicaid pharmacy director

Former state Medicaid medical benefits policy manager

CORE COMPETENCIES

Basic Health Plan (BHP) policy

Managed care procurement and implementation

Medicaid pharmacy policy

Pharmacy benefit management

Pharmacy reimbursement

Medical benefit drug reimbursement

Medication therapy management programs

Public policy and pharmacy program design

340B pricing analysis, strategy, and implementation

AFFILIATIONS

Licensed pharmacist in Minnesota

- Analysis and stakeholder work on a new pharmacy reimbursement methodology in compliance with the CMS covered outpatient drug rule.

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Presentation: “Medicaid and its role in US Healthcare” delivered at the MPhA annual learning conference, September 2017
- Presentation: “Minnesota Pharmacy Program Overview” presented annually to the Drug Formulary Committee and public attendees 2011-2016.
- Participant: NGA expert roundtable on opportunities and challenges presented by new HCV treatments and other high impact drugs, 2014.
- Presentation: “CMS covered outpatient drug rule” delivered at MPhA legislative day, April 2016.
- Webinar series: “Modernizing Minnesota’s Pharmacy Reimbursement”, 2016.
- Presentation: “Specialty Drugs, The Challenges and Opportunities,” September 2014. Delivered to MN Health Action Group.
- Panelist: “Life Savers or Budget Busters (or Both?): Welcome to the World of High-Cost Drugs. Delivered to the National Governor’s Association at the conference: Learning from Each Other: How States Are Transforming Their Health Care Systems, April 2015.
- Publication: Adoption of medication therapy management programs in Minnesota 2006-11. Journal of the American Pharmacists Association, May 2013.
- Publication: Specialty pharmacy management, what employers should know. Employee Benefits Planner, August 26, 2013.

Allen C. Gibson
602-377-7212
Charleston, West Virginia
Allen.C.Gibson@gmail.com

Role: On-site Program Management/Policy Analyst

Innovative Senior Program Management Professional recognized for competent and resourceful program management abilities. Effective leader, who embraces change, absorbs information quickly and works collaboratively across functional boundaries. Increasingly responsible experience in cross-functional, multiple business units and matrix managed environments. In depth understanding of government programs, call center operations and quality & cost control in the healthcare arena. Strong "can-do" attitude evidenced by a history of building sustainable relationships. Communicates vision and direction with clarity and enthusiasm inspiring others to succeed. Focused on high quality standards and bottom-line profitability.

Core Skill Area

BPO Vendor Management and Operational Improvement	Profit & Loss Responsibility
Regulatory Compliance Management	Client Relationship Building
New Business Development	Medicaid, Medicare, Chip Programs
Team Building, Mentoring & Leadership	Six-Sigma Greenbelt
Operations & Process Reengineering	Quality Assurance Management
Turnaround Management Strategy	Budget Planning and Administration

Technology Skill Area

Computer Literacy (Windows, Microsoft Office)	Cognos	Diamond reports
CRM: (Salesforce, Sugar)	SharePoint	Interactive Intelligence
Vonage	Nice Systems	Databases: Crystal. Access
Project Management 2016		

EXPERIENCE

Maximus Honolulu, HI **January 2015-January 2016**
Project Manager
Hawaii Health Connector Project.

Responsible for delivering projects against agreed scope, budget, schedule & customer expectations. Doing this whilst coaching and mentoring, directing & motivating teams of multi-discipline contractors & employees.

- Monitoring project risks and scope creep to identify potential problems and proactively identifying solutions to address them in advance.
- Producing stage plans, highlight reports, risk logs, requests for change etc
- Providing strategic direction during the course of the contract stages.
- Communicated extensively with clients, sub-contractors and vendors to establish cordial/effective working relationship.
- Managed and monitored a $14 million budget.
- Mentoring and coaching 40 staff & team performance.
- Implemented new efficient process using six sigma methodologies.

RFL: Hawaii Health Connector moved to the Federal site. **Returned to consulting in 2016.**

Consultant Nashville,TN **April 2006-Present**

Consulting with a variety of Medicare/Medicaid clients on their quality assurance, enrollment, member retention, pharmacy benefit management program, clinical and call center operations. Secured the following clients either by referral or repeat business.

Current Client: Teksystems(BerryDunn is their client)

Project 1: State of West Virginia: Technical and Information Enterprise Project Management Services (TEPMS) Project.

Project 2: State of West Virginia: Substance Use Disorder (SUD) Waiver Project. Phase 2.

- Develop Project Schedule
- Create all communication logs.
- Develop monthly State and Federal Partners' Dashboards
- Create SUD Matrix

Client: CVS Health: Completed 3 Management Projects. On call as needed

Length of Assignments: 2.5 years (March 2011- December 2014)

- Develop customer acquisition channel strategies for Medicare Part D business.
- Oversee Call Center marketing activities including strategy development, training, process improvements and on-site management.
- Act as acquisition marketing liaison for Online Enrollment Portal, consulting on copy, functionality and tools.
- Main strategist for Lead Generation project involving online, email and direct mail.

Clinical Pharmacy call center optimization and business process improvement project.

- Designed and developed key performance metrics and reporting (dashboard) for Senior Leadership.
- Created a weekly and monthly staffing report that improved schedule adherence from 75% to 90%.
- Designed and implemented call volume and staffing prediction model, where the clinical operations department meet their metrics for the first time in 15 months.

IVR optimization Project.

- Conducted detailed analysis of IVR call flows, IVR verbiage and prompts and IVR metrics.
- Designed potential call flow to leverage Care IVR call flow to indentify member # and route to fax on demand that resulted in a 5% decrease in call volume with an annual cost saving of $140,000.
- Reduced the number of prompts, clarified IVR verbiage, improved IVR interfaces into supporting data sources that resulted in 10% improved containment rate in IVR.

Client: eHealthTrust

Length of Assignment: 8 months

- Research, analyze, developed and implemented CRM, Email, and Chat software for new HIR product launch in the Arizona market for start-up company.
- Call Center marketing activities including strategy development, training, process improvements and on-site management.
- Created Customer Service policy and procedures, IVR trees and CS knowledge base library.
- Trained BPO vendor on policy and procedures, software and knowledgebase library, for product launch in 30 days, was completed in 25 days.

FIRSTCARE Health Plans Lubbock, TX **May 2009- December 2009**

Director, Customer Service

- Directed the Medicare, Commercial and Medicaid member and provider call center operations as a liaison between, CMS clients, 5 supervisors and 65 call center employees.
- Created and implemented operational procedures and a Quality Assurance training manual that increased efficiency within the call center operations.
- Implemented and trained staff on new call center phone system.
- Exceeded monthly KPI metrics by 15% for multiple lines of business.

  RFL: Company-wide layoffs in the call center due to declining membership. Returned to consulting in 2010.

Kaiser Permanente Stockton, CA **January 2007- February 2008**

Director of Operations, Member Services

- Directed and planned the operations of 7 Kaiser Permanente Member Services departments in the Central Valley Area.
- Coached and Mentored 21 Health Plan Representatives on Medicare complaints and grievances process and member benefits.
- Managed 2 separate budgets for the Kaiser Health Plan and for the Medical Plan Group, a $5 Million Operating Budget and approved all capital expenses.

  RFL: Recruited by Policy Studies to head up new program for AHCCCS enrollment contract, Arizona rescinded contract before start date and returned to consulting in 2008.

UnitedHealth Group Phoenix, AZ **March 2002- April 2006**

Director of Operations

- Directed the operations of the APIPA Medicare and Medicaid, Community Relations and Member Services and Marketing departments for APIPA's 300,000 membership.
- Formulated and implemented a marketing plan resulting in an increase of community awareness in establishing and developing relationships with community leaders and organizations to position UHG's brand for over 200 events.
- Administered the terms of the contract with an outsourced transportation company providing over 20,000 transportation trips monthly. Arizona's State and UHG's Key Performance Indicators were achieved.
- Analyzed, developed and implemented the Six Sigma member retention program for the State of Arizona Medicare and Medicaid membership.

Project Manager

- Developed member service handbook, policy and procedure call center training manual during the RFP process for Tenncare and the Medicare Star plus project. UHG was awarded both contracts.
- Responsible for the development of the master and flow charts of the customer service and the IVR paths of the transition team of the outsource call center to UHG call center in Houston.
- Chaired monthly cross-functional business segments to identify areas of opportunities to improve quality, service and new business to our Medicare and Medicaid membership and our internal and external clients.

Service Manager

- Administered terms of the contract with 2 outsourced call center vendor, including but not limited to P&L responsibility, KPI metrics levels, documentation standards, policy and procedure adherence, and Quality Assurance standards for members and providers calls for 3 Medicare and Medicaid health plans.
- Maintained open communications with key AmeriChoice plan departments and 2

outsource BPO vendors, ensuring that 400+ call center staff has access to most current benefits, contact and policy procedure information to ensure clients expectations are achieved.

- Traveled monthly to report status updates to executive leadership for 3 AmeriChoice health plans.

RFL: Organizational restructuring- impacted in second round of layoffs when my 3 groups were repositioned.

Washington School District Phoenix, AZ **August 1998- March 2002**

Educator (4-5 Grades)

- Instruct 4 and 5 grade looping curriculum, designing and developing programs to meet the academic, intellectual, and social needs of students.
- Coach the track and field team for Tumbleweed elementary of 50 students in grades 3-6.
- Developed and taught afterschool science program for students in Grades K-6.

