LEWINGROUP

October 30, 2017

WV Department of Health and Human Resources
Department of Administration
Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130
ATTN: April Battle (april.e.battle@wv.gov)

RE: CRFQ 0511 BMS1800000002 - Medicaid Managed Care Rate Setting and Program Administration

Dear Ms. Battle:

The Lewin Group, Inc. is pleased to submit our Proposal in response to the referenced CRFQ.

Our proposal includes the required resumes, references, attestations, forms and pricing pages, as well as a Vendor Preference Certificate for 2.5% preference request.

Please contact Sue Bembers, Director of Contracts, at 703-269-5684 or sue.bembers@lewin.com, if you have any questions or require additional information regarding our proposal.

We welcome the opportunity to assist the State of West Virginia on this very important endeavor.

Sincerely,

Lisa M. Chimento

Lisa Chimento
Chief Executive Officer

10/30/17 15:32:41
WV Purchasing Division

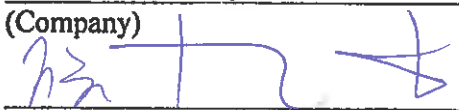
DESIGNATED CONTACT: Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

Sue Bembers, Director of Contracts
(Name, Title)

(Printed Name and Title)
3130 Fairview Park Drive, Suite 500, Falls Church, VA 22042
(Address)
703.269.5684 / 703.269.5501
(Phone Number) / (Fax Number)
sue.bembers@lewin.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contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated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.

The Lewin Group, Inc.
(Company)


(Authorized Signature) (Representative Name, Title)

Lisa Chimento, Chief Executive Officer
(Printed Name and Title of Authorized Representative)

10/30/2017
(Date)

703.269.5556 / 703.269.5501
(Phone Number) (Fax Number)

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: The Lewin Group, Inc. **Signed:** [signature]

Date: 10/30/2017 **Title:** Chief Executive Officer

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

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFQ 0511 BMS1800000002

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

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

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

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

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

The Lewin Group, Inc.
Company

Authorized Signature

10/30/2017
Date

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

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

CONSTRUCTION CONTRACTS: Under W. Va. Code § 5-22-1(i), the contracting public entity shall not award a construction contract to any bidder that is known to be in default on any monetary obligation owed to the state or a political subdivision of the state, including, but not limited to, obligations related to payroll taxes, property taxes, sales and use taxes, fire service fees, or other fines or fees.

ALL OTHER CONTRACTS: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that: (1) for construction contracts, the vendor is not in default on any monetary obligation owed to the state or a political subdivision of the state, and (2) for all other contracts, that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: The Lewin Group, Inc.

Authorized Signature: _____ Date: 10/30/2017

State of Virginia

County of Fairfax, to-wit:

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

My Commission expires January 31, 2021.

AFFIX SEAL HERE

SUSANNE C BENBERS
NOTARY PUBLIC
REG# 282196
MY COMMISSION EXPIRES
01/31/2021
COMMONWEALTH OF VIRGINIA

NOTARY PUBLIC Susanne C Benbers

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

Contracting business entity: The Lewin Group, Inc.

Address: 3130 Fairview Park Drive, Suite 500, Falls Church, VA 22042

Contracting business entity's authorized agent: Lisa Chimento, CEO

Address: 3130 Fairview Park Drive, Suite 500, Falls Church, VA 22042

Number or title of contract: CRFQ 0511 BMS1800000002

Type or description of contract: Medicaid Managed Care Rate Setting and Medicaid Managed Care Program Administration

Governmental agency awarding contract: WV Health and Human Services, Bureau of Medical Services

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

100% wholly-owned by OptumInsight, Inc.

Signature: [signature] Date Signed: 10/30/2017

☐ Check here if this is a Supplemental Disclosure.

Verification

State of Virginia, County of Fairfax:

I, Susanne C Bembers, the authorized agent of the contracting business entity listed above, being duly sworn, acknowledges that the Disclosure herein is being made under oath and under the penalty of perjury.

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

My commission expires January 31, 2021.

Susanne C. Bembers
Notary Public's Signature

SUSANNE C BEMBERS NOTARY PUBLIC REG# 252106 MY COMMISSION EXPIRES 01/31/2021 COMMONWEALTH OF VIRGINIA

To be completed by State Agency:

Date Received by State Agency: _____

Date submitted to Ethics Commission: _____

Governmental agency submitting Disclosure: _____

Medicaid Managed Care Rate Setting and Medicaid Managed Care Program Administration

Solicitation # CRFQ 0511 BMS 1800000002

Proposal

Prepared for:

West Virginia Department of Health and Human Resources

Submitted by:

The Lewin Group, Inc.

October 31, 2017

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1. Demonstration of RFQ Minimum Qualifications

The RFQ sets forth minimum qualifications for potential vendors, related to years of experience and required staff. In this section, for your convenience, we provide an excerpt of the RFQ requirement along with the Lewin-Aon Team's demonstrated compliance. Response Sections 3 and 4 provide additional details on our qualifications and experience.

1.1. Executive Summary

Seeking Innovative Solutions and Exceptional Support

West Virginia's Mountain Health Trust (MHT) program has served the State well for many years, offering its enrollees and the State's taxpayers quality services, a high level of budget predictability for Medicaid services, and efficient administration. As the largest component of the State's Medicaid program, the MHT Managed Care program has a tremendous impact on the lives of West Virginia's most vulnerable citizens. Its relative success or failure has critical implications for the State's budget, a fact exacerbated by the difficult financial environment currently facing many state Medicaid programs.

The Bureau for Medical Services (BMS) is soliciting vendors for Managed Care program administration/oversight and actuarial services. This procurement will be central to the program's future success, and it is essential that the winning bidder both (1) sustain the program's progress to date and (2) support BMS' ambitious goals for improvement and continued expansion. Much is at stake, and BMS needs a vendor that it can count on for innovative solutions and flawless execution.

The MHT enrollees and BMS staff leading the program deserve exceptional support. BMS requires a vendor who demonstrates an ability to be a true partner and perform exceptional work. We are that vendor.

Institutional Knowledge Coupled with Expanded Resources and Industry Thought Leadership

The Lewin Group (Lewin) is partnering with Aon PLC, our actuarial subcontractor (hereafter, the Lewin-Aon Team).

Aon, a leading actuarial firm, will be responsible for all actuarial services required under this contract. Aon brings lead actuarial staff with West Virginia rate setting experience and an actuarial team with managed care actuarial experience in nearly 20 states. This strong Lewin-Aon Team will support West Virginia's continued goals of ongoing accessible and cost effective health care for its Medicaid enrollees.

Lewin is a premier national health and human services consulting firm with 45 years of experience providing strategic counsel, objective analyses and implementation and program evaluation assistance to

Lewin–Aon offers BMS a team that combines:

- West Virginia Medicaid managed care institutional knowledge
- A deep actuarial and analytics bench
- Fresh perspective with industry insight and thought leadership.

our clients. We have been a trusted partner to West Virginia for over two decades. We provide a wide array of support across the development, implementation and expansion of the Medicaid Managed Care program. Our history with the program reflects an investment that no other vendor can match. We are committed to the State, the MHT program, and the staff who manage and guide it.

Lewin-Aon Brings Fresh Perspective While Maintaining Stability and Efficiency

The Lewin-Aon Team brings both program and actuarial team members with historical BMS program knowledge. We offer West Virginia the continuity of a managed care vendor with the historical program knowledge and relationships necessary to seamlessly support future program goals and help address program challenges. This valuable experience allows the State to immediately focus on program and budget priorities without service disruption. We bring:

Project Management: As the complexity of the program has changed, we have tailored our support to meet BMS' needs and with this proposal we offer additional project management professionals and tools.

Waiver Expertise: We have assisted BMS through nine waiver cycles and numerous waiver amendments, facilitating CMS approval.

MCO Contract Performance Management: Since the inception of the MHT program, Lewin has developed contracting and monitoring strategies to reflect the evolution of the managed care industry.

Performance and Quality Improvement: Implementation of a MCO performance withhold designed by Lewin, along with performance and quality improvement projects, have resulted in improvements in well child visits, adolescent care, obesity and diabetes care.

Lewin has been a long-term partner to BMS by successfully providing support across a variety of Managed Care program accomplishments:

- Managed care has become the dominant delivery system for West Virginia Medicaid covering over 80% of the Medicaid eligible members.
- Since 2014, managed care has expanded to include the Affordable Care Act (ACA) expansion and Social Security Income (SSI) populations, and has also expanded covered services with the inclusion of children's dental and behavioral health services.
- Medicaid enrollees now have a choice of four Managed Care Organizations (MCO) statewide. Lewin assisted BMS in MCO expansion, including developing readiness review criteria and conducting the reviews.
- In 2016, managed care created approximately $28 million in savings to the State by slowing growth in the use and cost of medical services.

Network Adequacy: Building on our understanding of "best-in-practice" network adequacy standards, we assisted BMS to move from network standards based on fee-for-service to those based on patterns-of-care.

Managed Care Rate Setting: Our transparent approach to rate development, along with our detailed documentation and rate certifications, makes the CMS review process very smooth for our clients.

Ad Hoc Services: Our national knowledge of best practices, coupled with our deep understanding of West Virginia, enables us to respond to a wide array of ad hoc requests.

Moving Forward from a Solid Foundation

As West Virginia continues to provide cost effective high-quality care to its Medicaid enrollees, we are excited to remain BMS' strategic partner. Given the successful expansion of the Managed Care program to cover more than 80 percent of eligible members, we understand the importance of a continued rigorous MCO oversight strategy in tandem with appropriate rate setting strategies that promote effective value-based purchasing.

Beyond a continuation of the current program, the health care system is rapidly evolving, demanding greater agility by health care purchasers. States face pressing issues, such as the Opioid crisis, which is compounded by the current uncertainty around coverage and funding regulations at the federal level. This creates both challenges and opportunities that necessitate BMS having ready access to subject matter expertise and sophisticated analytic tools.

As a longtime partner of BMS, Lewin is intimately familiar with West Virginia and MHT. We know the program's history, the state's political environment, the managed care vendors' strengths and weaknesses, and BMS' priorities. Combined with the Lewin-Aon Team's national experience and understanding of managed care best practices, this state-specific knowledge puts Lewin in the unique position to work through the challenging and sensitive issues that inevitably arise in Medicaid Managed Care programs. We look forward to a continued partnership, building upon BMS' strong managed care foundation to launch further program innovations.

1.2. Years of Experience

1.2.1. Years of Experience Requirements: Managed Care Program Administration and Oversight

The RFQ (Section 3: Qualifications, page 3) requires that vendor(s) have a minimum of 10 years of experience in providing Managed Care program administration and oversight and a minimum of 10 years of experience in developing Managed Care rates for state Medicaid agencies.

The Lewin-Aon Team brings more than 20 years of experience in Medicaid Managed Care Program Administration and Oversight as highlighted in Exhibit 1-1. *(Please see response Section 3 for more detail on these projects and additional relevant projects.)*

Exhibit 1-1: The Lewin-Aon Team's Experience with Medicaid Managed Care Program Administration and Oversight, Selected Projects

Client, Duration	Description
West Virginia Bureau for Medical Service ***Vendor: The Lewin Group*** **1995-Present**	**West Virginia Medicaid Managed Care Administration.** Since 1995, Lewin has assisted the State of West Virginia's Bureau for Medical Services with administration of its Managed Care program, MHT. Lewin assists the State with all aspects of design, operation, expansion, monitoring, and evaluation related to this program.
New York State Department of Health ***Vendor: The Lewin Group*** **1999-2011**	**Multiple Projects.** Lewin has had a successful relationship with the New York State Department of Health, including NYS Medicaid Managed Care program implementation and the NYS 1115 Waiver Evaluation. We collected and analyzed information on Medicaid primary care case management (PCCM) programs, including associated disease management and care management components for New York's consideration in exploring a PCCM program as an alternative to full-risk managed care in rural areas; and NYS Medicaid Managed Care program implementation, including assistance in

Client, Duration	Description
	implementing statewide Medicaid managed care, including several program administration and oversight tasks.
Georgia Department of Community Health ***Vendor: Aon (The Lewin Group's Subcontractor on this bid)*** **2007-Present**	For the **Georgia Department of Community Health, Medicaid/CHIP**, Aon provides both, managed care administration and oversight activities as well as actuarial services. • Oversight of accuracy and appropriateness of financial reporting by the MCOs • Fiscal modeling of different scenarios for how the state budget would be impacted by potential legislative changes to federal Medicaid funding • Regulatory and contract compliance review in accordance with the "Mega Rule" and MHPA guidance • Implementation of Medical Loss Ratio (MLR) and encounter data standards • Capitation rates for TANF, CHIP, Foster care children, family planning, NEMT • Risk adjustment design and implementation • IBNR actuarial services conducting annual valuation of all Medicaid programs
Delaware Department of Health and Social Services ***Vendor: The Lewin Group*** **2003-2007**	**Capitation Rate Setting and Procurement Support for the Delaware Medicaid Managed Care Program.** Lewin provided extensive administrative support to Delaware, supporting Delaware in its re-procurement of Medicaid MCO contracts: • Lewin assisted in developing the financial sections of the RFP (including provisions to leverage discounts if an entity were awarded contracts for both Medicaid and state employees at the same time), creating the scoring mechanism, training reviewers and facilitating the scoring at on-site meetings, and modeling the MCOs price bids to quantify the budget impacts of many program design and contractor selection permutations. • Lewin developed capitation rates for Delaware's acute care Managed Care program, Diamond State Health Plan (DSHP), studied many of the financial and design issues related to DSHP, and made strategic recommendations for the future structure of the program. Our work resulted in a successful competitive bid process for DSHP. Lewin supported this effort by creating data books both on the historical fee-for-service (FFS) experience alone and recent health plan encounter data blended with the FFS experience to distribute to prospective bidders.

1.2.2. Years of Experience Requirements: Developing Managed Care Rates for State Medicaid Agencies

The RFQ (Section 3: Qualifications, page 3) requires that "Vendor(s) have a minimum of 10 years of experience in providing Managed Care program administration and oversight and a minimum of 10 years of experience in developing Managed Care rates for state Medicaid agencies."

The Lewin-Aon Team brings more than 10 years of experience in developing Managed Care Rates for State Medicaid Agencies as highlighted in Exhibit 1-2. *(Please see response Section 3 for more detail on these projects and additional relevant projects.)*

Exhibit 1-2: The Lewin-Aon Team's Experience with Managed Care Rates, Selected Projects

Client, Duration	Description
Tennessee Health Care Finance and Administration (HCFA) ***Vendor: Aon (The Lewin Group's***	**TennCare, Medicaid Managed Care Actuarial Services.** Aon has performed all work related to MCO managed care rates for TennCare. This involves the creation of a databook, certifications, reviews with CMS, and all the necessary documentation. Aon has provided actuarial services for rate setting currently provided by three MCOs along with reconciliations for PCP enhancement and Health Insurer Fee (HIF) reimbursement, annual Medicaid budget and Comptroller reports, visual analytics with in-depth claims and

Client, Duration	Description
Subcontractor on this bid) **2004-Present**	membership movement analysis, dashboard development, and policy/program design support.
Georgia Department of Community Health ***Vendor: Aon (The Lewin Group's Subcontractor on this bid)*** **2007-Present**	**Medicaid Managed Care/CHIP Actuarial Services.** Aon develops actuarially sound rate ranges for Georgia, including the development of a data book and CMS certification documentation. • Capitation rates for TANF, CHIP, Foster care children, family planning, NEMT • Risk adjustment design and implementation • IBNR actuarial services conducting annual valuation of all Medicaid programs • Oversight of accuracy and appropriateness of financial reporting by the MCOs • Fiscal modeling of different scenarios for how the state budget would be impacted by potential legislative changes to federal Medicaid funding • Regulatory and contract compliance review in accordance with the "Mega Rule" and MHPA guidance • Implementation of MLR and encounter data standards
Delaware Department of Health and Social Services ***Vendor: The Lewin Group*** **2003-2007**	**Capitation Rate Setting and Procurement Support for the Delaware Medicaid Managed Care Program.** Lewin provided extensive administrative support to Delaware, supporting Delaware in its re-procurement of Medicaid MCO contracts: • Lewin assisted in developing the financial sections of the RFP (including provisions to leverage discounts if an entity were awarded contracts for both Medicaid and state employees at the same time), creating the scoring mechanism, training reviewers and facilitating the scoring at on-site meetings, and modeling the MCOs price bids to quantify the budget impacts of many program design and contractor selection permutations. • Lewin developed capitation rates for Delaware's acute care Managed Care program, Diamond State Health Plan (DSHP), studied many of the financial and design issues related to DSHP, and made strategic recommendations for the future structure of the program. Our work resulted in a successful competitive bid process for DSHP. Lewin supported this effort by creating data books both on the historical fee-for-service (FFS) experience alone and recent health plan encounter data blended with the FFS experience to distribute to prospective bidders.
Colorado Department of Health Care Policy and Financing ***Vendor: The Lewin Group*** **2010-2012**	Lewin assisted Colorado with their Medicaid Managed Care rate setting. Working with the Department of Healthcare Policy and Finance, Lewin conducted the following activities: reviewing programming logic for data collection and summarization, calculating and establishing trend rates, reviewing calculation of risk adjustment which was used for trend calculation and rate adjustment (for HMOs only), modeling the rate setting process in compliance with CMS rate setting guidelines, discussing assumptions and results with participating HMOs and establishing capitation rates and actuarial certification for the program. Lewin set rates for four programs, HMOs, Behavioral Health, CHP+, and PACE.

