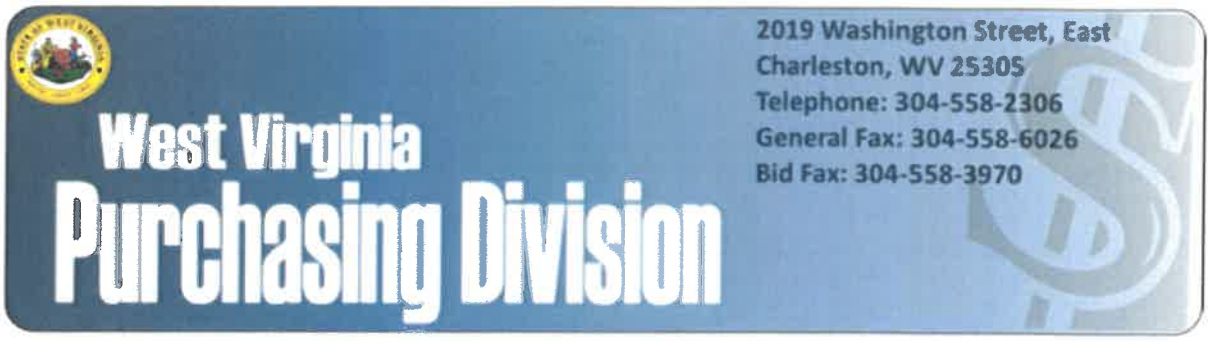
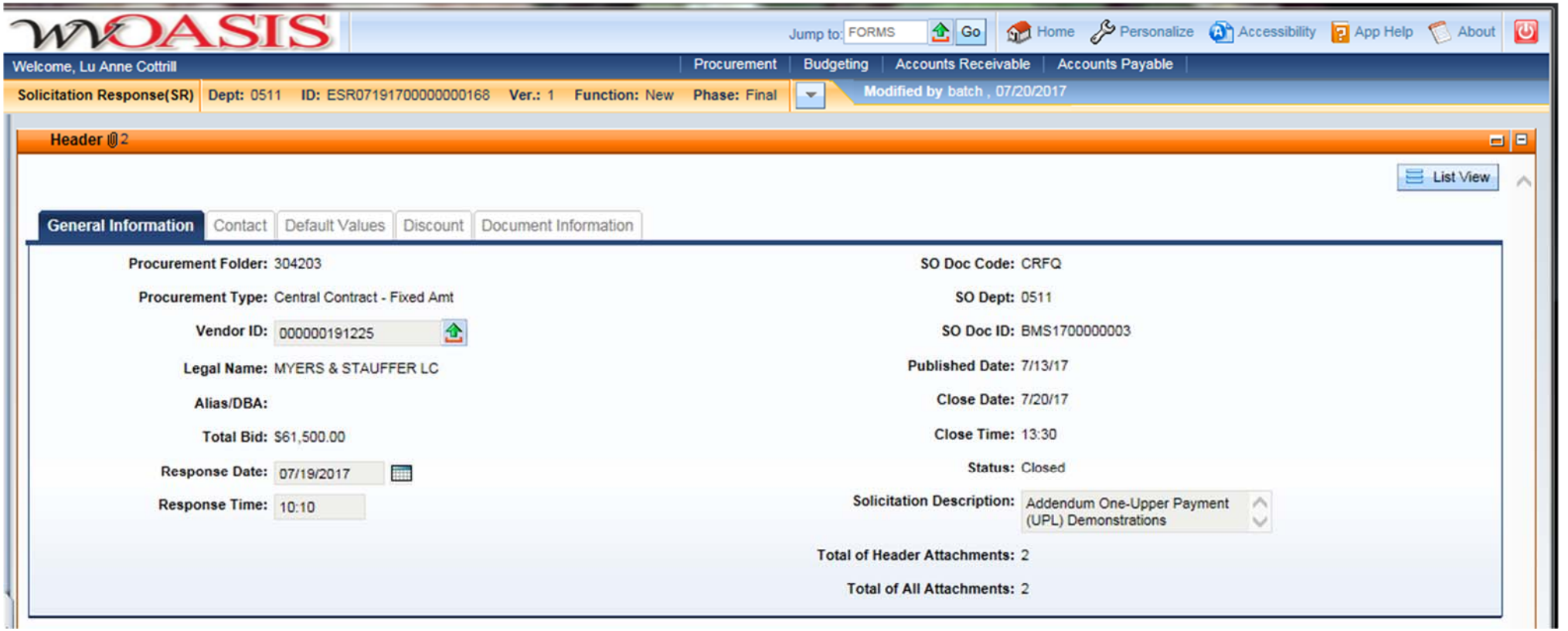



The following documentation is an electronically-submitted vendor response to an advertised solicitation from the *West Virginia Purchasing Bulletin* within the Vendor Self-Service portal at ***wvOASIS.gov***. As part of the State of West Virginia's procurement process, and to maintain the transparency 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.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Jump to: FORMS Go
Home
Personalize
Accessibility
App Help
About
Welcome, Lu Anne Cottrill
Procurement
Budgeting
Accounts Receivable
Accounts Payable
Solicitation Response(SR) Dept: 0511 ID: ESR07191700000000168 Ver.: 1 Function: New Phase: Final
Modified by batch , 07/20/2017
Header 2
List View
General Information
Contact
Default Values
Discount
Document Information
Procurement Folder: 304203
Procurement Type: Central Contract - Fixed Amt
Vendor ID: 000000191225
Legal Name: MYERS & STAUFFER LC
Alias/DBA:
Total Bid: $61,500.00
Response Date: 07/19/2017
Response Time: 10:10
SO Doc Code: CRFQ
SO Dept: 0511
SO Doc ID: BMS1700000003
Published Date: 7/13/17
Close Date: 7/20/17
Close Time: 13:30
Status: Closed
Solicitation Description: Addendum One-Upper Payment (UPL) Demonstrations
Total of Header Attachments: 2
Total of All Attachments: 2

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

# State of West Virginia
# Solicitation Response

**Proc Folder :** 304203

**Solicitation Description :** Addendum One-Upper Payment (UPL) Demonstrations

**Proc Type :** Central Contract - Fixed Amt

| Date issued | Solicitation Closes | Solicitation Response | Version |
|---|---|---|---|
| | 2017-07-20 13:30:00 | SR 0511 ESR07191700000000168 | 1 |

**VENDOR**

000000191225

MYERS & STAUFFER LC

**Solicitation Number:** CRFQ 0511 BMS1700000003

**Total Bid :** $61,500.00 **Response Date:** 2017-07-19 **Response Time:** 10:10:21

**Comments:**

**FOR INFORMATION CONTACT THE BUYER**

Charles D Barnette

(304) 558-2566
charles.d.barnette@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 | Accounting Services-UPL Demonstrations | | | | $61,500.00 |

| Comm Code | Manufacturer | Specification | Model # |
|---|---|---|---|
| 84111500 | | | |

**Extended Description :**

Accounting Services-UPL Demonstrations for Fiscal year 2016- 7/1/15-6/30/16

Service dates: 08/01/17-10/29/17

MYERS AND STAUFFER LC
1977 - 2017
CERTIFIED PUBLIC ACCOUNTANTS

# WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES

Upper Payment Limit Demonstrations

CRFQ BMS1700000003

Cost Proposal

July 20, 2017

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

# *Contract Award/Pricing Page* *(RFQ Sections 5.1/2)*

We have included our price estimate on the following pages. Our pricing is based on our understanding of your request and our previous experience conducting UPL demonstrations in West Virginia and numerous states.

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

**State of West Virginia**
**Request for Quotation**
**14 — Financial**

**Proc Folder:** 304203
**Doc Description:** Addendum One-Upper Payment (UPL) Demonstrations
**Proc Type:** Central Contract - Fixed Amt

| Date Issued | Solicitation Closes | Solicitation No | Version |
|---|---|---|---|
| 2017-07-13 | 2017-07-20 13:30:00 | CRFQ 0511 BMS1700000003 | 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:**
Myers and Stauffer LC
700 W. 47th Street, Suite 1100
Kansas City, MO 64112
816-945-5300

**FOR INFORMATION CONTACT THE BUYER**
Charles D Barnette
(304) 558-2566
charles.d.barnette@wv.gov

**Signature X** Amy Perry **FEIN #** 48-1164042 **DATE** 7/13/2017

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

**Page :** 1 FORM ID : WV-PRC-CRFQ-001

**ADDITIONAL INFORMAITON:**

Addendum One:

1 - To modify the bid opening date and time from July 18, 2017 to July 20, 2017 at 1:30 PM, EST

2 - To respond to technical questions submitted by the vendors.

No other changes.

| INVOICE TO | SHIP TO |
|---|---|
| PROCUREMENT OFFICER - 304-356-4861<br>HEALTH AND HUMAN RESOURCES<br>BUREAU FOR MEDICAL SERVICES<br>350 CAPITOL ST, RM 251<br>CHARLESTON WV25301-3709<br>US | PROCUREMENT OFFICER - 304-356-4861<br>HEALTH AND HUMAN RESOURCES<br>BUREAU FOR MEDICAL SERVICES<br>350 CAPITOL ST, RM 251<br>CHARLESTON WV 25301-3709<br>US |

| Line | Comm Ln Desc | Qty | Unit Issue | Unit Price | Total Price |
|---|---|---|---|---|---|
| 1 | Accounting Services-UPL Demonstrations | 1 | 1 | $61,500.00 | $61,500.00 |

| Comm Code | Manufacturer | Specification | Model # |
|---|---|---|---|
| 84111500 | | | |

**Extended Description :**

Accounting Services-UPL Demonstrations for Fiscal year 2016- 7/1/15-6/30/16

Service dates: 08/01/17-10/29/17

**SCHEDULE OF EVENTS**

| Line | Event | Event Date |
|---|---|---|
| 1 | Technical Qustion Deadline by 4:00 PM | 2017-07-10 |

**Page :** 2

| | Document Phase | Document Description | Page 3 |
|---|---|---|---|
| BMS1700000003 | Final | Addendum One-Upper Payment (UPL) Demonstrations | of 3 |

**ADDITIONAL TERMS AND CONDITIONS**

See attached document(s) for additional Terms and Conditions

Exhibit A:
**All inclusive price for UPL Demonstrations:**

**Medicaid State Plan Year 2016 (July 1, 2015-June 30, 2016) All UPL Demonstrations Year 1**

| | | | | Total Cost for UPL Demonstrations |
|---|---|---|---|---|
| Cost UPL Demonstrations | | | Year 1 | |
| Grand Total | | | | $61,500.00 |

Notes

1. The Vendors Grand Total Not to Exceed Cost will include all general and administrative staffing (secretarial, clerical, etc.), travel, supplies and other resource costs necessary to perform all services within the scope of this procurement.
2. The cost bid proposal will be evaluated based on the Grand Total.
3. The Vendor will invoice upon Agency acceptance of final UPL demonstrations . Payment will be withheld until final UPL Demonstrations are delivered and accepted by the Bureau.

Myers and Stauffer LC
(Company)

Amy C. Perry, Member
(Representative Name, Title)

816-945-5300/816-945-5301
(Contact Phone/Fax Number)

7/13/2017
(Date)

If applicable, sign and submit the attached Resident Vendor Preference Certificate with the quotation.

MYERS AND STAUFFER LC
1977 - 2017
CERTIFIED PUBLIC ACCOUNTANTS

# WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES

Upper Payment Limit Demonstrations

CRFQ BMS1700000003

July 20, 2017

Technical Proposal

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
1977 - 2017
CERTIFIED PUBLIC ACCOUNTANTS

July 20, 2017

Mr. Charles Barnette
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, West Virginia 25305-0130

Dear Mr. Barnette and Members of the Evaluation Committee:

Myers and Stauffer LC is pleased to present our proposal in response to *Request for Quotation (RFQ) CRFQ BMS1700000003: BMS Upper Payment Limit (UPL) Demonstrations* for the West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS).

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

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

Myers and Stauffer has 18 offices located nationwide that collectively manage active engagements with 48 state Medicaid agencies, including engagements with the state of West Virginia. The vast majority of our client engagements have been continued for more than five years, which is a clear indication of our clients' ongoing satisfaction with the services we provide.

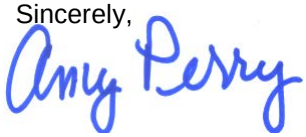
Our exemplary track record has led to the development of a dedicated team of consulting professionals who are committed to providing the highest quality and responsive personal service while staying abreast of regulatory changes and receiving formal training that exceeds professional requirements. In addition to our extensive regulatory health care experience, utilizing Myers and Stauffer to perform these technical services will afford BMS an additional level of quality and performance, since certified public accounting (CPA) firms are held to the highest professional standards for integrity, quality, and performance.



700 W 47th Street, Suite 1100 | Kansas City, MO 64112
PH 816.945.5300 | PH 800.374.6858 | FX 816.945.5301
www.mslc.com

If you require additional information or would like a presentation of our capabilities, please contact me at APerry@mslc.com or 800.374.6858. We look forward to continuing to work with BMS to ensure the integrity and fiscal efficiency of your Medicaid program.

Sincerely,



Amy C. Perry, CPA
Member

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# *Designated Contact/Certification*

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

Amy Perry, Member
(Name, Title)
Amy C. Perry, Member
(Printed Name and Title)
700 W. 47th Street, Ste 1100 Kansas City, MO 64112
(Address)
816-945-5300/816-945-5301
(Phone Number) / (Fax Number)
aperry@mslc.com
(email address)

**CERTIFICATION AND SIGNATURE:** By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

Myers and Stauffer LC
(Company)

Amy Perry, Member
(Authorized Signature) (Representative Name, Title)

Amy C. Perry, Member
(Printed Name and Title of Authorized Representative)

7/13/2017
(Date)

816-945-5300/816-945-5301
(Phone Number) (Fax Number)

Revised 04/07/2017

# *Firm Qualifications* *(CRFQ Section 3.1)*

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

**At A Glance: Myers and Stauffer**

- *A firm founded on a commitment to quality and client service that understands the need to do so in the most economical manner.*
- *Nearly 800 health care staff, including 27 partners and a vast network of experts, are trained in state and federal legislative and regulatory policy.*
- *Work full time serving our Medicaid and Medicare agency clients, with the majority of our work being for state Medicaid programs.*
- *Sixteen years of experience working with the state of West Virginia and its provider community.*
- *Participation in past West Virginia Medicaid reimbursement program changes and initiatives as a consultant and resource for BMS.*
- *Significant experience with provider fee, UPL, and other consulting services for numerous state Medicaid programs.*
- *Experience successfully defending our results against administrative and judicial scrutiny.*

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

Myers and Stauffer employs nearly 800 professionals, including 27 members/principals (partners), all of whom are fully engaged with our state and federal Medicaid/Medicare clients. Our team of health care experts is nationally recognized for their insight and ability to effectively communicate the complexities of managing a Medicaid program, including program integrity and complex Medicaid reimbursement systems. They have repeatedly accepted invitations to educate national associations, industry groups, and elected officials regarding Medicaid and public health care concerns.

We have worked with West Virginia since 2001. For this contract, West Virginia's public payors engaged Myers and Stauffer to assist with health care payment issues related to their inpatient hospital prospective payment system (PPS) and the physician resource-based relative value scale (RBRVS) system. Our current services to the Public Employees Insurance Agency (PEIA) and Medicaid consist of updates to diagnosis-related group (DRG) weights and base rates payors, updates to relative value units, and a review of the RBRVS system on an annual basis.

We previously assisted PEIA with the implementation of the ambulatory payment classification (APC)-based outpatient PPS and provided an annual fiscal review of the program.

## Our Services

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

- *Data aggregation and validation for UPL and provider fee calculations, and related state plan amendment (SPA) and demonstration assistance.*
- *Establishment of provider reimbursement rates, including upper payment limits (UPLs).*
- *Certified public expenditure (CPE) audits and consulting.*
- *Medicaid funding consulting, including provider assessment plans.*
- *Disproportionate share hospital (DSH) eligibility, payment methodologies and calculations, and SPA consulting.*
- *DSH audits.*
- *Medicaid policy consulting.*
- *Medicaid agency operations consulting.*
- *Reimbursement methodology design and implementation.*
- *Cost report examinations and settlements.*
- *CMS 64 – quarterly expense report reviews and reconciliations.*
- *Assistance with CMS and OIG audit findings.*
- *Representation of states before CMS, DOJ, and OIG.*
- *Medicaid performance audits and consulting engagements.*
- *MDS data processing, roster production, and case mix index (CMI) distribution.*
- *MDS audit and verification services.*
- *Rebasing initiatives and related activities for rate setting.*
- *Technical risk assessment.*
- *Fraud, waste, and abuse detection (FWAD) and identification of improper payments through claim/billing reviews.*
- *Financial/performance audits of Medicare and Medicaid managed care organizations.*
- *Service Organization Control (SOC) 1 (formerly Statements on Standards for Attestation Engagements [SSAE] 16), SOC 2, and SOC 3 attestation services.*

- *Appeal representation and expert witness testimony.*
- *Health Insurance Portability and Accountability Act (HIPAA) compliance risk assessment, gap analysis, and reviews.*
- *Information technology (IT) and operational performance audit services.*
- *IT security evaluation and assessment services, including penetration testing and vulnerability assessment services.*
- *Payment error rate measurement (PERM) eligibility activities.*
- *Electronic health records (EHR) incentive payment audits.*
- *Pharmacy claims and pharmacy benefit manager (PBM) audits.*
- *Delivery system reform incentive payment (DSRIP) system development and auditing.*
- *Recovery audit contractor (RAC) services.*
- *Medicaid Management Information Systems (MMIS) audits.*
- *State auditor assistance.*

## Certified Public Accounting Firm (3.1.1)

We are a licensed CPA firm in the state of West Virginia.

Firm Verification: Details - WV Board of Accountancy

West Virginia
Board of Accountancy

### Firm Verification: Details

| | |
|---|---|
| **Firm Name** | MYERS AND STAUFFER LC |
| **Address** | 700 W 47TH ST STE 1100 |
| **City** | KANSAS CITY |
| **State** | MO |
| **Zip** | 64112 |
| **County** | |
| **Permit Number** | F0188 |
| **Effective Date** | 07/01/2017 |
| **Current Status** | Active |
| **Expiration Date** | 06/30/2018 |

*Page Updated: 11/10/2016 1:55:45 PM*

https://www.boa.wv.gov/verifications/details-firm.asp

## Independence (3.1.2)

Myers and Stauffer is a CPA firm that intentionally limits its services to providing audit, rate setting, and consulting services to governmental entities managing health care programs. As a result, the firm is independent of the Medicaid agency and providers, as defined by the Comptroller General of the United States.

### Independence Policy (3.1.2.1)

Our independence policy applies the Generally Accepted Government Auditing Standards (GAGAS) Conceptual Framework Approach to Independence, and we have detailed procedures in our Quality Control Manual to ensure compliance with independence requirements and to avoid other conflicts of interest. Our policies are extensive and designed to meet the requirements of the American Institute of Certified Public Accountants (AICPA), the U.S. Securities and Exchange Commission (SEC), the Public Company Accounting Oversight Board (PCAOB), state licensing agencies, and Government Auditing Standards (GAS). Some of the key elements of our policies include:

- *Independence training for all professionals.*
- *Annual written representations of independence from all personnel who perform client services.*
- *Extensive client and engagement acceptance and continuance policies.*
- *Requirements for confirming independence of outside accounting firms and independent contractors.*
- *Maintenance of firm-wide client list.*

We have included “Chapter 2: Ethical Requirements” of our Quality Control Manual *as Appendix A: Quality Control Manual.*

***Additional Independence Procedures***

Myers and Stauffer is a nationally-based CPA firm, specializing in accounting, consulting, program integrity, and operational support services to public health care auditing and social service agencies. We are a limited liability company organized in the state of Kansas. In the fall of 1998, we entered into a transaction with Century Business Services, Inc. (CBIZ), which resulted in the creation of CBIZ M&S Consulting Services, LLC. CBIZ M&S Consulting Services, LLC is wholly-owned by CBIZ, Inc. As part of this business model, Myers and Stauffer acquires office space, personnel, and other business resources from CBIZ M&S Consulting Services, LLC. These resources, including personnel and consultants, are assigned exclusively to serve the clients of Myers and Stauffer. Myers and Stauffer is wholly-owned by its partners.