RFL: Recruited by UnitedHealth Group as the new Service Manager for substantial raise

EDUCATION: Bachelor of Arts, Education, Arizona State University

Holly Ekstrand
Role: On-site Program Integrity Analyst

EXPERIENCE

AdvanceMed Corp. Nashville, TN
2016 – 2017
Program Integrity Analyst

- Utilized data analysis techniques to detect aberrancies in Medicare claims data.
- Completed written referrals to PI.
- Reviewed information contained in standard claims processing system files to determine provider billing patterns and to detect potential fraudulent or abusive billing practices.
- Performed other duties as assigned by management that contribute to ZPIC goals and objectives.
- Conducted independent investigations resulting from the discovery of situations that potentially involve fraud or abuse.
- Utilized data analysis techniques to detect aberrancies in Medicare claims data.
- Reviewed information contained in standard claims processing system files to determine provider billing patterns and to detect potential fraudulent or abusive billing practices.
- Compiled and maintained various documentation and other reporting requirements.
- Performed other duties as assigned by management that contribute to ZPIC goals and objectives.
- Assisted co-employees in any aspect of their job duties.

AdvanceMed Corp. Nashville, TN
2014 – 2015
Program Integrity Project Manager

- Provide direction to program integrity staff regarding the identification, development, and resolution of Medicare fraud complaints, investigations, and cases.
- Coordinate communications with law enforcement and CMS related to requests to stay or delay administrative actions.
- Ensure that investigations and cases are reviewed for application of appropriate administrative actions (e.g., overpayment recoupment, suspension of payments education, etc.).
- Ensure investigations, cases, and requests for information are completed in accordance with internal policies and procedures, as well as the Medicare Program Integrity Manual and the ZPIC Statement of Work.
- Responsible for adjusting priorities in order to accomplish goals established via information received at task force meetings, CMS COR calls, and Senior Management meetings.
- Ensures appropriate staffing for all assigned program integrity areas and special projects.
- Responsible for timely completion of employee performance assessments and conducts employee counseling as needed.
- Responsible for providing input into the development of standard ad hoc reports for medical review, data analysis, and program integrity supervisory and management staff.
- Perform other duties as assigned by the Program Integrity Manager that contribute to ZPIC goals and objectives.

AdvanceMed Corp. Nashville, TN
2012 – 2014
Medi-Medi Program Integrity Supervisor

- Responsible for prioritization and assignment of workload, ensuring adherence to ZPIC policies and procedures; work with investigators to develop plans of action for investigation development and information request processing.
- Responsible for meeting quality and production standards.
- Produced and submitted required reports according to pre-established guidelines.
- Monitored security of evidence gathered during the development of fraud investigations.
- Helped in establishing and maintaining relationships with outside law enforcement agencies.
- Worked closely with data analysis team to identify and develop proactive fraud leads through investigation of identified leads.
- Ensured the departmental compliance with Quality Management System and ISO requirements.
- Responsible for the aggressive application of administrative actions during investigation development (including overpayment justification, payment suspension, and referrals for civil monetary penalties).
- Hired and supervised Program Integrity staff.
- Responsible for timely completion of annual performance assessments and, when necessary, employee counseling.
- Conducted matrix review meetings with investigators to ensure thorough and timely fraud investigations in accordance with ZPIC guidelines.
- Facilitated training of investigation-related skills development for fraud analysis to raise the level of knowledge and quality of investigative work performed by the ZPIC.
- Performed other duties as assigned by management that contribute to ZPIC goals and objectives.

AdvanceMed Corp. Nashville, TN
2012 – 2012
Senior Program Integrity Analyst

- Conducted independent investigations resulting from the discovery of situations that potentially involve fraud or abuse.
- Utilized data analysis techniques to detect aberrancies in Medicare claims data.
- Completed written referrals to law enforcement and took steps to recoup overpaid monies.
- Reviewed information contained in standard claims processing system files to determine provider billing patterns and to detect potential fraudulent or abusive billing practices.
- Compiled and maintained various documentation and other reporting requirements.
- Responded to requests for information from law enforcement.
- Maintained cases referred to law enforcement.
- Maintained the Do Not Pursue list.
- Ensured the ZPIC maintained effective communication and coordination with appropriate law enforcement agencies, as well as other involved in combating fraud, waste, and abuse issues.
- Prepared, developed, and participated in provider, beneficiary, law enforcement, or staff training as related to Medicare fraud and abuse issues.
- Provided leadership in onsite audits in conjunction with investigation development.
- Provided support to fraud analysts in the preparation and development of tasks related to onsite audits.
- Maintained chain of custody on all documents.
- Followed all confidentiality and security guidelines in accordance with CMS and ZPIC requirements.
- Compiled and maintained various documentation and other reporting requirements.
- Performed other duties as assigned by management that contribute to ZPIC goals and objectives, including special projects which demonstrated team leadership abilities and supported the efforts and goals of the ZPIC.
- Assisted co-employees in any aspect of their job duties, as necessary, as a Mentor.
- Coordinated provider payment suspensions.

AdvanceMed Corp. Nashville, TN
2010 – 2012
Program Integrity Analyst

- Conducted independent investigations resulting from the discovery of situations that potentially involve fraud or abuse.
- Utilized data analysis techniques to detect aberrancies in Medicare claims data.
- Completed written referrals to law enforcement and took steps to recoup overpaid monies.

- Reviewed information contained in standard claims processing system files to determine provider billing patterns and to detect potential fraudulent or abusive billing practices.
- Compiled and maintained various documentation and other reporting requirements.
- Performed other duties as assigned by management that contribute to ZPIC goals and objectives.
- Assisted co-employees in any aspect of their job duties, as necessary, as a Mentor.
- Coordinated provider payment suspensions.

ESIS, Inc./Nissan North America Smyrna, TN
2006 – 2010
Compensability Investigator/Claims Representative

- Worked in tandem with Safety Engineers to ensure employees are provided with a safe work environment, both ergonomically and environmentally.
- Investigated workers compensation claims to determine if the defined hazards could have caused the injury claimed.
- Managed a workload of approximately 140 cases.
- Attended meetings with Nissan North America executive and managerial staff to explain and update the status of claims.
- Lost-time/Litigation Adjuster promotion after two years in investigative position continued to handle investigations at from that time.

Self Employed Murfreesboro, TN
2004 – 2006
Contract Federal EEO Investigator

- Investigated EEO complaints filed within 7 federal entities.
- Conducted interviews with all complainants, responsible parties, and witnesses.
- Compiled Reports of Investigation which were submitted to the EEO Chairperson for the U.S. Government
- Acquired excellent time management skills.

EDUCATION

1999 - 2002 University of Tennessee Martin, TN

B.S., Criminal Justice and Sociology/Spanish.

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Kim Donica
Role: Senior Consultant

QUALIFICATIONS

Kim Donica is a Principal in Mercer's Government Human Services Consulting group. Kim has experience with Medicaid and other public assistance programs, and has worked extensively with long term services and supports (LTSS) and home and community based services (HCBS) initiatives. She has designed and implemented 1915(b) and (c) waivers along with 1915(i) state plan HCBS options. Kim has consulted to several states, including Florida and Kansas, on managed care program design, implementation and procurement issues.

Kim Donica
Principal

EDUCATION
Bachelor's degree, Social Work
Indiana University

EXPERIENCE
30 years
professional experience

CORE COMPETENCIES
LTSS program analysis, design and implementation
Program operations
Stakeholder Planning and Engagement
Medicaid Analysis

EXPERIENCE

Prior to joining Mercer in 2017, Kim served as the Chief of LTSS at the Ohio Department of Medicaid. In this capacity, Kim led development and implementation of all long term services and supports in Ohio.

Examples of Kim's experience and accomplishments include:

- Served as one of the team leaders in the development and implementation of Ohio's dual demonstration program (1915 b/c waiver), My Care Ohio. Activities included: program design, development of procurement documents, working with CMS and MCO's on the development of the 3 way agreement, development and approval of the b and c waiver components, Administrative Code rule development, providing program and policy expertise to actuarial contractor to support development of capitation payments, development of quality strategy, provider agreement development including development of provider network standards and leading the development and implementation a comprehensive stakeholder engagement strategy.
- Developed and implemented the *Specialized Recovery Services* program, Ohio's first HCBS 1915(i) state plan program. The Specialized Recovery Services program provides care management, employment and peer support to individuals with severe and persistent mental illness. Tasks included: assistance in developing the state plan amendment and the concurrent 1915(b)(4) waiver; development of Administrative Code rules, leading the development and implementation of a comprehensive stakeholder engagement strategy, developing program operating materials such as policy manual and service plans.
- Served as a team leader as Ohio transitioned from a 209(b) to a 1634 state for purposes of Medicaid eligibility for individual who are aged, blind or disabled. Tasks included: leading the development and implementation of a comprehensive stakeholder engagement strategy, developing an RFP for procurement of a vendor to help support QIT activities, developed QIT policies and procedures, assisted in the development of Administrative code rules, training and technical assistance to local partners regarding new eligibility rules.