1.3. References

1.3.1. Reference Requirements and Addendum 6 Questions and Answers for State Managed Care Program Administration and Oversight Services

The RFQ (Section 3: Qualifications, page 3) requires Vendor(s) shall have experience with at least three (3) individual state Medicaid programs for each service type: Managed Care program administration and actuarial services. Experience for each service is permitted to have occurred concurrently and within the same state, so long as three (3) individual state examples are provided.

RFQ Section 3.7, page 4, requires the vendor shall provide references from three individual states for Managed Care Program Oversight services for a state Medicaid agency. The references must be for work performed within the last ten years and must not include a reference from the West Virginia Department of Health and Human Resources. These documents shall be submitted with the bid response.

Addendum Number 6, Response to Questions 6 and 59: The vendor shall provide the name of the State, a contact (and associated information: address, phone, etc.) with the state and a summary of the work performed for that state that falls within the requested information outlined in items 3.7 and 3.10.

References for projects conducted by the Lewin-Aon Team, within the past 10 years, for Managed Care Program Administration and Oversight Services are highlighted in Exhibit 1-3. *(More detail on each of these reference projects, as well as supplemental references, is provided in response Section 3.)*

Exhibit 1-3: The Lewin-Aon Team's References relating to Medicaid Managed Care Program Administration and Oversight Services

Name of State, Department	Contact	Summary of Relevant Work
Indiana Family and Social Services Administration ***Vendor: The Lewin Group*** **2015-2018**	Name: Natalie Angel, Director, Healthy Indiana Plan Address: 402 W. Washington Street, Indianapolis, IN 46204 Phone: 317-234-5547 Email: natalie.angel@fssa.in.gov	**Healthy Indiana Plan (HIP) 2.0 Evaluation** For the HIP 2.0 1115 Medicaid waiver evaluation, Lewin collects and analyzes data from a number of sources including **managed care** entities, census data, state enrollment and claims data, and member and former member survey data. This evaluation includes conducting **policy analyses** of the impact of key waiver program features, including **program operations**, the waiver's impact on services and **network adequacy**, and the impact of several waiver cost-sharing features designed to incentivize members to seek preventive care and to be cost-conscious and health-conscious when seeking all types of health care. With this information we assess: (1) the number of uninsured low-income residents and their access to health care services; (2) the use of **value-based program design**, decision making and personal health responsibility; (3) the use and impact of disease prevention and health promotion to **achieve health outcomes**; (4) the level of private market coverage and family coverage options and their impact on network and provider fragmentation; (5) the impact of varying copays on **emergency room use**; and (6) the utilization of Power Accounts.

Name of State, Department	Contact	Summary of Relevant Work
Vermont Department of Vermont Health Access ***Vendor: The Lewin Group*** **2013-2014**	Name: Cynthia Thomas, Director Quality Improvement & Clinical Integrity Address: 312 Hurricane Lane, Ste. 201, Williston, VT 05495 Phone: 802-879-5613 Email: Cynthia.thomas@state.vt.us	**Quality Performance Measures and Performance Improvement Projects** Lewin's engagement with the Department of Vermont Health Access (DVHA), the agency responsible for the management of Medicaid within Vermont's Agency of Human Services (AHS), was to provide assessments, technical assistance and training related to **quality/performance improvement in the Medicaid Managed Care program** as part of their Medicaid Adult Quality Measures grant. Lewin provided technical assistance to support grant performance improvement activities which furthered the state's legacy of pioneering flexible and **patient centered care delivery systems**, strengthening and supporting primary care, and developing a **robust health information system** designed to gather, analyze, and distribute data to improve care. Lewin performed: • Validation of Quality Measures: Collection, Calculation and Reporting • Validation of Performance Improvement Projects: Implementation and Findings • Data Management Assessment • Operational Transformation: Building Staff Capacity • Combination of Training Approaches and Technical Assistance Employed to Boost Skills, Increase Knowledge, Improve Processes and Develop Tools and Job-Aids
Kentucky Department for Medicaid Services ***Vendor: Aon (The Lewin Group's subcontractor for this proposal)*** **2014-2017**	Name: Veronica Cecil, Deputy Medicaid Commissioner Address: 275 E. Main St., Frankfort, KY 40621 Phone: (502) 564-5472 x2253 Email: Veronica.Cecil@ky.gov	**For the Kentucky Department of Medicaid Services, Aon provides both, managed care administration and oversight activities as well as actuarial services.** • **Operational and fiscal strategies for Managed Care program** expansions to include additional populations and services • Analysis for **1115 waiver development** and budget neutrality • **Regulatory and contract compliance review** in accordance with the "Mega Rule" and MHPA guidance • TANF, CHIP, ABD, ACA Expansion adults, Former foster care children, NEMT, Medicare-Medicaid dual eligibles, Mental and Behavioral Health Services • **Risk adjustment** of all populations, including implementation of risk adjustment for ACA expansion population • Implementation of the pass-through payments phase-out, Medicaid Institutions for Mental Diseases (IMD) reimbursement policy, MLR and encounter data standards

1.3.2. Reference Requirements and Addendum 6 Questions and Answers for Actuarial Services

The RFQ (Section 3: Qualifications, page 3) requires vendor(s) shall have experience with at least three (3) individual state Medicaid programs for each service type: Managed Care program administration and actuarial services. Experience for each service is permitted to have occurred concurrently and within the same state, so long as three (3) individual state examples are provided.

RFQ Section 3.10, page 5, requires the vendor shall provide three individual state references for a state Medicaid agency. The references must be for work performed within the last ten years and must no include a reference from the West Virginia Department of Health and Human Resources. These documents shall be submitted with the bid response.

Addendum Number 6, Response to Questions 6 and 59: The vendor shall provide the name of the State, a contact (and associated information: address, phone, etc.) with the state and a summary of the work performed for that state that falls within the requested information outlined in items 3.7 and 3.10.

References for actuarial services conducted by the Lewin-Aon Team, within the past 10 years are highlighted in Exhibit 1-4. *(More detail on each of these reference projects, as well as supplemental references, is provided in response Section 3.)*

Exhibit 1-4: The Lewin-Aon Team's References relating to Actuarial Services

Name of State, Department	Contact	Summary of Relevant Work
Georgia Department of Community Health ***Vendor: Aon (The Lewin Group's subcontractor for this proposal)*** **2007-2017**	Name: Margaret Betzel, Policy and Budget Analyst Address: 2 Peachtree St., NW, Atlanta, GA 30303 Phone: (404) 463-0176 Email: mbetzel@dch.ga.gov	**Medicaid/CHIP Actuarial Services** Aon develops **actuarially sound rate ranges** for Georgia, including the development of a data book and CMS certification documentation. This work has recently included separate **capitation rates developed for the Medicaid NEMT program.** Aon also works with the State on conducting an annual **analysis of Incurred but not Reported (IBNR) payments** for the Medicaid fee-for-service program, which allows the state to better budget future Medicaid expenses for past periods. Aon has also assisted the State with MCO PBM procurements (including medical review compliance), Medicaid FFS IBNR annual studies, developed white paper studies on issues relevant to the recent CMS Mega Rule, and **value-based purchasing** support.
Kentucky Department for Medicaid Services ***Vendor: Aon (The Lewin Group's subcontractor for this proposal)*** **2014-2017**	Name: Veronica Cecil, Deputy Medicaid Commissioner Address: 275 E. Main St., Frankfort, KY 40621 Phone: (502) 564-5472 x2253 Email: Veronica.Cecil@ky.gov	**Actuarial Services** Aon has been developing **actuarially sound rates** for Kentucky over the course of multiple fiscal years and continues to be engaged with the Commonwealth on monitoring of the rates. Including rate corrections, amendments, and recently developed rates, Aon's actuaries have successfully **developed capitation rates** for five years (CY14 through SFY18) of the program. We have also worked together with the State through the new administration's transition to support the accomplishment of additional 1115 **waiver objectives.** Aon developed actuarially sound rate ranges, including the development of databook and CMS certification documentation. This included all aspects of the

Name of State, Department	Contact	Summary of Relevant Work
		Commonwealth's ACA **Medicaid expansion** actuarial support. Aon completed re-rating efforts to correct the work of a competing actuarial consulting firm. Aon also assisted Kentucky with their Health Home pricing for behavioral health and **substance use disorder**, and SIM actuarial projections.
Tennessee Division of Health Care Finance and Administration (TennCare) ***Vendor: Aon (The Lewin Group's subcontractor for this proposal)*** **2004-2017**	Name: William Aaron, CFO Address: 310 Great Circle Road, Suite 400 West, Nashville, TN 37243 Phone: (615) 507-6755 Email: william.aaron@tn.gov	**TennCare, Medicaid Actuarial Services** Aon has performed all work related to MCO **managed care rates** for TennCare. This involves the creation of a databook, certifications, reviews with CMS, and all the necessary documentation. Aon has provided actuarial services for rate setting currently provided by three MCOs along with reconciliations for PCP enhancement and HIF reimbursement, annual Medicaid budget and Comptroller reports, **visual analytics** with in-depth claims and membership movement analysis, **dashboard development**, and policy/program design support. Development of actuarially sound risk-adjusted capitation rates for Tennessee MCOs as specified in 42 CFR §438.6(c) has included TANF, disabled, dual-eligible, and LTSS populations. Tennessee has also required input on **reforming hospital reimbursement**, detailed analysis of state budget needs for Medicaid, development of an annual comptroller report, evaluation of programs, and **ad hoc actuarial and policy support**.

1.4. Required Staffing

1.4.1. Key Staffing Requirements and Addendum 6 Questions and Answers: Managed Care Program Administration and Oversight

The RFQ (Section 3.2, page 4) requires the vendor, and its subcontractor if used, must provide resume of key staff that will assist on this project with its bed submission. Key staff for this project shall be defined as the Project Management Lead, On-Site Program Management/Policy Analyst, and Program Integrity Analyst.

The RFQ (Section 3.4, page 4) requires the vendor must assign a Project Management Lead who will be responsible for ensuring project deliverables are met and communication is maintained with all parties. The Project Management Lead must have at least five (5) years of experience with projects of similar size and complexity within Medicaid.

The RFQ (Section 3.5, page 4) requires the vendor shall provide an on-site Program Integrity Analyst with at least three (3) years of experience in reviewing Medicaid fraud, waste and abuse cases and issuing recover notices.

The RFQ (Section 3.6, page 4) requires that the vendor must provide an on-sight Project Management/Policy Analyst with at least three (3) years of experience in Medicaid Managed Care. Analysts should have at least a Bachelor's degree in a field relevant to the services being rendered, such as Health Care Administration, Finance, Hospital Administration, Public Health, etc.

Addendum Number 6, Response to Question 8: The program management analyst and program integrity analyst is required to be two separate individuals, as they are both full time jobs for the Bureau.

Exhibit 1.5 provides an overview of the Lewin-Aon Key Staff for Managed Care Program Administration and Oversight. Resumes for these staff immediately follows Exhibit 1-5 and are also included in Attachment A. *(More detail on these and additional staff is included in response Section 3.4.)*

Exhibit 1.5: The Lewin-Aon Key Staff for Managed Care Program Oversight

Position	Staff	Key Qualifications
Project Management Lead	**Ryan Benson, MA, PMP**	• Certified Project Manager Professional, as required in the RFQ • Eight years of project management and leadership experience with large, complex Medicaid projects, exceeding the minimum qualification of five years • Led implementation of Maryland's expanded Medicaid Family Planning Program during his tenure with the Maryland Department of Health and Mental Hygiene
On-Site Program Management/ Policy Analyst	**Jean Kranz, MS, MBA**	• Current West Virginia on-Site Program Management/Policy Analyst, supporting BMS with contracting, rate setting, Directed Payment Program (DPP), network adequacy, monitoring and evaluation for the program, as well as preparing federal waiver materials for CMS • More than six years' experience working with Medicaid Managed Care delivery systems, exceeding the minimum qualification of three years

Position	Staff	Key Qualifications
Program Integrity Analyst	**Yelena Barzilla, B.L., M.L., CHC**	• Ten years of regulatory compliance and program integrity experience, exceeding the minimum qualification of three years. Researched and implemented various federal and state laws and regulations related to health care fraud and abuse issues and Medicaid reimbursement issues • Certified Health Compliance Officer • For West Virginia, developed key contractual provisions, advised on the enforcement, conducted compliance reviews

RYAN A. BENSON, MA, PMP

Project Management Lead

IDEALLY SUITED FOR WEST VIRGINIA MEDICAID MANAGED CARE LEADERSHIP

- Certified Project Manager Professional
- Led implementation of Maryland's expanded Medicaid Family Planning Program during his tenure with the Maryland Department of Health and Mental Hygiene
- Eight years of project management and leadership experience with large, complex Medicaid projects
- For West Virginia, supported efforts related to Medicaid managed care improvement plan, site visits to participating MCOs, and analyzed dental network adequacy
- Managed several large, complex Medicaid projects, including operations support and policy development for the Vermont and Rhode Island Health Benefit Exchanges and a strategic policy analysis for South Dakota Medicaid

PROFESSIONAL EXPERIENCE

THE LEWIN GROUP **AUGUST 2013 - PRESENT**

Senior Consultant

West Virginia Medicaid Managed Care Program

- Analyzed dental network adequacy for the State's Medicaid Managed Care program
- Supported stakeholder engagement efforts related to integration of behavioral health services into Medicaid managed care.

South Dakota Medicaid

- Led the development of a series of policy papers analyzing Medicaid expansion options in South Dakota. Assisted the State in weighing design alternatives for Medicaid expansion, including design features such as health savings accounts, work referral programs, co-pays, and premium assistance.

District of Columbia Department of Human Services, Medicaid

- Served as project manager for the implementation of a customer relationship management system for the District's Medicaid consumer contact center.
- As part of this role, Mr. Benson led various work streams including stakeholder engagement, business requirement collection, and user training.

HealthSource Rhode Island

- Led a team of consultants in making operational enhancements to the Rhode Island Health Benefit Exchange, including process mapping and process improvement focused on Medicaid and Qualified Health Plan enrollment.

Massachusetts Health Connector

- Supported the operation of the Commonwealth's health exchange by providing ongoing quantitative analysis and predictive models of application volumes.

- Led efforts to improve the operation of the consumer contact center, including implementing enhancements to the center's case management tool.

Vermont Health Connect

- Led a team of 15 consultants to provide process mapping, operational support and business process improvement services.