AICPA has reviewed our business structure and refers to this model as an alternative practice structure. AICPA professional standards provide specific guidance regarding independence within alternative practice structure firms. These professional standards are published in the Independence, Integrity and Objectivity section of the AICPA Code of Professional Conduct at ET Section 1.220.020. We fully comply with these, and all other, professional standards.

## UPL Demonstrations (3.1.3)

Myers and Stauffer acknowledges and agrees to provide UPL demonstrations using the guidance and instructions as established by CMS and provided in Attachments 2-18 of the CRFQ. Project staff are familiar with these requirements and have the skills necessary to comply with them.

Myers and Stauffer will prepare the UPL demonstrations and all materials required for submission by CMS. Currently CMS requires, or may require, the following items prior to UPL demonstration approval:

- ***Submission of a UPL guidance document.*** *The guidance document (or narrative document) provides substantial details relating to the underlying methodology and calculation of the UPL demonstration. It identifies the data source, the base rate, and payment information periods used in the calculation, as well as information pertaining to state funding resources.*
- ***Supporting rate documentation.*** *CMS may require states to submit additional detailed rate or payment calculation support prior to UPL demonstration approval.*
- ***CMS-required UPL demonstration templates and notation.*** *In the near future, CMS will begin requiring states to complete a UPL demonstration template for each required UPL demonstration. These standard templates may require additional notation to identify how current UPL demonstrations are cross-walked to required template fields.*

## Agency and Provider Independence (3.1.4)

By signature of this quotation, we attest that we meet all independence standards referenced in C*RFQ Section 3.1* and that our firm is independent of BMS and the providers listed in *Attachment 19* of the CRFQ.

## Subcontractors (3.1.4)

We have the resources, experience, and expertise to perform this engagement as the primary audit firm without the use of subcontractors.

## UPL Demonstration Experience (3.1.5)

Myers and Stauffer has more than 25 years' experience in preparing UPL demonstration models for several separate state Medicaid agencies, including the state of West Virginia. We have demonstrated the technical knowledge and skill necessary to prepare these UPL demonstrations, ensured their compliance with federal regulations, and satisfied all CMS reporting requirements. We will continue to provide the superior customer service, quality, timeliness, and technical consulting knowledge that you have come to expect. We also bring to this project the knowledge we have amassed regarding other Medicaid programs' approaches to UPL calculation strategies, techniques for incorporating intergovernmental transfer (IGT) and CPE into Medicaid payment systems, and mitigation techniques for common areas of CMS inquiry.

Myers and Stauffer has assisted several states with Medicare UPL calculations. Our work has encompassed preparing detailed analyses, developing alternative methodologies, and helping our clients address issues and/or questions raised by CMS. Representatives from CMS have reviewed UPL demonstrations we have prepared for our Medicaid agency clients for all required UPL demonstrations. As a result of our work with other states, we have developed a comprehensive understanding of Medicare reimbursement principles. We also have demonstrated our understanding of Medicare reimbursement through various Medicare UPL system development projects. In addition, we have modeled a variety of UPL methodologies, including cost-based, PPS, and payment-to-cost or payment-to-charge UPL systems for our clients. We have assisted our clients in maximizing federal leveraging opportunities while explaining the risks and potential liabilities. These efforts have resulted in millions of dollars in budgetary offsets and, in some cases, allowed the expansion of health care services.

We have performed UPL services for the following state agencies:

- *Alabama Medicaid Agency.*
- *Arkansas Department of Human Services.*
- *Colorado Department of Health Care Policy and Finance.*
- *Georgia Department of Community Health.*
- *Idaho Division of Medicaid, Department of Health and Welfare.*
- *Indiana Office of Medicaid Policy and Planning.*
- *Iowa Department of Human Services.*
- *Kansas Department for Aging and Disability Services (formerly Kansas Department of Social and Rehabilitation Services).*
- *Kentucky Department for Medicaid Services.*
- *Louisiana Bureau of Health Services Financing.*
- *Maryland Department of Health and Mental Hygiene.*
- *Mississippi Division of Medicaid.*
- *Missouri Department of Social Services.*
- *Montana Department of Health and Human Services.*
- *Nebraska Department of Health and Human Services.*
- *New Mexico Human Services Department.*
- *North Carolina Department of Health and Human Services.*
- *North Dakota Department of Health and Human Services.*
- *Pennsylvania Department of Public Welfare.*
- *South Dakota Department of Social Services.*
- *Virginia Department of Medical Assistance Services.*

- *West Virginia Bureau of Medical Services.*
- *Wyoming Department of Health.*

The table below shows additional details for a sampling of the clients listed above for which we currently provide UPL calculations. This clearly demonstrates that we have met the provider requirements outlined in C*RFQ Section 3.1.5*. Note that we have also been performing many of these for more than three years, including preparing the UPL demonstrations for Iowa since 2006 and for Mississippi since 2013. For additional details on our clients, please see our client profiles in *Medicaid Reimbursement Rate Models (3.1.6).*

| UPL Calculation Providers | AL | GA | IA | ID | IN | KY | NM | WY |
|---|---|---|---|---|---|---|---|---|
| Inpatient Hospital Services | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Outpatient Hospital Services, including Lab | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Clinics | ✓ | | ✓ | | ✓ | ✓ | | |
| Physician Services (Physician Supplemental Payments) | | | ✓ | | ✓ | | | |
| Psychiatric Residential Treatment Facilities (PRTF) | ✓ | | ✓ | | ✓ | | ✓ | |
| Institutes for Mental Disease (IMD) | ✓ | | ✓ | | | ✓ | | |
| Nursing Facilities | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

## Medicaid Reimbursement Rate Models (3.1.6)

Myers and Stauffer's qualifications for this proposal include extensive experience in preparing Medicaid reimbursement rate models. We have performed engagements addressing many different categories of health care providers, including inpatient and outpatient hospital services, nursing facilities, psychiatric residential treatment facilities (PRTFs), physicians, pharmacies, home health agencies (HHAs), federally qualified health centers (FQHCs), rural health clinics (RHCs), school-based services, home and community-based services (HCBSs), institutes for mental disease (IMDs), and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID). This experience and technical knowledge base allows Myers and Stauffer to seamlessly adapt UPL calculation approach and data collection strategies to match state reimbursement system modifications on an annual basis.

Specifically, Myers and Stauffer offers:

- *Many years of experience working with and developing cost reporting systems and cost data collection tools, including cost tools for several HCBS cost studies.*
- *Extensive database design and development.*
- *Payment system design, modeling, and analysis for many state Medicaid agencies.*
- *Presentation of alternative payment systems to various stakeholders.*
- *Developing and operating computerized payment/rate systems.*
- *Understanding of the current Medicaid environment for developmental disabilities services and CMS' policy direction for providing reimbursement and service.*
- *Health care-related cost analysis, long term care (LTC) studies, and waiver program analysis.*

The following provides a more detailed narrative of our experience with DRG, RBRVS, and nursing facility cost-based per diem with acuity grouper component reimbursement methodologies and fiscal modeling.

### DRG: Inpatient Hospital Rate Setting Experience (3.1.6.1)

Myers and Stauffer has provided DRG rate setting and related consulting services to 11 states, including West Virginia, Connecticut, Georgia, Indiana, Iowa, Kansas, Kentucky, New Jersey, New Mexico, North Carolina, and Oregon. The firm has provided these states with reimbursement system options to address issues related to neonatal, psychiatric, and rehabilitation services. Due to the confidential nature of our clients' fiscal information, we are unable to provide a sample report demonstrating our knowledge of Medicaid reimbursement rate models based on DRG. We would be able to provide sample documentation (e.g., fiscal impact model) upon project award or, upon request prior to award, as a separate confidential document.

In servicing these DRG rate setting engagements, the firm has also developed and refined specialized computer software tools that allow us to conduct the routine portions of the rate setting and modeling processes with superior efficiency and transparency. As a result, project team members are able to spend more time on analysis and issues of particular importance to our clients. Myers and Stauffer has extensive experience with DRG and all payer refined (AP/APR) DRG grouping software, and is a working partner with 3M (a common supplier of inpatient and outpatient grouping software).

The firm's expertise in hospital rate setting is enhanced by our experience in a number of other states with various hospital projects. In recent years, Myers and Stauffer has provided rate setting, reimbursement system development support, and hospital cost report audits to government agencies in multiple states. We conduct hospital cost report audits, hospital cost report review analysis, and/or cost settlements for the states of Colorado, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maryland, Mississippi, Nevada, New Jersey, North Carolina, North Dakota, South Carolina, and Virginia. We have also conducted on-site financial studies of hospital cost reports for Pennsylvania as part of its initiative to develop new cost finding rules.

We have worked with North Carolina's Department of Medical Assistance in the calculation of base weights, recalibration of relative weights, development of rates, policy analyses, and additional inpatient and outpatient cost report data analyses. The firm has provided North Carolina and other states with reimbursement system options to address issues related to neonatal, psychiatric, and rehabilitation services.

Myers and Stauffer produces fiscal impact studies for each of its rate setting engagements. The fiscal impact models demonstrate the fiscal impact on each individual hospital as well as the program in summary. They are often produced in conjunction with interactive rate setting models in order to allow system parameters to be modified with the resulting fiscal impact to be demonstrated immediately.

The fiscal impact models are based on historical claims data and make use of all changes to the reimbursement system. They demonstrate the calculated payments under the previous system parameters, actual payments (for comparison), and projected payments. Usually all payments including base DRG payments (current and projected hospital rates multiplied by current and projected DRG weights), capital payments (number of claims multiplied by current and projected capital rates), outlier payments (comparison of estimated claim cost compared to the current and projected outlier thresholds multiplied by a marginal outlier reimbursement factor [e.g., 75 percent]), medical education, and any other supplemental payments are included in the reimbursement systems under consideration for change. The differences in reimbursement are broken out by individual hospital and then summarized in aggregate.

We recently completed a project for the Medicaid program in the state of Connecticut where the hospital inpatient program went from a per discharge reimbursement process with cost settlements to the most recent version of the APR-DRG PPS. Steps involved included:

- *Reasons for making changes to the reimbursement system.*
- *Education as to the components and parameters of potential alternative reimbursement methodologies.*
- *Modeling of fiscal impact of these system parameters.*
- *Final system design based on input from hospitals and state decisions.*
- *Presentation of final reimbursement system design and anticipated fiscal impacts.*
- *Assistance with the fiscal intermediary on system implementation.*

### RBRVS: Physician Reimbursement Experience (3.1.6.2)

Myers and Stauffer has provided reimbursement analysis and rate setting assistance for physician services, including anesthesiology and other ancillary services billed on the CMS-1500. We have consulted with the states of West Virginia, Alaska, and Kansas regarding physician reimbursement issues. These projects included a thorough evaluation of the RBRVS physician payment methodology which is used by the Medicare program and many state Medicaid programs. These projects have also included the need to work with stakeholders representing the physician provider communities. Models prepared during these engagements included the

modeling of the fiscal impact of various reimbursement rate scenarios and determining the impact according to physician specialty.

As mentioned previously, Myers and Stauffer has been West Virginia's PEIA vendor for the RBRVS system update since 2001. The update process involves reviewing all aspects of the revisions to the Medicare system for that year, creation of the West Virginia RBRVS table, and calculation of a new conversion factor specific to each payor, based upon budget neutrality or any approved change in total reimbursement. The current update also includes the creation of fiscal impact analyses by specialty group and an analysis of how reimbursement for each payor compares to the Medicare Physician Fee Schedule. To demonstrate that we have prepared a Medicaid reimbursement rate model based on RBRVS, we have provided the fiscal impact model for the January 1, 2017 RBRVS update for the state of West Virginia in *Appendix C: RBRVS Rate Model,* which is already public information.

Myers and Stauffer also assisted the state of Indiana in data intensive analyses that identified a set of primary and preventive health care services provided by various primary medical providers (PMP). These services, and specifically the PMPs that provided the services, were eligible for a unique one-time bonus payment. Myers and Stauffer developed the algorithms, definitions, and parameters used for the allocation of this special funding opportunity to support quality health outcomes for Medicaid members in Indiana. Additional funds were directed to fee schedule updates and procedures that provide financial incentives to physicians that offer extended evening, weekend, or holiday hours in an effort to discourage the use of more resource-intensive and costly emergency room care.

### Nursing Home Cost-Based Per Diem with Acuity Grouper Component (3.1.6.3)

Myers and Stauffer has extensive experience providing nursing facility rate setting, consulting, and administrative services to more than 20 Medicaid agencies. Through our engagements with these Medicaid agencies, we have experience working in a variety of different care and payment delivery systems, including managed LTC services and support environments. Myers and Stauffer understands the intricacies and sensitivities of working in these varying environments, and we can leverage our experience, knowledge, and best practices.

During 2014 and 2015, we assisted BMS with the design and development of the framework to transition the current nursing facility reimbursement methodology to a resource utilization group (RUG)-IV PPS model. During this process, we developed a reimbursement tool that defined multiple reimbursement variables that could be changed interactively. By systematically varying basic design components, one can examine the cost benefit ratios and the effects on facility rates. The following are examples of key elements that were created as variables to allow the user to make changes and view results immediately:

- *Cost ceiling and pricing approach, as well as a "hybrid" model combining the cost and pricing approaches.*
- *Assign cost report data to a specific cost center which allows the user to assign which costs are classified as direct care and case mix adjusted.*
- *Alternative peer groupings.*

- *Alternative cost ceilings.*
- *Alternative incentives.*
- *Effects of hold harmless or phase-in provisions.*

The reimbursement tool calculated pro forma facility rates and provided a comparison to current rates to determine projected program expenditures and fiscal impact at both the facility and statewide level. Due to the confidential nature of our clients' fiscal information, we are unable to provide a sample report demonstrating our knowledge of nursing home cost-based per diem with acuity grouper component. As stated above, we have prepared a nursing home cost-based per diem with acuity grouper component Medicaid reimbursement rate model for BMS, and would be able to provide sample documentation (e.g., fiscal impact model) upon project award or, upon request prior to award, as a separate confidential document.

In addition, Myers and Stauffer currently assists states in a variety of nursing facility rate setting activities such as implementing case mix reimbursement systems, rebasing case mix reimbursement systems, modeling reimbursement revisions, forecasting expenditures based on modeling tools, serving on task force committees for quality measures, and performing federally mandated UPL demonstrations for nursing facilities.

Our experience with RUG-based case mix reimbursement systems began with the federal nursing facility multi-state case mix demonstration project, dating back to 1989, when we participated in a wide variety of MDS design and development functions. Members of our staff were actively engaged in demonstration project meetings in which MDS form design and clinical definitions were discussed and refined. We continue to remain a leader in the ongoing development and enhancement of nursing facility reimbursement models throughout the country. In addition to rate setting and auditing services, our goal for all of our services is to develop Medicaid payment policies and methodologies that focus on reliable data collection with transparency in process that leads to high levels of accountability and defensible rates.

**Client Profiles**

On the following pages, we have included client profiles – including an overview of our work in West Virginia – that are most representative of the requirements for this engagement.

## WEST VIRGINIA: HOSPITAL AND PHYSICIAN REIMBURSEMENT

West Virginia's three public payors engaged Myers and Stauffer to assist with health care payment issues related to their inpatient hospital PPS and the physician RBRVS system. Myers and Stauffer was further engaged to develop and implement an outpatient PPS for West Virginia's PEIA.

Services provided/deliverables achieved include:

- *Update DRG weights and base rates for each of the individual payors annually.*
- *Update other DRG systems annually.*
- *Update relative value units annually and review the RBRVS system.*
- *Develop fiscal impact models to demonstrate impacts of annual updates to the inpatient hospitals and physician specialties.*
- *Implement APC-based outpatient PPS and provide annual updates.*
- *Assess alternative reimbursement schemes for skilled nursing facilities (SNFs), rehabilitation services, pain management, and ambulance services.*

**CLIENT**

***West Virginia Public Employees Insurance Agency***

*Ted Cheatham*
*PEIA Director*

*601 57th Street SE*
*Ste. 2*
*Charleston, West Virginia*
*25304*

*PH 304.588.7850*
*ted.m.cheatham@wv.gov*

**TERM OF CONTRACT**

*2001 – Present*

## GEORGIA: UPL CALCULATION AND DSH CONSULTING

Myers and Stauffer has completed DSH audits in compliance with the federal DSH audit regulations for the state of Georgia since the 2005 state plan year, and audits have been accepted by CMS. Myers and Stauffer also assisted with the redesign and calculation of the Medicaid DSH reimbursement system, and the technical and accounting issues related to the preparation of Medicare UPL findings for its nursing facility and inpatient and outpatient hospital programs. The result was the development of a new DSH payment system that maximized the use of available DSH allotments, improved data accuracy, and generated broad-based support within the hospital provider community. Georgia Medicaid developed UPL methodologies that are defendable and allowed under the Medicaid program to continue using federal funds maximization strategies that generate hundreds of millions of dollars in additional federal participation.

**CLIENT**

***Georgia Department of Community Health***

*John Upchurch*

*Director Reimbursement Services*

*2 Peachtree Street NW*
*39th Floor*
*Atlanta, Georgia 30303*

*PH 404.657.0229*

*jupchurch@dch.ga.gov*

**TERM OF CONTRACT**

*2005 – Present*

Services provided/deliverables achieved include:

- *Develop Medicare UPL payments using Medicaid data and Medicare payment principles for both the hospital and nursing facility programs.*
- *Use Medicare RUG categories from MDS data received for Medicaid residents in developing the nursing facilities UPL.*
- *Use Medicare DRG payment amounts based on Medicaid claims data to develop inpatient hospital UPL.*
- *Consult with and attend meetings with the Department and Hospital Advisory Group on modifications to the DSH program, including recent federal legislation.*
- *Develop a DSH survey to be sent to all hospitals to obtain the information necessary to operate the DSH program.*
- *Present information on alternative DSH payment methodologies.*
- *Prepare and present training materials to the hospitals on the proper completion of the DSH survey document.*
- *Upon receipt of the data, model alternative DSH reimbursement systems.*

## MISSISSIPPI: UPL CALCULATIONS AND DSH CONSULTING

Myers and Stauffer has assisted the Mississippi Medicaid program with UPL and DSH calculations since 2006. Our services include developing data collection tools, preparing UPL and DSH calculations for review and acceptance by the Medicaid program, assisting with meetings attended by hospital representatives and their consultants, and assisting with meetings and/or correspondence with CMS officials.