- Developed and operated 1915 (c) waivers administered directly by the Ohio Department of Medicaid. Activities included: program design, development and approval of waiver amendments, waiver renewal activities, administrative code rule development, rate development, quality strategy and oversight of case management agency vendors.
- Responsible for the administrative oversight of Ohio's 1915(c) waiver programs administered by Medicaid's partner agencies. Activities included: ensuring compliance with federal and state statutes and regulations governing LTSS, overseeing the completion of waiver amendments and renewals and implementing a quality strategy that aligned quality expectations across waiver programs.
- Assisted in the development of innovative quality initiatives, payment methodologies and program integrity projects related to HCBS and nursing facility services. Activities included: development of an electronic visit verification program for use with certain waiver and state plan services, implementation of quality improvement projects related to nursing facilities who serve individuals who are vent dependent and the development and implementation of an EPSDT exception process.

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Heather Huff, MA
Role: Senior Consultant

QUALIFICATIONS

Heather leads clinical quality, clinical efficiency and behavioral health projects for Medicaid/CHIP and long term care (LTC) populations. Heather has led performance based contracting, compliance, quality measurement and management activities for Connecticut, Delaware, District of Columbia, Florida, New Jersey, Oklahoma, Pennsylvania and Texas. Her knowledge of nationally recognized performance measures, accuracy with data analysis, ability to translate data into actionable steps and project management skills result exceptional deliverables for client projects.

Heather Huff, MA
Senior Associate

EDUCATION
Master's degree, Sociology
University of Akron

Bachelor's degree, Sociology
Mount Vernon Nazarene University

EXPERIENCE
24 years
Professional experience

CORE COMPETENCIES
Performance based contracting

Quality measurement and reporting

Focus study design, data collection, analysis and presentation

External quality review and regulatory compliance

Project management

EXPERIENCE

Prior to joining Mercer, Heather worked for a health care quality improvement and quality review organization. Heather's responsibilities included:

- Data integrity testing.
- Conducting data analysis.
- Developing and disseminating data files and reports.
- Educating data users and stakeholders on findings and applications.

Heather's current responsibilities at Mercer include:

- Acting as team lead and coordinator for conducting External Quality Review Organization and managed care organization clinical and operational assessment review activities including desk review, onsite interviews, and evaluation. Validating performance measures and performance improvement projects for external quality reviews. Assisting with Information Systems Capabilities Assessments. Heather has led managed care organization review activities in Delaware and Pennsylvania.
- Conducting managed care organization readiness and clinical and operational efficiency reviews to ensure success during new program implementations or current program operations in Delaware, District of Columbia, Kansas, Pennsylvania and New Jersey.
- Designing performance based incentive structures and performance measures, implementing incentive initiatives and evaluating performance measure outcomes for Delaware, District of Columbia, New Jersey and Pennsylvania.
- Interpreting and implementing nationally recognized performance measures such as Healthcare Effectiveness Data and Information Set (HEDIS®), measures endorsed by the National Quality Forum, and Centers for Medicaid and Medicare Services core set of adult and pediatric health care

quality measures for Medicaid in Connecticut, Delaware, District of Columbia, New Jersey, New Mexico, and Pennsylvania.

- Researching and recommending national benchmarks utilizing data sources such as Quality Compass and Substance Abuse and Mental Health Services Administration for Connecticut, Delaware, and Pennsylvania.
- Developing performance measure technical specifications to establish accurate and consistent reporting across contractors in Delaware, District of Columbia, New Mexico and Pennsylvania.
- Analyzing emerging trends in health care data and policy to be certain clients are leveraging current opportunities and adhering to regulations.
- Developing innovative compliance and readiness review tools to accurately measure and report contractor performance.
- Developing quality management strategies to align with the National Quality Strategy and assist with state oversight of Medicaid/CHIP and LTC populations.
- Leading and managing multiple client projects to ensure complete, accurate and on-time deliverables within project budgets.

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Laurie Klanchar, RN, MSN, CRNP
Role: Senior Consultant

QUALIFICATIONS

Laurie brings extensive Medicaid and Commercial managed care proficiency to the Mercer team. Areas of expertise include clinical, quality and operations in the areas of mental health, substance use disorders and physical health integration. Laurie is a registered nurse and a certified registered nurse practitioner with experience ranging from direct care within inpatient and outpatient settings, case management, teaching, and quality management to senior leadership positions within a large statewide behavioral health managed care organization (BH-MCO).

Laurie Klanchar RN, MSN, CRNP
Senior Assiociate

EDUCATION
Master of Science, Nursing
University of Pittsburgh

Bachelor of Science, Nursing,
University of Pittsburgh

EXPERIENCE
28 years
professional experience

CORE COMPETENCIES
Medicaid Managed Care

Integrated care delivery

Quality Management

Member Services

AFFILIATIONS
RN and CRNP Licenses, Pennsylvania

Lean Six Sigma Green Belt Certified

EXPERIENCE

Laurie began her career working as a staff nurse in acute care behavioral health settings. She transitioned to a care management/utilization management role within MCOs and, upon earning a master's degree worked as a nurse practitioner providing primary care and obstetrics/gynecology services to uninsured women. Prior to joining Mercer, Laurie served in various capacities over 12+ years at a BH-MCO that served nearly 1 million Medicaid lives within 10 contracts. Most recently, she served as the Senior Director of Care Management, Customer Services and Training, assuming oversight of nearly 300 employees over 10 office sites. She was accountable for all operations within the three departments and facilitated extensive interdepartmental collaboration with quality management, finance, data analytics, network relations, and provider reimbursement. Laurie assisted with integration of physical and behavioral health projects for seven physical health MCOs. She ensured compliance with all state regulatory agencies governing behavioral health managed care services as well as oversight of three successful NCQA accreditations and one URAC accreditation. Laurie was a leader in new business development pursuits, including drafting responses for entities implementing managed care or pursuing re-procurement opportunities. During her tenure, three contracts were awarded through re-procurement and three were a result of transition from FFS to managed care.

Some of Laurie's notable clinical accomplishments include:

- Designing a complex case management program
- Developing a protocol for onsite care management
- Promoting use of evidence based practices such as Clozapine and medication assisted therapy (MAT) within care management.

- Developing metrics to evaluate performance and analyze outcomes.
- Policy and procedure development

Laurie was responsible for the development and implementation of numerous operational projects including:

- Care management career ladder
- Customer services career ladder
- Work from home capability for care management and customer services staff
- Call recording and after-call satisfaction survey
- Use of document capture software

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Jessica Osborne
Role: Senior Consultant

QUALIFICATIONS

Jessica is proposed as a Senior Consultant in Mercer's Government Human Services Consulting group, a part of Mercer Health & Benefits LLC (Mercer). Jessica has a Bachelor's Degree in Social Work and more than 12 years of state health policy and operations experience. She is a Principal in our Policy and Operations Sector (POpS) and works from our office in Washington, DC. Jessica focuses on Medicaid operations, risk assessment, managed care organization (MCO) procurement, readiness assessment and implementation, development/implementation of care coordination models, children's services, preparation/implementation of state plan amendments (SPAs) and training. Jessica is a trained social worker with extensive experience in situational assessment, consensus building, negotiations and facilitating high-level visioning and decision making. Jessica has served as the facilitator for large public meetings, functional workgroup sessions and acted as a negotiator in small group meetings. Jessica has experience leading teams on large and small projects and is an effective communicator.

EXPERIENCE

Prior to joining Mercer, Jessica was a health and human services consultant at Alicia Smith & Associates, LLC (ASA), which was acquired by Mercer in January 2012. Before she joined ASA, Jessica was the Director of Operations for the Safe Children Coalition, a community-based foster care service organization in Sarasota, Florida from 2000 to 2008.

Jessica Osborne
Principal

EDUCATION
Bachelor's degree, Social Work
University of South Florida
Certified Child Welfare Professional
Domestic Violence Counselor

EXPERIENCE
20 years
professional experience

CORE COMPETENCIES
Procurements & Readiness Review
Plan Implementation & Oversight
Child Welfare Services
Health Homes
Mental Health Parity Addictions & Equity Act (MHPAEA)
Care Coordination Design
Operations Assessment
Meeting Facilitation
Training

AFFILIATIONS
National Association of Social Workers
Alexandria Social Services Advisory Board

Jessica's recent accomplishments have included:

- Worked with Ohio's Bureau of Managed Care to improve compliance and monitoring standards for its contracted MCOs. This project includes developing questions and conducting interviews with State staff, MCO staff and comparison states. Review of current MCO compliance contract sections and comparison state MCO contracts, analyzing work flows and current reports and making recommendations' to Medicaid on potential contract revisions and internal operations.
- Since 2013, Jessica has worked with New Mexico on a on the redesign and modernization of New Mexico's Medicaid program. Jessica met with stakeholders, facilitated public meetings, and coordinated with State staff and advocates to inform the drafting of the State's section 1115 demonstration application and the 2017 waiver renewal application. Jessica worked on the RFP and

model contract for MCOs; designed policies/procedures for care coordination and disease management; participated in the design of the State's carve-in of behavioral health; and assisted the State with its health home initiative. Currently Jessica is leading the procurement of MCOs to deliver the services as described in Centennial Care 2.0.