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE **2009 - 2013**

Health Policy Analyst

- Served as project manager for the expansion of the Medicaid Family Planning program. Led the development of regulations, implementation of eligibility systems and outreach efforts to newly-eligible beneficiaries. The expanded program increased enrollment from 20,000 to 25,000 Marylanders over the course of 2012.
- Served as project manager for a stakeholder workgroup charged with planning the integration of behavioral health services. Managed a diverse set of over 75 stakeholders, including payers, physicians, hospital systems and community organizations.
- Developed and implemented enhancements to the Medicaid value-based purchasing program, enhancing quality monitoring of a $3 billion dollar Managed Care program servicing over 800,000 Marylanders.
- Supported reforms to Medicaid eligibility policies in preparation for the ACA
- Prepared policy analyses of the State's substance abuse treatment programs.
- Supported activities under the Medicaid State Innovation Model Planning Grant.
- Performed fiscal and policy analyses of Medicaid legislation in the Maryland General Assembly.
- Assisted in the implementation of the State's Electronic Health Records Incentive Program.

JOHNS HOPKINS UNIVERSITY INSTITUTE FOR POLICY STUDIES **2008 – 2009**

Student Consultant and Teaching Assistant

- Designed an evaluation of substance abuse treatment access to assist a quasi-governmental organization that leverages funding for family-support programs.
- Supported public policy students in econometrics and statistics courses by giving lectures, providing tutoring services, and leading workshops in STATA and Excel.

EDUCATION

M.A., Public Policy, Johns Hopkins University, Baltimore, MD

B.S., Mechanical Engineering, Tufts University, Medford, MA

TECHNICAL SKILLS

- MS Project
- STATA
- Visual Basic (Excel macro programming)

G. JEAN FISHER-KRANZ, MS, MBA

On-Site Program Management/Policy Analyst

IDEALLY SUITED FOR WEST VIRGINIA MEDICAID MANAGED CARE PROGRAM MANAGEMENT

- Current West Virginia on-site Program Management/Policy Analyst
- NCQA Patient Centered Medical Home Content Expert Certification
- More than six years of experience working with Medicaid Managed Care delivery systems
- Coordinated quality improvement efforts for providers serving Medicaid and CHIP children through managed care delivery systems in Oregon and Alaska, to include eight MCOs
- Liaison between the Bureau for Medical Services' and the managed care organizations to build and delegate work plans, and communicating progress to the client executives
- Supported WV BMS with contracting, rate setting, directed payment program, network adequacy, monitoring and evaluation for the program as well as preparing federal waiver materials for CMS preparing federal waiver materials for CMS

PROFESSIONAL EXPERIENCE

THE LEWIN GROUP **JULY 2015 – PRESENT**

Senior Consultant

West Virginia Managed Care Program

- Serves as the onsite project manager assisting with the administration of the Medicaid Managed Care program
- Support the state with contracting, rate setting, network adequacy, monitoring and evaluation for the program as well as preparing federal waiver materials to submit to CMS
- Assists the WV Medicaid Managed Care program, facilitating team and client project meetings, bridging client and vendor relationships, and directing and implementing managed care systems for the Bureau for Medical Services'
- Serves as a liaison between the Bureau for Medical Services' and the managed care organizations to build and delegate work plans, communicating progress to the client executives
- Provide centralization of all managed care activities, oversight for implementation of managed care guidelines, implementation and coordination of managed care reporting and related activities, to include corrective action plans
- Assist in conducting system-wide managed care activities and in arranging affiliation relationships with other health care and health care-related organizations, while providing oversight for affiliation relationships

WEST VIRGINIA HEALTH IMPROVEMENT INSTITUTE **2011 – 2015**

Project Director, Tristate Children's' Health Improvement Consortium

- Guided quality improvement efforts across three states, serving children through a managed care delivery system for quality improvement, that included eight health plans
- Provided technical direction to an alliance between the Medicaid/CHIP programs of Alaska, Oregon and West Virginia, formed with the goal of markedly improving children's health care quality as part of a Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Demonstration Project
- Coordinated quality improvement efforts for providers serving Medicaid and CHIP children through multiple managed care organizations in Oregon and Alaska
- Developed within each state an enhanced capacity to report and use the Child Core Set of quality measures for children, including the Consumer Assessment of Healthcare Providers and Systems surveys (CAHPS); developing and enhancing health information technology to improve quality of care, reduce cost and increase transparency; and developing and expanding provider-based care models
- Supported provider practice transformation to the patient-centered medical home model; care management entities, which aim to improve services for children and youth with serious emotional disorders and school based health centers
- Assessed current patient centered care measurement across the partner states and identified common state or site specific measures of implementation and impact for collecting and reporting quality measures
- Worked with the project subcontractor to facilitate the administration of the CAHPS survey across the providers in the health plan networks

HIGHMARK HEALTH SERVICES **2013 – 2014**

Clinical Transformation Consultant

- Guided health plan providers to assist with administrative coordination of and complex technical assistance to the Highmark network providers and to facilitate practice transformation in various strategic care delivery models
- Worked directly with the network of providers to assist the practice team with the day to day execution of projects, initiatives and significant work streams related to provider transformation and performance excellence in various health care delivery settings
- Served as the primary catalyst for developing standards for identifying and facilitating major systems change in the form of industry standard evidence-based best practice improvement opportunities to accelerate the achievement of goals related to clinical operations excellence and sustained quality patient care as manifested by patient outcomes

WEST VIRGINIA PRIMARY CARE ASSOCIATION **2009 – 2011**

Director, Clinical Quality

- Provided technical assistance to Federally Qualified Health Centers (FQHC) and Rural Health Clinics in West Virginia to support clinical/performance improvement, for community health center personnel
- Assisted in the development and maintenance of policies, procedures and methods to improve provider network function
- Assisted Association members to develop and test state-wide emergency preparedness policies and procedures

WHEELING JESUIT UNIVERSITY **2009 – 2010**
Adjunct Faculty (on-line)

- Conducted online learning sessions for students enrolled in the BA Program

WEST VIRGINIA HOSPITAL ASSOCIATION **2001 – 2009**
Vice President, Patient Safety and Education

- Worked with hospitals statewide to plan, develop and execute educational workshops for hospital leadership and clinical staff
- Conducted both classroom and virtual programs to provide a cost effective venue for education in a rural state
- Partnered with 40 states to develop an on-line learning platform to assist hospital administrators and education staff to meet clinical competencies required by licensing boards and accreditation agencies
- Technical support for the "super users" of the care Learning platform
- Development of multiple state-wide hospital standardization projects for emergency audible pages, color coding of armbands, patient sitter protocols and a universal protocol for site marking and verification during invasive procedures

UNIVERSITY OF CHARLESTON **1991 – 2001**
Director of Clinical Education and Mentoring Program Coordinator

- Conducted classroom and clinical education for 2- and 4-year Respiratory Care students
- Planned, coordinated and supervised all clinical laboratory experiences for students in the program
- Delivered didactic instruction in areas of study to include respiratory care, human resource management, business and the "Freshmen Experience"

HEALTHFOCUS/JACKSON GENERAL HOSPITAL **1987 – 1991**
Director of Respiratory Care Department

- Provided respiratory care technical direction in a 50 bed rural West Virginia hospital
- Supervised 10 employees

EDUCATION

MS, Human Resource Management, University of Charleston, Charleston, WV

MBA, Business Administration, University of Charleston, Charleston, WV

BA, Arts, Glenville State College, Glenville, WV

TECHNICAL SKILLS

- MS Map Developer
- Dreamweaver Video Production
- Blackboard Course Design
- Avilar Webauthor

YELENA BARZILLA, B.L., M.L., CHC

Program Integrity Analyst

IDEALLY SUITED FOR WEST VIRGINIA MEDICAID MANAGED CARE PROGRAM INTEGRITY

- Certified Health Compliance Officer
- Ten years of regulatory compliance and program integrity experience, exceeding the minimum qualification. Researched and implemented various federal and state laws and regulations related to health care fraud and abuse issues and Medicaid reimbursement issues
- For West Virginia, developed key contractual provisions, advised on the enforcement, conducted compliance reviews
- For the Office of Inspector General, developed policies, procedures, and compliance strategies to ensure appropriate monitoring, auditing and evaluation of Medicaid program integrity resulting in higher recoveries
- For multiple state agencies, managed CMS Medicaid Integrity Group Comprehensive Program Integrity Reviews, responded to findings, and developed corrective actions
- For CMS, Centers for Medicaid, CHIP, and Survey and Certification (CMCS): Development of Infrastructure for Oversight of Medicaid Managed Care Delivery Systems, served as a lead policy expert and a drafter for the CMS MCO compliance tool

PROFESSIONAL EXPERIENCE

AON **JULY 2016 - PRESENT**

Assistant Vice President

- Medicaid policy lead providing expertise on state health policy and reimbursement issues, particularly Medicaid and CHIP, to states, third party vendors, and Aon actuarial team
- Analyzed regulations, legislation, and program guidance for impact on Medicaid and CHIP programs across the country

THE LEWIN GROUP **2012 - 2016**

Senior Consultant

West Virginia Medicaid Managed Care Program

- Policy SME on managed care, eligibility, program integrity and enforcement issues. Supported the state with all aspects of design, administration, monitoring and evaluation of the program.
- Project manager for the MCO readiness reviews and contract compliance reviews.
- Principal drafter for the managed care waiver and MCO contracts (SFY 13-SFY17).
- State policy expert for the CMS MIG reviews.
- Project manager for pharmacy, dental, behavioral, and ACA transitions into managed care.

Centers for Medicare & Medicaid Services (CMS), Office of Financial Management: Payment Error Rate Measurement (PERM) Eligibility Support

- Lead policy expert for the federal eligibility regulations review. Provided ongoing consulting to CMS, through the PERM project, on a variety of issues related to Medicaid and CHIP policy, payment methodology and program integrity.
- Conducted a comprehensive study to evaluate the impact of four proposed Medicaid regulations on each of the 50 states and the District of Columbia for CMS.

CMS, Center for Consumer Information and Insurance Oversight (CCIIO): Marketplace Network Standards Adequacy

- Policy expert on the Medicaid regulatory compliance. Conducted reviews of the state Medicaid contracts to identify provider network and member communication requirements.

TEXAS HEALTH AND HUMAN SERVICES COMMISSION **2007 - 2012**

Managed Care Oversight

- Monitored managed care organization performance to ensure compliance with federal regulations, state laws, contracts and manuals. Updated Texas HHSC contracts and manuals to ensure appropriate monitoring and evaluation of Medicaid/CHIP programs.
- Served as an Office of Inspector General liaison for the program integrity questions.

Office of the Inspector General

- Planned, implemented and evaluated oversight strategies and methodologies for Medicaid providers, recipients and managed care organizations as related to program integrity functions.
- Project manager for 2010 CMS Medicaid Integrity Group Comprehensive Program Integrity Review.

EDUCATION

LL.M., magna cum laude, University of Florida, Gainesville, FL

M.L., Master of Laws, A.B.A., Karaganda State University, College of Law, Russia

B.L., Bachelors of Laws, summa cum laude, (undergraduate law degree), Karaganda State University, College of Law, Russia

1.4.2. Key Staffing Requirements and Addendum 6 Questions and Answers: Actuarial Services

The RFQ (Section 3.8, page 5) requires that the vendor, and its subcontractor if used, must provide resumes of key staff that will assist on this project with its bid submission. Key staff for this project shall be defined as the Lead Actuary, which the State may request to be available on a full-time basis if warranted.

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

Addendum 6, Response to Question 11: Yes, more than one lead actuary can be used.

Addendum 6, response to Questions 19,42, 48 and 49: The Lead Actuary may be an FSA or MAAA.

Exhibit 1-6 provides an overview of the Lewin-Aon Key Staff for actuarial services. Resumes for these staff immediately follow Exhibit 1-6 and are also included in Attachment A. *(More detail on these and additional staff is included in response Section 3.4.)*

Exhibit 1-6: The Lewin-Aon Key Actuarial Staff

Position	Staff	Key Qualifications
Co-Lead Actuary	**Russ Ackerman, ASA, MAAA, FCA**	• More than 25 years of consulting and MCO pricing/rate setting experience, including more than 12 years working with numerous state Medicaid programs, exceeding RFQ qualification requirements • Prior experience leading the development of a study for West Virginia including pharmacy analysis to compare states who have carve-in versus carve-out programs
Co- Lead Actuary	**Colby Schaeffer, ASA, MAAA**	• More than 10 years of consulting and MCO pricing/rate setting experience, including more than 6 years working with numerous state Medicaid programs, exceeding RFQ qualification requirements • Direct experience in all facets of rate setting for West Virginia Medicaid from 2012 to 2015 including involvement in certifying rates that were submitted timely to BMS and accepted by CMS and the participating MCOs during a period that covered rapid expansion of the Mountain Health Trust program (carve-in of pharmacy, dental, and behavioral health services and inclusion of Medicaid Expansion population)

RUSSELL H. ACKERMAN, ASA, MAAA, FCA

Lead Actuary

IDEALLY SUITED FOR WEST VIRGINIA MEDICAID MANAGED CARE ACTUARIAL ANALYSIS

- More than 25 years of consulting and MCO pricing/rate setting experience, including more than 12 years working with numerous state Medicaid programs, exceeding RFQ qualification requirements
- Prior experience leading the development of a study for West Virginia including pharmacy analysis to compare states who have carve-in versus carve-out programs
- Client leader, project director, and/or certifying lead actuary for multiple states, including Georgia, Idaho, Kansas, Kentucky, Massachusetts, Ohio, and Tennessee, having provided subject matter expertise to other states
- Prior experience includes chief actuary of a large health plan that was the largest Medicaid carrier in the state of Minnesota

PROFESSIONAL EXPERIENCE

AON **2014 - PRESENT**

Senior Vice President and Medicaid National Practice Leader

- Leads all activities related to Medicaid.
- Responsible for executive, management, actuarial, pricing, reserving, underwriting, and financial consulting.
- Strategy and actuarial leader specifically for Georgia, Tennessee, Kansas, and Kentucky Medicaid programs.
- Managed care, state agency, legislative, and other stakeholder facilitation.
- Oversight of all pricing/rate-setting, financial management, analytics, policy, and operations for all Medicaid clients.
- Involvement in and support of State Innovation Model (SIM), 1915b, c, and combo waivers, 1115 waivers, ACO, and PCMH strategy, analysis for alternative.
- Experience consulting with a variety of states on public exchanges, analysis of rural health programs, behavioral health programs, and various disability programs, both for physically disabled and developmentally disabled populations, primarily in the managed care environment, but also in fee for service.
- Medicaid rate setting strategy, health care reform consulting, state innovation model strategies, waiver development, and development and implementation of ACOs and PCMHs and associated alternative payment methodologies to serve Medicaid and other higher risk populations.

MERCER **2012 - 2014**

Principal and Client Leader within Company's Government Human Services Consulting Practice

- Client leader, with primary client and actuarial responsibility for Massachusetts managed care, Ohio financial analytics and health care reform, and Idaho SIM grant application oversight, strategy and development.
- Practice leadership over all SIM and public exchange business.
- Assisted states in developing strategies and applications to CMS for SIM grants, implementation of approved SIM funded programs, and development and implementation of various waiver demonstrations.
- Actuarial leader for various clients, including Massachusetts rate setting.

MEDICA **2005 - 2012**

Financial Department Leader, with Chief Actuary Responsibility

- Corporate leadership and oversight over all government sponsored, commercial, and retail lines of business, including Medicaid, Medicare Cost and Medicare Advantage, Individual, Large and Small Group.
- Built actuarial department from ground up.
- Developed strategy and implemented company-wide improvements affecting all actuarial, reserving, capitalization, pricing, underwriting, financial reporting, and operations across all corporate lines of business.

DELOITTE **2003 - 2005**

Consultant

- Consulted health insurers, third party administrators, and managed care organizations including various for-profit and Blue Cross and Blue Shield not-for profit organizations nationally and in various states).
- Responsible for executive, management, actuarial, pricing, reserving, underwriting, and financial consulting.

AON **2001 - 2003**

Assistant Vice President and Actuarial/ Underwriting Consultant

- Responsible for consulting large corporations on benefit design, pricing, underwriting activities, and health care funding mechanisms.

PACIFICARE HEALTH SYSTEMS (NOW UNITED HEALTHCARE) **1995 - 2000**

Corporate leader for National and Major Accounts

- Responsible for pricing and underwriting activities for the company's National accounts.
- Responsible for California Major Accounts underwriting.