**CLIENT**

***Mississippi Division of Medicaid***

*Margaret King, CPA*
*Office of the Governor*

*550 High Street, Ste. 1000*
*Jackson, Mississippi 39201*

*PH 601.359.6155*
*margaret.king@medicaid.ms.gov*

**TERM OF CONTRACT**

*2006 – Present*

Services provided/deliverables achieved include:

- *Develop electronic DSH/UPL survey document.*
- *Prepare inpatient and outpatient hospital UPL calculations.*
- *Prepare nursing facility, ICF/IID, and PRTF UPL calculations.*
- *Prepare quarterly physician supplemental payments.*
- *Prepare Mississippi Medicaid DSH eligibility and payment calculations.*
- *Present DSH and UPL payment calculations at state/industry meetings.*
- *Assist state to obtain federal approval of DSH/UPL payments and DSH eligibility calculations.*
- *Model alternative DSH/UPL methods to assist the Medicaid program in evaluating possible program changes.*
- *Develop state funding options for the DSH/UPL payment systems. Funding options include utilizing IGTs and provider assessments (taxes).*
- *Maintain a telephone help line to answer questions about DSH/UPL data and payment calculations for hospitals.*

## NEW MEXICO: UPL CALCULATIONS AND DSH CONSULTING

Myers and Stauffer has been contracted to assist New Mexico with the calculation of the Medicare UPL finding, and to provide consulting on the Medicaid DSH program since 1995. Our services include the creation of a UPL methodology that provides reimbursement flexibility, which has been in use for more than 15 years. Myers and Stauffer has also worked with New Mexico to develop a DSH survey tool to allow collection of hospital data and to perform the calculations annually.

Services provided/deliverables achieved include:

- *Prepare the Medicare upper limit calculation for use in conjunction with the IGT program.*
- *Prepare the outpatient, nursing facility, ICF/IID, and PRTF UPL calculations.*
- *Assist the state in getting its DSH allotment increased and developing its DSH payment plan.*
- *Develop DSH survey document for distribution to hospitals.*
- *Send DSH survey to hospitals annually and coordinate the receipt of all necessary information for the DSH calculation.*
- *Perform annual DSH payment calculations for the state.*
- *Provide training to state staff and providers on the UPL and DSH calculations.*

**CLIENT**

***New Mexico Human Services Department***

*Ellie Lopez*

*Financial Analyst*

*P.O. Box 2348*
*Santa Fe, New Mexico 87504*

*PH 505.827.6234*

*Ellie.Lopez@state.nm.us*

**TERM OF CONTRACT**

*1995 – Present*

## INDIANA: COST REPORT REVIEWS AND RATE SETTING FOR INPATIENT AND OUTPATIENT HOSPITAL SERVICES, PHYSICIAN, AND OTHER AMBULATORY PROVIDERS

Myers and Stauffer provides accounting, auditing, data management, research, fiscal analysis, and consulting services to support Indiana Medicaid hospital, health clinics, physician, dental, pharmacy, and other ambulatory provider reimbursement systems.

Services provided/deliverables achieved include:

- *Receive and process cost reports, develop and maintain a cost report database, and conduct field and desk reviews of hospital, FQHC, and RHC cost reports.*
- *Compute and maintain inpatient PPS, including base rates, relative weights, graduate medical education, level of care per diems, capital reimbursement, outlier threshold, cost-to-charge ratios, and marginal cost factors.*
- *Compute and maintain rates for the outpatient PPS, including emergency room, surgical procedures, clinic, laboratory, and radiology rates.*
- *Compute and maintain Medicaid physician, dental, and other ambulatory reimbursement rates and prepare fiscal analyses.*
- *Prepare UPL demonstrations, in compliance with federal Medicaid UPL requirements, for nursing facility, ICF/IID, inpatient hospital, outpatient hospital, physician services, clinic, and PRTF services.*
- *Develop federally-compliant provider tax programs and monitor provider assessments, accounting for collections and payments.*
- *Develop databases, analyze reimbursement alternatives, and analyze bills from the General Assembly.*
- *Assist with reconsideration and appeal requests and with administrative rule filings and SPAs.*
- *Determine DSH eligibility and comply with federal limitations.*

**CLIENT**

***Indiana Family and Social Services Administration: Office of Medicaid Policy and Planning***

*Chris Fletcher*

*Director of Reimbursement Section*

*402 W. Washington Street*
*W374*
*Indianapolis, Indiana 46204*

*PH 317.234.4753*

*chris.fletcher@fssa.in.gov*

**TERM OF CONTRACT**

*1995 – Present*

## IDAHO: RATE CALCULATIONS, AUDITS, COST SETTLEMENTS, DSH PAYMENTS, UPL, AND PROVIDER TAX CALCULATIONS

Myers and Stauffer performs audits, rate calculations, and data management services for hospitals, nursing facilities, and other health care providers in the state of Idaho. Our work involves audit and reimbursement issues, as well as performing approximately 140 annual audits of Medicaid cost reports of health care providers. This project requires an understanding of the entire reimbursement system, including facility operations, health care issues, and issues involving the valuation of property.

**CLIENT**

***Idaho Department of Health and Welfare***

*Sheila Pugatch*

*Chief*
*Medicaid Division*

*P.O. Box 83720*
*Boise, Idaho 83720*

*PH 208.287.1141*

*Sheila.Pugatch@dhw.idaho.gov*

**TERM OF CONTRACT**

*1992 – Present*

Services provided/deliverables achieved include:

- *Verify cost report accuracy and establish reimbursement rates.*
- *Receive, process, and track provider cost reports.*
- *Develop and maintain a database of cost report information.*
- *Develop detailed cost estimates of proposed or pending reimbursement system modifications.*
- *Perform annual DSH survey of Idaho hospitals and calculate allowable DSH payment in accordance with state and federal regulations.*
- *Conduct annual audits of the DSH program.*
- *Perform a combination of field audits and desk reviews on cost reports to determine allowable cost in accordance with federal and state reimbursement criteria.*
- *Calculate UPL and provider taxes for hospitals, nursing facilities, and ICF/IID.*
- *Establish hospital per diem payments based on cost reports in accordance with Idaho Medicaid limits.*
- *Calculate a reimbursement settlement amount with reimbursement criteria.*
- *Testify at hearings in defense of the audit adjustments made.*
- *Calculate interim reimbursement rates and class ceiling limitations.*
- *Prepare monthly status reports which track provider cost reports through the audit and settlement process.*

## IOWA: MEDICAID ENTERPRISE PROVIDER AUDIT, RATE SETTING, COST SETTLEMENT, AND DSH

Myers and Stauffer is engaged to provide professional accounting and consulting services as the Provider Cost Audit and Rate Setting Unit of the Iowa Medicaid Enterprise.

Services provided/deliverables achieved include:

- *Medicaid nursing facility case mix rate setting.*
- *Rate setting, auditing, and cost settlement for nursing facilities, ICF/IID, residential care facilities, home and community-based waiver providers, targeted case management, adult rehabilitation option, FQHCs, home health, RHCs, psychiatric medical institutions for children (PMIC), critical access hospitals, acute psych hospitals, and general acute care hospitals.*
- *Medicaid fee schedule updates.*
- *State maximum allowable cost (SMAC) reimbursement for drugs.*
- *DSH, IGT, and UPL calculations, and other revenue maximization.*
- *Hospital payment rate setting, including outpatient and inpatient services.*
- *Consulting and litigation support services.*
- *Policy assistance with case management reform and other provisions of the Deficit Reduction Act of 2005.*

**CLIENT**

***Iowa Department of Human Services, Division of Medicaid Services***

*Deborah Johnson*

*IME Unit Manager, Long Term Care*

*100 Army Post Road*
*Des Moines, Iowa 50315*

*PH 515.256.4662*

*Djohnso6@dhs.state.ia.us*

**TERM OF CONTRACT**

*July 2004 – Present*

## KENTUCKY: HOSPITAL, LONG TERM CARE, AND OTHER FACILITY RATE SETTING

Myers and Stauffer is engaged with the state of Kentucky to perform rate setting services for hospitals (freestanding psychiatric, distinct part unit, long term acute care, inpatient and outpatient), long term care facilities, ICF/IIDs, FQHCs, RHCs, and hospice providers. We also perform DSH audits for the Department of Medicaid Services.

**CLIENT**

***Kentucky Department for Medicaid Services***

*David Dennis*

*Administrative Branch Manager*

*275 East Main Street*
*6th Floor*
*Frankfort, Kentucky 40621*

*PH 502.564.8196*

*David.dennis@ky.gov*

**TERM OF CONTRACT**

*July 1998 – Present*

Services provided/deliverables achieved include:

- *Request, receive, and track LTC, hospital, FQHC, RHC, IMD, and ICF/IID cost reports.*
- *Develop and track data with the Medicaid Rate Setting Information System, a computer program that tracks the due dates for provider cost reports, stores the cost report data, and calculates the rates.*
- *Establish long term care nursing facility case mix rates, distribute resident rosters through preliminary reports, final rosters, and audit rosters and supporting documents for DMS audit contractor.*
- *Conduct statewide training to long term care providers on MDS 3.0 transition.*
- *Conduct technical training to state audit vendor for case mix field reviews.*
- *Calculate and distribute long term care, ICF/IID, FQHC, RHC, IMD, and hospice rates to facilities.*
- *Perform hospital outpatient cost report reviews and related settlement calculations.*
- *Perform certified public expenditure calculations.*
- *Request and receive hospital DSH survey forms of cost information and perform DSH audits for hospital providers.*
- *Coordinate with other contractors and DMS on receipt of hospital claims data for the DSH project through electronic means using secure file transfer protocol.*
- *Perform desk reviews for ICF/IID and FQHC/RHC providers.*
- *Provide consulting services to the state on various issues, including review of rules and regulations, ad hoc requests, and data analyses.*
- *Perform UPL and state plan/regulation review for various providers.*
- *Provide expert testimony for rate or desk review appeal cases as needed.*
- *Perform DRG rate setting and payment analysis.*

## NORTH CAROLINA: AUDITING, RATE SETTING, AND DSH AUDITING SERVICES

For the state of North Carolina, we provide field audits and agreed-upon procedures (AUPs) engagements of selected Medicaid providers to determine whether financial and statistical information reflected on Medicaid cost reports is reasonable and allowable under relevant federal and state regulations. Provider types included in the scope of our work include nursing facilities, ICF/IID, hospitals (inpatient, outpatient, state-owned, non-state public, teaching, and critical access), home offices/related organizations, FQHCs, RHCs, and physician practice plans of affiliated teaching hospitals. We also provide calculation of hospital-specific base rates, recalibration of DRG relative weights, and other analyses.

In addition, we perform the state's DSH audit and annual reporting. All of our DSH audit reports have been accepted by CMS.

**CLIENT**

***North Carolina Department of Health and Human Services Division of Medical Assistance***

*Jim Flowers*
*Chief Audit Section*

*333 E. Six Forks Road*
*Raleigh, North Carolina*
*27609*

*PH 919.814.0011*
*Jim.flowers@dhhs.nc.gov.*

**TERM OF CONTRACT**

*1993 – Present*

Services provided/deliverables achieved include:

- *Recalibrate DRG relative weights, inflate base rates, and conduct additional analyses to support the DRG system.*
- *Review changes to Medicare DRG system and advise the Division regarding any changes that it should consider including reviewing grouper software and providing DMA with grouper logic.*
- *Calculate relative weights for all DRGs.*
- *Adjustments made prior to calculating relative weights to remove statistical outliers, transfer cases, cases with lengths of stay equal to zero, and claims for PPS-exempt and specialty hospitals prior to calculating relative weights.*
- *Adjust low volume or statistically unstable relative weights to determine whether there are sufficient numbers of claims to establish relative weights for each DRG. Includes the additional DRGs that have been expanded from the Medicare DRGs.*
- *Calculate case-mix indices for each hospital and adjust the DRG weights as necessary.*
- *Develop the final set of relative weights and provide data in the requested format for publication and installation in claims processing system.*
- *Inflate Medicaid base rates, including per diem rates using the National Hospital Market Basket Index as published by Medicare (not to exceed the update amount approved by the North Carolina General Assembly). Perform on-site, risk-based audits based on Medicaid policy and related federal requirements.*

- *Prepare draft and final audit/AUP reports.*
- *Provide access to work papers as needed.*
- *Submit a database of adjusted cost report data for use in annual rate setting calculation.*
- *Supply periodic status reports detailing the status of each engagement.*
- *Respond to Public Information Act requests received by the Division pertaining to the cost report or audit process.*
- *Testify at hearings in defense of adjustments as needed.*
- *Report any suspected fraudulent activities to the MFCU and provide documentation to support our suspicions.*
- *Provide consulting services on a variety of cost report and reimbursement issues.*
- *Perform federally mandated independent certified audits of the state's DSH program.*

## Medicare Reimbursement Methodologies (3.1.7)

Per the CRFQ, the vendor must provide documentation to demonstrate they have met the requirements of this section. The documentation should be included with the bid, but must be provided prior to award. As the incumbent vendor of these services, we have experience and knowledge of the West Virginia BMS program objectives and project nuances that are unmatched by any other vendor, and we have fully demonstrated that we meet this requirement. Should the state need further documentation, we can provide copies of project deliverables upon project award or, upon request, prior to award.

The Code of Federal Regulation at 42 CFR 447.272(a) states "…in aggregate payments by an agency to each group of health care facilities (that is, hospitals, nursing facilities and ICF/IID), may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles." The Medicare upper limit, in essence, is the amount the state would pay its Medicaid providers if Medicare payment principles were adopted in West Virginia. States have been provided a great deal of discretion in determining if this requirement has been met.

Final rules were published on January 12, 2001, and the Federal Register modified the upper limit requirement effective March 13, 2001. These final rules established three groups of facilities that each must have aggregate payments at or below the UPL. The three categories of facilities are: state-owned or operated, non-state government owned or operated, and privately owned or operated facilities. Within each type of service and category of facility, states must assure CMS that Medicaid payments do not exceed a reasonable estimate of the amount the state would have paid using Medicare payment principles.

On March 18, 2013, CMS published a "State Medicaid Director" letter which outlined new requirements Medicaid programs must satisfy regarding UPL demonstrations. Starting in 2013, CMS began requiring states to submit UPL demonstrations on an annual basis. Previously, this information was collected or updated only when a state was proposing an amendment to reimbursement methodology in its Medicaid state plan.

In 2013, CMS required Medicaid programs to submit UPL demonstrations for inpatient and outpatient hospital services, as well as nursing facility UPL demonstrations. In addition to these UPL demonstrations, beginning in 2014, CMS also required Medicaid programs to submit UPL demonstrations on an annual basis for the following:

- *Clinics.*
- *Physician services (for states that reimburse targeted physician supplement payments).*
- *ICFs/IID.*
- *PRTFs.*
- *IMDs.*

In early 2017, CMS notified states that standardized UPL templates will be required when submitting UPL demonstrations to CMS. CMS developed these templates for all UPL

demonstration types, but the requirement to utilize the templates will be phased in, with inpatient hospital, outpatient hospital, and nursing facility demonstrations subject to the new requirements for state fiscal year 2018 UPL demonstrations. The templates will be required for the remaining UPL categories for state fiscal year 2019 demonstrations.

States continue to have considerable flexibility in developing their UPL test. We have assisted many clients in selecting the methodology most appropriate to support their specific objectives. Our goal for previous engagements has been to develop a defendable UPL calculation that maximizes the Medicare and Medicaid rate differential for our client while simultaneously maximizing and leveraging opportunities. We have applied our knowledge of and experience with UPL demonstrations for several provider types, including nursing facilities, hospitals, ICF/IID, PRTFs, and clinic providers.

Our detailed understanding of UPL demonstrations and our experience with West Virginia's UPL calculations and current reimbursement methodologies will benefit BMS on this project. The following is a brief summary of a sample of approaches we have prepared for our state clients:

***Inpatient Hospital Services***

- ***Prospective payment system.*** *In the PPS option, Medicaid utilization data and hospital financial data would be used to complete the analysis. Under this methodology, Medicaid utilization is classified into Medicare DRGs using the Medicare grouper. The estimated Medicare payment is computed using Medicare PPS payment policies. Beyond the PPS DRG payments, the comparison can also include capital payments, medical education payments, outlier payments, Medicare DSH payments, and any other additional reimbursement subject to the UPL determination.*
- ***Tax Equity and Fiscal Responsibility Act (TEFRA) targets.*** *The computation of the Medicare UPL can be based on the Medicare payment methodology known as TEFRA, which specifies the computation of hospital-specific target rates and rates-of-increase. TEFRA was used by Medicare as a reimbursement methodology for all hospitals during the transition from retrospective cost reimbursement to the PPS. Medicare continues to use TEFRA principles to reimburse hospitals and units exempt from the PPS.*
- ***Inpatient costs.*** *A third upper limit model option uses total allowable Medicaid costs. Medicaid costs would be identified using information contained in facility cost reports. The estimated UPL will be computed using Medicare cost principles, including capital and medical education costs. The UPL is limited to the lower of the cost of the service or the usual and customary charge.*
- ***Medicare payment-to-charge/cost.*** *Another approach to determine a reasonable estimate of the Medicare UPL is to calculate the ratio of Medicare payments to either Medicare billed charges or costs. The ratio is then applied to the corresponding Medicaid billed charges or cost to determine the UPL.*

***Outpatient Hospital Services***

- ***Ambulatory payment classification.*** *In the APC model, we will review and analyze Medicaid utilization data and hospital financial data. We will use a version of the 3M APC*

*grouper to classify Medicaid utilization into Medicare APCs. The estimated Medicare payment will be computed using Medicare APC payment policies. Similar to the inpatient PPS model, it may be permissible to include the Medicare shortfall (the difference between APC reimbursement and costs) to the APC reimbursement, essentially using all allowable outpatient costs as the Medicare payment amount.*

- ***Outpatient costs.*** *A second model may be developed using total allowable Medicaid costs. Medicaid costs would be identified using information contained in facility cost reports. The estimated Medicare payment will be computed using Medicare cost principles to calculate allowable Medicaid cost. Similar to the inpatient strategy, it may also be permissible to include net cost of care to the uninsured, though we will seek advisement from CMS. Current provider opinions suggest that Medicare APC payments are a reduction from previous cost settlements. Therefore, a cost-based model is likely to be a more financially beneficial model and an easier comparison to complete.*

### *Physician Services*

- ***Commercial payment rates.*** *Since a cost-based UPL is not feasible, Medicare allows the physician UPL to be based on applicable commercial rates. Medicaid claims data, usually limited to state-owned or operated facilities, is re-priced using average commercial rates by Current Procedural Technology/Health Care Common Procedure Coding System (CPT/HCPCS) code. Dental services can be included in this calculation.*
- ***Medicare physician fee schedule.*** *This model involves a comparison between the Medicare physician rates to Medicaid physician rates by CPT/HCPCS code.*

### *Nursing Facility Services*

- ***Medicare prospective payment system.*** *Medicare's PPS is an acuity-based, pricing system with a specific rate paid for each resident based on the resident assessment classification and the facility's urban/rural designation. Under the PPS option, MDS assessment data is used to determine the appropriate RUG classification and Medicare PPS rate for each Medicaid resident. Myers and Stauffer has all available grouper software that is necessary to determine the appropriate 44 RUG-III classification for each assessment. Individual resident PPS rates are aggregated to determine a facility average estimated Medicare PPS rate. Because the PPS rate is all-inclusive, an analysis to determine coverage differences between Medicare and West Virginia Medicaid will need to be completed. These coverage differences typically include services such as pharmacy, laboratory, and radiology. The average per diem Medicaid payment will be adjusted upward to account for services covered and reimbursed by Medicare through the PPS rate, but not within the nursing facility per diem rates.*
- ***Nursing facility costs.*** *This model is developed using total allowable Medicaid costs. Medicaid costs would be identified using information contained in the facility cost reports. The estimated Medicare payment will be computed using Medicare cost principles to calculate allowable Medicaid cost.*

***Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)***

- ***ICF/DD costs.*** *This model is developed using total allowable Medicaid costs. Medicaid costs would be identified using information contained in the facility cost reports. The estimated Medicare payment will be computed using Medicare cost principles to calculate allowable Medicaid cost.*

***Clinic Services***

- ***State payment rate to Medicare RBRVS comparison.*** *This UPL methodology is a payment-based approach in which Medicaid clinic rates are compared to the rate determined through the Medicare physician fee schedule RBRVS system. The comparison is done through a side-by-side comparison by CPT code of the Medicaid payment to the Medicare payment.*

***PRTF Services and IMDs***

- ***Provider customary charge.*** *Under this model, Medicaid payments are compared to providers' usual and customary charges, which are the UPL. Unlike other UPL demonstrations, the PRTF UPL is a comparison on a facility-specific basis rather than by ownership type (privately owned and operated, non-state government owned and operated, or state-owned and operated).*

## Health Care Claims Coding and Procedures (3.1.8)

Myers and Stauffer has significant experience with claims and MMIS data. We have a demonstrated ability to successfully understand and utilize large and complex data sets including claims, prior authorization, provider files, member files, reference data, and financial data within state MMIS systems. This experience is essential to our successful performance of rate setting, auditing, and other operational support functions for our clients. We currently maintain a comprehensive data warehouse of complete MMIS data for several state Medicaid clients. One of the most critical components in understanding claims data is how fiscal agent contractors and vendors address claims adjustments, voids, and replacement claims. We often request claim companion guides and other information to support our research.