- Working with the Medicaid Centennial Care Bureau and Quality team to conduct on-site and enrollee file reviews post-implementation of Centennial care in 2014 to evaluate compliance and early outcomes of the care coordination program. Jessica is currently using this experience to help inform program design in the renewal application and future implementation of Centennial Care 2.0.
- Providing technical support, training and analysis for the compliance activities required by MHPAEA in New Mexico, Ohio and Louisiana.
- Led the design team and assisted with the development and submission of SPAs authorizing Health Homes in New Mexico. Jessica developed the requirements documentation, application and readiness review process for potential health homes and facilitated the on-site reviews for the pilot sites.
- Worked with Delaware Medicaid to review program operations in writing and in practice to assess compliance with the new managed care rule. Jessica worked directly with network, member and provider services and oversight workgroups to review and document areas of compliance, update contract language and put into action changes necessary for full compliance.
- Assisted in the development of a Request for Qualifications for managed care plans and facilitated the consensus review and scoring of MCO responses.
- Providing Puerto Rico with all necessary technical assistance related to federal compliance including, providing training and developing systems that encourage Medicaid staff to deliver care as required by law since 2010. Examples include developing and delivering EPSDT training for community providers and agency staff, developing compliant contract language for MCOs, reviewing and revising agency policy and working as a liaison with the Centers for Medicare & Medicaid Services (CMS).
- Consulting on a redesign of the Medicaid program in Puerto Rico in 2010. The Medicaid redesign in Puerto Rico included 1) integration of physical and behavioral health, 2) design of care coordination requirements, and 3) returning the Territory to a full-risk MCO arrangement. Multiple agencies and diverse population needs were vetted with community-based and territory-wide stakeholders through small meetings and public communication documents. Jessica facilitated the competitive procurement of MCOs, helped draft the MCO contract, conducted readiness reviews, assisted in the Medicaid agency's reorganization and ensured compliance with federal requirements. Jessica has led three procurements in Puerto Rico since 2010 and is currently engaged to assist with additional program revision and procurement activity in 2017/2018.
- Assisting in readiness assessments for the implementation of new Medicaid MCO contracts for the State of Delaware's managed care program to provide integrated medical, behavioral health, and long-term services and supports to Medicaid beneficiaries.
- Working with Pennsylvania's Office of Long Term Living to complete an independent survey, analysis and provide recommendations aimed to improve the intake and enrollment process in the waiver programs. This work included, provider surveys, conducting town hall meetings and visiting provider sites all over the State, meeting with OLTL staff at all levels, reviewing all policy and procedure and

testing systems. The survey results and long and short-term solutions were presented to Executive Leadership in February 2014.

- Working collaboratively with State staff and stakeholders and assisting in the design and implementation of a comprehensive care coordination program for the elderly and disabled Medicaid population in Tennessee. This work included program design, stakeholder feedback, and training efforts.

CHILD WELFARE EXPERIENCE

Jessica worked in the State of Florida's child welfare system in a variety of positions under the lead agency for Sarasota, Manatee and Desoto Counties. Under a Federal Waiver, all child welfare activities are contracted by the State to private community-based agencies. Jessica worked as a direct case worker, supervisor, Assistant Director of Operations and Director of Operations. Jessica has worked closely with and provided leadership to families, community organizations and State sponsored programs to assist at-risk families in accessing all social services to promote independence and well-being. These increasingly responsible positions included responsibility for:

- Leadership within the management team and Project to design, implement, evaluate and improve an effective system of care for abused and neglected children that meet all Federal and State requirements, contractual, and accredited standards of care.
- Oversight of daily operations of assigned Project field office, subcontract agencies and contract compliance.
- Prepare, present and defend the annual operations budget.
- Administrative management and oversight to all activities related but not limited to time studies, utilization management, purchase of service, incident reports/reviews and client relation's inquiries, quality assurance.
- Managed selected functions that support the system of care, including but not limited to physical and behavioral health delivery, Interstate Compact on Placement of Children, Courtesy Supervision Referrals, Client Trust Funds and Adoption Subsidies.
- Oversight and program development of Independent Living Services, Adoption Subsidy, Adoption programs, Licensing, Re-Licensing, Retention and Placement services for Manatee, Sarasota, and Desoto Counties.
- Served as Liaison to the Department of Children and Families, Manatee County Sheriff's Offices investigative staff, Office of the Attorney General, legislative members.
- Provided oversight of Court related issues and liaison activities and provided frequent best interest testimony.

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Presenter - HCBS Annual Conference, *Behavioral Health and Intellectual Disability populations being served in Medicaid Managed Long-term Services and Support Programs -- Program Design for Sustainable Financing, Improved Community Integration/Recovery and Resiliency-Oriented programs and Operational implementation.*, September 2014

MERCER
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Michele Puccinelli Walker, MSG, MPA
Role: Senior Consultant

QUALIFICATIONS

Michele specializes in policy and program development for Medicaid and Children's Health Insurance programs (CHIP) with a focus on delivery system innovation, managed care, behavioral health, dual eligibles and long-term care (LTC). She serves as project manager for the states of Kansas, Ohio and South Carolina coordinating a multi-faceted team and team member for other states such as Delaware, Louisiana and New York.

EXPERIENCE

Prior to joining Mercer, Michele held senior positions for over 17 years within the U.S. Department of Health and Human Services (DHHS), including the Administration on Aging, the Centers for Medicare & Medicaid Services (CMS) and the Office of the Secretary's Regional Director for Region IX. During her 12 years at CMS, Michele served in senior positions within the Office of Legislation, the Division of Medicaid and Children's Health Operations and the Division of Medicare Health Plan Operations. Michele served as the Regional Executive Officer for the Office of the Regional Director, focusing on the implementation of health care reform. Highlights of her projects included:

Michele Puccinelli Walker, MSG, MPA
Senior Associate

EDUCATION
Master's Degree, Gerontology
Master's Degree, Public Administration
University of Southern California

Bachelor's Degree, Human Development
University of California, Davis

EXPERIENCE
24 *years*
professional experience

CORE COMPETENCIES
Program design and implementation
Policy and regulatory analysis
Managed care program design

AFFILIATIONS
Member, American Society on Aging

- Managing the collaboration of a federal-private partnership with a foundation focusing on the impact of health care reform on the aging population.
- Directing the Federal Regional Council, which was comprised of 19 federal agencies in Region IX, including initiatives on health care reform, homelessness, Native Americans and sustainable communities.
- Designing, implementing and coordinating oversight of the Programs for All-Inclusive Care for the Elderly (PACE), including coordinating and tracking Medicare, Medicaid and Part D policy issues between PACE organizations, states and CMS; managing the PACE application review process; and directing the review and approval of PACE Medicaid capitation rates and program compliance/monitoring.
- Coordinating the oversight of Medicaid managed care and waiver programs, including 1915(b) and 1115 waivers and state plan amendments and review of actuarial sound rates.

While at Mercer, Michele has worked with the states of Arizona, California, Connecticut, Delaware, Florida, Kansas, Louisiana, Massachusetts, New Jersey, New Mexico, New York, North Carolina Ohio, Pennsylvania and South Carolina, as well as the District of Columbia.

Michele's experience includes:

- Preparing and negotiating 1915(b), 1915(c), 1915(b)/(c) concurrent and 1115 waivers and 1932(a) State Plan Amendments for the states of Delaware, Kansas, Louisiana, New Mexico, New York, Ohio, Pennsylvania, South Carolina and the District of Columbia.
- Working on the design and implementation of statewide Medicaid managed LTC programs for the states of Delaware, Kansas, New Jersey, New Mexico, and Ohio.
- Advising clients on changes in federal laws, regulations and policy in the area of health care reform, managed care, state funding mechanisms, managed care rate-setting, fee-for-service rate-setting, PACE, long-term care and dual-eligibles for the states of California, Delaware, Massachusetts, North Carolina, Ohio, and Pennsylvania.
- Participating in a workgroup with the National PACE Association on Medicaid ratesetting for PACE programs.
- Advising clients and designing behavioral health coordinated systems of care for children at risk for out of home placement for the states of Louisiana and South Carolina.
- Working on the design and implementation of behavioral health system redesigns, including the Autism benefit for the states of Louisiana, North Carolina, Ohio, and South Carolina.
- Designing health insurance exchanges and evaluating alternative (benchmark) benefit package options for Connecticut and Ohio.

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Publication: Torres-Gil, Fernando M. and Michele A. Puccinelli. "Aging Policy in the Clinton Administration." *Journal of Aging and Social Policy*, Vol. 7(2) (1995): 13-18.
- Torres-Gil, Fernando M. and Michele A. Puccinelli. "Mainstreaming Gerontology in the Policy Arena." *The Gerontologist*, 34 (1994): 749-752
- Torres-Gil, Fernando M. and Michele A. Puccinelli. "Aging: Public Policy Issues and Trends." *Encyclopedia of Social Work*, 19th Edition (1) (1993): 159-164.
- Presentation: The SCAN Foundation's 2013 LTSS Summit. *ARDC Business Plan Development.* November 13, 2013.
- Presentation: Mercer's Webinar for Clients. *Informational Review for Mercer Clients: Medicaid Home and Community-Based Services New Rule.* June 27, 2014.
- Presentation: Ohio's HCBS Public Stakeholder Meeting. *Medicaid Home and Community-Based Services Basics and New Rules.* July 30, 2014.

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Rachel Wright, RN, MSN, PHN
Role: Senior Consultant

QUALIFICATIONS

Rachel brings a unique understanding of state Medicaid and Public Health systems. She has over 13 years of nursing experience in physical, behavioral and long-term health care. As a certified public health nurse, Rachel is passionate about building community health capacity focusing on population health measurement.

EXPERIENCE

Prior to joining Mercer in 2015, Rachel started her administrative nursing career in New Mexico's Department of Public Health as the Director of Nursing Services Coordinator before joining the Board of Nursing as the Program Director for the Nursing Diversion program and ending her time at the State as the Quality Bureau Chief for the Medical Assistance Division. As the Quality Bureau, Chief Rachel supported the State's successful Medicaid expansion and implementation of the State's 1115 waiver.