WATSON WYATT (NOW WILLIS TOWERS WATSON) **1992 - 1995**

Consultant

- Responsible for consulting large corporations on benefit design, pricing, underwriting activities, and health care funding mechanisms.

EDUCATION

B.S., Brigham Young University, Provo, UT

CERTIFICATIONS

Associate of the Society of Actuaries (ASA)

Member of the American Academy of Actuaries (MAAA)

Fellow of the Conference of Consulting Actuaries (FCA)

SOCIETY OF ACTUARIES DIRECTORY – CREDENTIALS AND COMPLIANCE PRINTOUT

Russell H Ackerman

Personal Information
Russell H Ackerman
Senior Vice President
Aon Hewitt
1900 16th Street
Suite 1000
Denver, CO 80202
United States

Tel: +1(480)318-9390
Email: russ.ackerman@aonhewitt.com

Designations
ASA 2007
MAAA 2007
FCA 2015

SOA Continuing Professional Development Requirement
Compliant(2015-2016)

Academic Degrees
B.S.

Other Professional Designations

Industry
Consulting

Primary Area of Practice
Health

Specializations
Capital Management
Financial Reporting
Product Pricing/Development
Public Systems/Social Insurance
Regulatory
Risk Management

Society of Actuaries Sections
Entrepreneurial & Innovation
Health
Marketing & Distribution
Social Insurance & Public Finance

COLBY SCHAEFFER, ASA, MAAA

Lead Actuary

IDEALLY SUITED FOR WEST VIRGINIA MEDICAID MANAGED CARE LEADERSHIP AND ACTUARIAL ANALYSIS

- More than 10 years of consulting and MCO pricing/rate setting experience, including more than 6 years working with numerous state Medicaid programs
- Client leader, project manager, and/or certifying lead actuary for multiple states, including Georgia, New Hampshire, Tennessee, Vermont, and West Virginia having provided subject matter expertise to other states
- Direct experience in all facets of rate setting for West Virginia Medicaid from 2012 to 2015 including involvement in certifying rates that were submitted timely to BMS and accepted by CMS and the participating MCOs during a period that covered rapid expansion of the Mountain Health Trust program (carve-in of pharmacy, dental, and behavioral health services and inclusion of Medicaid Expansion population)
- Prior experience includes all actuarial activities for what was the largest Medicaid health plan (Missouri) at Coventry (now part of Aetna) in addition to supplemental Medicare plan valuation.

PROFESSIONAL EXPERIENCE

AON **JUNE 2015 - PRESENT**

Assistant Vice President

General Role

- Assisting in the management of Medicaid activities at Aon and overseeing large pricing/actuarial engagements for both Georgia and Tennessee. These projects have covered many needs for state agencies including Medicaid managed care pricing/rate setting, health reform modeling, budget analyses, IBNR valuations, value-based payment methodologies, fiscal analyses of policy changes, and data analytics presentations.

Georgia Department of Community Health

- Project manager and client lead overseeing rate development process and ad hoc projects.
- Signing actuary for SFY17-18 rates for CMO rate development that saw implementation of value-based purchasing initiatives and risk adjustment.
- Developed NEMT rates for transportation brokers.
- Assisted modeling and review of annual IBNR valuations.

Tennessee Division of Health Care Finance & Administration

- Signing actuary for CY15-18 capitation rates, which included LTSS population and HCBS rates.
- Peer reviewed all elements of project including State budget forecasts, risk adjustment, and annual reports.

- Led the development of modeling administrative expense needs for insurance plans participating in ASO arrangement for IDD kids called ECF CHOICES.

THE LEWIN GROUP **2012 - 2015**

Senior Consultant

West Virginia Bureau for Medical Services: Medicaid Managed Care Administration Oversight

- Project manager for actuarial modeling, capitation rate setting (SFY13-16), and MCO quarterly monitoring reports.
- Developed and modified monitoring reports on Medicaid plans' utilization, cost, and access to care, grievances and appeals, and call center volume.
- As both a consultant and signing actuary, oversaw rate development through several transformations of the project.

Centers for Medicare & Medicaid Services (CMS), Office of Financial Management: Payment Error Rate Measurement (PERM)

- Data Manager role involved reviewing quality and reasonability of data through data submission (universe).
- Became lead details manager conducting final review of claim extracts for all States, including Virginia, prior to submission.

Vermont Green Mountain Care Board

- Project manager for actuarial side of State Innovation Model grant project that kicked off July 2014.
- Developed share savings models for Medicaid and Commercial Accountable Care Organizations that included exchange premium modeling and risk adjustment.

State of New Hampshire

- Modeled expansion population costs for Medicaid agency.
- Projected membership and costs through 2020 and included scenarios to price new essential health benefits for mental health.

Colorado CHIP

- Provided actuarial support including analysis and modeling of SFY13 CHIP rates.
- Assisted in pulling together provider network contact data.

COVENTRY HEALTHCARE (NOW AETNA) **2010 - 2012**

Actuarial Analyst

Missouri Medicaid (Healthcare USA plan)

- Actuarial analyst assigned to plan to perform all actuarial modeling functions including SFY12 rate setting modeling, Fee Schedule analysis, Medical Home MLR targets, Provider Contract Analysis for SSM, CY11 Budget Refresh, CY12 Budget, FY12 PDR, and RFP support.

Virginia Medicaid

- Conducted monthly reserve analysis for health plans' claims that have been incurred but not received.

LYNCHVAL SYSTEMS WORLDWIDE **2009 - 2010**

Actuarial Analyst

- Bridged actuarial and developer departments as actuarial programmer.

- Consulted on post-retiree Medicare supplemental plans.
- Developed enhancements to software for stochastic modeling, cash balance plans, and medical plans.

JOHN S. AGATSTON ACTUARIAL SERVICES **2007 - 2009**

Actuarial Analyst

- Redesigned valuation system based on research of new regulatory requirements under the Pension Protection Act of 2006.
- Analyzed expected future costs through plan valuations.

EDUCATION

B.S. Mathematics, State College, PA

CERTIFICATIONS

Associate of the Society of Actuaries (ASA)

Member of the American Academy of Actuaries (MAAA)

1.5. Attestation of Contract Services that Must Meet or Exceed the Mandatory Requirements

4.1 Mandatory Contract Services Requirements and Deliverables: Contract Services must meet or exceed the mandatory requirements listed below.

Addendum Number 6, Response to Questions 6 and 60: The Vendor need only to attest to the ability to meet all mandatory requirements of the procurement.

Exhibit 1-7 provides the Lewin-Aon Team's attestation to the mandatory requirements.

Exhibit 1-7: The Lewin-Aon Team will meet all of the requirements in the RFQ

Requirement	The Lewin-Aon Team Attests	
	Yes	No
4.1 Mandatory Contract Services Requirements and Deliverables: Contract Services must meet or exceed the mandatory requirements listed below.	✓	
Actuarial Services	✓	
Actuarial Services will be billed on an hourly basis, based upon program need and established delivery orders.	✓	
4.1.1 Rate Development	✓	
4.1.1.1 The vendor shall complete the development, setting, certification, and/or review of rates for the State's Managed Care program.	✓	
Capitation rates for Managed Care shall be developed based on readily available State data and set by cohorts, including, but not limited to, age, gender, eligibility category, geographic location, and population risk factors.	✓	
4.1.1.2 Vendor shall develop high, mid, and low capitation rate ranges for review.	✓	
4.1.1.3 Vendor must develop Managed Care rates at the individual MCO level, should BMS choose to develop MCO-specific rates based on risk stratification.	✓	
4.1.1.4 Vendor shall participate and provide support in rate setting discussion and meetings as needed, and provide supporting documentation, including but not limited to: presentations, rate workbooks, Excel files, and rate memos, as requested by Bureau staff for meetings.	✓	
4.1.1.5 Vendor shall work collaboratively with Department staff to improve the accuracy and efficiency of the existing data sources and new data sources used for rate development, and the methodologies used in the rate setting process.	✓	
Collaboration shall include attending meetings, conference calls, and other requests that BMS deems necessary.	✓	
It is the expectation of BMS that the vendor shall provide new and innovative ideas around the rate setting process and efficiencies of such.	✓	
4.1.1.6 Vendor shall provide BMS with reports and calculations in the formats specified by BMS, including all formulae, databases, data sets, and other documents as requested on an as needed basis in an agreed-upon standard format compliant to the data being requested.	✓	
4.1.1.7 The vendor shall assist the Department in identifying where rate uniformity needs to occur to ensure payments are made consistently across all bureaus by conducting a rate	✓	

Requirement	The Lewin-Aon Team Attests	
	Yes	No
uniformity workgroup and analysis of all rates currently administered in a schedule to be coordinated between the vendor and Department.		
The analysis shall identify inconsistencies and recommendations to the Department for improving its rate setting process and helping align areas that are not in uniformity.	✓	
4.1.1.8 Vendor shall update the capitation rates based on data, pricing trends, changes resulting from federal and/or state requirements, program changes and certify such amendments, at a minimum of one time per fiscal year.	✓	
4.1.1.9 The vendor shall develop and successfully implement a plan to transition all data, methodologies, documentation, and ongoing projects to the next succeeding vendor, at least thirty (30) calendar days in advance of the contract end date.	✓	
4.1.1.10 The vendor shall coordinate with the State's fiscal agent to ensure accurate encounter, claims, and eligibility data is used for rate setting	✓	
Vendor shall review encounter data for completeness and/or inconsistencies as part of rate setting process, and provide a summary report of any inconsistencies to BMS for review on an ad hoc basis in a format agreed upon between the vendor and Bureau.	✓	
4.1.1.11 Vendor shall work with fiscal agent to ensure completeness of any and all reports used for state and federal reporting, as requested by BMS.	✓	
4.1.1.12 The vendor must gather, process, validate and analyze Managed Care encounter and claims data, including carved out services and provide technical assistance to the Managed Care organizations on data issues.	✓	
4.1.1.13 The vendor shall provide assistance in development of methodologies for calculating Directed Payment Program amounts or other supplemental payments.	✓	
4.1.1.14 The vendor must perform actuarial analysis and valuation of the costs or savings established by implementing programmatic changes, including, but not limited to, the transitioning of populations from FFS to managed care or alternate coverage options.	✓	
Managed Care Program Administration	✓	
4.1.2 Waivers	✓	
The State Medicaid Managed Care Program currently operates under a 1915(b) waiver.	✓	
Requests for services related to waiver analyses outside of the Managed Care waiver shall be accounted for under ad hoc services.	✓	
Services provided under the ad hoc section will be done at an hourly rate and will require execution of an approved delivery order before work can commence.	✓	
Waiver documents must be submitted ninety (90) days prior to the expiration of the current waiver, June 30, 2018.	✓	
4.1.2.1 The vendor shall assist with current and new programs developed and operating under new waivers or waiver renewals, including:	✓	
4.1.2.2 Assistance with drafting waiver applications.	✓	
4.1.2.3 Developing correspondence, such as waiver applications, letters to federal entities, etc.	✓	

Requirement	The Lewin-Aon Team Attests	
	Yes	No
4.1.2.4 Conducting financial analysis of waiver programs and developing recommendations for improving effectiveness and efficiency of waiver programs.	✓	
4.1.2.5 Developing an annual report on BMS for Medical Services waiver programs, including a financial, service, and demographic overview of the programs.	✓	
4.1.2.6 Assisting BMS with activities related to its 1115 waiver for Substance Use Disorder, including but not limited to, federal reporting requirements and financial analysis, as needed, which will be administered under the managed care organizations.	✓	
4.1.3 Analysis	✓	
4.1.3.1 The vendor shall provide policy impact analyses and support to BMS, including, but not limited to, reviewing and analyzing policy options, developing documents for review, fiscal analysis and programmatic impact, conducting federal regulatory review, developing presentations, and assisting with implementation of adopted strategies (i.e. preparation of work plans, facilitation of meetings, monitoring, and evaluation).	✓	
4.1.3.2 The vendor must agree to revise all analyses based on future releases or revisions of information at the state or federal level within an agreed upon timeframe between the vendor and Bureau.	✓	
4.1.3.3 The vendor shall monitor federal regulations and requirements for potential changes and provide analysis on program impact on an ongoing basis.	✓	
4.1.3.4 The vendor shall provide a full-time program integrity analyst to assist with oversight of managed care fraud, waste and abuse reporting and improvement in recouping Medicaid funds.	✓	
4.1.4 Operations Plan	✓	
The vendor must develop an Operations Plan within the first 30 calendar days of contract that addresses compliance with the following program requirements and services:	✓	
4.1.4.1 Development and maintenance of provider enrollment and Managed Care contracts and agreements	✓	
4.1.4.2 Coordinating with state staff on the development of the Managed Care contract	✓	
4.1.4.3 Analysis and monitoring of Managed Care contract performance	✓	
4.1.4.4 The vendor shall develop quarterly MCO performance scorecards for public distribution and an annual report on MCO performance and compliance with contractual obligations within 30 calendar days of the end of the reporting period.	✓	
The annual report shall also address program enrollment, services available, cost savings resulting from the program, performance on key quality indicators, Medical Loss Ratio (MLR) overview, improvement strategies implemented, program goals, and other information as requested by BMS.	✓	
4.1.4 5 Conduct program readiness document and desk reviews, as needed, for an undetermined number of managed care entities, dependent upon entry into the WV Medicaid program.	✓	
Reviews shall also be provided on an on-going basis for existing MCOs in the event BMS would add a new population or benefit to the MCO contract, and such review was warranted to ensure continued network adequacy compliance and readiness to meet Medicaid standards.	✓	
4.1.5 Evaluation of network adequacy	✓	

Requirement	The Lewin-Aon Team Attests	
	Yes	No
4.1.5.1 Perform analyses and ongoing monitoring of MCO provider networks, conduct quarterly analyses of the MCOs' networks against program requirements.	✓	
Develop MCO-specific reports and maps showing providers, clinics, and hospitals by specialty and location.	✓	
Information shall be submitted within 10 calendar days of request, unless otherwise noted.	✓	
4.1.5.2 Operations plan shall include work plan and timeline for project.	✓	
4.1.5.3 The vendor shall work with BMS to develop a comprehensive reporting calendar for the Mountain Health Trust program that complies with federal, state, and bureau-specific reporting requirements as currently defined by the managed care contract.	✓	
A copy is available at the below link:	✓	
http://www.dhhr.wv.gov/bms/Members/Managed%20Care/Documents/Contracts/SFY18%20MCO%20Contract%20Final_7-25-17.pdf	✓	
4.1.5.4 The vendor must identify and comply with all federal and state Medicaid laws, regulations, and policies, as outlined by the Centers for Medicare and Medicaid Services and BMS for Medical Services, which can be accessed at www.medicaid.gov/medicaid/managed-care/index.html.	✓	
http://www.dhhr.wv.gov/bms/Members/Managed%20Care/Pages/default.aspx.	✓	
4.1.5.5 Analyze Early Periodic Screening, Diagnosis and Treatment (EPSDT) service provisions and prepare federal and state reports on methods to improve efficiency, effectiveness, coordination and quality of those services in West Virginia as needed, in an agreed upon format and submission standard between the vendor and BMS.	✓	
4.1.5.6 The vendor must provide ad-hoc reports upon request on information including, but not limited to, comparisons of the Managed Care program with the fee-for-service program to improve the efficiency, effectiveness, and quality of the Managed Care program within the timelines established for each project as outlined by the Department.	✓	
4.1.5.7 The vendor must provide an analysis tool for use in identifying medical service utilization patterns by category of service and medical and administrative cost profiles for all Managed Care cohorts, major lines of business, and individual Managed Care recipients to improve quality of care and outreach.	✓	
4.1.5.8 The vendor must provide all data, program and regulatory analyses required to respond to, but not limited to, Legislative, Federal, State, Budgetary, Provider or Advocacy requests.	✓	
4.1.5.9 The vendor must develop a strategy for MCO contracting, including options for performance targets, use of incentives and/or penalties, modifications to program requirements, implementation and oversight of a Managed Care medical loss ratio (MLR), and others as requested.	✓	
4.1.5.10 The vendor shall develop a comprehensive quality assessment and performance improvement strategy, that complies with federal regulations, Quality Improvement Systems for Managed Care (QISMC), CMS standards, other quality review programs, and input from enrollees, advocates, Managed Care organizations, and other stakeholders to identify options and recommendations for monitoring and evaluating the quality and appropriateness of care and services to enrollees.	✓	