In addition, Myers and Stauffer has significant expertise in CPT, ICD-9, and HCPCS codes. We have gained experience with an understanding of HCPCS codes and National Drug Codes (NDC) through our projects relating to physician reimbursement, pharmacy reimbursement, and our various program integrity projects.

The relationship between HCPCS codes and NDC codes has been a factor in several projects undertaken by Myers and Stauffer. In several states in which Myers and Stauffer has provided pharmacy reimbursement consulting services, the issue of mapping NDC codes to relevant HCPCS codes (and vice versa) has come up in the context of Medicaid rebate settlements. Additionally, Myers and Stauffer completed a contract for CMS that studied high-cost drugs in the proposed outpatient hospital PPS. For this project, we collected and analyzed acquisition costs and utilization data for drugs supplied to Medicare outpatients. The relationship between HCPCS codes and NDC codes were integral to the CMS project. We understand that CMS has defined

each HCPCS code with specific units of measure that can be distinct from the unit of measure of its NDC code counterparts.

To demonstrate our knowledge of health care claims coding procedures and claims processing systems, we have provided a brief narrative of the work we have completed on three specific projects. Should the state need further documentation, we can provide copies of project deliverables upon project award or, upon request, prior to award.

**Centers for Medicare & Medicaid Services:** Since 2006, we have conducted financial-related and operational examinations (audits) of health and drug plans throughout the country that participate in the Medicare Advantage Program (MA) (Part C) and Prescription Drug Program (PDP) (Part D). These audits include extensive sampling of medical claims and prescription drug events ensuring that direct/indirect remuneration (including drug rebates) is correct and properly reported and that CMS programs are properly implemented and administered by plan sponsors. We developed audit protocols and began providing health and drug benefit plan audit services for CMS in 2004. We have been providing similar services every year since that initial contract. The CMS audit work includes the review of hundreds of millions of pharmacy claims adjudicated by multiple PBMs, health plans, and third party administrators (TPAs). We have completed the following health and drug plan audits under this contract:

- *37 for contract year 2006.*
- *82 for contract year 2007.*
- *51 for contract year 2008.*
- *43 for contract year 2009.*
- *58 for contract year 2010.*
- *28 for contract year 2011.*
- *60 for contract year 2012.*

We are currently auditing 35 contract year 2013 plans. These engagements involve auditing the largest PBMs in the industry including CVS Caremark, Optum Rx/UHC, Express Scripts, Medco, and Catamaran.

These CMS PBM and health plan audits have identified areas of non-compliance with CMS guidance, including issues such as improper interpretation of published guidance, technical/systems deficiencies, operational problems, staffing issues, and poorly defined or incomplete processes.

**Georgia Department of Community Health:** Since 2004, we have performed testing and analysis of the adjudication of fee-for-service claims, managed care capitation payments (claims), and other administrative fee transactions (claims) for Georgia Medicaid and PeachCare for Kids© medical claims. We analyze member program eligibility status, capitation rate cell assignments, and the claims adjudication processes to confirm claim processing and financial transaction accuracy. We also compute overpayments and underpayments of sample claims. In addition, we prepare analyses to assist the Department in prioritizing mis-payment issues; perform analyses of

the entire claims population based on the findings identified in the samples to confirm potential fraud, abuse, or compliance-related billing issues and overpayments; and identify and prepare claims processing system correction tickets.

As a result of our work, we have assisted the Department in the identification of enhancement opportunities to MMIS system edit and audits; identified overpayments for collection; and prepared estimates of the Department's annual financial liabilities and receivables related to paid claims, capitation payments, and administrative fees. We deliver an annual AUP report that can be relied on by financial statement auditors in order to complete an annual audit of financial statements.

***Alaska Department of Health and Social Services:*** We perform desk reviews and on-site field examinations of all Alaska Medicaid provider types to validate proper documentation and reimbursement for a sample of Medicaid claims. For each annual cycle of the contract, we review Medicaid claims data and analyze risk factors in order to select a sample of approximately 80 Medicaid providers. These providers are chosen for desk review and/or field examination and represent a broad range of geographic locations and provider types. Each provider's claim documentation is reviewed by our team of experts to determine that the services were medically necessary, that documentation supports that services were actually provided and that Medicaid claims were properly submitted and adjudicated. Enhanced review procedures are performed on-site for some providers. Our review teams also examine provider compliance with applicable federal and state statutes and regulations, Medicaid provider agreements, and Medicaid provider billing manual instructions.

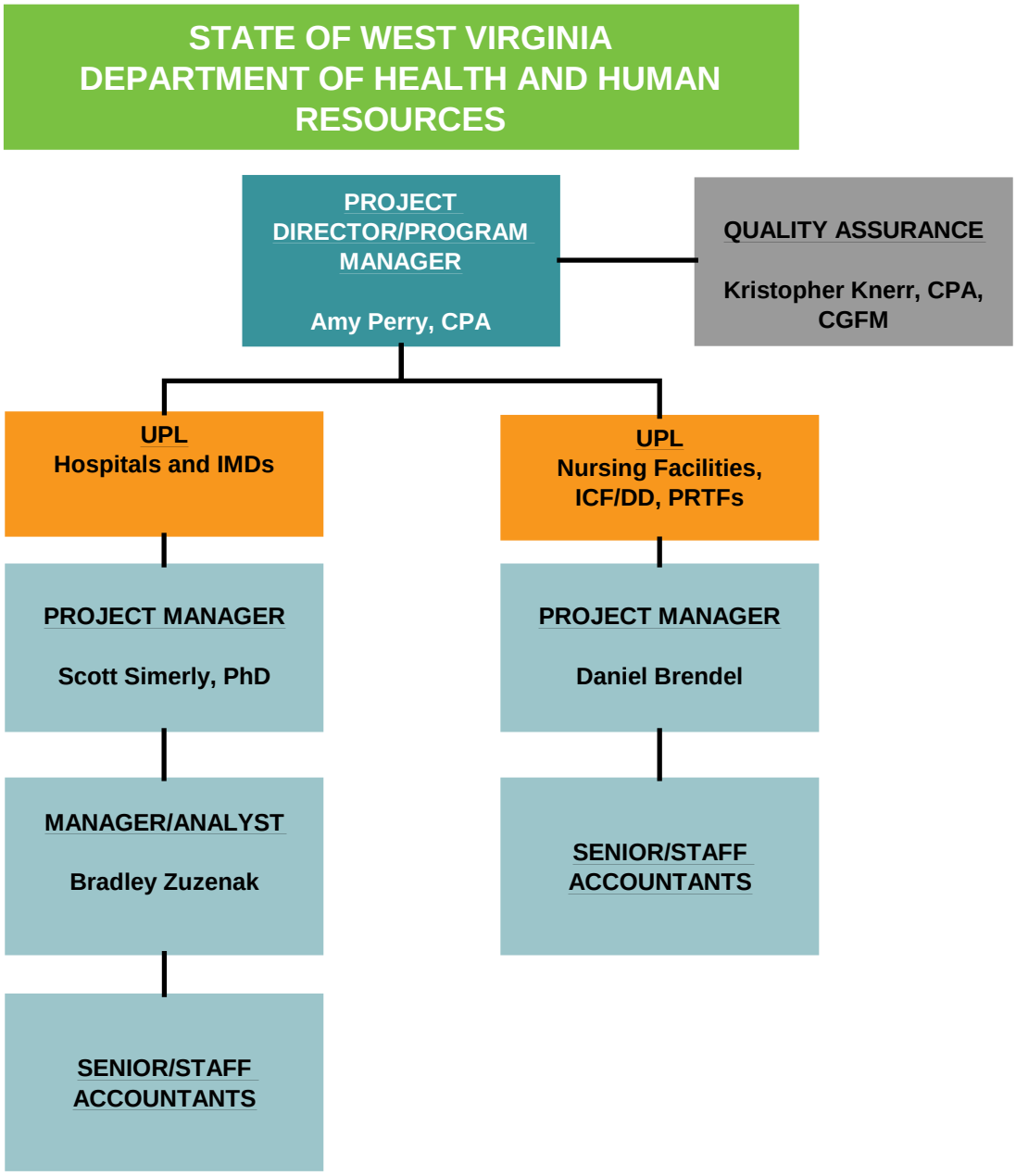
## Staffing (3.2)

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

We know our clients will not be successful unless we provide them with the highest levels of accuracy, accountability, responsiveness, and experience in health care policy and auditing staff. We, as a firm and as individuals, pride ourselves on our professionals' depth of experience and will provide that same level of expertise to the state.

Equally important are the roles and responsibilities of each team member. We are confident that our proposed level of staffing will allow us to complete the contract requirements of this CRFQ, while concurrently and effectively addressing any unexpected problems or delays.

**Engagement Team Organizational Chart**



## Overview and Resumes of Your Myers and Stauffer Team (3.2.1)

We operate on the principles of extraordinary client service and an unwavering commitment to quality. We are highly regarded nationwide for our professional objectivity, innovation, quality staff, and unparalleled service. Our success has been achieved by providing our clients with excellent service on a timely basis, including those times when clients have made urgent requests with minimal turnaround time. We are committed to serving BMS as effectively and economically as possible, while maintaining the highest levels of integrity, quality, and service.

All staff members dedicated to this contract have direct, hands-on experience performing auditing and consulting services for state and local health care agencies or CMS. Each staff member exceeds the minimum requirement of three years' experience working with two or more separate states with Medicaid UPL demonstration. In addition, we currently have the team members and resources in-house and will not need to hire any staff to complete this project.

We will staff this project in order to exceed your expectations. The following is a brief summary of our staff and their roles. We have included resumes for all key management staff in *Appendix B: Resumes*. Should we be the successful bidder, these professionals will be the personnel working on the project. In addition, we will assign senior associates and associates as needed. We assure BMS that the quality of staff will be maintained over the term of the contract agreement due to the depth of our experience with Medicaid agencies.

| Myers and Stauffer: Proposed Key Staff | | | | |
|---|---|---|---|---|
| **Team Member** | **Role in Project** | **Health Care Exp.** | **Exp with WV** | **Qualifications** |
| **Amy Perry, CPA**<br><br>*Member/Partner* | ***Project Director/Program Manager:*** Overall responsibility for all aspects of the project and will ensure total client satisfaction and establish the overall client service approach. Work with project manager to ensure successful outcomes. | 25 years | ✓ | Ms. Perry leads the firm's rate setting and consulting engagement team which includes the firm's hospital reimbursement practice area. She provides consulting and public accounting services to state Medicaid agencies regarding health care reimbursement issues. She is currently assisting the states of Connecticut, Georgia, and Kentucky with developing DRG- and APC-based hospital reimbursement methodologies. In addition, she is involved in assisting various states with annual DRG rebase/weight setting and UPL determinations. |

| Myers and Stauffer: Proposed Key Staff | | | | |
|---|---|---|---|---|
| **Team Member** | **Role in Project** | **Health Care Exp.** | **Exp with WV** | **Qualifications** |
| **Kristopher Knerr, CPA, CGFM**<br><br>*Member/Partner* | ***Quality Assurance/Technical Advisor:*** Will provide project quality review and serve as a technical resource. | 24 years | ✓ | Mr. Knerr is currently the project director for the firm's nursing facility rate setting and MDS verification practice area serving numerous states across the country on MDS and case mix projects. In this role, he has directed the design and implementation of state reimbursement methodologies, policies, and procedures; met with legislators and presented testimony to legislative committees; and drafted revised regulations and SPAs. Mr. Knerr has extensive experience assisting state Medicaid agencies in identifying and resolving case mix issues. Mr. Knerr also has extensive experience with UPL demonstrations and value-based payment systems. |
| **Scott Simerly, PhD**<br><br>*Senior Manager* | ***Project Manager (Hospitals/ Physicians/IMDs):*** Overall responsibility for all components of the hospital, clinic, and physician UPL demonstrations of this project. Review and approve all reports and deliverables, be available to discuss the progress of the project, attend meetings, and provide consulting services as needed. | 19 years | ✓ | Dr. Simerly has direct experience leading reimbursement system design, development, and implementation of multiple inpatient hospital reimbursement system engagements. He leads the firm's DRG recalibration and rebasing projects for the states of West Virginia, Connecticut, Georgia, Iowa, Kansas, New Jersey, North Carolina, New Jersey, and New Mexico. |
| **Daniel Brendel**<br><br>*Senior Manager* | ***Project Manager (ICFs/DD/PRTFs)*:** Oversee the ICF/DD and PRTF demonstrations. | 9 years | -- | Mr. Brendel is responsible for providing consulting and public accounting services to state Medicaid agencies addressing health care reimbursement issues. He has led various Medicaid accounting, auditing, and rate setting engagements. His duties include assisting in setup of initial project requirements, assisting in the development of standard work papers for auditing engagements, communicating with clients and providers, running the daily |

| Myers and Stauffer: Proposed Key Staff | | | | |
|---|---|---|---|---|
| **Team Member** | **Role in Project** | **Health Care Exp.** | **Exp with WV** | **Qualifications** |
| | | | | operations of selected Medicaid rate setting engagements, and developing and delivering tailored reimbursement system methodology training to state and provider community stakeholders. |
| **Bradley Zuzenak**<br><br>*Manager* | ***Analyst:*** Responsible for assisting Dr. Simerly and Mr. Brendel with UPL calculations, other required analyses, and extensive integrity review. | 9 years | ✓ | Mr. Zuzenak has more than seven years of health care compliance experience, including UPL reimbursement methodology projects for Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, New Mexico, and North Dakota. He has also assisted with DRG rate setting recalibrations for clients in West Virginia, Indiana, Kansas, and North Carolina. |

### Training (3.2.1)

Because our team includes experts in UPL demonstrations, the learning curve for training will be significantly reduced. Many of the issues typically encountered during a UPL engagement are not taught in a classroom, nor are they discussed in periodicals. It takes substantial exposure to the health care reimbursement field to provide the depth of understanding necessary to arrive at supportable conclusions. Myers and Stauffer incorporates an overview of Medicaid systems into its staff development protocol. This includes a review of pertinent federal statutes and regulations, state plan requirements, and state-specific reimbursement requirements. The firm's resource libraries contain all pertinent resource material including professional pronouncements issued by AICPA.

Our personnel participate in general and industry-specific continuing professional education and development activities. These activities enable staff to satisfy assigned responsibilities and fulfill applicable continuing professional education requirements. In addition, we utilize structured and supervised training for specific project tasks. We have implemented firm-wide professional development policies that:

- *Encourage participation in professional development programs that meet requirements of AICPA, state boards of accountancy, and regulatory agencies in establishing the firm's continuing professional education requirements.*
- *Provide orientation and training for new employees.*
- *Develop in-house staff training programs that focus on general and industry-specific subject matter.*

Our professionals routinely attend relevant national health care conferences to stay current with trends and issues. We also conduct local office training sessions that are specific to our Medicaid clients.

Our professionals who are CPAs are required to complete 40 hours annually of continuing professional education. Those employees who work on GAGAS engagements must complete 24 hours biennially in subjects directly related to government auditing, the government environment, or the specific or unique environment in which the audited entity operates (Yellow Book). We have included continuing professional education information for our key staff in *Appendix B: Resumes.*

Finally, all training is managed so that there will be no disruption to the work on our specific contracts. Staff members are assigned to a project team only after they have successfully completed a training program designed specifically to their needs.

# *Mandatory Requirements (CRFQ Section 4.1)*

Based on *CRFQ Section 4.1.2*, it is our understanding that the selected vendor will prepare the following UPL demonstrations:

- ***Medicaid State Plan Year 2016***
  - *Inpatient hospital services for the state-only provider group.*
  - *Outpatient hospital services for the state-only provider group.*
  - *Nursing facilities.*
  - *ICFs/DD.*
  - *PRTFs.*
  - *IMDs.*

## UPL Demonstration Work Plan (4.1.1)

The UPL demonstrations must show that Medicaid payments for each of these service categories are at or below a reasonable estimate of what Medicare would have paid for these Medicaid covered services using Medicare payment principals. While some of the service categories are actually covered by the Medicare program, others are not. This will necessitate that unique UPL demonstrations be developed for each of the service categories, based on our in-depth understanding of Medicare payment principles, federal UPL requirements, UPL models and calculations, and in conjunction with West Virginia's reimbursement methodologies and program needs. In recent months, we have prepared several UPL demonstrations for various clients, including UPLs for hospitals, nursing facilities, ICFs/DD, PRTFs, IMDs, and clinic providers. We will approach each UPL finding as follows:

- ***Keep BMS abreast of UPL issues raised by CMS.*** *Project staff that have been assigned to this project prepare UPL demonstrations for multiple states and are continuously responding to questions raised by CMS. As new issues are raised by CMS, project staff will review the current West Virginia UPL demonstrations to identify any possible concerns in the methodology that may raise questions from CMS. All concerns will be communicated to BMS along with alternative methodologies and/or strategies to address our concerns. One specific issue that CMS continues to raise is ensuring that the demonstration considers population, benefit, and acuity differences in Medicare and Medicaid. Myers and Stauffer has extensive experience in preparing payment-based demonstrations that recognize the acuity differences between Medicare and Medicaid populations. An example is using the Medicare RUGs with appropriate adjustments to consider population and benefit difference in Medicare and Medicaid. Myers and Stauffer is the only vendor that has the experience, software tools, and capability to perform a Medicare RUG-based nursing facility UPL demonstration.*
- ***Gather necessary data.*** *To perform the annual UPL findings, we will collect Medicaid payment and utilization statistics at the individual provider level. For the providers that file*

*cost reports with the Medicaid program, we will also need to collect their cost report data. Ownership information (privately owned and operated, non-state government owned and operated, or state-owned and operated) data will also be needed. For some service categories, we may also need Medicaid claims level data for the UPL analyses.*

- ***Model alternative UPL demonstrations.*** *CMS continues to provide states with a great deal of flexibility with respect to their UPL demonstration methodologies. Myers and Stauffer will review options with the Medicaid program and develop analyses for your evaluation as to which UPL approach best meets program objectives. As previously noted, the most common approaches to demonstrating UPL compliance follow either a cost-based, payment-to-charge ratio, or prospective payment approach. We will work with Medicaid staff to identify the approach most appropriate for West Virginia. These decisions for 2016 are important. It may be more difficult to adopt an alternative UPL approach in future years, since the state will likely need to defend transition, and show CMS that any alternative approach would result in a more precise estimate of what Medicare would have paid for the Medicaid covered services.*
- ***Prepare materials for UPL submission to CMS.*** *CMS also requires states to submit a guidance document with each UPL demonstration. We will prepare these documents for the Medicaid program's review.*
- ***Assist with correspondence with CMS.*** *The Medicaid program may receive questions or request for additional information from CMS following the submission of your UPL demonstrations. We will assist in addressing these issues and drafting replies to CMS.*

Myers and Stauffer is committed to meeting the state's goals and objectives. We have provided a draft of our proposed work plan and timeline for the UPL calculations in *CRFQ Section 4.1.4* which includes each of the following:

- *Compliance with the requirements contained in State Medicaid Director Letter SMD #13-003, referenced in Attachment 18, and the agreed-upon submission to CMS (CRFQ Section 4.1.1.1).*
- *The work plan covers "Medicaid State Plan Year" 2016 (July 1, 2015 through June 30, 2016) for all UPL demonstrations included in section 4.1.2 (CRFQ Section 4.1.1.2).*
- *Compilation of all data to complete the UPL demonstration from multiple databases, including the state MMIS and the current Medicaid State Plan (CRFQ Section 4.1.1.3).*

## Prepare UPL Calculations (4.1.2)

We confirm that we will produce the calculation and information necessary for the state UPL demonstrations for inpatient hospital services, outpatient hospital services, nursing facilities, ICF/DD, PRTFs, and IMDs. For the following UPL demonstrations we propose to utilize the methodologies described below:

- *For the state-only inpatient and outpatient hospital UPL demonstrations, the vendor will utilize the privately owned and non-state-government UPL calculations/models developed by the West Virginia Hospital Association (CRFQ Section 4.1.2.1).*

- *For the nursing facility UPL demonstration, we propose to utilize a Medicare RUGs-based methodology or alternative method in order to comply with federal requirements.*
- *For the ICF/DD UPL demonstration, we propose to utilize a cost-based UPL methodology based on current cost data collected using a simplified cost report.*
- *For the PRTFs and IMDs UPL demonstrations, we propose to utilize a charge-based methodology.*

## Acceptance of UPL Demonstrations (4.1.3)

Based on our experience, CMS does not always provide a verbal and/or written acceptance of UPL demonstrations submitted by states. Therefore, it appears that no response is considered acceptance. As shown in our experience above, we have prepared UPL demonstrations for several states. We have assisted the states of Idaho and New Mexico in responding to questions regarding the UPL demonstrations we prepared. For both these states, we were able to resolve all issues raised by CMS.