Rachel's experience includes:

- External Quality Review (EQR) compliance review and reporting in Delaware and New Mexico.
- Medicaid Health Plan Review and technical assistance in Delaware, Pennsylvania, Virginia, and New Mexico.
- Developing and obtaining Centers for Medicare & Medicaid Services (CMS) approval of the New Mexico 1115 Quality Strategy in New Mexico.
- Developing network standards and managed care rule technical assistance for provider network compliance, measurement, contract language, and quality strategy in Delaware.
- Developing Provider network utilization analysis and reporting for Delaware.
- Case management, care coordination and long term care services and supports (LTSS) program review and technical assistance in Delaware, Pennsylvania, Connecticut, and New Mexico.
- Developing readiness review criteria and conducting readiness reviews, reporting and technical assistance in New Mexico.
- Developing auditing and reporting tools in Delaware, Pennsylvania, Ohio, and New Mexico.
- Developing and presenting trainings for quality improvement processes including performance improvement projects and data analysis and interpretation in Pennsylvania.

Rachel Wright, RN, MSN, PHN
Senior Associate

EDUCATION
Master's degree, Nursing
Benedictine University
Bachelor's degree, Nursing
Regis University

EXPERIENCE
12 years
Professional experience

CORE COMPETENCIES
Managed Care Program Operations
Provider Network Access, Utilization, and Availability Measurement
Compliance Reviews
Clinical Efficiency Analysis

AFFILIATIONS
Licensed Registered Nurse, Minnesota and New Mexico (compact license)
Certified Public Health Nurse, Minnesota
MLC Certified Medicaid Professional

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Jonathan Myers, MS
Role: Junior Consultant

QUALIFICATIONS

Jonathan is an Associate in our Policy and Operations Sector (POpS) and works from our office in Washington, DC. With over 5 years of state health policy experience, Jonathan focuses on Medicaid operations, managed care organization (MCO) procurements, readiness assessments and program evaluation, program implementation, MHPAEA analysis/compliance, statewide Medicaid research studies, survey design/analysis, and preparation/implementation of state plan amendments and State training. Jonathan has extensive experience coordinating reporting and program evaluations, survey design and analysis, procurement activities, readiness reviews, policy analysis, and program implementation for multiple state Medicaid programs. Jonathan has worked extensively with multiple entities coordinating multifaceted projects from conception to implementation.

EXPERIENCE

Prior to joining Mercer, Jonathan worked as a research consultant with London-based firm Strategic Communications Laboratories. Jonathan specialized in the coordination of social research campaigns, survey development/design, data analysis and developed strategic communication initiatives for specific populations in remote regions of Asia and East Africa.

Jonathan's recent accomplishments have included:

- Project leader, project management, consulting and analysis of MHPAEA compliance activities with specific focus on NQTL analysis. Currently work with Delaware, Ohio and New Mexico clients to assess State compliance, MCO compliance and regulatory analysis activities.
- Project management and consulting activities to develop ongoing compliance mechanisms for Delaware DD program with HCBS regulations and state administrative code.
- Project management and researching consultant of statewide research study of Virginia's Medicaid program evaluating trends, drivers, utilization, costs of all VA Medicaid programs. In addition, Jonathan has conducted in-depth analysis of complex-care populations evaluating costs, trends and utilization.
- Developing and managing the start-to-end administrative, performance and utilization reporting tools for multiple contracted managed care entities providing services to Medicaid recipients in Puerto Rico and New Mexico.
- Designing and coordinating complex member, provider, MCO and stakeholder surveys assessing HCB setting requirements for specific Medicaid populations in Connecticut, New Mexico and Delaware.

Jonathan Myers
Associate

EDUCATION
Master of Science, War Psychiatry
King's College London
Bachelor of Arts, Psychology
SUNY Stony Brook

EXPERIENCE
7 years professional experience

CORE COMPETENCIES
Reporting & Monitoring
Health homes readiness reviews, reporting, monitoring & SPA
MHPAEA analysis and compliance
HCB-setting evaluations and compliance
Evaluation of complex care populations
MCO procurements & readiness reviews
Program integrity
Operations assessments
Meeting facilitation
Project management
Training

AFFILIATIONS
None

- Coordinating MCO procurements in Puerto Rico; including providing assistance in developing RFPs, client facilitation of proposal evaluations, designed/managed proposal scoring methodology, and assisted in final presentations to Agency Board of Directors and executive leadership.
- Designing and coordinating CareLinkNM health home readiness reviews in New Mexico including, the design and development of review tools, client training, and facilitation of onsite readiness review meetings and final readiness review deliverables to CMS.
- Designing and coordinating MCO readiness reviews in New Mexico, Delaware and Puerto Rico including, the design and development of review tools, client training, and facilitation of onsite readiness review meetings (including both client and MCO staff) and final readiness review deliverables to CMS.
- Providing technical assistance helping the client design program integrity regulatory requirements and responses to Corrective Action Plan with CMS.
- Providing technical assistance and contract review of program integrity regulatory requirements for States following release of 2016 managed care rule.
- Providing Puerto Rico with on-site operational technical assistance, including program design, training activities to promote organizational capacity building, and executive level updates and briefings.
- Developing time tracking methodologies for the US Virgin Islands' Medicaid transformation project to ensure proper FMAP of current HIE and HIT capacity building.

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- January 2017, presentation to New Mexico Behavioral Health Collaborative on MHPAEA.

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Son Yong Pak, CPHQ, CPC
Role: Junior Consultant

QUALIFICATIONS

Son Yong combines her experience in operations and project management and in clinical quality and efficiency in physical and behavioral health (BH) for Medicaid, children's health insurance program, and long term care (LTC) populations to plan and monitor project implementations to ensure initiatives are completed with the scope, on time, and within the budget. Also, she is a key contributor to the internal Mercer medical coding team and has contributed medical coding knowledge to almost every Mercer's Medicaid clients. Son Yong researches federal and state regulations and guidelines as well as clinical and medical coding guidelines and provides coding expertise and support to the actuarial and clinical teams.

EXPERIENCE

Prior to joining Mercer, Son Yong worked for various health care entities including, but not limited to: the Arizona Chapter of the American Academy of Pediatrics as an Improvement Coach working with primary care physicians transforming their practices into patient-centered medical homes (PCMH); Medicaid managed care organizations (MCOs) as the Director of Early and Periodic Screening, Diagnosis and Treatment; Chief Operations Officer at the Department of Economic Security, Comprehensive Medical and Dental Program, which is a Medicaid health plan for the children in the foster care system; the Arizona Health Care Cost Containment System (AHCCCS), Arizona's single state Medicaid agency as Operations and Compliance Officer and at BH-MCO as a Quality Management Analyst. While at AHCCCS, Son Yong was responsible for oversight and conducting operational and financial reviews of Medicaid capitated acute care managed care organizations (MCOs), BH MCOs, and LTC MCOs.

Son Yong Pak, CPHQ, CPC
Senior Associate

EDUCATION
Bachelor's degree, Sociology
University of California, Berkeley

EXPERIENCE
20 years
professional experience

CORE COMPETENCIES
Medical coding
Health care data analysis and interpretation
Regulatory and operations compliance
Practice transformation
Quality improvement
Evaluating MCO readiness and compliance
Project management

AFFILIATIONS
Certified Professional in Healthcare Quality
Certified Professional Coder
Member, National Association for Healthcare Quality (NAHQ)
Member, American Academy of Professional Coders (AAPC)

In her role as Government Consultant, Son Yong's accomplishments include:

- Assisting Commonwealth of Pennsylvania, Office of Mental Health and Substance Abuse Services, with BH-MCO operations assessment.
- Assisting Commonwealth of Pennsylvania, Office of Mental Health and Substance Abuse Services, with assessing program integrity efforts of BH-MCOs, developing program integrity monitoring tool, assessing corrective action plans, and providing a program integrity overview presentation for staff training.

- Assisting Delaware with assessing progress integrity efforts of managed care organizations.
- Developing project management plans and tools including communication and risk management plans for the States of Arizona, Georgia, New Mexico, Ohio, and Commonwealth of Pennsylvania.
- Project management of a State Innovation Model (SIM) design grant, assisting with the Centers of Medicare & Medicare Services (CMS) deliverables, drafting steering committee presentations, and facilitating stakeholder meetings for Arizona.
- Assisting Arizona with 1115 transformational delivery system reform waiver design, which includes project management, researching performance measures, drafting stakeholder feedback summary, and facilitating client meetings.
- Assisting with 1115 waiver, which includes project management, drafting Medicaid Advisory Committee Subcommittee meeting minutes, and facilitating client meetings for the Department of Human Services, New Mexico.
- Project management of a request for proposal (RFP) of an administrative services organization for the Department of Behavioral Health and Developmental Disabilities, Georgia.
- Developing a procurement and contractor readiness review manual for the Office of Mental Health and Substance Abuse Services, Pennsylvania.
- Researching best practices in preventing potentially preventable hospital admissions and readmissions for home health agencies, facilitating stakeholder meetings, developing provider toolkit, and designing provider evaluation survey for the Ohio Department of Medicaid.
- Supporting all state actuarial teams through the review of medical codes and service categorizations, including ICD-9 and ICD-10 diagnosis and procedural codes, CPT-4 and HCPCS procedure codes, DRGs and ADA dental codes as well as codes specific to UB04 and CMS-1500 forms for rate development and clinical efficiency reviews for California, Connecticut, Delaware, Florida, Louisiana, Massachusetts, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Texas and Washington DC.
- Assisting Ohio Department of Medicaid with behavioral health redesign and implementing the National Correct Coding Initiative.
- Working to implement ICD-10 changes, within both our own data systems and those of our clients.
- Developing and assisting with medical coding logic for family planning services and preventive services for additional federal match for California, Delaware, Louisiana, New Jersey and Ohio.
- Mapping ICD-9 to ICD-10 codes for MMIS claims edit and assisting with MMIS vendor programming oversight for Delaware.
- Assisting with correct coding and reviewing provider qualifications for behavioral health redesign for the Ohio Department of Medicaid and Ohio Department of Mental Health and Addiction Services.
- Developing a provider billing manual for therapy providers for the Department of Economic Security/ Division of Developmental Disabilities, Arizona.
- Updating the Behavioral Health Services Manual with revised procedure codes and guidelines for the Department of Health and Hospitals, Louisiana.