Requirement	The Lewin-Aon Team Attests	
	Yes	No
4.1.5.11 The vendor shall meet with the State's Managed Care entities, provider groups and other parties as determined necessary by BMS at locations to be determined dependent upon availability of space.	✓	
4.1.5.12 The vendor shall assist in developing options for program expansion and assist in implementation of program expansion, including preparation of documents outlining options for program expansions, including cost savings, policy considerations, risks, issues, agency and bureau coordination requirements, and legal constraints, etc.	✓	
4.1.5.13 The vendor shall assist with the development of reports for WV House Bill 4217:	✓	
http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=HB4217%20SUB%20ENR.htm&yr=2014&sesstype=RS&billtype=B&houseorig=H&i=4217	✓	
4.1.6 Project Management System:	✓	
The vendor shall provide an electronic tool that serves as a program compliance dashboard that will allow BMS to track, at a minimum, but to be refined by BMS:	✓	
4.1.6.1 All deliverables submitted by the MCOs as outlined under the Managed Care contract	✓	
4.1.6.2 MCO policies and procedure documents	✓	
4.1.6.3 Contract and amendment language and version history	✓	
4.1.6.4 MCO quality metrics and report card	✓	
4.1.6.5 Network adequacy documents and readiness review materials	✓	
4.1.6.6 Grievances and Appeals	✓	
4.1.6.7 Vendor shall provide classroom-led training to staff on utilizing the project management system and maintain a training manual for reference.	✓	
4.1.6.8 Platform must be hosted by the vendor and allow access for up to ten (10) users at any time.	✓	
Settings must be configurable to meet state needs.	✓	
4.1.7 Ad Hoc Services	✓	
The contractor must provide BMS and/or Department with additional consultation and actuarial services and complete other work as requested.	✓	
The vendor shall provide a scope of work, including but not limited to, number of project hours, resources to be used, and cost affiliated with each ad hoc request for review by BMS/Department which may include, but is not limited to:	✓	
4.1.7.1 Analyzing accurate payments and reimbursements related to changes under the Affordable Care Act (ACA) or other federal or state health care and/or payment provision rules, regulations, laws, or codes.	✓	
4.1.7.2 Provide analysis and other consultation services as needed in the development of a risk-adjusted payment model	✓	
4.1.7.3 Provide assistance in development of payment methodologies for other programs, including, but not limited to, long-term care, nursing home, waiver programs, etc.	✓	

Requirement	The Lewin-Aon Team Attests	
	Yes	No
4.1.7.4 Assist with programmatic activities associated with the Medicaid program, including State Plan Amendments (SPA), contract amendments, and regulatory changes.	✓	
4.1.7.5 Analyze proposed adjustments to provider reimbursement rates.	✓	
4.1.7.6 Conduct research and recommend approaches in key areas of chronic care/disease management, pharmacy, eligibility and coverage, quality improvement, improved rural health delivery, provider networks, and others as requested.	✓	
4.1.7.7 Provide assistance to DHHR in responding to various information requests from the Governor's Office or Legislative leadership.	✓	
4.1.7.7 Assistance may include, but is not limited to, development of written correspondence, preparation of presentation materials, attending meetings, and presenting upon request, on an as needed basis at a location to be determined by the meeting organizer.	✓	
4.1.7.8 The vendor shall assist with the development of procurement materials, including Request for Proposals, Requests for Quotations, and Requests for Information related to any service covered under this procurement.	✓	
Service Level Agreements	✓	
Vendor shall be assessed a penalty of $250 per day for each day a deliverable is not provided past the requested due date.	✓	
The State will work with the vendor and its subcontractor, if appropriate, to define dates for each deliverable throughout the duration of the contract.	✓	
Deliverables will vary in date between one (1) and ninety (90) days depending on the nature of the request.	✓	
BMS will consider requests for extensions on an as needed basis.	✓	

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

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Attachment 1: Exhibit A Pricing Page

Please reference **Exhibit A: Pricing Page** to complete the bid information.

The contract shall be awarded to the vendor with the lowest total cost bid meeting all of the specifications.

Vendor Name:	The Lewin Group, Inc.
Remit to Address:	3130 Fairview Park Drive, Suite 500, Falls Church, VA 22042
Phone #:	703.269.5556
Vendor Fax #:	703.269.5501
Email Address:	lisa.chimento@lewin.com
Signature:	[signature] Date: 10/30/2017

Exhibit A: Pricing Page - CRFQ 0511 BMS1800000002
Section Actuarial Services
Section Managed Care Oversight
Section Ad Hoc Services

Vendor should complete highlighted cells; formulas built into cells will calculate total costs.

Section A: Mandatory Services
Actuarial Services will be billed on an hourly basis for services as they are needed. Vendors should provide the hourly rate for the below staffing levels.

Actuarial Services*

Staff by Level	# of Hours (total)	Cost Per Hour	Total Cost
Lead Actuary	2,080	$ 350.00	$ 728,000.00
Staff Actuaries (4)	8,320	$ 215.00	$ 1,788,800.00
Technical Support Staff (non-actuary)	2,080	$ 175.00	$ 364,000.00
Clerical Support Staff	2,080	$ 75.00	$ 156,000.00

*hours are estimated on a per year (2,080 hours) basis and subject to change. The hourly rate established for each position will carry forward throughout the life of the contract, including any optional renewals and extention awarded. Vendor is responsible for all travel costs.

Managed Care Program Oversight will be billed on a fixed annual amount divided into 12 equal monthly installments and is all-inclusive of all services outlined within that section of the RFQ.
Vendor should provide the annual cost in the highlighted box below for Managed Care Program Oversight.

Managed Care Program Oversight

Total Cost (Annual)	**$ 782,858.00**

Ad hoc services may be rendered for various services. Vendor shall provide an estimated rate that would cover any of the potential services outlined within the Ad Hoc section of the RFQ.

Section B: Ad Hoc Services:

Staff	# of Hours Per Year	Cost Per Hour	Total Cost
Managed Care Oversight Projects	5,000	$ 145.00	$ 725,000.00
Actuarial Services Projects	5,000	$ 235.00	$ 1,175,000.00

Total Project Cost (Sum of Actuarial Services Cost, Managed Care Oversight Cost and Ad Hoc Cost):
$ 5,719,658.00

Notes:

1.) Total Project Cost will be used for purposes of bid evaluation.

2.) Contract services will be paid monthly in arrears.

3.) Payment for Ad Hoc Services will be based on an approved Statement of Work .

4.) All amounts bid shall include all general and administrative expenses, including travel, training and supplies necessary to provide the services required in this solicitation.

5.) Total Project Cost shall be calculated as Total Cost of Mandatory Services (Section A) + Total Cost of Ad Hoc Services (Section B)

6.) Hours in Ad Hoc section are for bid purposes only and are not to be considered an annual project cap.

The Lewin Group, Inc.
(Company)

Lisa Chimento, CEO
(Representative, Name, Title)

703.269.5500 / 703.269.5501
(Contact Phone/Fax Number)

October 30, 2017
(Date)

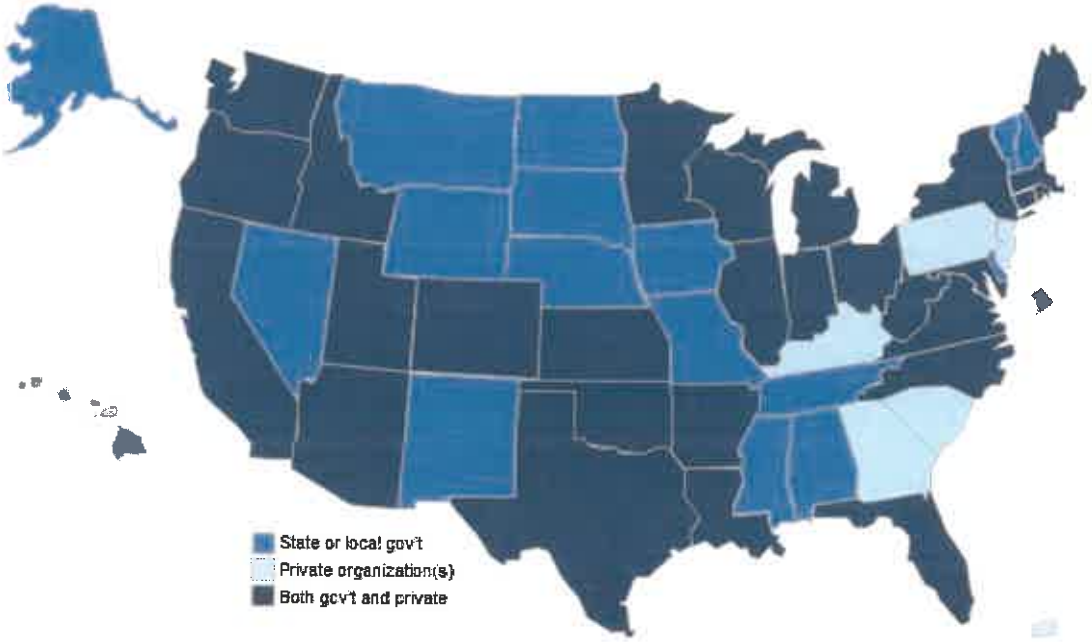
*Vendor Preference Certificate for 2.5% preference request submitted with this proposal.

3. Qualifications (RFQ 3)

Section 3 provides expanded detail to the minimum qualifications addressed in response Section 1 including project experience and staffing.

Lewin is a market leader in Medicaid managed care consulting and analytics. Together with our subcontractor Aon, the Lewin-Aon Team brings direct experience with Medicaid agencies in this realm going back more than two decades. The Lewin-Aon Team's senior staff has decades of professional experience as state Medicaid agency officials, federal managers, consultants, and health plan executives. Much of our professional focus is on assisting states in creating, implementing, enhancing, and broadening Medicaid Managed Care programs. As shown in Exhibit 3-1, Lewin has worked in all of the states through direct state and local government contracts, federal engagements, and with numerous private sector entities on a variety of Medicaid initiatives. Additionally, Aon, brings Medicaid managed care experience in more than 20 states.

Exhibit 3-1: Lewin's National Medicaid Experience



3.1. Medicaid Managed Care Program Administration and Oversight

Both Lewin and Aon bring Medicaid Managed Care program administration and oversight experience. Lewin has significant experience assisting states in the ongoing management of Medicaid Managed Care programs, including program administration and oversight. Over several decades, Lewin has supported Medicaid agencies across the country in ongoing program management, including program expansions and modifications. We have supported many state Medicaid Managed Care programs, including West Virginia, in identifying options for program changes, assisting in the selection and refinement of appropriate options, waiver support, developing implementation plans, and assisting in the realization of selected program design options. We have also consulted with numerous states on a variety of tasks related to program management and improvement, including providing day-to-day support for state

agency staff, providing ongoing and ad hoc technical assistance, serving as staff-extenders when necessary, and assisting in program monitoring and evaluation activities.

Beyond managed care administration, Lewin has a long history of collaborating with states to improve their Medicaid programs, including waiver administration. Lewin has worked with more than 15 states on waiver tasks. Most recently, Lewin has worked with Indiana, West Virginia and Colorado on efforts related to 1115, 1915(c) and 1915(b) waivers, long term services and supports, and cost containment. Lewin recognizes the pressures faced by state Medicaid agencies to provide people with accessible quality care within budget constraints. We have prepared program review and cost analyses for Missouri and New York. Additionally, we have worked with both state and federal government agencies through numerous regulatory changes and new program implementations, including most recently the Patient Protection and Affordable Care Act, in West Virginia and other states.

> Lewin is known for providing strategic guidance, sophisticated analytic and actuarial analysis, and program support for nearly half a century.

Similarly, Aon's Medicaid team members have been involved in the early review process of Medicaid Managed Care regulations and have a clear understanding of the new CMS managed care "Mega Rule" and how it strengthens actuarial soundness. We have already produced a number of white papers on various topics related to the new payment and managed care accountability provisions as well as the new mental health parity requirements for Medicaid Managed Care programs. In addition to producing white papers and qualitative research, we began timely implementation of the several complex provisions regarding pass-through payments, Medicaid Institutions for Mental Diseases (IMD) reimbursement policy and Medical Loss Ratio standards. Our actuarial and policy leadership is actively engaged with the Society of Actuaries Medicaid Subgroup as well as the American Academies of Actuaries Medicaid Subcommittee where several are members.

Our combined experience gives the Lewin-Aon Team a unique and broad insight into federal policies and how states can best respond to them. It also gives us access to promising practices pulled at both a federal level and from contacts with individual states. Exhibit 3-2 provides the Lewin-Aon Team's experience in assisting clients in Medicaid Managed Care program administration and oversight.

Exhibit 3-2: The Lewin-Aon Team's Experience with Medicaid Managed Care Program Administration and Oversight

Client, Duration	Project Title, Description
Lewin Representative Projects	
California HealthCare Foundation **3 years**	**California Purchasing Specification For Managing Care for Persons With Disabilities and Chronic Illnesses.** To inform the California Department of Health Services with the future planning, administration, and oversight of the Medi-Cal program (California's Medicaid Managed Care program), Lewin assisted the California HealthCare Foundation (CHCF) in developing purchasing specifications and performance measures for California to use as it expanded mandatory managed care for people with disabilities and chronic illnesses. This program administrative and oversight support included the following: • First, Lewin worked with a variety of California stakeholders to identify opportunities for improvement and assess whether those with diverse interests could support such improvements and find common ground. • Next, Lewin gathered data from other state programs, reviewed current Medi-Cal program specifications, and developed a set of revised performance standards and measures. Lewin, along with CHCF, then facilitated a series of workgroups of California stakeholders to discuss the proposed standards and measures, which

Client, Duration	Project Title, Description
	were used to develop a final set of recommendations to present to the California Department of Health Services (DHS). • Our work in California resulted in the creation of a set of recommended strategies for DHS for health plan contract compliance and oversight, including a readiness tool to assess the ability of health plans to serve a large influx of new enrollees with disabilities and chronic illnesses.
Delaware Department of Health and Social Services **4 years**	**Capitation Rate Setting and Procurement Support for the Delaware Medicaid Managed Care Program.** Lewin provided extensive administrative support to Delaware, supporting Delaware in its re-procurement of Medicaid MCO contracts: • Lewin assisted in developing the financial sections of the RFP (including provisions to leverage discounts if an entity were awarded contracts for both Medicaid and state employees at the same time), creating the scoring mechanism, training reviewers and facilitating the scoring at on-site meetings, and modeling the MCOs price bids to quantify the budget impacts of many program design and contractor selection permutations. • Lewin developed capitation rates for Delaware's acute care Managed Care program, Diamond State Health Plan (DSHP), studied many of the financial and design issues related to DSHP, and made strategic recommendations for the future structure of the program. Our work resulted in a successful competitive bid process for DSHP. Lewin supported this effort by creating data books both on the historical fee-for-service (FFS) experience alone and recent health plan encounter data blended with the FFS experience to distribute to prospective bidders.
Illinois Economic and Fiscal Commission **4 months**	**Medicaid Managed Care Options Assessment.** Lewin conducted a comprehensive assessment of Medicaid managed care expansion options for the State of Illinois, which focused on managed care purchasing and administrative models. Managed care models assessed included a range of disease management and case management initiatives, as well as capitated managed care models. Lewin's recommendations involved a managed care administrative program design which leveraged disease management in conjunction with primary care case management throughout all the rural regions of the State (where the capitated model was not deemed viable), and implementing a capitated program in other areas. Lewin also identified strategies to maximize federal matching funds through special financing arrangements in certain geographic areas. Lewin provided a detailed overview of each model's strengths and shortcomings, and prepared cost savings estimates for each model by geographic region eligibility group. Lewin's work resulted in a detailed report which our team presented to the State Legislature.
Indiana Family and Social Services Administration **3 years**	**Healthy Indiana Plan (HIP) 2.0 Evaluation** The purpose of this report was to evaluate the progress of the Healthy Indiana Plan (HIP) 2.0 made in the first year of a three-year waiver demonstration period that runs February 1, 2015 through January 31, 2018, as required by the Centers for Medicare & Medicaid Services (CMS). The HIP 2.0 waiver program affords health insurance coverage to most non-disabled Indiana adults ages 19 to 64 whose family income is at or below 138 percent of the federal poverty level (FPL) and who are not eligible for other Medicaid programs or Medicare. HIP 2.0 has several cost-sharing features more characteristic of commercial plans than of traditional Medicaid products, the goals of which are to incentivize members to seek preventive care and to be cost-conscious and health-conscious when seeking all types of health care.
Massachusetts Executive Office of Health and Human Services **2 years**	**Assistance with MassHealth Payment Reform Design.** Lewin is currently supporting the Commonwealth of Massachusetts in the implementation of its Medicaid (MassHealth) ACO payment programs, providing quarterly Pilot ACO performance reports. Previously, Lewin supported MassHealth by providing support during the design of its ACO program, including providing support to s six stakeholder