## Overall Project Work Plan (4.1.4)

We have provided a draft of our proposed work plans and timelines for the UPL calculations on the following pages.

Upon award of the contract, Myers and Stauffer will meet with BMS staff to discuss the proposed work plans and timelines and address any concerns. Following our initial meeting, the work plans and timelines will be revised to reflect any requested revisions and will encompass the entire contract period.

## Service Level Agreement (4.1.5)

We agree to the provisions of the *Service Level Agreement (CRFQ Attachment 20).*

**West Virginia Medicaid State Plan Year 2016 UPL Demonstrations**
**Project Work Plan: Data Requirements and UPL Demonstration Deliverables**

| UPL - CMS | Deliverables | UPL Methodology | Data Requirements / Comments | Deadline To Submit All Data/Inputs to Myers & Stauffer in Order to Meet Deliverable Date | Myers & Stauffer Deliverable Date to BMS |
|---|---|---|---|---|---|
| **Inpatient Hospital** | SFY 2016 Inpatient Hospital UPL Demonstration plus UPL Narrative for the State-only provider group | Inpatient Medicare Payment to Charge Ratio - The methodology is defined in the Medicaid State Plan. Based on review of Medicaid state plan it is not clear if Medicaid charges are are obtained from the CMS 2552 Medicare cost report or from Medicaid paid claims data. Work plan assumes Medicaid paid claims data. | 1. FFS Claims Data only (excluding cross overs) - Dates of Service to be determined. Both header and detail line item claims data. Also, include the provider type field and the claim group indicator field in the header record. 2. CMS 2552 Medicare Cost report fiscal year end to be determined based on discussions with state. | 1. Myers and Stauffer to submit cost report and claims data request to BMS within 15 business days from contract award date. **Approximate date August 21, 2017.** 2. Claims data and cost reports need to be submitted to Myers and Stauffer within 10 business from request. **Approximate date September 5, 2017 and no later than September 13, 2017.** | Myers and Stauffer will deliver the SFY 2016 Inpatient Hospital UPL Demonstration and UPL Narrative no later than **October 15, 2017.** |
| **Outpatient Hospital - Including Clinical Diagnostic Laboratory** | SFY 2016 Outpatient Hospital UPL Demonstration plus UPL Narrative for the State-only provider group | Outpatient Medicare Payment to Charge Ratio - The methodology is defined in the Medicaid State Plan. Per review of Medicaid state plan it is not clear if Medicaid charges are are obtained from the CMS 2552 Medicare cost report or from Medicaid paid claims data. Work plan assumes Medicaid paid claims data. Based on review of the Medicaid State Plan, reimbursement for laboratory and x-ray services are limited to the amount established by Medicare. Therefore, no separate UPL demonstration will need to be completed for outpatient clinical diagnostic laboratory services. | 1. FFS Outpatient Claims Data only excluding cross-overs - Dates of Service to be determined. Both header and detail line item claims data. Also include the provider type field and the claim group indicator field in the header record. 2. Hospital's CMS 2552 Medicare cost report fiscal year end to be determined based on discussions with state. | 1. Myers and Stauffer to submit cost report and claims data request to BMS within 15 business days from contract award date. **Approximate date August 21, 2017.** 2. Claims data and cost reports need to be submitted to Myers and Stauffer within 10 business days from request. **Approximate date September 5, 2017 and no later than September 13, 2017.** | Myers and Stauffer will deliver the SFY 2016 Outpatient Hospital UPL, including clinical diagnostic laboratory Demonstration and UPL Narrative no later than **October 15, 2017.** |
| **Nursing Facilities** | SFY 2016 NF UPL Demonstration plus UPL Narrative | Medicare Resource Utilization Group Payment Demonstration | 1. MDS assessment data. 2. NF FFS claims data - dates of service to be determined. 3. SFY 2016 NF rates 4. NF cost report database - cost report period to be determined. 5. Medicaid FFS claims data for pharmacy, x-ray and laboratory services provided to individuals residing in a NF. Dates of service to be determined. 6. NF bed hold report. | 1. Myers and Stauffer to submit data request to the state within 15 business days from contract award date. **Approximate date August 21, 2017.** 2. State to submit all requested to Myers and Stauffer within 20 business days from request. **Approximate date September 19, 2017 and no later than September 26, 2017.** | Myers and Stauffer will deliver the SFY 2016 NF UPL Demonstration and UPL Narrative no later than **October 31, 2017.** |

**West Virginia Medicaid State Plan Year 2016 UPL Demonstrations**
**Project Work Plan: Data Requirements and UPL Demonstration Deliverables**

| UPL - CMS | Deliverables | UPL Methodology | Data Requirements / Comments | Deadline To Submit All Data/Inputs to Myers & Stauffer in Order to Meet Deliverable Date | Myers & Stauffer Deliverable Date to BMS |
|---|---|---|---|---|---|
| **ICF/DD** | SFY 2016 ICF/DD UPL Demonstration plus UPL Narrative | Cost-Based | 1. ICFs/DD Medicaid rates effective July 1, 2016. 2. FFS claims Data only. 3. It is our understanding that ICFs/DD are not required to submit a cost report. Per the CMS guidance, because Medicare does not pay for services within ICFs/DD states have limited UPL methodology options and typically use a cost demonstration. Myers and Stauffer will develop a simplified cost data survey tool to collect current cost data from ICFs/DD. | 1. Myers and Stauffer to submit data request to BMS within 15 business days from contract award date. **Approximate date August 21, 2017.** 2.Requested data to be submitted to Myers and Stauffer within 10 business days from request. **Approximate date September 5, 2017 and no later than September 13, 2017.** 3. Myers and Stauffer to modify current cost data survey and submit to BMS for approval by **August 21, 2017.** 3. Cost data surveys mailed to ICF/DD and submitted back to Myers and Stauffer by **October 6, 2017.** 4. Myers and Stauffer to review cost survey data for reasonableness and compile into a database. | Myers and Stauffer will deliver the SFY 2016 ICF/DD UPL Demonstration and UPL Narrative no later than **October 31, 2017.** |
| **PRTF** | SFY 2016 PRTF UPL Demonstration plus UPL Narrative | Provider Customary Charge | 1. FFS claims Data only - Dates of Service to be determined. 2. Cost report if available 3. PRTF Medicaid rates effective July 1, 2016. | 1. Myers and Stauffer to submit data request to BMS within 15 business days from contract award date. **Approximate date August 21, 2017.** 2.Requested data to be submitted to Myers and Stauffer within 10 business days from request. **Approximate date September 5, 2017 and no later than September 13, 2017.** | Myers and Stauffer will deliver the SFY 2016 PRTF UPL Demonstration and UPL Narrative no later than **September 30, 2017.** |
| **IMD** | SFY 2016 IMD UPL Demonstration plus UPL narrative | Provider Customary Charge | 1. FFS claims Data only - Dates of Service to be determined. 2. Cost report if available | 1. Myers and Stauffer to submit data request to BMS within 15 business days from contract award date. **Approximate date August 21, 2017.** 2.Requested data to be submitted to Myers and Stauffer within 10 business days from request. **Approximate date September 5, 2017 and no later than September 13, 2017.** | Myers and Stauffer will deliver the SFY 2016 IMD UPL Demonstration and UPL Narrative no later than **September 30, 2017.** |

# *Deliverables* *(CRFQ Section 4.2)*

We agree to provide the following deliverables:

- *Prescribed forms for each UPL demonstration, along with supporting calculations within the timeframes established in 4.1.1 (CRFQ Section 4.2.1).*
- *An electronic version of the completed demonstration forms, along with electronic version of all calculations. We will provide our calculations and supporting workpapers in Microsoft Excel. We understand that BMS will transmit the copies of demonstrations to CMS (CRFQ Section 4.2.2).*
- *Exit conference with the DHHR and BMS representatives once the forms referenced in CRFQ Section 4.2.1 have been accepted by BMS. We understand that the exit conference will be scheduled upon project completion and will be conducted via teleconference (CRFQ Section 4.2.3).*
- *Technical assistance to BMS regarding questions from CMS related to the UPL demonstrations submitted (CRFQ Section 4.2.4).*

# *Contract Award/Pricing Page (CRFQ Sections 5.1/2)*

We have included our price estimate separately through wvOASIS, per the CRFQ instructions. Our pricing is based on our understanding of your request and our previous experience conducting UPL demonstrations in numerous states.

# *Additional Information* *(CRFQ Sections 6 – 11)*

## Performance (6)

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

## Payment (7)

Myers and Stauffer understands and accepts that we will receive a flat fee, all-inclusive, for all contract services performed and accepted under this contract. We shall accept payment in accordance with the payment procedures of the state of West Virginia.

## Travel (8)

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

## Facilities Access (9)

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

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

## Vendor Default (10)

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

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

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

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

## Miscellaneous (11)

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

Contract Manager: Amy Perry
Telephone Number: 816.945.5300
Toll-free Number: 800.374.6858
Fax Number: 816.945.5301
Email: APerry@mslc.com

Please note we have included all required CRFQ forms in *Appendix D: CRFQ Forms*. In addition, we have included evidence of our insurance in *Appendix E: Insurance.*

# *Appendix A: Quality Control Manual*

## CHAPTER 2 Ethical Requirements

**[QC §10.21-10.26; 10.A7-10.A10]**

It is the policy of the firm that all personnel be familiar with and adhere to relevant ethical requirements of the AICPA in its *Code of Professional Conduct* and pertinent regulatory agencies, and when applicable to the engagement, Generally Accepted Government Auditing Standards.

Certified Public Accountants (CPAs) must be familiar with and adhere to all relevant *AICPA Professional Standards* and requirements of state boards of accountancy and CPA societies for states germane to one's practice area.

The following is offered to clarify this policy:

1. The firm endeavors to avoid situations that present conflicts of interest. It does not accept providers of health care services as clients. It is the policy of the firm not only to maintain independence in fact and appearance, but also in mental attitude. Although not all-inclusive, the following are considered prohibited transactions:

    a. Investments by the firm or its personnel in a client's or health care provider's business, except indirectly as a passive investor through a mutual fund or retirement plan.

    b. Partnership, joint venture, or joint investment by the firm or its personnel with a client or health care provider, or their personnel.

    c. The firm or its personnel borrowing from or making loans to a client or health care provider, or their personnel.

    d. The firm's personnel accepting cash or gifts from or offering cash or gifts to a client or health care provider, or their personnel (with the exception of non-cash token gifts of nominal value).

    e. Certain close family relationships between the firm's personnel and client or health care provider personnel – consult the Quality Control Committee for a ruling and relevant mitigation steps.

f. The firm or its personnel engaging in any activity or undertaking any transaction that may give the appearance that the firm is not independent of a client or a health care provider, or their personnel.

g. The firm or its personnel engaging in any transaction, event, circumstance, or action that would impair independence or violate the firm's ethical policies.

2. When facing situations that raise potential independence threats not specifically addressed by independence rules, one should report the matter to the Quality Control Committee. Such threats will be evaluated by reference to *Conceptual Framework for AICPA Independence Standards* contained in the *AICPA Professional Standards*, Volume 2 ET §100, through professional judgment to determine whether an independence breach exists. When necessary, appropriate authorities from AICPA or state CPA societies are consulted. The firm will take appropriate action to mitigate the threat.

3. Notwithstanding the preceding guidance and list of prohibited transactions, at the Quality Control Committee's discretion, prohibitions can be waived if deemed in the best interest of the firm and if allowed by professional standards.

The firm implements this policy through the following procedures:

Requiring all personnel to sign an Independence, Integrity, and Objectivity Representation when hired, and annually thereafter, that acknowledges familiarity with the firm's relevant ethical requirements policies and procedures, including independence.

Requiring all personnel to promptly notify the Quality Control Committee of any circumstances or relationships that may create a potential threat to independence or an independence breach, so that appropriate action can be taken. To acknowledge these responsibilities, personnel are required when hired, and annually thereafter, to sign the Representation and list known circumstances and relationships that may create a potential threat to independence or violate the firm's ethical requirements policy. The *Code of Professional Conduct* is contained in the *AICPA Professional Standards*, Volume 2 ET and is available in each office. Authoritative resources and advice of the Quality Control Committee should be consulted when one is not sure if a transaction, event, or circumstance may be a violation or should be reported.

Requiring all personnel to determine annually whether their situation (personal and business) involves a prohibited transaction with a state agency or a health care provider or their personnel. If one determines that a prohibited transaction may exist, one is required to review the firm's client list and related health care provider lists. The time sheet program includes a listing of all state agency contracts and is updated regularly. The engagement partner in charge of each

state agency contract maintains a current listing of all health care providers covered under that contract. When hired, and annually thereafter, all personnel are required to sign a representation that confirms this responsibility.

Assigning responsibility for obtaining a signed Independence, Integrity, and Objectivity Representation from all personnel each year to the Quality Control Committee. It is reviewed for completeness and information relating to identified threats to ethical requirements. If a potential threat is identified, the Quality Control Committee communicates relevant information to management so it can take appropriate action to address identified threats. In determining a resolution, refer to paragraph 2 in the clarification above. Documentation of resolution is filed in the employee's personnel folder.

Requiring independence representations from other CPA firms when necessary. During the course of performing an accounting and auditing engagement, the ET may utilize a report prepared by another independent accountant to corroborate the ET's independent findings. Under these circumstances, no independence representation is required from the other auditors. On the other hand, if another auditor performs a segment of our accounting and auditing engagement, a separate independence representation is required from such auditor.

Assigning to the Executive Committee the primary responsibility for determining whether there are unpaid fees by clients that would impair the firm's independence and determine its impact.

Assigning to the Executive Committee the primary responsibility for determining whether actual or threatened litigation has an effect on the firm's independence with respect to a client.

Assigning to the engagement partner the responsibility for promptly notifying the Quality Control Committee when personnel may have violated the firm's independence or other ethics policies or procedures. The engagement partner, in consultation with the Quality Control Committee, may initiate other reasonable steps to mitigate the firm's risk exposure.

Requiring notification of breach. If a breach of independence or other ethics issue is identified, all parties that know of a possible breach in Ethical Requirements should promptly notify the Quality Control Committee. The committee should determine the facts and circumstances and promptly notify the Executive Committee of the incident and recommended action. Recommended action for each incident is determined by facts and circumstances and may include eliminating a personal impairment, requiring additional training, drafting a reprimand letter, or even termination.

Assigning to the Executive Committee resolution of breaches in ethical requirements. The committee confirms its resolution to the Quality Control Committee and notifies other affected parties.

**Table of Selected Rules in the AICPA Code of Professional Conduct**
(These rules apply to all personnel.)

| Description of Rule | Location in Professional Standards* |
|---|---|
| Article I Responsibilities | ET §52 |
| Article II The Public Interest | ET §53 |
| Article III Integrity | ET §54 |
| Article IV Objectivity, Independence | ET §55 |
| Article V Due Care | ET §56 |
| Article VI Scope, Nature of Services | ET §57 |
| Rule 101 Independence | ET §101.01 |
| Rule 101 Interpretations | ET §101.02-.19 |
| Rule 102 Integrity and Objectivity | ET §102.01 |
| Rule 102 Interpretations | ET §102.02-.07 |
| Ethics Rulings | ET §191.001-.229 |

* From *AICPA Professional Standards*, Volume 2

# Appendix B: Resumes

## AMY PERRY, CPA

Ms. Perry has more than 25 years of experience with the firm and provides consulting and public accounting services to state Medicaid agencies regarding health care reimbursement issues. Ms. Perry leads the firm's rate setting and consulting engagement team which includes the firm's hospital reimbursement practice area.

She is currently the project director and program manager for UPL demonstration calculations in West Virginia. She also assists the states of Connecticut, Georgia, and Kentucky with developing DRG- and APC-based hospital reimbursement methodologies. In addition, she is involved in assisting various states with annual DRG rebase/weight setting and UPL determinations.

Ms. Perry's responsibilities also include supervising project staff and planning and organizing day-to-day project operations. She also has the responsibility of keeping abreast of current statutes, rules, and regulations that govern the industry, and researching and evaluating the impact of state and federal legislation on provider reimbursement issues.

**Amy Perry, CPA**

*Member*

**EDUCATION**

*B.S., Accounting, Northeast Missouri State University*

**EXPERIENCE**

*25 years of professional experience*

**CORE COMPETENCIES**

*verifications, desk reviews, cost reporting, rate setting*

*litigation consultation*

*explanation and analysis of reporting requirements*

*partner-in-charge of rate setting and consulting*

She has direct experience assisting the New Jersey Department of Health in developing and drafting the financial protocols required at the inception of its DSRIP program and obtaining CMS approval of those protocols.

In 2004, Ms. Perry established the firm's Iowa office and hired and trained approximately 15 staff, including CPAs, CPA candidates, computer professionals, and accounting technicians. Prior to that, she served as manager on many projects of the firm whose primary focus was the design and development of nursing facility rate setting systems for state Medicaid agencies and preparing analyses to support the Medicare UPL and justification of rates to comply with federal requirements. She has been active in all phases of case mix development and maintenance for projects in Colorado, Hawaii, Iowa, Louisiana, Montana, New Jersey, and North Carolina. She also prepared exhibits used in the presentation of the case mix system to the Colorado, Iowa, Kansas, and Montana legislatures.

Ms. Perry's experience with nursing facility and ICF/IID rate setting includes researching and developing alternative reimbursement methodologies with emphasis on case mix reimbursement.

Her experience includes all phases of design, development, implementation, and maintenance. She has prepared pro forma reimbursement models and financial and statistical analyses that allow states to define multiple reimbursement variables that can be changed interactively. This type of modeling provides states the ability to evaluate multiple options quickly and efficiently. She also assists states with their regulatory process formulating state plan/rule language, reviewing regulations, drafting responses to questions from CMS and other interested parties, and preparing analyses.