- Assisting with medical coding logic for maternity kick-payment for Louisiana.
- Developing Medicaid encounters via current procedural terminology, healthcare common procedure coding system, and ICD-9 coding logic to identify US Preventative Task Force Recommendations for Delaware, New Jersey, and Ohio.

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Medical home and quality improvement presentations, Arizona Chapter of the American Academy of Pediatrics, Medical Home Learning Collaboratives, 2012-2013.

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Maija Welton
Role: Junior Consultant

QUALIFICATIONS

Maija has worked on a wide range of projects for clients including Arizona, Delaware, Idaho, Kansas, Missouri, New Jersey, New Mexico, Ohio, Oklahoma, and the U.S. Virgin Islands. She has also worked on many ad hoc projects including those for New York, North Carolina, and the North Carolina Hospital Association. The wide range of client work at Mercer in many ways parallels her experience working as a policy advisor for a member of Congress, which required thorough and timely analysis on a multitude of health policy issues. During her eight years working on Capitol Hill, six of which were dedicated to health policy, she was charged with responsibilities ranging from conceiving legislation to building support for that legislation among other members of Congress and relevant stakeholders.

Maija Welton
Associate

EDUCATION
Bachelor's degree, Economics
Smith College

EXPERIENCE
11 years
professional experience

CORE COMPETENCIES
Stakeholder Engagement
Policy Implementation Analysis
Contract and Regulation Review

EXPERIENCE

At Mercer, Maija has contributed to a number of projects, a significant portion of which have focused on compliance with Medicaid managed care regulations; specifically, the 2016 Medicaid Managed Care Rule. Examples of client deliverables that she has worked on include the following:

- Revisions to Medicaid managed care contracts to reflect compliance with the 2016 Medicaid Managed Care Rule.
- Policies and procedure documents to operationalize the 2016 Medicaid Managed Care Rule.
- Major components of two Medicaid-related policy manuals.
- A policy paper on Medicaid organ transplant coverage.
- A policy paper on emergency department diversion programs.
- Statewide Health Innovation Plan (SHIP) communication plan and communication material.
- Stakeholder engagement plan and materials.
- A 1915(b)(4) waiver.
- A state self-assessment redraft of the federal Home and Community Based Services (HCBS) rule.
- Research on Medicare enrollment of Medicaid beneficiaries, Managed Long-Term Services and Supports (MLTSS) contracts, and dual-eligible special needs plan (D-SNP) contracts.
- Summary of federal sanctions for managed care contract violations.
- Summary of state regulations on accountable care organizations (ACOs).

Prior to joining Mercer, Maija she was the health care advisor to Congressman Joe Courtney (CT-02), a House member with committee jurisdiction over the Affordable Care Act. In that role, she was the lead author and face for all health policy related communications for the Congressman, including in-person meetings with local and national advocacy groups, updates to the Congressman's website and Facebook pages, newsletters, press releases, letters to House and Senate leadership, letters to the Administration, opinion editorials, constituent mail, and updates to local and national stakeholders on the Congressman's accomplishments. Additionally, she worked as the primary constituent mail program manager for Congressman Jim Kolbe (AZ-02).

Maija's accomplishments include the following:

- Advisor to Congressman Joe Courtney during the health care reform debate, including management of Congressman's committee work on the House version of the Affordable Care Act. Committee work on health reform included submission and management of two adopted amendments, preparing amendment background papers for committee members and staff, as well as drafting press statements and updates on amendment progress for relevant stakeholder groups.
- Drafted letter that generated support from over 200 Members of Congress in opposition to a proposed Senate health care excise tax which helped facilitate a scaled-back version of the tax in a final compromise.
- Drafted opinion pieces in Congressman's name for publication in such news outlets as the *Huffington Post*, *Roll Call*, *Politico*, *The Hill*, and *USA Today*.
- Initiated and ensured proper execution of Congressman's legislation, including three health policy-related bills: 1.) insurance restrictions on pre-existing condition exclusions; 2.) skilled nursing facility coverage access; 3.) loan repayment for pediatric mental health providers and subspecialists.
- Recruited broad support for legislation sponsored by Congressman among other Members of Congress, as well as industry and advocacy groups. Recruitment of support among Members of Congress included drafting and disseminating background papers on legislation and targeted letters on how the legislation would benefit different constituencies. Recruitment of support among industry and advocacy groups included initiating discussions on why the legislation was relevant, drafting and disseminating background papers on the legislation, and maintaining support through regular email updates and in-person meetings.

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James Moore
Role: Research Analyst

James Moore
Associate

EDUCATION
Bachelor's Degree, Mathematics
University of Georgia

EXPERIENCE
2.5 years
professional experience

CORE COMPETENCIES
Data Management and processing
Design of quantitative studies
Developing capitation rates

AFFILIATIONS
Continuing pursuit of a Fellow of the Society of Actuaries designation

QUALIFICATIONS

James is an Associate in Mercer's Government Human Services Consulting group, a part of Mercer Health & Benefits LLC (Mercer) in the Atlanta office. Skills in data organization and analysis allow him to accurately evaluate health care data. He is a team member for the client states of Louisiana, New Mexico, North Carolina, and Oklahoma. James provides a helping hand in determining data accuracy and completeness, cost reporting, waiver application, and rate development.

EXPERIENCE

James' current responsibilities include, but are not limited to, assisting the actuarial team in claims analysis, data book preparation, and rate setting.

James' experience includes:

- Assisting with enrollment and expenditure forecasting and ad hoc reporting for North Carolina's AIDS Drug Assistance Program.
- Assisting with North Carolina's 1115 budget neutrality waiver application for Managed Care implementation
- Utilizing Microsoft SQL Server for data book processing of claims for rate setting projects in Louisiana.
- Calculating budget neutrality reports for Louisiana's 1115 waiver program Greater New Orleans Community Health Connection
- Calculating reconciliation amounts for Retroactive enrollment, Hepatitis-C drug risk corridor, LTSS Patient Liability, and Medicaid Expansion risk corridor for various programs in New Mexico.
- Researching and analyzing program changes in Louisiana.
- Calculating impact of fee schedule changes for Louisiana rate setting.
- Collection, analysis and interpretation of health care data including fee-for-service (FFS), financial, and encounter data in the states of Louisiana, New Mexico, and Oklahoma.
- Calculating trends for Medicaid rate setting projects in Louisiana and Oklahoma.
- Developing logic to identify Specialized Behavioral Health services in encounter experience in Louisiana's Physical Health/Behavioral Health-integrated managed care program, Healthy Louisiana.
- Calculating the amount of Full Medicaid Payment for rate setting in the state of Louisiana regarding increased payment for hospital, ambulatory, and physician services.

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Madison Surdyke, PMP
Role: Research Analyst

QUALIFICATIONS

Madison combines her experience in project management and data analysis to assist in setting actuarially sound capitation rates and to facilitate a team culture that encourages ownership of team goals. She is a team member for the client state of New Jersey.

EXPERIENCE

Prior to joining Mercer, Madison attended the University of Florida where she studied Accounting and Actuarial Science. At UF, Madison honed in on her leadership skills though involvement in various organizations, holding roles such as Treasurer of an organization of 225 members and Executive Director of Finance and Operations for a leadership conference.

Madison's experience includes:

- Developing project management plans and tools including work breakdown structures, communication plans, change management plans, and schedule management plans
- Developing curricula and facilitating training sessions for staff on the New Jersey team
- Developing a team binder to serve as a tool for New Jersey team members to have the resources they need to succeed including an introduction to the team, roles and responsibilities, team standards, information on New Jersey, and training materials
- Developing a team debrief survey to collect and analyze feedback on our projects to learn from our successes, determine changes needed to our processes, assess areas for improvement, and to document lessons learned
- Assisting in setting actuarially sound Medicaid capitation rates and Program of All-Inclusive Care for the Elderly (PACE) capitation rates and Amount that Would have Otherwise been Paid (AWOP)
- Collecting, analyzing, and interpreting health care data including FFS, financial, and encounter data for the State of New Jersey
- Focused data-driven analyses to calculate patient liability
- Health plan reviews for compliance, accuracy, and efficiency benchmarking

Madison Surdyke, PMP
Associate

EDUCATION
Bachelor's degree, Accounting with minor in Actuarial Science
University of Florida

EXPERIENCE
3 years professional experience

CORE COMPETENCIES
Project planning and management

Training development and facilitation

Analysis and interpretation of health care data

Health plan reviews

AFFILIATIONS
Project Management Professional (PMP), Project Management Institute

Exams: Probability, Financial Mathematics, Models for Financial Economics
Society of Actuaries

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Alec Zuber, MPA
Role: Research Analyst

QUALIFICATIONS

Alec works on varying projects related to actuarial rate setting for state Medicaid agencies.