Client, Duration	Project Title, Description
	workgroups, each of which is focused on a different aspect of the future state payment model, as well as providing analytics and actuarial modeling.
Missouri Department of Social Services **1 year**	**Medicaid Review.** For the State of Missouri, Lewin conducted a comprehensive review of the Medicaid program with recommendations on how the State can achieve short-term Medicaid savings, conducted detailed assessments on achieving longer-term program savings, and evaluated options to improve the effectiveness and efficiency of the Medicaid program. Missouri was particularly interested in the effect of expanding their Medicaid Managed Care program and Lewin's analysis included several expansion approaches and the effects this would have on their savings. Lewin developed a series of reports as well as supporting materials, and Lewin's analyses were used by State policymakers to craft the state fiscal year 2011 budget as well as guide decisions about future Medicaid program design and operations. Specific areas of analysis included short-term cost containment opportunities, long-term care, pharmacy, care management, non-emergency medical transportation, and overall program financing and operations. Lewin's final report provided a series of recommendations regarding the structure and operation of the program, performance metrics to guide program management, and proposed approaches and priorities for enhancing the quality and efficiency of care to advance value-based purchasing and care coordination.
Nebraska Health and Human Services System Finance and Support **9 months**	**Waiver Application and Stakeholder Meetings.** Lewin worked with the State of Nebraska Health and Human Services System, legislators and the Governor to design and implement a plan to move adults out of State run psychiatric hospitals and into home and community-based supportive services. Tasks under this project included working with a large stakeholder group on a variety of options including use of the Medicaid Rehabilitation Option and/or a Home and Community-Based Waiver. Lewin also developed regulatory and administrative tools to provide Medicaid State Plan Personal Assistance Services to persons with severe mental illness and to offer intensive services to persons with severe mental illness who also met the State's nursing home level of care.
New York State Department of Health/AIDS Institute **15 years**	**Development of HIV Special Needs Plan (SNP).** For 15 years, Lewin assisted New York's Department of Health in developing, operating, and strengthening its Medicaid Managed Care program targeted exclusively for enrollees with HIV. Lewin has assisted in designing the program, including the financial and rate-setting aspects; writing segments of the RFA; developing criteria and a scoring methodology for evaluation and selection of SNP contracts; and directly assisting in the procurement process. Lewin also prepared a suggested monitoring approach to help assure that the SNP initiative is closely overseen during its initial implementation and beyond and is assisting in those efforts, and has evaluated the solvency of the SNPs, conducting a detailed assessment of the smallest entity during early 2006. Lewin assisted in the design and implementation of SNPs to serve Medicaid-eligible individuals with HIV/AIDS.
New York State Department of Health **11 years**	Lewin has had a successful and fruitful relationship with the New York State Department of Health. We are proud to have partnered with the department several times and Lewin is confident that their trust in us has improved the quality and delivery of health care for residents of New York. **NYS 1115 Waiver Evaluation.** Lewin collected and analyzed information on Medicaid primary care case management (PCCM) programs, including associated disease management (DM) and care management components, for New York's consideration in exploring a future PCCM program as an alternative to full-risk managed care in rural areas. State and Lewin staff identified five states (Illinois, Maine, Massachusetts, North Carolina, and Pennsylvania) with PCCM programs. We researched and reviewed state-specific information and conducted interviews to understand current PCCM and MCO programs; implementation strategies, including associated DM programs; PCCM program design strategies, including program administration and characteristics; comparisons of PCCM and MCO program outcomes; and lessons learned. Based on this information, Lewin prepared a memo to summarize key

Client, Duration	Project Title, Description
	components of the five state programs, particularly around common PCCM program design strategies, with a focus on program outcomes, including DM and pay-for-performance strategies, innovative features, and lessons learned regarding PCCM programs. **New York State Medicaid Managed Care Program Implementation.** Lewin assisted New York in implementing its statewide mandatory Medicaid Managed Care program, with several program administration and oversight tasks. Lewin assisted the Department of Health in designing program modifications to support the enrollment of the SSI population, including the development of quality assurance standards for MCOs, and a program oversight and monitoring plan for the State. Lewin facilitated a statewide task force to consider various design issues, including those related to quality assurance and performance improvement, and investigated the experiences of other states that have enrolled SSI adults and children. Lewin reviewed financial incentive systems used by several state Medicaid Managed Care programs and developed a white paper summarizing potential approaches for New York's mandatory Medicaid Managed Care program. Lewin also assisted with monitoring the Medicaid Managed Care programs, including conducting English and foreign language beneficiary focus groups to identify successful mechanisms for outreach and enrollment, and surveying enrollees on their experiences with managed care. Lewin worked with the State to develop and administer a survey of auto-assigned enrollees, using Consumer Assessment of Healthcare Providers and Systems (CAHPS) as a model, and conducted a survey of enrollees regarding access to dental services.
Vermont Department of Vermont Health Access **1.5 years**	**Quality Performance Measures and Performance Improvement Projects.** Lewin's engagement with the Department of Vermont Health Access (DVHA), the agency responsible for the management of Medicaid within Vermont's Agency of Human Services (AHS), was to provide assessments, technical assistance and training related to quality/performance improvement in the Medicaid Managed Care program as part of their Medicaid Adult Quality Measures grant. Lewin provided technical assistance to support grant performance improvement activities which furthered the state's legacy of pioneering flexible and patient centered care delivery systems, strengthening and supporting primary care, and developing a robust health information system designed to gather, analyze, and distribute data to improve care. Lewin performed: • Validation of Quality Measures: Collection, Calculation and Reporting – CMS Medicaid Managed Care External Quality Review (EQR) Protocols Utilized to Assess Validity and Reliability – Onsite Assessment of Integrity of Information Systems – Detailed Review of Select Measures • Medical Record Review • Claims Review – Observance of Key Processes – Interviews with Staff and Vendors – Policy, Procedure and Methodology Review • Validation of Performance Improvement Projects: Implementation and Findings – CMS Medicaid Managed Care External Quality Review (EQR) Protocols Utilized to Assess Validity and Reliability – Review Study Questions, Population and Selected Indicators – Review Data Collection Procedures and Sampling Methodologies – Assess Improvement Strategies – Review Data Analysis and Interpretation of Results – Assess Likelihood of Sustainability of Improvements • Data Management Assessment:

Client, Duration	Project Title, Description
	– Onsite Review of Data Management Processes – Assess Documentation of Data Processes vs. Observed Demonstration – Evaluate Quality of Data and Fidelity of Processes • Operational Transformation: Building Staff Capacity – Training Series to Develop State Expertise to Analyze and Utilize Data for Establishing and Maintaining Sustainable, Ongoing Quality Improvement – Combination of Training Approaches and Technical Assistance Employed to Boost Skills, Increase Knowledge, Improve Processes and Develop Tools and Job-Aids
West Virginia Bureau for Medical Service **22 years**	**West Virginia Medicaid Managed Care Administration.** Since 1995, Lewin has assisted the State of West Virginia's Bureau for Medical Services with administration of its Managed Care program, MHT. Lewin assists the State with all aspects of design, operation, expansion, monitoring, and evaluation related to this program. Since the project's inception, Lewin has provided overall program support to BMS for Medical Services. Key activities in this work area include preparing the initial and renewal 1915(b) waiver application, securing waiver amendments and state plan authority for various program changes, drafting MCO contracts, providing guidance to BMS on compliance with federal and state policies and regulations, and participating in ongoing MCO activities. Lewin has worked with West Virginia to develop an overarching strategy for improving the quality of care delivered to Medicaid managed care enrollees. To this end, we helped the state select a focused set of performance measures and improvement goals that reflect the State's priorities while promoting alignment with national quality initiatives. We also implemented a structure for measuring, monitoring, and improving care so that the state can successfully reach its stated goals. Recent and current tasks with the state include: • Conducting MCO readiness reviews, including both desk reviews and on site reviews, evaluating the MCO's readiness to expand to new service areas, and reviewing policies, procedures, and enrollee materials • Monitoring of MCO performance and compliance, including development and review of routine reporting • Supporting MCO quality assessment and performance improvement program including providing a review of BMS' external quality review organization (EQRO) annual audits • Assisting BMS in establishing its performance incentive program that encourages MCOs to implement quality improvement activities to increase rates of well-child visits, immunizations, and postpartum care. In SFY 2016, Lewin assisted BMS in designing a performance-based withhold that requires MCOs to earn back money (5%) withheld from their capitation payments.
Aon Representative Projects	
Georgia Department of Community Health **10+ years**	For the Georgia Department of Community Health, Medicaid/CHIP, Aon provides both, managed care administration and oversight activities as well as actuarial services. • Oversight of accuracy and appropriateness of financial reporting by the MCOs • Fiscal modeling of different scenarios for how the state budget would be impacted by potential legislative changes to federal Medicaid funding • Regulatory and contract compliance review in accordance with the "Mega Rule" and MHPA guidance • Implementation of MLR and encounter data standards • Capitation rates for TANF, CHIP, Foster care children, family planning, NEMT • Risk adjustment design and implementation

Client, Duration	Project Title, Description
	• IBNR actuarial services conducting annual valuation of all Medicaid programs
Kentucky Department for Medicaid Services **3 years**	For the Kentucky Department of Medicaid Services, Aon provides both, managed care administration and oversight activities as well as actuarial services. • Operational and fiscal strategies for Managed Care program expansions to include additional populations and services • Analysis for 1115 waiver development and budget neutrality • Regulatory and contract compliance review in accordance with the "Mega Rule" and MHPA guidance • TANF, CHIP, ABD, ACA Expansion adults, Former foster care children, NEMT, Medicare-Medicaid dual eligibles, Mental and Behavioral Health Services • Risk adjustment of all populations, including implementation of risk adjustment for ACA expansion population • Implementation of the pass-through payments phase-out, Medicaid IMD reimbursement policy, MLR and encounter data standards

3.2. Actuarial Services

The Lewin-Aon Team has significant experience with Medicaid managed care rate setting and actuarial analyses using a number of pricing and payment models. Supplemented with guidance and perspective from Lewin's lead actuaries, who have many years of Medicaid and West Virginia-specific experience, Aon will deliver the actuarial support required under this contract. Aon brings lead project staff with West Virginia rate setting experience and an actuarial team with managed care actuarial experience in over 20 states.

Lewin's actuarial experience includes helping design, implement, operate, and evaluate capitated Medicaid and CHIP programs in many states, most recently-developing managed care capitation rates for Colorado, New York, and West Virginia. We have also worked with Alaska, California, Massachusetts, Missouri, New Hampshire, and Rhode Island on cost projections for their Medicaid programs as a result of the ACA or potential policy changes that could reduce expenditures for the states. Lewin has also worked with Vermont with a focus on calculating, measuring, and monitoring the implementation and impact of the Accountable Care Organizations (ACOs) and the Shared Savings Program (SSP). Through each of these engagements, capitation rates, cost projections, potential savings, and financial impact of programs changes were developed using claims data (Medicaid/CHIP FFS, MCO encounter data, commercial claims) supplemented with financial information. Our actuarial expertise includes development, evaluation of capitation rates and comparing costs across different programs or scenarios.

We have developed rate setting methodologies that incorporate individual or aggregate reinsurance, risk sharing and risk corridor arrangements, and incentive payment structures. In addition to rate setting and actuarial services, we have also worked with these states on waiver and contract development, quality monitoring and assurance activities, and claim analytics. Our actuarial team is supported by a strong analytics team that uses tools such as Symmetry and Tableau to group claims not just for risk adjustment of payments but also to visualize and present analytic results to better identify health care trends, super-utilizers and those with multiple chronic conditions. Using cutting edge data visualization techniques, we presents these insights in order to better assist states in monitoring and taking timely action to address the high risk areas of their health care system.

The Lewin-Aon Team understands that part of the primary responsibilities under this proposal issued by West Virginia is to develop capitation rates in compliance with current regulatory and waiver requirements for the Managed Care program. Aon brings a unique combination of experience not only in consulting but in operation of MCOs; their team members are intimately familiar with Medicaid programs, their financing, and operations from the MCO perspective.

In 2015, CMS greatly expanded their certification review process, and Aon was at the forefront of those reviews with their clients. This provides Aon with an early and full understanding of the new mode of questions CMS asks and expects in certifications.

Over the past decade and beyond, Aon team members have submitted over 50 actuarial certifications to CMS for review and approval for a variety of programs for numerous states. In the last ten years, Aon has developed and certified capitation rates for similar Medicaid populations in an established approach for four States (Georgia, Tennessee, Kentucky, and Kansas). All of these rates have been approved by CMS and successfully implemented in the operation of each of the four unique Medicaid Managed Care programs. Furthermore, Aon's actuaries have also developed capitation rates for Medicaid and CHIP programs in Colorado, Massachusetts, Ohio, and West Virginia.

The Lewin-Aon Team offers BMS a team of professionals well versed in the intricacies of Managed Care programs and the difficulties such programs may face during times of regulatory change or program implementations.

Aon team members, including our two lead actuaries, Russ Ackerman and Colby Schaeffer, are active members of the American Academy of Actuaries Medicaid Committee and the Society of Actuaries Medicaid Subgroup. These committees are regularly called upon by regulatory bodies for thought leadership on current Medicaid topics. Beyond that, Mr. Ackerman is a member of Aon's actuarial leadership body that is called upon by U.S. government legislative bodies for guidance. For example, at the beginning of March 2017, Mr. Ackerman and the Aon leadership were asked by both the House and Senate Ways and Means Committees to weigh in with an analysis of Congress' proposed bill "The American Health Care Act" prior to its official release to the public, in an unbiased, nonpartisan way.

Our team's knowledge of MCO provider contracting, and financial and risk management opportunities, position the Lewin-Aon Team to provide insight to West Virginia on managing work in the current shifting environment while achieving the overarching state funding targets, especially at this time when MCO MLRs are a primary concern to West Virginia. Exhibit 3-3 details the Lewin-Aon Team's experience (Aon and Lewin, respectively) providing actuarial services for Medicaid agencies.

Exhibit 3-3: The Lewin-Aon Team's Experience with Actuarial Services

Client, Duration	Project Title, Description
Aon Representative Actuarial Experience	
Georgia Department of Community Health **10 years**	**Medicaid/CHIP Actuarial Services.** Aon develops actuarially sound rate ranges for Georgia, including the development of a data book and CMS certification documentation. • This has recently included separate capitation rates developed for the Medicaid NEMT program. • Aon also works with the State on conducting an annual analysis of Incurred but not Reported (IBNR) payments for the Medicaid fee-for-service program, which allows the state to better budget future Medicaid expenses for past periods.