**CERTIFICATION**
Certified Public Accountant

**PRESENTATIONS**
"Louisiana Medicaid Nursing Facility Case Mix Reimbursement," Gulf States Association of Homes and Services for the Aging, 2003.
"Current Trends in Nursing Facility Rate Setting," Myers and Stauffer Workshop, Indianapolis, Indiana, 2003.
"RUG-III Case Mix Reimbursement System," North Carolina Medicaid, 2003.

**AFFILIATIONS**
American Institute of Certified Public Accountants
Kansas Society of Certified Public Accountants

**CONTINUING PROFESSIONAL EDUCATION**
Formal training through a balance of internal and external programs including nationally sponsored programs of the state societies of CPAs, AICPA, and other organizations. As a CPA, Ms. Perry's total continuing professional education meets or exceeds the professional standard of 40 hours annually. CPE courses that Ms. Perry participated in in the past three years include *The Trustworthy Leader: Ethics and Trust, Benefit/Program Integrity Training Conference, Integrated Care Models (ICM) Training Academy, Ethical Considerations for CPAs, Advanced Compilation & Review Engagement Issues: Striking the Right Balance (ADCR), Heartland Technology Conference, Fundamentals of Government Accounting and Reporting: Measurement Focus and Basis of Accounting; Governmental Funds - Revenues and Expenditures, Government and Not-for-Profit Annual Update, Critical Skills for Budgeting Success, Real-Work Business Ethics for CPAs in Business & Industry - How Will You React?, Anatomy of a Negotiation: Reaching Agreements with Creativity and Flexibility, Strategic Management: Concepts and Tools, and A&A Year in Review: Exploring the Latest Issues and Challenges Facing CPAs*.

## KRISTOPHER KNERR, CPA, CGFM

Mr. Knerr is responsible for providing consulting and public accounting services to state and federal agencies regarding health care reimbursement issues.

He is currently the quality assurance partner for the West Virginia preparation of UPL demonstration calculations. In addition, Mr. Knerr serves as project director for the development and operation of case mix reimbursement systems for nursing facilities for several state Medicaid agency clients. In this role, he has developed reimbursement strategies to address the treatment of nursing services within the case mix system as well as strategies to address non-nursing services, including administration, environmental, support care, and capital costs. He presents and defends the case mix system proposal at numerous task force meetings, meets with legislators and providers to explain the systems, and presents testimony to various legislative committees.

He also serves as project director for the development, implementation, and operation of SMAC and AAC pharmacy pricing programs for the states of Alabama, Idaho, Indiana, Iowa, Louisiana, Mississippi, and Oregon. He also leads the contract with the CMS to develop a nationwide benchmark for the pricing of generic, brand, and over-the-counter covered outpatient drugs, having completed the nationwide pharmacy Retail Price Survey and developed the National Average Drug Acquisition Cost (NADAC). For all of these engagements, Mr. Knerr guides the development of program goals and strategy sessions to determine how to achieve those goals, and oversees all phases of the engagement, from development to implementation and operation, including rate setting, fiscal analysis and modeling, reporting, and production of timely and accurate project deliverables. He serves as a resource and liaison to state agency staff, providers, regulators, and other external stakeholders interested in the SMAC/AAC program, addressing questions or issues raised by the General Assembly, the Governor's office, and CMS.

**Kristopher Knerr, *CPA, CGFM***

**EDUCATION**

*B.A., Accounting, University of South Florida*

**EXPERIENCE**

*32 years of professional experience*

**CORE COMPETENCIES**

*analyses and reviews of provider cost data and economic data to support state assurances to CMS*

*expert testimony and litigation consultation*

*well-respected resource in Medicaid community for state MAC programs*

*extensive experience modeling, analyzing, drafting and implementing regulatory changes*

In all of these engagements, Mr. Knerr implements or oversees the performance of complex financial and utilization modeling and analysis, including UPL calculations and provider tax assessment initiatives, and assists state Medicaid agencies in drafting and implementing Medicaid regulatory changes. This includes compilation of empirical evidence regarding policy issues for presentation to state Medicaid staff. He provides expert testimony and consultation in defense of various suits brought forth by providers in various state and administrative forums. He performs critical analysis, fiscal impact modeling, and reviews provider cost data and relevant

economic data used in developing findings to support state Medicaid agency assurances to CMS. Mr. Knerr develops cost reporting methodology and forms with instructions for state Medicaid agency clients.

**CERTIFICATIONS**
Certified Public Accountant
Certified Government Financial Manager

**PRESENTATIONS**
"Unanticipated Acuity Changes: The Impact on Government Assistance Budgets," Case Mix Conference, New Frontiers in Health Information.

"Components of the Medicare Prospective Payment System" and "Impact on State Medicaid Programs," Myers and Stauffer Home Health Workshop.

"Current Status of State Medicaid Case Mix Systems, Putting Policy into Action: Are we Making a Difference," National Case Mix Conference.

**AFFILIATIONS**
American Institute of Certified Public Accountants
American Public Human Services Association
Association of Government Accountants
Indiana Certified Public Accountants Society

**CONTINUING PROFESSIONAL EDUCATION**
Formal training through a balance of internal and external programs including nationally sponsored programs of the state societies of CPAs, AICPA, and other organizations. As a CPA, Mr. Knerr's total continuing professional education meets or exceeds 40 hours annually, and at least 24 hours of the 80 hours must be in subjects directly related to government auditing, the government environment, or the specific or unique environment in which the audited entity operates (Yellow Book). CPE courses that Mr. Knerr participated in the past three years include *Tax Practitioner Institute, A&A Conference CONF7-16, Cost Report/DSH/Litigation Support Training Conference (Audit Training Conference), Real World Business Ethics for CPAs in Business and Industry, Fraud Update: Detecting and Preventing the Top Ten Fraud Schemes, Annual Accounting and Auditing Update: Indianapolis, Technology for CPAs: Don't Get Left Behind, To the Cloud or Not? Cloud and Mobile Technology Symposium, Getting Ready for Busy Season: A Guide to New Forms, Filing Issues and Other Critical Developments, What Drive Fraud and How to Stay of the Fraud Ditch, Financial Statement Disclosures: Guide to Current Requirements and Developing Issues, Long Term Care Payment Forum, Long Term Care Payment Forum (teaching credit), Cost Report/DSH/Litigation Support Training Conference (Audit Training Conference), and NF Rate Setting Engagement Team Training Conference.*

## SCOTT SIMERLY, PH.D.

Dr. Simerly has 19 years of direct experience leading reimbursement system design, development, and implementation of multiple inpatient hospital reimbursement system engagements. He leads the firm's DRG recalibration and rebasing projects for the states of West Virginia, Connecticut, Georgia, Iowa, Kansas, New Jersey, New Mexico, and North Carolina.

Dr. Simerly provides consulting support for these hospital programs including ad-hoc analyses and federal UPL determinations. In West Virginia, besides the annual updating of the DRG system, he is responsible for an annual review of the RBRVS system and the outpatient PPS. He has also constructed modifiable reimbursement models comparing Alaska and Kansas physician reimbursement to surrounding states, Medicare, and private insurance rate.

Additionally, he leads the firm's outpatient PPS engagements, including the planned implementation of an APC system for Connecticut and Georgia. He also leads the existing system for PEIA in West Virginia and a conversion of the Iowa APG system to an APC system. His responsibilities include the determination of hospital rates and case mix index factors, calculation of DRG relative weights and outlier thresholds, fiscal impact studies, management of databases, and preparation of other statistical analyses.

**Scott Simerly, Ph.D.**
*Senior Manager*

**EDUCATION**

*M.B.A., West Virginia University*

*Ph.D., Chemistry, University of Illinois*

*B.S., Chemistry, Iowa State University*

**EXPERIENCE**

*26 years of professional experience*

**CORE COMPETENCIES**

*DRG recalibration and rebasing*

*hospital rates and case mix index factors*

*federal UPL requirements*

*constructs modifiable reimbursement models*

**PRESENTATIONS**

"Price vs Cost Reimbursement," Myers and Stauffer Workshop, Indianapolis, Indiana, 2003.

**CONTINUING PROFESSIONAL EDUCATION**

While Dr. Simerly is not a CPA and his continuing professional education is not tracked, he does receive formal training through a balance of internal and external programs including nationally sponsored programs and conferences.

## DANIEL BRENDEL

Mr. Brendel is responsible for providing consulting and public accounting services to state Medicaid agencies addressing health care reimbursement issues. He has led various Medicaid accounting, auditing, and rate setting engagements. He is responsible for supervising staff for contract engagements, while also running the daily activities of select Medicaid contracts. His duties include assisting in setup of initial project requirements and development of standard work papers for auditing engagements, communicating with clients and providers, disseminating and monitoring staff workload assignments, running the daily operations of selected Medicaid rate setting engagements, and developing and delivering tailored reimbursement system methodology training to state and provider community stakeholders.

He is currently working as the West Virginia project manager for UPL Demonstration Calculations for SNFs, nursing facilities, ICF/DD, and PRTF. In addition, Mr. Brendel is in charge of running the day-to-day operations of the Louisiana nursing facility case mix engagement. His responsibilities include nursing facility case mix rate setting; rebasing of nursing home rates using Medicare and Medicaid cost reports; consulting on various nursing facility issues; and monitoring UPLs.

**Daniel Brendel**
*Senior Manager*

**EDUCATION**
*B.B.A., Accounting, University of Miami*

**EXPERIENCE**
*11 years of professional experience*

**CORE COMPETENCIES**
*cost report auditing*

*Medicaid DSH auditing*

*nursing facility case mix rate setting*

*cost report development*

*develops course curriculum and conducts training for client personnel, providers and Myers and Stauffer staff*

As part of the Louisiana nursing facility case mix engagement, Mr. Brendel assists in the writing and implementation of reimbursement rule changes and SPAs designed to refine the rate setting process. He has been actively involved in supporting the state in their discussions with the nursing home association and providing analysis and expert opinions on both informal and formal appeal processes. He is also responsible for the development, maintenance, and modification requests of the Medicaid supplemental cost reports utilized for the nursing facility, adult day health care (ADHC), intermediate care facility provider entities, and HCBS.

Mr. Brendel has assisted the states of New Jersey and North Carolina in transitioning to the Medicare cost report as the basis for their nursing facility case mix rate setting. He was actively involved in the development and continued maintenance of the Medicaid supplemental cost reports, and was responsible for the day-to-day operations of the development of proprietary automated rate setting system software with associated database capabilities. He also assisted in the day-to-day operations of the rate calculation process.

Mr. Brendel was actively involved in the transition for the Louisiana ADHC entities from a per diem reimbursement system to a per quarter hour reimbursement system. His duties included the

development of quarter hour reimbursement rates and revisions to existing Louisiana ADHC rule and state plan language. Throughout the transition process, he was actively involved in discussions between the state and the ADHC provider community. Mr. Brendel was also responsible for provider education meetings that displayed the new reimbursement methodology.

For the state of Louisiana, Mr. Brendel has also assisted in developing rates for the Coordinated Systems of Care (CSOC) initiative. Within the CSOC initiative, he assisted in the development of a reimbursement methodology and reimbursement rates for PRTF and therapeutic group homes (TGH). He revised rule and Medicaid state plan language to account for the development and institution of the reimbursement methodologies. Throughout the rate development process, he was actively involved with discussions between the state and provider communities, and assisted in several reimbursement methodology demonstrations. Mr. Brendel also developed a Medicaid cost reporting instrument to capture the allowable costs of these specific provider entities.

Mr. Brendel has also been involved with the development of reimbursement rates for therapeutic foster care, medical therapeutic foster care, and non-medical group homes on behalf of the Louisiana Department of Children and Family Services. Throughout the rate development process, Mr. Brendel was actively involved with discussions between the state and the provider communities and assisted in several reimbursement methodology demonstrations.

Mr. Brendel has assisted in the development of a reimbursement methodology for personal attendant care services for the state of Louisiana. The rate setting process included the development of a Medicaid specific HCBS cost report; collection and analysis of cost reporting information; development of estimates on productive labor time; and comparison of costs to known data sources. Mr. Brendel has been actively involved in discussion with the state and provider community to ensure all stakeholders had sufficient input on the methodology design.

**PRESENTATIONS**

“2015 HCBS Cost Report Training”, Louisiana Home and Community Based Services Cost Report Provider Training, Baton Rouge, Louisiana, 2015.

“HCBS Cost Report Training”, Louisiana Home and Community Based Services Cost Report Provider Training, Baton Rouge, Louisiana, 2014.

“Long Term Care Reimbursement Methodologies,” Louisiana Long Term Care Financing Study Group, Baton Rouge, Louisiana, 2012.

“Louisiana Case Mix,” Louisiana Nursing Facility Case Mix Training, Baton Rouge, Louisiana, 2010.

“New Jersey Case Mix Reimbursement System,” Myers and Stauffer Internal Training, Kansas City, Raleigh, Baltimore.

**CONTINUING PROFESSIONAL EDUCATION**

While Mr. Brendel is not a CPA and his continuing professional education is not tracked, he does receive formal training through a balance of internal and external programs including nationally sponsored programs and conferences.

## BRADLEY ZUZENAK

Mr. Zuzenak has more than eight years of health care compliance experience, including UPL reimbursement methodology projects for Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, New Mexico, and North Dakota. He has also has assisted with DRG rate setting recalibrations for clients in West Virginia, Indiana, Kansas, and North Carolina.

Prior to joining Myers and Stauffer, he worked as an analyst at Humana, Inc. He was responsible for analyzing hospital contracts, claims, provider information, and bonuses for the Medicare division of the central and intermountain regions. In addition, he pulled detailed claims to perform ad-hoc analysis on hospitals and physicians, and worked with large datasets that were pulled using Oracle databases, Procedural Language/Structured Query Language (PL/SQL), and SAS.

**CONTINUING PROFESSIONAL EDUCATION**
While Mr. Zuzenak is not a CPA and his continuing professional education is not tracked, he does receive formal training through a balance of internal and external programs including nationally sponsored programs and conferences.

**Bradley Zuzenak**
*Manager*

**EDUCATION**
*M.B.A., Rockhurst University*

*B.A., Business Administration, Lindenwood University*

**EXPERIENCE**
*9 years of professional experience*

**CORE COMPETENCIES**
*analysis and data management of state reimbursement systems*

*DRG rate setting recalibrations*

*UPL calculations*

# *Appendix C: RBRVS Rate Model*

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

TO: WV Medicaid

FROM: Joe Gamis

DATE: January 12, 2017

SUBJECT: CY 2017 RBRVS Update

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Attached are the Medicaid RBRVS update exhibits for CY 2017. As in previous years, Myers and Stauffer has reviewed the changes addressed by Medicare in the Federal Register Physician Fee Schedule and applied appropriate measures to the West Virginia Medicaid system. Our analysis includes calculations of an updated statewide budget neutral conversion factor (CF) and an updated CF for codes specific to obstetrics and gynecology (OB/Gyn) services. We have also prepared a payment rate table for all HCPCS codes in use for CY 2017. Additional aspects of the update that have influenced the calculation of the RBRVS system are discussed below.

Each HCPCS code is assigned a Relative Value Unit (RVU) total that is multiplied by the appropriate CF to yield the payment rates for that service. Medicare has divided each service into three component values—work, practice expense (PE), and malpractice (MP)—that are separately scaled by geographic practice cost indices (GPCIs) and summed to generate the RVU total. The work component reflects the average resource costs associated with performing a specific service and comprises approximately 50% of the RVU total. The PE component reflects resource costs generated by operating a physician's practice and it comprises approximately 40% of the RVU total. For each code, separate PE calculations are assigned depending upon whether the service was performed in a facility or non-facility setting. The MP component reflects cost attributable to malpractice insurance premiums and comprises approximately 10% of the RVU total.

Medicare calculates GPCIs across 88 different localities covering the entire United States to identify resource cost differences compared to the national average. The state of West Virginia is treated as a single locality for this calculation. In Medicare's CY 2017 Federal Register Final Rule, West Virginia GPCIs are 1.000 for the work component, 0.847 for the PE component, and 1.289 for the MP component.

To determine the statewide conversion factor, we used physician claims from both facility and non-facility settings that were serviced between July 1, 2015 and June 30, 2016. We calculated RVU totals for all codes that had RVU assignments in both CY 2016 and CY 2017. This total excludes any HCPCS codes that will no longer be used starting in 2017 and any replacements or newly added HCPCS codes beginning in 2017. For calculation of the CY 2017 Statewide CF, the breakout exhibit uses 1,861,864 total units spread across 79 specialty groups. A set of 10 HCPCS codes is designated to calculate the OB/Gyn CF, and these account for 5,558 units across 6 specialty groups. An additional 22,503 units are billed to HCPCS codes that are not assigned by Medicare in CY 2017. Each year Medicare updates the list of HCPCS codes and some valid codes during the billing period will no longer be assigned in the upcoming data. More than three quarters of the non-assigned units this year (19,826) occur in HCPCS codes 77051, 77052, 77055, 77056, 77057 for Mammography and 97001 – 97004 for PT/OT Outpatient

DEDICATED TO GOVERNMENT HEALTH PROGRAMS 700 W 47th Street, Suite 1100 | Kansas City, MO 64112
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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Speech-Language Pathology Services that were removed. Another 3,270 units are in HCPCS codes 73500 – 73550 that were removed last year.

For the Statewide breakout, six new specialty groups are included that did not have units for CY 2016 (IC Interventional Cardiology, LS Licensed Independent Clinical Social Worker, EC Muli-Specialty Group, E1 Physician Group, EF Podiatry Group, PR Resident), accounting for 1,818 units. Three specialty groups with units for CY 2016 – F4 Dialysis, H8 Health Department, H5 Pasaar – did not have units in CY 2017. The total number of units is 41.02% less than CY 2016 and the RVU total shows a decrease of 48.02% over the data we had for last year's update. These calculations indicate a decrease of Statewide CF from $26.25 to $26.11 in order to maintain budget neutrality.

For OB/Gyn services, the unit total shows a decrease of 80.72% over the number of units from CY 2016 and the decrease is seen across all OB specialty codes. The calculated RVU total for OB/Gyn services also saw a decrease of 80.07% over the CY 2016 RVU Total. One additional specialty group was identified that was not included in the CY 2016 data- PR Resident 1 Unit. To maintain budget neutrality, the OB/Gyn CF would need to decrease from $37.77 to $37.51.

Along with calculation of budget neutral conversion factors, we have included a calculation for increase using the Medicare Economic Index (MEI). Medicare has allowed 1.2% growth for expected increases in Medicare pricing throughout the year. Medicaid has not applied the MEI increase in previous years, but we want to make the data available. With the 1.2% MEI, the Statewide CF would be $26.42 and the OB/Gyn CF would be $37.96.

Projected changes in payments for individual specialty groups were not very large for this update. Among Statewide specialties, the Fiscal Impact shows M1 Allergy having the largest gain at 2.8% and K1 Laboratory with the largest decline at -4.33%. For OB/Gyn specialties, no specialty groups have an increase in projected payments and the largest decrease is PR Resident at -.41%.

The RVU table shows all HCPCS codes recognized by Medicare for CY 2017. Each code has Medicare's allowed RVUs for work, PE (facility or non-facility), and malpractice listed. An indicator showing if the code is non-allowed within facility or non-facility setting applies to each HCPCS code except those adjusted by an outpatient imaging cap. Medicare has set a payment limit on the codes for these 188 imaging services to ensure they receive the same payments whether performed as hospital outpatient services or physician services. Any code identified for the imaging cap will receive payment for facility or non-facility even if payment is otherwise not allowed. The final RVU totals for some codes are also adjusted to compensate for rounding errors. These adjustments are applied to codes that have both professional component (mod 26) and technical component (mod TC) so that payment for individual components equals payment for the full HCPCS code. The professional component is adjusted by 0.01 RVU on 13 codes in both facility and non-facility settings following recalculation of RVU total due to the imaging cap. For 190 codes in non-facility setting, the RVU total of the full HCPCS is adjusted by 0.01 to equal sum of mod 26 and mod TC.