EXPERIENCE

Prior to joining Mercer, Alec was a support coordinator for the State of Utah's Division of Services for People with Disabilities – Utah's 1915(c) Medicaid waiver authority.

During his time as a Qualified Intellectual Disabilities Professional support coordinator, Alec gained experience in the following:

- Individualized care plan development and monitoring to support successful community living.
- Health and Safety considerations for individuals living with developmental or intellectual disabilities.
- Project management of 40+ client care plans and corresponding teams.
- Monitored licensed Medicaid provider compliance to state and federal contract standards – initiating program improvements and corrective actions when needed.
- Oversaw allocation and expenditure of long-term care services budgets totaling over $2.5 million.
- Evaluation of program effectiveness— made regular recommendations to state agency and contractors.

His experience at Mercer includes:

- Actuarial rate-setting analysis of major State client Managed Care program elements including:
  - Development of Low Acuity Non-emergent (LANE) and Potentially Preventable Admissions efficiency adjustments for both the State of New Jersey and the State of New York's Medicaid managed care programs. Led the effort to incorporate methodology improvements to cost offset logic for laboratory and radiology components.
  - Continuous management and production of the State of New York's quarterly pharmacy encounter data dashboards across multiple participating Medicaid plans and programs. Led the development and implementation of several new data dashboards including: Fee-for-service (FFS) environment vs. managed care pharmacy benchmarking, Hepatitis C pharmacy drug utilization, HIV Antiretroviral Therapy drugs utilization and special needs program membership.
  - Development and monitoring of the State of New Jersey's Medicaid Managed Long-Term Care Case Management rate component. Led the efforts to improve and monitor plan reporting of administrative expenses related to the provision of member care management.

Alec Zuber, MPA
Consulting Analyst

EDUCATION
Master's degree, Public Administration
Brigham Young University
Bachelor's degree, Political Science,
Brigham Young University

EXPERIENCE
10 years
professional experience

CORE COMPETENCIES
Managed Care Rate setting
1915(c) waiver populations
DD/ID population considerations
HCBS services administration
Vulnerable populations
Care management

- Participated in comprehensive review and analysis of the State of New Jersey participating health plan-submitted financial statements. This entailed review of appropriate medical expenditures and administrative costs reviews. Participated in efforts to improve the coordination of State and health plan financial monitoring.
- Led development, monitoring, and projection of the State of New Jersey's Medicaid member enrollment. This spanned several distinct populations with varying acuity dynamics across multiple programs.
- Led development of pharmacy industry trend metrics to inform the State of New York's Medicaid Managed Care rate setting.
- Modeling and project management of various newly implemented State Medicaid member benefits.

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PROPOSED STAFF

MEDICAID MANAGED CARE
RATE SETTING (ACTUARIAL SERVICES)

Resumes for the following staff (in this order) are provided in this section.

MANAGED CARE ACTUARIAL SERVICES			
Position	**Name**	**Actuarial Designation**	**Years of Experience**
Lead Actuary	Katherine Long, FSA, MAAA	FSA, MAAA	9+
Actuaries	Lisa Deyer, ASA, MAAA James Matthisen, ASA, MAAA Brandon Odell, FSA, MAAA Adam Sery, FSA, MAAA	ASA, MAAA ASA, MAAA FSA, MAAA FSA, MAAA	11+ 32+ 4+ 13+
Actuarial Analysts	Christina Coleman James Moore Madison Surdyke, PMP	N/A N/A N/A	2+ 2+ 3+
Support Staff	TBD	TBD	TBD

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Katherine Long, FSA, MAAA
Role: Lead Actuary

QUALIFICATIONS

Katherine is a Principal and Actuary with Mercer's Government Human Services Consulting specialty practice, a part of Mercer Health & Benefits LLC (Mercer). Katherine provides actuarial consulting services to develop rates reflective of the efficient managed care environments expected by state clients and supports her clients during negotiations with contractors and CMS. Katherine's experience includes capitation rate development and actuarial support on various projects for Florida, New York, New Mexico, and Pennsylvania.

EXPERIENCE

Katherine has extensive experience developing rates for different types of managed care programs, including acute care programs for the Temporary Assistance for Needy Families (TANF) and Aged, Blind or Disabled (ABD) populations, managed behavioral health, managed long term services and supports (MLTSS), Duals demonstrations in partnership with the Centers for Medicare & Medicaid Services (CMS), and the Program for All-Inclusive Care for the Elderly (PACE). Her continuous years of experience with New York and New Mexico has included supporting programs through significant changes at the state and federal level, including supporting actuarial rate development through periods of program redesign.

Katherine Long
Principal

EDUCATION
Bachelor's degrees, Mathematics and Biology
Arizona State University
Barrett, the Honors College

EXPERIENCE
9 years professional experience

CORE COMPETENCIES
Capitation rate development
Long term services and supports
Implementing and conducting risk adjustment

AFFILIATIONS
Fellow of the Society of Actuaries
Member, American Academy of Actuaries

Katherine's experience includes:

- Developing and certifying Medicaid capitation rates for New York, New Mexico, and Pennsylvania; including collecting, analyzing and interpreting managed care organization (MCO) financial and encounter data and developing detailed analyses and actuarial assumptions for various rate adjustments.
- Extensive experience developing and certifying capitation rates for MLTSS programs, including Duals Demonstrations and PACE (upper payment limits). Including actuarial support for New York implementing mandatory managed care for the MLTSS population, tripling program enrollment across four available managed long term care programs.
- Developing risk adjustment factors for risk adjusted payment rates for both acute and long term care programs. Application of risk scores for alternative purposes, including use in clinical efficiency analysis, voluntary selection bias, and rating populations new to managed care.
- Presenting results to key stakeholders including state leadership, CMS, and participating MCOs.

- Understanding and interpreting significant policy changes (state and federal) and implications on managed care programs. Working closely with Mercer specialty sectors to identify savings opportunities and provide on-going support for the state and other stakeholders.
- Creating, maintaining, and evaluating various risk mitigation programs, including risk corridors, risk sharing arrangements, and risk pools.
- Partnering with New Mexico to provide actuarial support for the cost component of their competitive MCO procurements in 2012 and 2017, including advising on available approaches, messaging strategy, bidder's conference support and cost scoring.
- Supporting clients to achieve maximum match from CMS through enhanced funding for family planning services, Money Follows the Person, and Community First Choice Option.
- Strong knowledge of actuarial requirements, including Actuarial Standards of Practice, Final Rule for Medicaid and the Children's Health Insurance Program (CHIP) managed care programs, and CMS Medicaid Managed Care Rate Development Guide. Experience preparing robust documentation to comply with changing regulatory environment.

MERCER
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Lisa Deyer, ASA, MAAA
Role: Actuary

QUALIFICATIONS

Lisa applies her advanced actuarial skills to develop rates reflective of the efficient managed care environments expected by state clients. Lisa's experience includes rate development for the client states of New York and Pennsylvania. She supports her teams by providing clear guidance and leadership on actuarial processes.

EXPERIENCE

Lisa's experience includes:

- Developing Medicaid capitation rates for New York and Pennsylvania; this includes collecting, analyzing and interpreting health plan financial and encounter data and developing detailed analyses and actuarial assumptions for various rate adjustments.
- Developing rates for various types of programs including Medicaid Managed care for acute care, HIV special needs program for acute care, and Adult Expansion.
- Review and implementation of efficiency analysis within the managed care acute care programs related to pharmacy, inpatient and emergency room services. Detailed understanding of clinical concepts as it related to the rate-setting process.
- Guiding prospective trend analyses, incurred but not reported (IBNR) claims review, and several other program change analyses for the New York and Pennsylvania rate-setting projects.
- Providing consulting reviews in several key areas of the rate-setting process to ensure high quality work products for clients.
- Presenting results and actuarial concepts to key stakeholders including state leadership and participating health plans.
- Participating in health plan on-site reviews to provide guidance on health plan efficiencies and areas for improvement at the State's request.
- Understanding and interpreting significant policy changes (state and federal) and implications on managed care programs. Working closely with Mercer specialty sectors to identify savings opportunities and provide on-going support for the State and other stakeholders.
- Preparing robust documentation to comply with changing regulatory environment.

Lisa Deyer, ASA, MAAA
Actuary

EDUCATION
Master's degree, Economics
Boston University
Bachelor's degree, Mathematics and Economics
Boston University

EXPERIENCE
11 years
professional experience

CORE COMPETENCIES
Managed care rate development
Adult Expansion rating
Special Needs Program rating
Actuarially sound principles

AFFILIATIONS
Associate Society of Actuaries
Member American Academy of Actuaries

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Brandon Odell, FSA, MAAA

Role: Actuary

QUALIFICATIONS

Brandon has extensive experience working in the area of financial analysis, efficient capitation rate setting, and Medicare Advantage bidding.

EXPERIENCE

Prior to joining Mercer, Brandon worked at an insurance company and consulting firms.