Client, Duration	Project Title, Description
	• Aon also assisted the State with MCO PBM procurements (including medical review compliance), Medicaid FFS IBNR annual studies, developed white paper studies on issues relevant to the recent CMS Mega Rule, and value-based purchasing support.
Kansas Department of Health and Environment **3 years**	**Medicaid Actuarial Services.** Aon provided actuarial services for the Kansas Medicaid agency, including risk adjustment design and implementation, and DRG weight and rate development. Aon provided support for the Medicaid expansion enrollment and budget analysis, including ad hoc support during the uncertain time of the ACA roll-out. Aon also developed capitation rates for comprehensive Medicaid covered services and all Medicaid/CHIP populations including TANF, CHIP, Foster Care, ABD Non-Dual, Medicare- Medicaid dual eligible, Medically Needy/Spend Down, 1915c HCBS waivers, and other LTSS populations.
Kentucky Department for Medicaid Services **3 years**	**Actuarial Services.** Aon developed actuarially sound rate ranges, including the development of databook and CMS certification documentation. This included all aspects of the Commonwealth's ACA Medicaid expansion actuarial support. Aon completed re-rating efforts to correct the work of a competing actuarial consulting firm. Aon also assisted Kentucky with their Health Home pricing for behavioral health and substance use disorder, and SIM actuarial projections. Aon has been developing actuarially sound rates for Kentucky over the course of multiple fiscal years and continues to be engaged with the Commonwealth on monitoring of the rates. This also included correcting rates that were developed by a prior actuarial firm. Between rate corrections, amendments, and recently developed rates, Aon's actuaries have successfully developed capitation rates for five years (CY14 through SFY18) of the program. Aon have also worked together with the State through the new administration's transition to support the accomplishment of additional 1115 waiver objectives.
North Carolina Office of State Auditor **3 years**	**Medicaid IBNR Audit.** Aon provided IBNR actuarial services to the North Carolina Office of State Auditor, which included the auditing of all the North Carolina Medicaid-related projects. The audit included the development of Incurred But Not Reported (IBNR) models to measure liability for the medical and prescription drug Medicaid plans sponsored by the State of North Carolina. The results of the IBNR analyses conducted by Aon were presented in an annual report on the IBNR reserve. The IBNR reserve is the amount set aside to provide for claims incurred prior to each estimate date that are expected to be paid after this date but within the next fiscal year. The final report included actuarial certification of the analyses provided by Aon.
Tennessee Health Care Finance and Administration (HCFA) **13 years**	**TennCare, Medicaid Actuarial Services.** Aon has performed all work related to MCO managed care rates for TennCare. This involves the creation of a databook, certifications, reviews with CMS, and all the necessary documentation. Aon has provided actuarial services for rate setting currently provided by three MCOs along with reconciliations for PCP enhancement and HIF reimbursement, annual Medicaid budget and Comptroller reports, visual analytics with in-depth claims and membership movement analysis, dashboard development, and policy/program design support. Development of actuarially sound risk-adjusted capitation rates for Tennessee MCOs as specified in 42 CFR §438.6(c) has included TANF, disabled, dual-eligible, and LTSS populations. Tennessee has also required input on reforming hospital reimbursement, detailed analysis of state budget needs for Medicaid, development of an annual comptroller report, evaluation of programs, and ad hoc actuarial and policy support. In addition to Aon developing, implementing and monitoring the risk payment methodology for the MCOs, Aon has worked on numerous other projects, and continues working on those that are detailed in our contract.

Client, Duration	Project Title, Description
Lewin Representative Actuarial Experience	
Alabama Department of Health **1 year**	**Expanding Insurance Coverage in Alabama.** For the Alabama Children's Health Insurance Program, Lewin designed eight options for expanding insurance coverage in the state including Medicaid eligibility expansion for parents, employer based initiatives such as the "Healthy New York" model, and a Medicaid Buy-in program. This project included actuarial analysis of program benefits costs and simulation of enrollment and stakeholder impacts using the Health Benefits Simulation Model. Lewin also performed an analysis of tax credits for small employers of low-wage workers.
California Department of Health Care Services (Ingenix Consulting) **4 months**	**Medi-Cal Rate Study.** Lewin was commissioned by the California Department of Health Care Services, Medi-Cal Benefits, Waiver Analysis and Rates Division (BWARD) to compare Medi-Cal outpatient provider fee-schedule payment amounts with Medicare fee-schedule payments amounts for 2009 and to estimate the impact of setting minimum and maximum Medi-Cal fees based on a percentage of the comparable Medicare fees. Our analysis estimated the additional Medi-Cal FFS payments that would be required to increase payment rates for each procedure to a minimum level of equivalent Medicare payment (80% and 100%) for selected provider types. Scenarios were also developed that estimate the potential savings from reducing Medi-Cal FFS payment rates for higher priced procedures to a maximum level of equivalent Medicare payment (80% and 100%) for selected provider types.
Colorado Department of Health Care Policy and Financing **2 years**	**Actuarial Services.** Lewin assisted Colorado with their rate setting for Medicaid programs enrolled in managed care. Working with the Department of Healthcare Policy and Finance, Lewin conducted the following activities: reviewing programming logic for data collection and summarization, calculating and establishing trend rates, reviewing calculation of risk adjustment which was used for trend calculation and rate adjustment (for HMOs only), modeling the rate setting process in compliance with CMS rate setting guidelines, discussing assumptions and results with participating HMOs and establishing capitation rates and actuarial certification for the program. Lewin set rates for four programs, HMOs, Behavioral Health, CHP+, and PACE.
Colorado Department of Health Care Policy and Financing **1 year**	**Actuarial Services for HMO Rates.** Lewin assisted Colorado with its rate setting for Medicaid Managed Care programs. In conjunction with the Department of Health Care Policy and Financing, Lewin has conducted the following activities: reviewed programming logic for data collection and summarization, calculated and established trend rates, reviewed calculation of risk adjustment which was used for trend calculation and rate adjustment, modeled the rate setting process in compliance with CMS rate setting guidelines, discussed assumptions and results with participating HMOs and established capitation rates and actuarial certification for the program. Lewin initially conducted this rate setting exercise for rates in the Denver region and later assisted the State with an expansion of the program into nearby Weld County.
Delaware Department of Health and Social Services **4 years**	**Capitation Rate Setting for the Delaware Medicaid Managed Care Program.** Lewin developed capitation rates for Delaware's acute care Managed Care program, Diamond State Health Plan (DSHP), studied many of the financial and design issues related to DSHP, and made strategic recommendations for the future structure of the program. To assist the state with the a competitive bid process for DSHP, Lewin created data books both on the historical fee-for-service (FFS) experience alone and recent health plan encounter data blended with the FFS experience to distribute to prospective bidders. Lewin also provided assistance in evaluating the cost proposals of the bidding health plans.
Indiana Family and Social Services Administration **1.5 years**	**Actuarial and Economic Analyses.** Lewin worked closely with State staff and consultants to design several options for expanding insurance coverage through a combination of public and private initiatives. We estimated the cost of expanding Medicaid and CHIP eligibility under a wide range of design alternatives including: alternative income eligibility levels, use of a health insurance purchasing program (HIPP) for low-income workers with access to employer coverage, coverage for

Client, Duration	Project Title, Description
	parents and childless adults and the use of waiting periods to deter people from discontinuing private coverage to enroll in the state program (i.e., "crowd-out"). We also evaluated a wide range of benefits packages including variations on patient cost-sharing (i.e., deductibles and co-payments). Lewin estimated the actuarial cost for all basic and additional services to be offered under the proposed expansion plan. We then verified compliance with the actuarial requirements of Title XXI of the Social Security Act and drafted an Actuarial Opinion Memorandum, which included an explanation of the methodologies and factors used in determining the actuarial values of the proposed benefits.
Minnesota Department of Human Services **2 years**	**Minnesota Health Care Risk Adjustment.** Lewin worked with the Minnesota Department of Human Services (DHS) to evaluate risk adjustment models that are used to adjust quality measure adherence rates and develop an innovative, agency-specific approach for DHS. This project goal was to assess the extent to which differences in health status and social determinants among Medicaid members enrolled in MCOs explain variations in quality outcomes. This project was innovative in quality measurement and adjustment because Lewin included a set of demographic and social determinants of health variables along with the enrollee health status in the testing process. The subsequent analysis demonstrated the influence of an array of clinical and sociodemographic characteristics on adherence rates to quality measures. This discovery enabled Minnesota DHS to make more meaningful comparisons of quality performance among MCOs.
Health Strategies of New Hampshire (for the Department of Health and Human Services) **10 months**	**New Hampshire Medicaid Expansion.** The New Hampshire Department of Health and Human Services contracted with Lewin to understand the potential financial impacts of expanding its Medicaid program. The first phase modeled a total of 11 policy options to estimate the costs and benefits of each. The second phase analyzed secondary effects of expansion on other state health programs, health care providers, commercial premiums, and the overall state economy. The third phase included four analyses to help the state explore various benefit design options.
New York State Department of Health/AIDS Institute **15 years**	**Development of HIV Special Needs Plan (SNP).** Lewin assisted New York in the design and implementation of SNPs to serve Medicaid-eligible individuals with HIV/AIDS. As is often the case, this work involved much overlap between program administration and actuarial analysis. Lewin established the initial capitation rates for the program, designed many features of the program's shared risk financial model, wrote segments of the request for applications, developed criteria and a scoring methodology for evaluation and selection of SNP contracts, directly assisted in the procurement process, assisted in the development of the health plan readiness review process, participated in on-site readiness reviews, assisted in the development of the HIV SNP model contract, and prepared a suggested monitoring approach to help assure oversight during initial implementation. Lewin has also established capitation rates annually for the program, including individual stop loss options and aggregate risk corridors, and assessed the medical cost experience of SNP enrollees longitudinally versus pre-enrollment (while in the state's fee-for-service system).
Vermont Green Mountain Care Board **3 years**	**SIM Statewide Analytics.** Lewin is providing statewide analytics related to the implementation, monitoring, reporting, and modification of the Vermont Health Care Innovation Project ACO Commercial and Medicaid SSP program (also known as the Vermont State SIM project). The innovative payment model that we delivered uses financial incentives to drive quality and performance for the state's five ACOs (three commercial and two Medicaid). Lewin is also conducting statewide analytics using Medicaid, Medicare, and commercial claims data to assess quality and financial performance in order to inform ongoing decisions on the design and implementation of the state's ACO SSP program. To carry out this project Lewin is contracting with the Green Mountain Care Board (GMCB). In addition to working with the GMCB, Lewin worked with many other organizations and agencies including the Medicaid program, private insurers, and all of the ACOs.

Client, Duration	Project Title, Description
West Virginia Bureau for Medical Services **22 years**	**West Virginia Medicaid Managed Care Administration.** Lewin is the actuarial contractor for West Virginia's MHT Medicaid Managed Care program. Each state fiscal year, our actuarial team develops capitation rates and maternity delivery payments paid to MCOs for the four populations covered in MHT. To do this, Lewin collects the most recent detailed encounter data from the MCOs, summarizes it, adjusts it based on fee schedule and other program changes, applies trend to project it to the future rate period, and adds an administrative load. In addition, Lewin uses FFS claim data to develop portions of the rates for services and populations transitioning from FFS to managed care. Lewin documents the final rates and the process used to develop them and presents to the State and MCOs. Once finalized, Lewin then certifies the rates as actuarially sound and submits to CMS for approval. Additionally, our team successfully worked with the state on developing a UPL solution that was the first nationally to be approved by CMS. Lewin's actuarial work has expanded over the life of the engagement with West Virginia, and we have come to play an increasingly instrumental role. As the State is well-aware, the actuarial process has grown increasingly complex in recent years and Lewin has been a partner with West Virginia every step of the way. Lewin helped the State of West Virginia meet various new challenges with its actuarial rate setting process that came about as a result of the ACA and other legislation and regulations. Specific actuarial work streams on this project include: • Actuarial analytics to assist the State with adjusting capitation rates to accommodate the integration of dental health services into managed care • Actuarial analytics to assist the State with adjusting capitation rates to accommodate the integration of dental health services into managed care • Implementing Risk Corridors for MCOs • Analytic support for the program's performance withhold program • Developing capitation rates for expansion populations, including ACA expansion and SSI eligibility groups • Actuarial analysis to support new MCO entrants • Actuarial analysis around hospital Direct Payment Program • Developing individualized budgets for populations with developmental disabilities. • Provided analysis to assist the State with reconciliation of health insurer fees (assessed as part of the ACA) with capitation rates • Performed actuarial analysis to support Medicaid PCP fee increase to 100% of Medicare rates, as required under the ACA • Performed various ad hoc analysis including pharmacy utilization, cost drivers, and cost savings estimates

3.3. References

3.3.1. Managed Care Program Oversight (RFQ 3.7)

Please refer to section 1.4.1 for the Lewin-Aon Team's References.

3.3.2. Actuarial Services (RFQ 3.10)

Please refer to section 1.4.2 for the Lewin-Aon Team's References.

3.4. The Lewin-Aon Team's Staffing Approach and Resumes

The Lewin-Aon Team consists of Lewin and our subcontractor Aon PLC, a leading global professional services firm who will provide actuarial support. The Lewin-Aon Team is well prepared to continue to support the Bureau of Medical Services (BMS) in the administration of West Virginia's Medicaid Managed Care program (MHT); sustaining the program's progress and supporting BMS' goals for continued innovation and improvement.

As highlighted in Exhibit 3-4, the Lewin-Aon Team includes the key personnel requested in the RFQ as well as the consulting and research staff who bring the specified educational and experience. Supplementing these core Lewin-Aon Team members are subject matter experts who bring a wide range of Medicaid managed care administrative oversight and actuarial experience. The Lewin-Aon Team has been designed to offer BMS a team that combines West Virginia managed care institutional knowledge, a deep actuarial and analytics bench, fresh perspective, industry insight and thought leadership. The Lewin-Aon Team brings the stability and value offered by a vendor with longstanding knowledge of the program coupled with new team members who bring a range of subject matter expertise and experience to continue to support BMS' efforts to effectively organize, finance, and deliver quality health care services to Medicaid enrollees through its comprehensive capitated risk contracts with MCOs.

The Lewin-Aon Team includes current staff assisting BMS:

- Linda Shields, RN, BNS
- Chris Bach, ASA, MAAA, FCA
- Michelle Rork, MPP, MPA
- Jean Kranz, MS, MBA (onsite)

3.4.1. Project Staffing

Exhibit 3-4 provides an overview of our Key Personnel, as required by the RFQ, responsible for overall delivery of all contract deliverables and day-to-day project support.