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Concerns with Data Review and Validity

There has been a significant decrease in the total units and RVU total across all specialties within the state compared to the previous exhibits. This overall decrease from the previous deliverable is due to the exclusion of all managed care claims. Specialty codes that are no longer assigned units or value are: Managed Care C1, Licensed Certified, Social Worker LC, Geriatrics R3, Critical Access Hospital A5, and Colorectal Surgery L5. OB/GYN codes that had units and values in our previous deliverable that are now assigned no values are: Anesthesiology L0 and Managed Care C1.

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## Medicaid RBRVS Physician Reimbursement System

**Conversion Factor Calculation, CY 2017**

Draft: January 04, 2017

*NOTE: Imaging Service RVUs Calculated at Medicare Outpatient Threshold Using Conversion Factor = 35.8887*

| Specialty | Code | Units | 2016 RVU | 2017 RVU | Absolute Difference | Percent Difference |
|---|---|---|---|---|---|---|
| *A* | *B* | *C* | *D* | *E* | *F = E - D* | *G = F / D* |
| Acute Care | A0 | 22,029 | 55,295 | 56,299 | 1,004 | 1.82% |
| Adult Nurse Practitioner (NP) | AD | 1,213 | 2,456 | 2,472 | 17 | 0.68% |
| Allergy | M1 | 20,274 | 5,475 | 5,659 | 184 | 3.35% |
| Anesthesiology | L0 | 10,863 | 26,436 | 26,987 | 551 | 2.08% |
| Audiology | W5 | 5,822 | 4,667 | 4,701 | 34 | 0.73% |
| Behavioral Health And Health Facilities (BHHF) | D2 | 10,763 | 23,321 | 23,511 | 190 | 0.81% |
| Behavioral Health Managed Care | C6 | 10,972 | 23,423 | 23,621 | 198 | 0.85% |
| Cardio Surgery | R9 | 195 | 2,121 | 2,119 | (2) | -0.08% |
| Cardiology | M6 | 48,065 | 91,484 | 91,932 | 448 | 0.49% |
| Child Rehab in Group Home | W1 | 652 | 1,231 | 1,242 | 11 | 0.87% |
| Chiropractic | S1 | 8,049 | 8,026 | 8,059 | 33 | 0.41% |
| Critical Care | K6 | 2,072 | 6,190 | 6,225 | 34 | 0.55% |
| Dermatology | M0 | 8,562 | 20,842 | 20,873 | 31 | 0.15% |
| Emergency Medicine | M3 | 53,336 | 164,572 | 165,140 | 567 | 0.34% |
| Endocrinology | M7 | 1,491 | 4,041 | 4,058 | 16 | 0.41% |
| Family Practice | K7 | 220,508 | 487,320 | 490,957 | 3,637 | 0.75% |
| Gastroenterology | M9 | 11,765 | 39,717 | 38,810 | (907) | -2.28% |
| General Practice | K5 | 87,891 | 221,702 | 222,895 | 1,193 | 0.54% |
| General Surgery | R7 | 41,274 | 148,026 | 148,063 | 37 | 0.03% |
| Genetics | K9 | 2 | 4 | 4 | 0 | 0.51% |
| Gerontology | GE | 375 | 764 | 769 | 5 | 0.68% |
| Hematology | M5 | 2,270 | 5,983 | 6,029 | 46 | 0.77% |
| Hospitalist | C9 | 342 | 868 | 876 | 8 | 0.92% |
| Immunology | N6 | 179 | 58 | 59 | 1 | 2.26% |
| Independent Diagnostic Treatment Facility (IDTF) Group | EH | 1,525 | 7,729 | 7,821 | 93 | 1.20% |
| Infectious Disease | L2 | 4,427 | 10,992 | 11,056 | 64 | 0.59% |
| Internal Medicine | M4 | 274,230 | 634,996 | 638,624 | 3,628 | 0.57% |
| Interventional Cardiology | IC | 192 | 644 | 644 | 0 | 0.00% |
| Laboratory | K1 | 10,319 | 16,644 | 16,009 | (635) | -3.81% |
| Licensed Independent Clinical Social Worker | LS | 1,418 | 3,539 | 3,539 | (1) | -0.01% |
| Mental Health Rehabiliation | W0 | 38,569 | 81,635 | 82,370 | 735 | 0.90% |
| Multi-specialty Group | EC | 1 | 3 | 3 | 0 | 0.71% |
| Neonatalogy | L3 | 457 | 2,311 | 2,350 | 39 | 1.69% |
| Nephrology | M8 | 13,405 | 38,713 | 38,954 | 241 | 0.62% |
| Neurology | N1 | 25,247 | 76,813 | 77,356 | 544 | 0.71% |
| Neurosurgery | N0 | 4,151 | 28,651 | 28,728 | 77 | 0.27% |
| Nuclear Medicine | Q6 | 385 | 682 | 688 | 6 | 0.82% |
| Nurse Midwife | W4 | 2,395 | 4,351 | 4,388 | 37 | 0.85% |
| Nurse Practitioner | E3 | 224 | 499 | 503 | 4 | 0.75% |
| OB/Gyn | N5 | 23,980 | 64,737 | 65,377 | 640 | 0.99% |

## Medicaid RBRVS Physician Reimbursement System

**Conversion Factor Calculation, CY 2017** Draft: January 04, 2017

*NOTE: Imaging Service RVUs Calculated at Medicare Outpatient Threshold Using Conversion Factor = 35.8887*

| Specialty | Code | Units | 2016 RVU | 2017 RVU | Absolute Difference | Percent Difference |
|---|---|---|---|---|---|---|
| *A* | *B* | *C* | *D* | *E* | *F = E - D* | *G = F / D* |
| Occupational Therapy | W3 | 20,160 | 17,826 | 18,048 | 223 | 1.25% |
| Oncology | L9 | 5,922 | 12,657 | 12,798 | 140 | 1.11% |
| Ophthalmology | P0 | 19,292 | 41,863 | 41,530 | (332) | -0.79% |
| Optometry | H9 | 45,210 | 107,742 | 107,405 | (337) | -0.31% |
| Orthopedics | P5 | 16,760 | 44,136 | 44,447 | 311 | 0.70% |
| Otolaryngology | Q0 | 16,387 | 21,868 | 21,927 | 59 | 0.27% |
| Otorhinolaryngology | Q1 | 12,106 | 8,852 | 8,941 | 89 | 1.00% |
| Pain Management | A6 | 610 | 1,747 | 1,758 | 11 | 0.61% |
| Pathology | Q5 | 61,200 | 63,213 | 63,356 | 143 | 0.23% |
| Pediatric Cardiology | M2 | 624 | 1,483 | 1,484 | 1 | 0.08% |
| Pediatrics | R0 | 59,374 | 118,962 | 120,239 | 1,277 | 1.07% |
| Physiatry | R1 | 6,627 | 14,467 | 14,558 | 91 | 0.63% |
| Physical Therapy | WA | 71,792 | 54,847 | 55,872 | 1,025 | 1.87% |
| Physician Assistant | H0 | 17 | 8 | 8 | 0 | 1.41% |
| Physician Group | E1 | 47 | 95 | 96 | 1 | 1.01% |
| Plastic Surgery | R2 | 1,581 | 7,379 | 7,426 | 46 | 0.63% |
| Podiatric Surgery | P2 | 323 | 634 | 640 | 6 | 0.95% |
| Podiatry | P6 | 134,898 | 239,710 | 242,080 | 2,370 | 0.99% |
| Podiatry Group | EF | 109 | 174 | 175 | 1 | 0.57% |
| Portable X-Ray | P9 | 1,721 | 569 | 573 | 4 | 0.74% |
| Private Duty Nurse School | W7 | 2 | 4 | 4 | 0 | 0.49% |
| Psychiatry | R5 | 73,775 | 158,331 | 159,407 | 1,076 | 0.68% |
| Psychologist | W8 | 31,705 | 86,632 | 86,622 | (10) | -0.01% |
| Pulmonary | R4 | 14,449 | 38,666 | 38,877 | 211 | 0.54% |
| Radiation Oncology | N2 | 10,559 | 36,909 | 37,264 | 355 | 0.96% |
| Radiology | R6 | 262,044 | 227,978 | 229,016 | 1,038 | 0.46% |
| Rehabilitation (Rehab) | A3 | 9 | 9 | 9 | 0 | 1.00% |
| Resident | PR | 51 | 87 | 87 | 0 | 0.23% |
| Rheumatology | N3 | 1,395 | 3,021 | 3,046 | 25 | 0.82% |
| School Psychologist | W9 | 1,551 | 3,532 | 3,532 | (0) | -0.01% |
| School Speech Therapy | V6 | 129 | 399 | 404 | 5 | 1.29% |
| Skilled Nursing Facility | B4 | 10 | 20 | 20 | 0 | 1.02% |
| Speech Therapy | V5 | 6,157 | 13,478 | 13,560 | 82 | 0.61% |
| Sports Medicine | L8 | 295 | 650 | 655 | 5 | 0.76% |
| Thoracic Surgery | R8 | 2,638 | 16,303 | 16,325 | 22 | 0.14% |
| Urology | S0 | 10,131 | 27,869 | 27,440 | (428) | -1.54% |
| Vascular Surgery | N4 | 1,902 | 5,782 | 5,830 | 48 | 0.83% |
| Vision Center | V1 | 35 | 31 | 31 | 0 | 0.16% |
| Women's Health | WO | 378 | 797 | 802 | 6 | 0.70% |
| Managed Care | C1 | | | | | |

## Medicaid RBRVS Physician Reimbursement System

**Conversion Factor Calculation, CY 2017** Draft: January 04, 2017

*NOTE: Imaging Service RVUs Calculated at Medicare Outpatient Threshold Using Conversion Factor = 35.8887*

| Specialty | Code | Units | 2016 RVU | 2017 RVU | Absolute Difference | Percent Difference |
|---|---|---|---|---|---|---|
| *A* | *B* | *C* | *D* | *E* | *F = E - D* | *G = F / D* |
| Licensed Certified Social Worker | LC | | | | | |
| Geriatrics | R3 | | | | | |
| Critical Access Hospital | A5 | | | | | |
| Colectoral Surgery | L5 | | | | | |
| **Total RVU** | | **1,861,864** | **3,695,689** | **3,716,060** | **20,371** | **0.55%** |
| **Estimated Payment** | | | **$ 97,011,840** | **$ 97,546,585** | | |
| **[1]Budget Neutral Conversion Factor (CF)** | | | **$ 26.25** | **$ 26.11** | | |
| **[2]Economic Index Update %** | | | **0.00%** | **1.20%** | | |
| **[3]Updated Conversion Factor (CF)** | | | | **$ 26.42** | | |

**OB/GYN Codes Only**

| Specialty | Code | Units | 2016 RVU | 2017 RVU | Absolute Difference | Percent Difference |
|---|---|---|---|---|---|---|
| *A* | *B* | *C* | *D* | *E* | *F = E - D* | *G = F / D* |
| Family Practice | K7 | 318 | 868 | 875 | 7 | 0.80% |
| General Practice | K5 | 14 | 70 | 70 | 0 | 0.60% |
| Nurse Midwife | W4 | 1,227 | 3,932 | 3,961 | 29 | 0.74% |
| OB/Gyn | N5 | 3,953 | 18,315 | 18,436 | 122 | 0.66% |
| Resident | PR | 1 | 24 | 24 | 0 | 0.38% |
| Women's Health | WO | 45 | 66 | 67 | 1 | 0.79% |
| Anesthesiology | L0 | | | | | |
| Managed Care | C1 | | | | | |
| **Total RVU** | | **5,558** | **23,275** | **23,433** | **159** | **0.68%** |
| **Estimated Payment** | | | **$ 879,094** | **$ 885,081** | | |
| **[1]Budget Neutral Conversion Factor (CF)** | | | **$ 37.77** | **$ 37.51** | | |
| **[2]Economic Index Update %** | | | **0.00%** | **1.20%** | | |
| **[3]Updated Conversion Factor (CF)** | | | | **$ 37.96** | | |
| **Total RVU** | | | **3,718,964** | **3,739,494** | **20,530** | **0.55%** |
| **Estimated Payment** | | | **97,890,934** | **98,431,666** | **540,732** | **0.55%** |

[1]Budget Neutral Conversion Factor implemented in 2015 does not include Economic Index Update

[2]Medicare Economic Index (MEI) adjustment, 2006-based: CY2017 percent update = 1.2; CY2016 percent update = 1.1

*Source (2016): Federal Register, Vol. 80, No. 220, p. 71065, published Monday, November 16, 2015, Table 22*

*Source (2017): Federal Register, Vol. 81, No. 220, p. 80202, published Tuesday, November 15, 2016, Table 6*

[3]Updated Conversion Factor for 2017 includes MEI projection to allow for expected increaese in Medicare prices

**RBRVS Physician Reimbursement System**
**Medicaid Data, CY 2016**

**Draft: December 7, 2016**

| | | | | | New CF: | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | $ 26.25 | $ 26.11 | | | |
| Specialty | Code | 2016 RVU | 2017 RVU | 2016 Payments | 2017 Payments | Absolute Difference | Percent Difference | |
| *A* | *B* | *C* | *D* | *E = C * [2016 CF]* | *F = D * [2016 CF]* | *G = F - E* | *H = G / E* | |
| Allergy | M1 | 5,475 | 5,659 | $ 143,726 | $ 147,754 | $ 4,029 | 2.80% | |
| Immunology | N6 | 58 | 59 | $ 1,525 | $ 1,551 | $ 26 | 1.71% | |
| Anesthesiology | L0 | 26,436 | 26,987 | $ 693,952 | $ 704,627 | $ 10,675 | 1.54% | |
| Physical Therapy | WA | 54,847 | 55,872 | $ 1,439,744 | $ 1,458,820 | $ 19,076 | 1.32% | |
| Acute Care | A0 | 55,295 | 56,299 | $ 1,451,501 | $ 1,469,968 | $ 18,467 | 1.27% | |
| Neonatalogy | L3 | 2,311 | 2,350 | $ 60,665 | $ 61,359 | $ 694 | 1.14% | |
| Physician Assistant | H0 | 8 | 8 | $ 205 | $ 207 | $ 2 | 0.87% | |
| School Speech Therapy | V6 | 399 | 404 | $ 10,478 | $ 10,557 | $ 79 | 0.75% | |
| Occupational Therapy | W3 | 17,826 | 18,048 | $ 467,924 | $ 471,239 | $ 3,314 | 0.71% | |
| Independent Diagnostic Treatment Facility (IDTF) Group | EH | 7,729 | 7,821 | $ 202,880 | $ 204,219 | $ 1,339 | 0.66% | |
| Oncology | L9 | 12,657 | 12,798 | $ 332,253 | $ 334,144 | $ 1,892 | 0.57% | |
| Pediatrics | R0 | 118,962 | 120,239 | $ 3,122,748 | $ 3,139,443 | $ 16,695 | 0.53% | |
| Skilled Nursing Facility | B4 | 20 | 20 | $ 515 | $ 517 | $ 2 | 0.48% | |
| Physician Group | E1 | 95 | 96 | $ 2,489 | $ 2,501 | $ 12 | 0.47% | |
| Otorhinolaryngology | Q1 | 8,852 | 8,941 | $ 232,366 | $ 233,449 | $ 1,083 | 0.47% | |
| Rehabilitation (Rehab) | A3 | 9 | 9 | $ 237 | $ 238 | $ 1 | 0.46% | |
| Podiatry | P6 | 239,710 | 242,080 | $ 6,292,379 | $ 6,320,706 | $ 28,327 | 0.45% | |
| OB/Gyn | N5 | 64,737 | 65,377 | $ 1,699,339 | $ 1,706,986 | $ 7,647 | 0.45% | |
| Radiation Oncology | N2 | 36,909 | 37,264 | $ 968,863 | $ 972,973 | $ 4,110 | 0.42% | |
| Podiatric Surgery | P2 | 634 | 640 | $ 16,633 | $ 16,702 | $ 68 | 0.41% | |
| Hospitalist | C9 | 868 | 876 | $ 22,781 | $ 22,868 | $ 88 | 0.39% | |
| Mental Health Rehabiliation | W0 | 81,635 | 82,370 | $ 2,142,913 | $ 2,150,672 | $ 7,759 | 0.36% | |
| Child Rehab in Group Home | W1 | 1,231 | 1,242 | $ 32,324 | $ 32,431 | $ 107 | 0.33% | |
| Nurse Midwife | W4 | 4,351 | 4,388 | $ 114,204 | $ 114,561 | $ 357 | 0.31% | |
| Behavioral Health Managed Care | C6 | 23,423 | 23,621 | $ 614,850 | $ 616,746 | $ 1,896 | 0.31% | |
| Vascular Surgery | N4 | 5,782 | 5,830 | $ 151,768 | $ 152,216 | $ 448 | 0.30% | |
| Nuclear Medicine | Q6 | 682 | 688 | $ 17,909 | $ 17,960 | $ 51 | 0.29% | |
| Rheumatology | N3 | 3,021 | 3,046 | $ 79,310 | $ 79,534 | $ 224 | 0.28% | |
| Behavioral Health And Health Facilities (BHHF) | D2 | 23,321 | 23,511 | $ 612,181 | $ 613,867 | $ 1,686 | 0.28% | |
| Hematology | M5 | 5,983 | 6,029 | $ 157,060 | $ 157,426 | $ 365 | 0.23% | |
| Sports Medicine | L8 | 650 | 655 | $ 17,062 | $ 17,100 | $ 39 | 0.23% | |
| Nurse Practitioner | E3 | 499 | 503 | $ 13,102 | $ 13,130 | $ 28 | 0.22% | |
| Family Practice | K7 | 487,320 | 490,957 | $ 12,792,143 | $ 12,818,884 | $ 26,740 | 0.21% | |
| Portable X-Ray | P9 | 569 | 573 | $ 14,926 | $ 14,957 | $ 31 | 0.20% | |
| Audiology | W5 | 4,667 | 4,701 | $ 122,501 | $ 122,742 | $ 241 | 0.20% | |
| Multi-specialty Group | EC | 3 | 3 | $ 74 | $ 74 | $ 0 | 0.17% | |
| Neurology | N1 | 76,813 | 77,356 | $ 2,016,329 | $ 2,019,777 | $ 3,448 | 0.17% | |
| Orthopedics | P5 | 44,136 | 44,447 | $ 1,158,567 | $ 1,160,502 | $ 1,935 | 0.17% | |
| Women's Health | WO | 797 | 802 | $ 20,918 | $ 20,951 | $ 33 | 0.16% | |
| Gerontology | GE | 764 | 769 | $ 20,052 | $ 20,082 | $ 30 | 0.15% | |
| Adult Nurse Practitioner (NP) | AD | 2,456 | 2,472 | $ 64,461 | $ 64,553 | $ 92 | 0.14% | |
| Psychiatry | R5 | 158,331 | 159,407 | $ 4,156,186 | $ 4,162,124 | $ 5,937 | 0.14% | |
| Physiatry | R1 | 14,467 | 14,558 | $ 379,746 | $ 380,108 | $ 362 | 0.10% | |
| Plastic Surgery | R2 | 7,379 | 7,426 | $ 193,706 | $ 193,882 | $ 176 | 0.09% | |
| Nephrology | M8 | 38,713 | 38,954 | $ 1,016,207 | $ 1,017,081 | $ 874 | 0.09% | |
| Pain Management | A6 | 1,747 | 1,758 | $ 45,855 | $ 45,891 | $ 35 | 0.08% | |
| Speech Therapy | V5 | 13,478 | 13,560 | $ 353,796 | $ 354,040 | $ 244 | 0.07% | |
| Infectious Disease | L2 | 10,992 | 11,056 | $ 288,541 | $ 288,683 | $ 143 | 0.05% | |
| Internal Medicine | M4 | 634,996 | 638,624 | $ 16,668,655 | $ 16,674,485 | $ 5,829 | 0.03% | |
| Podiatry Group | EF | 174 | 175 | $ 4,570 | $ 4,571 | $ 1 | 0.03% | |
| Critical Care | K6 | 6,190 | 6,225 | $ 162,500 | $ 162,522 | $ 22 | 0.01% | |
| Pulmonary | R4 | 38,666 | 38,877 | $ 1,014,979 | $ 1,015,066 | $ 88 | 0.01% | |
| General Practice | K5 | 221,702 | 222,895 | $ 5,819,681 | $ 5,819,782 | $ 102 | 0.00% | |
| Genetics | K9 | 4 | 4 | $ 103 | $ 103 | $ (0) | -0.03% | |
| Cardiology | M6 | 91,484 | 91,932 | $ 2,401,464 | $ 2,400,349 | $ (1,115) | -0.05% | |