Brandon's experience includes:

- Developing Medicaid managed care capitation rates for Louisiana, New Mexico, and New York.
- Analyzing Medicaid managed care cost savings.
- Analyzing costs of breakthrough therapy drugs.
- Leading transition from use of Access-based data analysis to SQL-based analytics.
- Pricing and rate filing of Medicare Advantage and Part D plans.
- Prospective trend analyses.
- Lead development of Enhanced Primary Care Case Management (ePCCM) benchmarks and analysis of MCO performance to benchmarks.
- Presenting results and actuarial concepts to key stakeholders including state leadership and participating health plans.
- Development of FFS rates for HCBS services.
- Development of financial projections for a 1915(c) waiver.
- Evaluating savings generated by pediatric Accountable Care Organization (ACO).
- Forecasting budget neutrality for an 1115 waiver.
- Analyzing claims seasonality for commercial CDHP populations.
- Forecasting and financial reporting for commercial, Medicare Advantage, and Medicare Supplemental lines of business.
- Comparing commercial PPO network costs.

Brandon Odell, FSA, MAAA
Associate Actuary

EDUCATION
Bachelor of Science, Applied Mathematics with Honors
Ferris State University

EXPERIENCE
13 years professional experience

CORE COMPETENCIES
Managed care capitation rates
Actuarially sound practices
Adult Expansion rating
Financial analysis

AFFILIATIONS
Fellow Society of Actuaries
Member American Academy of Actuaries

MERCER
MAKE TOMORROW, TODAY

Adam G. Sery, FSA, MAAA
Role: Actuary

QUALIFICATIONS

Adam applies his ability to analyze complex financial and data issues, develop methodologies for detailed data analyses, and develop actuarially sound rates in Medicaid projects for our state clients.

EXPERIENCE

Adam joined Mercer as an intern in February 2003, and joined Mercer full-time in July 2004.

Adam has participated in rate-setting and clinical actuarial projects. His current duties include:

- Leading capitation rate-setting development for Medicaid managed care programs, specifically for behavioral health programs.
- Calculating capitation rates; major elements include inflation factors, completion factors and the impact of program and policy changes.
- Assist in developing methodologies for program changes for transitioning Medicaid recipients from institutional to community-based settings and other program changes related to transitioning individuals from fee-for-service to managed care.
- Calculating fee for service rate schedules for Medicaid programs, including home and community-based services, mental health and substance abuse services and evidence-based practices for children and adults, such as MST, FFT, and ACT.
- Assist in developing methodologies for alternative payment systems and working with clients to analyze the impact of various options.
- Working with consultants and clients to develop metrics for assessing the quality and efficiency of behavioral health managed care programs.
- Developed standardized reports to provide contractors with information on cost drivers for specific services and populations.
- Assisted in the development of dashboard metrics to display emerging experience in managed care programs.
- Developed savings measurement tools to assist states with implementation of new programs and monitoring managed care efficiency and effectiveness to reduce institutional costs and promote cost-effective care in home- and community-based settings.

Adam G. Sery, FSA, MAAA
Actuary

EDUCATION
Bachelor's degree, Actuarial Science and Economics
Summa Cum Laude
University of Saint Thomas

EXPERIENCE
13 years
Professional experience

CORE COMPETENCIES
Design of quantitative studies
Actuarially sound practices
Behavioral health financial modeling and rate development with clinical integration

AFFILIATIONS
Fellow Society of Actuaries
Member American Academy of Actuaries

MERCER
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Christina Coleman

Role: Actuarial Analyst

QUALIFICATIONS

Christina is an Actuarial Analyst in Mercer's Government Human Services Consulting group, a part of Mercer Health & Benefits LLC (Mercer) in the Atlanta office. She has a Bachelor's degree and more than two years of experience at Mercer. She has been a team member for the client state of Louisiana. Her current responsibilities include, but are not limited to, project management, claims-based health risk adjustment, analysis of financial statements, assisting the actuarial team in claims analysis, trend analysis, IBNR modeling, and rate setting.

Christina Coleman
Associate

EDUCATION
Bachelor's Degree, Actuarial Science
Georgia State University

EXPERIENCE
2 years
professional experience

CORE COMPETENCIES
Developing capitation rates
Claims-based health risk adjustment
Project Management

EXPERIENCE

Examples of Christina's experience include:

- Developing work plans and implementing best practices to effectively manage the Louisiana project team.
- Analyzing and adjusting Medicaid capitation rates for health risk of members enrolled in health plans in the State of Louisiana. Specifically, Christina validates the diagnostic data, monitors the population acuity, evaluates the risk score based on rate category acuity, and maintains budget neutrality in modeling.
- Analyzing the quarterly financial statements submitted by health plans to evaluate performance and identify any reporting issues.
- Lead analyst for the clinical efficiency analyses used to provide savings for the Louisiana Medicaid program by identifying costs that could have been avoided with better management from the Managed Care health plans.
- Collection, analysis, and interpretation of health care data including FFS, financial, and encounter data for the State of Louisiana.
- Calculating claims completion factors and trends for Medicaid rate setting projects in Louisiana.
- Using SQL for data book processing of claims for rate setting projects for Louisiana.
- Analyzing program changes for Louisiana.
- Drafting rate certifications and CMS responses in order to obtain approval of rates from CMS.
- Assisting the Joint Legislative Auditor Review Committee in reviewing the Virginia Medicaid Managed Care Rate-Setting process for reasonability.

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James Moore
Role: Actuarial Analyst

James Moore
Associate

EDUCATION
Bachelor's Degree, Mathematics
University of Georgia

EXPERIENCE
2.5 years
professional experience

CORE COMPETENCIES
Data Management and processing
Design of quantitative studies
Developing capitation rates

AFFILIATIONS
Continuing pursuit of a Fellow of the Society of Actuaries designation

QUALIFICATIONS

James is an Associate in Mercer's Government Human Services Consulting group, a part of Mercer Health & Benefits LLC (Mercer) in the Atlanta office. Skills in data organization and analysis allow him to accurately evaluate health care data. He is a team member for the client states of Louisiana, New Mexico, North Carolina, and Oklahoma. James provides a helping hand in determining data accuracy and completeness, cost reporting, waiver application, and rate development.

EXPERIENCE

James' current responsibilities include, but are not limited to, assisting the actuarial team in claims analysis, data book preparation, and rate setting.

James' experience includes:

- Assisting with enrollment and expenditure forecasting and ad hoc reporting for North Carolina's AIDS Drug Assistance Program.
- Assisting with North Carolina's 1115 budget neutrality waiver application for Managed Care implementation
- Utilizing Microsoft SQL Server for data book processing of claims for rate setting projects in Louisiana.
- Calculating budget neutrality reports for Louisiana's 1115 waiver program Greater New Orleans Community Health Connection
- Calculating reconciliation amounts for Retroactive enrollment, Hepatitis-C drug risk corridor, LTSS Patient Liability, and Medicaid Expansion risk corridor for various programs in New Mexico.
- Researching and analyzing program changes in Louisiana.
- Calculating impact of fee schedule changes for Louisiana rate setting.
- Collection, analysis and interpretation of health care data including fee-for-service (FFS), financial, and encounter data in the states of Louisiana, New Mexico, and Oklahoma.
- Calculating trends for Medicaid rate setting projects in Louisiana and Oklahoma.
- Developing logic to identify Specialized Behavioral Health services in encounter experience in Louisiana's Physical Health/Behavioral Health-integrated managed care program, Healthy Louisiana.
- Calculating the amount of Full Medicaid Payment for rate setting in the state of Louisiana regarding increased payment for hospital, ambulatory, and physician services.

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Madison Surdyke, PMP

Role: Actuarial Analyst

QUALIFICATIONS

Madison combines her experience in project management and data analysis to assist in setting actuarially sound capitation rates and to facilitate a team culture that encourages ownership of team goals. She is a team member for the client state of New Jersey.

EXPERIENCE

Prior to joining Mercer, Madison attended the University of Florida where she studied Accounting and Actuarial Science. At UF, Madison honed in on her leadership skills though involvement in various organizations, holding roles such as Treasurer of an organization of 225 members and Executive Director of Finance and Operations for a leadership conference.

Madison's experience includes:

- Developing project management plans and tools including work breakdown structures, communication plans, change management plans, and schedule management plans
- Developing curricula and facilitating training sessions for staff on the New Jersey team
- Developing a team binder to serve as a tool for New Jersey team members to have the resources they need to succeed including an introduction to the team, roles and responsibilities, team standards, information on New Jersey, and training materials
- Developing a team debrief survey to collect and analyze feedback on our projects to learn from our successes, determine changes needed to our processes, assess areas for improvement, and to document lessons learned
- Assisting in setting actuarially sound Medicaid capitation rates and Program of All-Inclusive Care for the Elderly (PACE) capitation rates and Amount that Would have Otherwise been Paid (AWOP)
- Collecting, analyzing, and interpreting health care data including FFS, financial, and encounter data for the State of New Jersey
- Focused data-driven analyses to calculate patient liability
- Health plan reviews for compliance, accuracy, and efficiency benchmarking

Madison Surdyke, PMP
Associate

EDUCATION
Bachelor's degree, Accounting with minor in Actuarial Science
University of Florida

EXPERIENCE
3 years professional experience

CORE COMPETENCIES
Project planning and management

Training development and facilitation

Analysis and interpretation of health care data

Health plan reviews

AFFILIATIONS
Project Management Professional (PMP), Project Management Institute

Exams: Probability, Financial Mathematics, Models for Financial Economics
Society of Actuaries

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