## RBRVS Physician Reimbursement System

**Medicaid Data, CY 2016**

**Draft: December 7, 2016**

| | | | | | New CF: | | |
|---|---|---|---|---|---|---|---|
| | | | | $ 26.25 | $ 26.11 | | |
| Specialty | Code | 2016 RVU | 2017 RVU | 2016 Payments | 2017 Payments | Absolute Difference | Percent Difference |
| *A* | *B* | *C* | *D* | *E = C * [2016 CF]* | *F = D * [2016 CF]* | *G = F - E* | *H = G / E* |
| Private Duty Nurse School | W7 | 4 | 4 | $ 108 | $ 108 | $ (0) | -0.05% |
| Radiology | R6 | 227,978 | 229,016 | $ 5,984,412 | $ 5,979,598 | $ (4,814) | -0.08% |
| Chiropractic | S1 | 8,026 | 8,059 | $ 210,688 | $ 210,420 | $ (268) | -0.13% |
| Endocrinology | M7 | 4,041 | 4,058 | $ 106,080 | $ 105,944 | $ (136) | -0.13% |
| Emergency Medicine | M3 | 164,572 | 165,140 | $ 4,320,017 | $ 4,311,793 | $ (8,224) | -0.19% |
| Otolaryngology | Q0 | 21,868 | 21,927 | $ 574,043 | $ 572,523 | $ (1,520) | -0.26% |
| Neurosurgery | N0 | 28,651 | 28,728 | $ 752,087 | $ 750,077 | $ (2,009) | -0.27% |
| Resident | PR | 87 | 87 | $ 2,291 | $ 2,284 | $ (7) | -0.31% |
| Pathology | Q5 | 63,213 | 63,356 | $ 1,659,347 | $ 1,654,234 | $ (5,113) | -0.31% |
| Vision Center | V1 | 31 | 31 | $ 805 | $ 802 | $ (3) | -0.37% |
| Dermatology | M0 | 20,842 | 20,873 | $ 547,102 | $ 544,998 | $ (2,104) | -0.38% |
| Thoracic Surgery | R8 | 16,303 | 16,325 | $ 427,962 | $ 426,254 | $ (1,708) | -0.40% |
| Pediatric Cardiology | M2 | 1,483 | 1,484 | $ 38,920 | $ 38,743 | $ (178) | -0.46% |
| General Surgery | R7 | 148,026 | 148,063 | $ 3,885,679 | $ 3,865,924 | $ (19,755) | -0.51% |
| Interventional Cardiology | IC | 644 | 644 | $ 16,910 | $ 16,820 | $ (90) | -0.53% |
| School Psychologist | W9 | 3,532 | 3,532 | $ 92,718 | $ 92,215 | $ (504) | -0.54% |
| Psychologist | W8 | 86,632 | 86,622 | $ 2,274,090 | $ 2,261,698 | $ (12,392) | -0.54% |
| Licensed Independent Clinical Social Worker | LS | 3,539 | 3,539 | $ 92,900 | $ 92,391 | $ (509) | -0.55% |
| Cardio Surgery | R9 | 2,121 | 2,119 | $ 55,668 | $ 55,324 | $ (344) | -0.62% |
| Optometry | H9 | 107,742 | 107,405 | $ 2,828,221 | $ 2,804,334 | $ (23,887) | -0.84% |
| Ophthalmology | P0 | 41,863 | 41,530 | $ 1,098,903 | $ 1,084,361 | $ (14,542) | -1.32% |
| Urology | S0 | 27,869 | 27,440 | $ 731,554 | $ 716,469 | $ (15,086) | -2.06% |
| Gastroenterology | M9 | 39,717 | 38,810 | $ 1,042,574 | $ 1,013,336 | $ (29,238) | -2.80% |
| Laboratory | K1 | 16,644 | 16,009 | $ 436,914 | $ 418,006 | $ (18,908) | -4.33% |
| Colectoral Surgery | L5 | | | | | | |
| Critical Access Hospital | A5 | | | | | | |
| Geriatrics | R3 | | | | | | |
| Licensed Certified Social Worker | LC | | | | | | |
| Managed Care | C1 | | | | | | |
| **Total** | | **3,695,689** | **3,716,060** | **$ 97,011,840** | **$ 97,026,337** | **$ 14,497** | **0.01%** |

| | | | | | New CF: | | |
|---|---|---|---|---|---|---|---|
| OB/GYN Codes Only | | | | $ 37.81 | $ 37.51 | | |
| Specialty | Code | 2016 RVU | 2017 RVU | 2016 Payments | 2017 Payments | Absolute Difference | Percent Difference |
| Family Practice | K7 | 868 | 875 | $ 32,836 | $ 32,838 | $ 1 | 0.00% |
| General Practice | K5 | 70 | 70 | $ 2,645 | $ 2,640 | $ (5) | -0.20% |
| Nurse Midwife | W4 | 3,932 | 3,961 | $ 148,674 | $ 148,581 | $ (93) | -0.06% |
| OB/Gyn | N5 | 18,315 | 18,436 | $ 692,478 | $ 691,541 | $ (936) | -0.14% |
| Resident | PR | 24 | 24 | $ 892 | $ 888 | $ (4) | -0.41% |
| Women's Health | WO | 66 | 67 | $ 2,500 | $ 2,500 | $ (0) | -0.01% |
| Anesthesiology | L0 | | | | | | |
| Managed Care | C1 | | | | | | |
| **Total** | | **23,275** | **23,433** | **$ 880,025** | **$ 878,988** | **$ (1,037)** | **-0.12%** |

# *Appendix D: CRFQ Forms*

## HIPAA Business Associate Addendum

**WV STATE GOVERNMENT**

**HIPAA BUSINESS ASSOCIATE ADDENDUM**

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

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

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

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

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

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

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

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

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

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

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

1

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

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

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

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

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

2. **Permitted Uses and Disclosures.**

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

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

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

3. Obligations of Associate.

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

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

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

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

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

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

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

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

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

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f. **Support of Individual Rights.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. **Addendum Administration.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPROVED AS TO FORM THIS 26th
DAY Of June 20 17
Patrick Morrisey
Attorney General
BY

AGREED:

Name of Agency:

Signature:_____

Title:_____

Date:_____

Name of Associate: Amy Perry

Signature: Amy Perry

Title: Member

Date: 7/13/2017

Appendix A

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

Name of Associate:

Name of Agency: WV DHHR / Bureau for Medical Services

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

All (types of PHI) in paper, electronic, verbal or any other form. Including, but not limited to:
The claim ID, Claim Header Status, Paid Date, Bill Type, Claim type, Plan provider number, Provider name, Member ID, Member First Name, Member Last Name, Member Middle Name, Control Number, Claim Line Number, claim line Status, Date of Service-From, Date of Service-To, Revenue Code, Revenue Code Description, Modifier, Billed Units, Services Units, Line Billed Amount, Line Paid Amount, Coordination of Benefits Amount, Medicare Paid Amount, State Fiscal Year, Total Paid Amount, and End date.

## Addendum Acknowledgement Form

**ADDENDUM ACKNOWLEDGEMENT FORM**
**SOLICITATION NO.:** BMS1700000003

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

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

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

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

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

Myers and Stauffer LC
Company

Amy Perry
Authorized Signature

7/13/2017
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

## Purchasing Affidavit

STATE OF WEST VIRGINIA
Purchasing Division

# PURCHASING AFFIDAVIT

**MANDATE:** 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 neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.**

**WITNESS THE FOLLOWING SIGNATURE:**

Vendor's Name: Myers and Stauffer LC

Authorized Signature: Amy Perry Date: 7/13/17

State of Missouri

County of Jackson, to-wit:

Taken, subscribed, and sworn to before me this 13th day of July, 2017.

My commission expires October 4, 2020.

AFFIX SEAL HERE

NOTARY PUBLIC

## Vendor Preference Certificate

WV-10
Approved / Revised
12/16/15

State of West Virginia
**VENDOR PREFERENCE CERTIFICATE**

Certification and application is hereby made for Preference in accordance with ***West Virginia Code***, §5A-3-37. (Does not apply to construction contracts). ***West Virginia Code***, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the ***West Virginia Code***. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Vendor Preference, if applicable.

1. ☐ **Application is made for 2.5% vendor preference for the reason checked:**
Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

☐ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification;

☐ Bidder is a resident vendor partnership, association, or corporation with at least eighty percent of ownership interest of bidder held by another entity that meets the applicable four year residency requirement; **or,**

☐ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

2. ☐ **Application is made for 2.5% vendor preference for the reason checked:**
Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

3. ☐ **Application is made for 2.5% vendor preference for the reason checked:**
Bidder is a nonresident vendor that employs a minimum of one hundred state residents, or a nonresident vendor which has an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia and employs a minimum of one hundred state residents, and for purposes of producing or distributing the commodities or completing the project which is the subject of the bidder's bid and continuously over the entire term of the project, on average at least seventy-five percent of the bidder's employees or the bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years and the vendor's bid; **or,**

4. ☐ **Application is made for 5% vendor preference for the reason checked:**
Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or,**

5. ☐ **Application is made for 3.5% vendor preference who is a veteran for the reason checked:**
Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

6. ☐ **Application is made for 3.5% vendor preference who is a veteran for the reason checked:**
Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

7. ☐ **Application is made for preference as a non-resident small, women- and minority-owned business, in accordance with *West Virginia Code* §5A-3-59 and *West Virginia Code of State Rules*.**
Bidder has been or expects to be approved prior to contract award by the Purchasing Division as a certified small, women- and minority-owned business.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) rescind the contract or purchase order; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

**Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.**

**Bidder:** Myers and Stauffer LC **Signed:** Amy Perry

**Date:** 7/13/2017 **Title:** Member

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

# *Appendix E: Insurance*

ACORD®

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 07/10/17

**THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.**

**IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).**

| | |
|---|---|
| PRODUCER<br>Aon Insurance Services<br>159 East County Line Road<br>Hatboro, PA 19040 | CONTACT NAME:<br>PHONE (A/C, No, Ext):<br>FAX (A/C, No):<br>E-MAIL ADDRESS: |
| INSURED<br>Myers and Stauffer LC<br>700 W 47th St. Suite 1100<br>Kansas City MO 64112 | INSURER(S) AFFORDING COVERAGE / NAIC #<br>INSURER A : Continental Casualty Company (CNA)<br>INSURER B :<br>INSURER C :<br>INSURER D :<br>INSURER E :<br>INSURER F : |

**COVERAGES** **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR LTR | TYPE OF INSURANCE | ADDL INSD | SUBR WVD | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS |
|---|---|---|---|---|---|---|---|
| | COMMERCIAL GENERAL LIABILITY<br>CLAIMS-MADE / OCCUR<br>GEN'L AGGREGATE LIMIT APPLIES PER:<br>POLICY / PRO-JECT / LOC<br>OTHER: | | | | | | EACH OCCURRENCE $<br>DAMAGE TO RENTED PREMISES (Ea occurrence) $<br>MED EXP (Any one person) $<br>PERSONAL & ADV INJURY $<br>GENERAL AGGREGATE $<br>PRODUCTS - COMP/OP AGG $ |
| | AUTOMOBILE LIABILITY<br>ANY AUTO<br>ALL OWNED AUTOS / SCHEDULED AUTOS<br>HIRED AUTOS / NON-OWNED AUTOS | | | | | | COMBINED SINGLE LIMIT (Ea accident) $<br>BODILY INJURY (Per person) $<br>BODILY INJURY (Per accident) $<br>PROPERTY DAMAGE (Per accident) $ |
| | UMBRELLA LIAB / OCCUR<br>EXCESS LIAB / CLAIMS-MADE<br>DED / RETENTION $ | | | | | | EACH OCCURRENCE $<br>AGGREGATE $ |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY<br>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N / N/A<br>If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | PER STATUTE / OTH-ER<br>E.L. EACH ACCIDENT $<br>E.L. DISEASE - EA EMPLOYEE $<br>E.L. DISEASE - POLICY LIMIT $ |
| A | Professional Liability Insurance | | | ABF 188181819 | 12/31/16 | 12/31/17 | $1,000,000 Per Claim and in the annual aggregate |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

| CERTIFICATE HOLDER | CANCELLATION |
|---|---|
| West Virginia Dept. of Administration, Purchasing Division<br>2019 Washington Street East<br>Charleston, WV 25305<br>Attn: Charles Barnette | SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.<br>AUTHORIZED REPRESENTATIVE: Gretchen McCole |

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Client#: 2372 CBIZINC

ACORD™

# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 7/10/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

| PRODUCER | CONTACT NAME: | |
|---|---|---|
| CBIZ Insurance Services, Inc.<br>700 West 47th Street, Suite 1100<br>Kansas City, MO 64112<br>816 945-5500 | PHONE (A/C, No, Ext): - | FAX (A/C, No): |
| | E-MAIL ADDRESS: kpeed@cbiz.com | |
| | INSURER(S) AFFORDING COVERAGE | NAIC # |
| | INSURER A : Hartford Insurance- Comml Lines | |
| INSURED<br>CBIZ, Inc. and Subsidiaries<br>6050 Oak Tree Blvd., South, Suite 500<br>Cleveland, OH 44131 | INSURER B : | |
| | INSURER C : | |
| | INSURER D : | |
| | INSURER E : | |
| | INSURER F : | |

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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| INSR LTR | TYPE OF INSURANCE | ADDL INSR | SUBR WVD | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS | |
|---|---|---|---|---|---|---|---|---|
| | COMMERCIAL GENERAL LIABILITY | | | | | | EACH OCCURRENCE | $ |
| | ☐ CLAIMS-MADE ☐ OCCUR | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | $ |
| | | | | | | | MED EXP (Any one person) | $ |
| | | | | | | | PERSONAL & ADV INJURY | $ |
| | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | | | GENERAL AGGREGATE | $ |
| | ☐ POLICY ☐ PRO-JECT ☐ LOC | | | | | | PRODUCTS - COMP/OP AGG | $ |
| | ☐ OTHER: | | | | | | | $ |
| | AUTOMOBILE LIABILITY | | | | | | COMBINED SINGLE LIMIT (Ea accident) | $ |
| | ☐ ANY AUTO | | | | | | BODILY INJURY (Per person) | $ |
| | ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS | | | | | | BODILY INJURY (Per accident) | $ |
| | ☐ HIRED AUTOS ☐ NON-OWNED AUTOS | | | | | | PROPERTY DAMAGE (Per accident) | $ |
| | | | | | | | | $ |
| | ☐ UMBRELLA LIAB ☐ OCCUR | | | | | | EACH OCCURRENCE | $ |
| | ☐ EXCESS LIAB ☐ CLAIMS-MADE | | | | | | AGGREGATE | $ |
| | ☐ DED ☐ RETENTION $ | | | | | | | $ |
| A | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | | | 37WNS46900 | 09/30/2016 | 09/30/2017 | X PER STATUTE ☐ OTH-ER | |
| A | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N [N] N/A | | | 37WBRS46901WI | 09/30/2016 | 09/30/2017 | E.L. EACH ACCIDENT | $1,000,000 |
| | (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | E.L. DISEASE - EA EMPLOYEE | $1,000,000 |
| | | | | | | | E.L. DISEASE - POLICY LIMIT | $1,000,000 |
| | | | | | | | | |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

| CERTIFICATE HOLDER | CANCELLATION |
|---|---|
| West Virginia Dept. of Administration, Purchasing Division<br>2019 Washington Street East<br>Charleston, WV 25305 | SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.<br><br>AUTHORIZED REPRESENTATIVE<br>CBIZ Insurance Services, Inc. |

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ACORD 25 (2014/01) 1 of 1 #S1601397/M1420458

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51LW

Client#: 52154 MYERSTA

**ACORD** **CERTIFICATE OF LIABILITY INSURANCE**

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| CBIZ Insurance Services<br>700 W 47th St<br>Suite 1100<br>Kansas City, MO 64112 | PHONE (A/C, No, Ext): | FAX (A/C, No): |
| | E-MAIL ADDRESS: kpeed@cbiz.com | |
| | INSURER(S) AFFORDING COVERAGE | NAIC # |
| | INSURER A : Hartford Casualty Insurance Co | 29424 |
| INSURED<br>Myers and Stauffer, LC<br>700 W. 47th Street, Suite 1100<br>Kansas City, MO 64112 | INSURER B : | |
| | INSURER C : | |
| | INSURER D : | |
| | INSURER E : | |
| | INSURER F : | |

**COVERAGES** **CERTIFICATE NUMBER:** **REVISION NUMBER:**

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| INSR LTR | TYPE OF INSURANCE | ADDL INSR | SUBR WVD | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS | |
|---|---|---|---|---|---|---|---|---|
| A | X COMMERCIAL GENERAL LIABILITY | | | 42SBAUH8895 | 05/01/2017 | 05/01/2018 | EACH OCCURRENCE | $1,000,000 |
| | CLAIMS-MADE X OCCUR | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | $300,000 |
| | | | | | | | MED EXP (Any one person) | $10,000 |
| | | | | | | | PERSONAL & ADV INJURY | $1,000,000 |
| | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | | | GENERAL AGGREGATE | $2,000,000 |
| | X POLICY PRO-JECT LOC | | | | | | PRODUCTS - COMP/OP AGG | $2,000,000 |
| | OTHER: | | | | | | | $ |
| A | AUTOMOBILE LIABILITY | | | 42SBAUH8895 | 05/01/2017 | 05/01/2018 | COMBINED SINGLE LIMIT (Ea accident) | $1,000,000 |
| | ANY AUTO | | | | | | BODILY INJURY (Per person) | $ |
| | ALL OWNED AUTOS / SCHEDULED AUTOS | | | | | | BODILY INJURY (Per accident) | $ |
| | X HIRED AUTOS / X NON-OWNED AUTOS | | | | | | PROPERTY DAMAGE (Per accident) | $ |
| | | | | | | | | $ |
| A | X UMBRELLA LIAB X OCCUR | | | 42SBAUH8895 | 05/01/2017 | 05/01/2018 | EACH OCCURRENCE | $5,000,000 |
| | EXCESS LIAB CLAIMS-MADE | | | | | | AGGREGATE | $5,000,000 |
| | DED X RETENTION $10,000 | | | | | | | $ |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N | | | | | | PER STATUTE OTH-ER | |
| | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N / A | | | | | | E.L. EACH ACCIDENT | $ |
| | (Mandatory in NH) | | | | | | E.L. DISEASE - EA EMPLOYEE | $ |
| | If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | E.L. DISEASE - POLICY LIMIT | $ |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

**CERTIFICATE HOLDER**

West Virginia Dept. of
Administration, Purchasing
Division
2019 Washington Street East
Charleston, WV 25305

**CANCELLATION**

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

CBIZ Insurance Services, Inc.

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