Exhibit 3-4: Key Project Staff

Position	Staff	Key Qualifications
Project Management Lead	**Ryan Benson, MA, PMP**	• Certified Project Manager Professional • Led implementation of Maryland's expanded Medicaid Family Planning Program during his tenure with the Maryland Department of Health and Mental Hygiene • Eight years of project management and leadership experience with large, complex Medicaid projects, exceeding the minimum qualification • For West Virginia, supported efforts related to Medicaid managed care improvement plan, site visits to participating MCOs, and analyzed dental network adequacy • Managed several large, complex Medicaid projects, including operations support and policy development for the Vermont and Rhode Island Health Benefit Exchanges and a strategic policy analysis for South Dakota Medicaid

Position	Staff	Key Qualifications
Lead Actuary	**Russ Ackerman, ASA, MAAA, FCA**	• More than 25 years of consulting and MCO pricing/rate setting experience, including more than 12 years working with numerous state Medicaid programs, exceeding RFQ qualification requirements • Prior experience leading the development of a study for West Virginia including pharmacy analysis to compare states who have carve-in versus carve-out programs • Client leader, project director, and/or certifying lead actuary for multiple states, including Georgia, Idaho, Kansas, Kentucky, Massachusetts, Ohio, and Tennessee, having provided subject matter expertise to other states • Prior experience includes chief actuary of a large health plan that was the largest Medicaid carrier in the state of Minnesota
Lead Actuary	**Colby Schaeffer, ASA, MAAA**	• More than 10 years of consulting and MCO pricing/rate setting experience, including more than 6 years working with numerous state Medicaid programs, exceeding RFQ qualification requirements • Client leader, project manager, and/or certifying lead actuary for multiple states, including Georgia, New Hampshire, Tennessee, Vermont, and West Virginia having provided subject matter expertise to other states • Direct experience in all facets of rate setting for West Virginia Medicaid from 2012 to 2015 including involvement in certifying rates that were submitted timely to BMS and accepted by CMS and the participating MCOs during a period that covered rapid expansion of the Mountain Health Trust program (carve-in of pharmacy, dental, and behavioral health services and inclusion of Medicaid Expansion population) • Prior experience includes all actuarial activities for what was the largest Medicaid health plan (Missouri) at Coventry (now part of Aetna) in addition to supplemental Medicare plan valuation.
On-Site Program Management/ Policy Analyst	**Jean Kranz, MS, MBA**	• Current West Virginia on-site Program Management/Policy Analyst • NCQA Patient Centered Medical Home Content Expert Certification • More than six years of experience working with Medicaid Managed Care delivery systems, exceeding the minimum qualification • Coordinated quality improvement efforts for providers serving Medicaid and CHIP children through managed care delivery systems in Oregon and Alaska, to include eight MCOs • Liaison between the Bureau for Medical Services' and the managed care organizations to build and delegate work plans, and communicating progress to the client executives • Supported WV BMS with contracting, rate setting, directed payment program, network adequacy, monitoring and evaluation for the program as well as preparing federal waiver materials for CMS

Position	Staff	Key Qualifications
Program Integrity Analyst	**Yelena Barzilla, B.L., M.L., CHC**	• Certified Health Compliance Officer • Ten years of regulatory compliance and program integrity experience, exceeding the minimum qualification. Researched and implemented various federal and state laws and regulations related to health care fraud and abuse issues and Medicaid reimbursement issues • For West Virginia, developed key contractual provisions, advised on the enforcement, conducted compliance reviews • For the Office of Inspector General, developed policies, procedures, and compliance strategies to ensure appropriate monitoring, auditing and evaluation of Medicaid program integrity resulting in higher recoveries • For multiple state agencies, managed CMS Medicaid Integrity Group Comprehensive Program Integrity Reviews, responded to findings, and developed corrective actions • For CMS, Centers for Medicaid, CHIP, and Survey and Certification (CMCS): Development of Infrastructure for Oversight of Medicaid Managed Care Delivery Systems, served as a lead policy expert and a drafter for the CMS MCO compliance tool

In addition to the Key Personnel, the RFQ specifies a team of Consulting and Research staff with a Bachelor's Degree and two years of Medicaid experience. As highlighted in Exhibit 3-5, our proposed team members bring a range of Medicaid experience, from policy and waiver expertise to operations and analytics support and meet or exceed the minimum qualifications. The Lewin-Aon Team can also draw from their deep bench of personnel to support BMS across subject matter areas.

Exhibit 3-5: Consulting and Research Staff as Specified in RFQ

Position	Staff	Key Qualifications
Senior Consultant	**Leslie Weems, MSW**	• More than nine years of Medicaid experience, exceeding the minimum requirement • Medicaid Reform Specialist for the Colorado Department of Health Care Policy and Financing, supported a wide range of reform projects, including redesign of statewide Community Behavioral Health Program managed care contracts, Accountable Care Collaborative Payment Reform Initiative and implementation of 1115 Demonstration Waiver • Health Policy Analyst with the Texas Department of State Health Services supported health care delivery redesign efforts • Senior Policy Analyst/Project Manager with Texas Health and Human Services Commission • Program Specialist, Texas Health and Human Services Commission for the Texas Medicaid and CHIP programs
Junior Consultant	**Neil McCray, MPP**	• More than two years Medicaid experience • West Virginia managed care data modeling consultant • Experienced with Medicaid data analysis, including providing operations support and data analysis for the Maryland Health Benefits Exchange, eligibility and enrollment data analytics, and reporting to CMS and Maryland's Department of Health and Mental Services

Position	Staff	Key Qualifications
Junior Consultant	**Julia Truelove, RN, MSN**	• More than two years Medicaid experience • On the CMS Financial Alignment Initiative, completed desk reviews of provider data to ensure network adequacy • For the District of Columbia, worked on implementation of program redesign
Research Analyst	**Heather Feng, BA**	• More than two years Medicaid experience • Experienced in program evaluation activities • To support the State of Maine's SIM evaluation, conducts data collection and analysis and creates visual representation for evaluation reports
Research Analyst	**Chandler Gray, BA**	• More than two years Medicaid experience • Supports evaluation of CMS demonstration grants, conducting state-level qualitative research • For a large CMS project, maintains website for quarterly data submission, including updating data collection tool, exporting the data for analysis, and preparing the data for submission to CMS.
Research Analyst	**Samuel Kallman, BA, BS**	• More than two years Medicaid experience • Works with Medicaid and CHIP claims in numerous states, including West Virginia, Indiana, and others through the Payment Error Rate Measurement (PERM) project to stratify PMPMs and quality outcomes by eligibility groups, including waivers, the Medicaid expansion population, and managed care vs fee-for-service

In addition to the core team members requested, the RFQ requires an adequate number of staff actuaries to support the Lead Actuary. The Lewin-Aon Team offers the actuarial team as shown in Exhibit 3-6. Additional senior-level actuaries are included among the subject matter experts (SMEs) presented in Exhibit 3-7.

Exhibit 3-6: Actuarial Team Members

West Virginia Priority Area	Staff	Key Qualifications
Staff Actuary, Primary Modeler for Rate Development	**Nicholas Gersch, ASA, MAAA**	• More than three years of Medicaid consulting experience, exceeding RFQ qualification requirements • Analyst and led actuarial modeling for multiple states, including Georgia, Kansas, Kentucky, and Tennessee in addition to several employers
Staff Actuary, Oversees data needs for actuarial projects	**Jeff Yang, ASA, MAAA**	• More than five years of consulting and MCO experience working with numerous state Medicaid programs, exceeding RFQ qualification requirements

West Virginia Priority Area	Staff	Key Qualifications
Staff Actuary, Peer Review	**Don Wakefield, ASA, MAAA**	• More than 20 years of experience, including 3 years working directly with state Medicaid programs, exceeding RFQ qualification requirements • Client leader, project manager, and/or certifying lead actuary for multiple states, including Georgia and Kentucky having provided subject matter expertise to other states • Prior experience included working with health plans and administrators in Massachusetts and Utah
Staff Actuary, Peer Review	**Sterling Felsted, ASA, MAAA**	• More than seven years of consulting and MCO experience working with numerous state Medicaid programs, exceeding RFQ qualification requirements • Client leader, project manager, and/or certifying lead actuary for Tennessee and having provided subject matter expertise to other states (Kentucky, Georgia)
Staff Actuary, Peer Review	**Betsy Hanson, FSA, MAAA**	• More than five years of Medicaid consulting experience, exceeding RFQ qualification requirements • Led actuarial consulting for multiple states, including Iowa, Massachusetts, and New York in addition to several employers

In addition to the previously described staff, the Lewin-Aon Team include SMEs who bring highly relevant state experience and knowledge of the policy, regulatory, contractual, legal, and financial levers available to states to shape and monitor their Medicaid Managed Care programs. Supporting the team previously described, the Lewin-Aon Team has a broad and deep bench of experts in Medicaid, managed care, and program oversight and managed care rate setting.

Exhibit 3-7: Additional Subject Matter Experts and Actuarial Team Members

West Virginia Priority Area	Staff	Key Qualifications
Managed Care Expertise	**Linda Shields, RN, BSN**	• Current Lewin West Virginia Project Director • More than 20 years of Medicaid Managed care experience • Direct experience in Health Plan operations and compliance • Expertise in performance measurement and improvement • External Quality Review Organization experience • Supported the Financial Alignment program, overseeing MCO readiness in several states implementing managed care for Medicare and Medicaid Enrollees
Medicaid Managed Care Payment Methodology	**Chris Bach, ASA, MAAA, FCA**	• More than 20 years of managed care rate setting experience, including 3 years with West Virginia • Credentialed actuary with experience and expertise in alternative payment models for Medicaid programs • Experience in developing and modeling risk sharing arrangements

West Virginia Priority Area	Staff	Key Qualifications
Program Administration, Management, and Oversight	**Patrick Finnerty, MPA**	• Served as Virginia's Medicaid Director for 8 years under 2 Governors • Expanded and enhanced Virginia's Managed Care Program • Directed the implementation of the state employees first statewide Managed Care program • Extensive experience working with provider groups, health plans, legislators and stakeholders on managed care issues • Co-authored chapter in NGA Managed Care Purchasing Guide
Managed Care Program Management and Oversight	**Liz MacFarlane**	• Nine years as Director, Office of Managed Care, Bureau of Program Planning, New York State Department of Health overseeing program development and program administration and compliance • Experience with information optimization and administering health plans to improve program efficiencies • Demonstrated proficiencies in execution of critical managed care initiatives in stable and unstable environment while managing costs, growth and change • Proven stakeholder communication skills, promoting internal state and external business relationships and stakeholder confidence
Managed Care Program Administration	**Rebecca Mendoza, MA**	• More than 20 years of progressive management experience with implementing effective Medicaid and Children's Health Insurance Programs • Experienced program administer, serving as Virginia's Children's Health Insurance Programs (CHIP) and as Virginia's Director of Maternal and Child Health Division • Experienced in operations oversight, including policy interpretation, program implementation, eligibility and enrollment systems, training facilitation and community outreach
Managed Care	**Michelle Rork, MPP, MPA**	• More than 20 years of state and federal Medicaid and CHIP policy and operations experience • Experienced program administrator, managing operations for Rhode Island's Medicaid managed care and premium assistance programs and as Georgia's CHIP Director • Managed several large, complex Medicaid projects, including the administration of the Medicaid Managed Care program for West Virginia, which involves providing support with contracting, rate setting, network adequacy, monitoring and evaluation • For West Virginia, supported expansions of the Managed Care program to include behavioral health and children's dental benefits, the ACA Expansion and SSI populations, and a new MCO • Supported the Financial Alignment Demonstration by conducting readiness reviews of health plans and developing network adequacy standards
Health Homes	**Julie Trottier, MSA**	• SME in patient-centered medical homes, health homes and care coordination • Experienced in readiness review of Medicare-Medicaid health plans

West Virginia Priority Area	Staff	Key Qualifications
		• Experienced in providing technical assistance to health plans and providers in delivering integrated, coordinated care to both Medicaid and Medicare enrollees • Leadership team of the Vermont Chronic Care Initiative, providing successful chronic care management program to improve clinical outcomes and reduce unnecessary utilization • State of Vermont Chronic Care Management Program Administrator
Lead Actuary and Reviewing Actuary	**Michael Halford, FSA, MAAA**	• More than 10 years of consulting and MCO experience, working with state Medicaid programs and health plans, exceeding RFQ qualification requirements • Client leader, project manager, and/or certifying lead actuary for Georgia and having provided subject matter expertise to other programs
Staff Actuary, U.S. Chief Actuary and Reporting SME	**Mike Morrow, FSA, MAAA**	• More than 15 years of health care consulting experience, including Medicaid and exceeding RFQ qualification requirements • U.S. Chief Actuary for Aon Health & Benefits • SME MCO reporting and health analytics (previously Health and Benefits Initiative Leader at the Aon Center for Innovation which first developed AonPulse reporting)
SME, Lead Data Manager	**Kory Wolf, B.A.**	• More than 15 years of consulting and MCO experience working with numerous state Medicaid programs, exceeding RFQ qualification requirements • Project manager for all data processing elements of many state Medicaid projects including Georgia, Kansas, Kentucky, and Tennessee in recent years • Expertise includes Excel, SQL Server Management Studio (SSMS), SQL Server Integration Services (SSIS), SQL Server Analysis Services (SSAS); Medical informatics, health claims and member data analysis • Worked with a variety of stakeholders such as MMIS vendors and health plans ensuring Medicaid data is appropriately validated (as required in RFQ)
SME, Lead Pharmacist	**Hitesh Patel, Pharm.D.**	• More than 16 years of related experience including 12 years of direct experience in the PBM industry in various clinical, financial, analytical and outcomes leadership roles • Presented at the Academy of Managed Care Pharmacists, the International Society of Pharmacoeconomics and Outcomes Research, various national and regional PBM conferences, employer coalitions, the National Managed Health Care Congress, the University of Arizona and the DNA forum • Provided subject matter expertise to Aon actuarial teams for pharmacy pricing, trend analysis, and audits for Georgia, Kansas, and Virginia
SME, Data Manager	**Ryan Esslinger, M.S.**	• More than 10 years of health care consulting experience, including Medicaid and exceeding RFQ qualification requirements • Extensive background in health care analytics and data visualization, data management, informatics, ACOs and population health

West Virginia Priority Area	Staff	Key Qualifications
		• As a senior data consultant, he performs client data analysis, data loading, SQL coding, processing and investigation to support rate setting and dashboard development

The Lewin-Aon Team has extensive national Medicaid managed care experience, and over two decades of prior experience working specifically in West Virginia. Our team understands the details and intricacies of West Virginia's Medicaid Managed Care program as well as emerging Medicaid managed care best practices. Our practical and pragmatic experience allows us to shape our vision for effecting transformation into concrete and actionable recommendations that yield positive results. The strength of the Lewin-Aon Team is founded on the effective leadership, strong organizational skills, and expertise on Medicaid managed care of our personnel.

3.4.2. Resumes (RFQ 3.2, 3.3, 3.4, 3.5, 3.6, 3.8, 3.11)

Resumes for our personnel, as specified in the RFQ, are included in Attachment A.

4. Approach to Mandatory Requirements (RFQ 4)

Actuarial Services

4.1.1. Rate Development (RFQ 4.1.1.1 – 4.1.1.14)

The Lewin-Aon Team has extensive experience developing actuarially sound capitation rates and actuarial models using a broad variety of data sources for various types of Medicaid Managed Care programs in 17 states and the District of Columbia, as shown in Exhibit 4-1. In addition to this broad, national experience, ***Lewin has performed the managed care capitation rate development for the West Virginia Mountain Health Trust program since its inception.*** We are pleased to combine that experience and insight with additional expertise and resources on our proposed actuarial team. We have subcontracted with Aon to bring additional actuarial expertise and resources to BMS, while leveraging our extensive knowledge and background in West Virginia. With the growth of the Managed Care program in the past few years, along with anticipated future transformation and innovation of the program, this expanded actuarial expertise and insight will ensure BMS has the actuarial resources needed to support the program.

Exhibit 4-1: The Lewin-Aon Team's State Medicaid Managed Care Rate Setting Experience

Our proposed actuarial team, led by Aon senior actuaries and comprised of members from both, Aon and Lewin actuarial staff, is collectively referred to throughout the remainder of this proposal as "the Lewin-Aon Team," "our team," or "actuarial team."

We are well-positioned to assist BMS with capitation rate development to meet the State's Medicaid managed care expansion goal. ***We are intimately familiar with all sources of Medicaid data and have deep expertise in actuarially sound capitation rate development***

for virtually all types of Medicaid populations. We feature a team of credentialed actuaries and actuarial support staff that have extensive experience with State Medicaid agencies, including BMS, in various stages of Medicaid managed care implementation.

Task 4.1.1.1 Development, setting, and/or review of rates for the Managed Care program

The Lewin-Aon Team will complete the development, setting, certification, and/or review of rates for the State's Managed Care program. In addition, the Lewin-Aon Team will also develop capitation rates for Managed Care based on readily available State data and set by cohorts, including, but not limited to, age, gender, eligibility category, geographic location, and population risk factors.

The following sections describe the Lewin-Aon Team's approach to developing actuarially sound capitation rates for Medicaid Managed Care programs. This approach conforms to applicable Actuarial Standards of Practice (ASOPs), CMS Medicaid Managed Care Capitation Rate Development guidance (updated each year), and applicable provisions included in the Medicaid and the Children's Health Insurance Program Managed Care Final Rule (Final Rule). This basic method has been used by the Lewin-Aon Team for recent and current capitation rate development and will continue to be used and updated as needed as the program is further developed.

As highlighted in Exhibit 4-2, capitation rate setting is generally composed of five primary steps and associated sub steps. The Lewin-Aon Team is well-versed in the successful completion of this rate development process for state Medicaid programs.

Exhibit 4-2: Capitation Rate Development Steps

Step	Task Description	Rate Development Time Period (Month)											
		1	2	3	4	5	6	7	8	9	10	11	12
1	Base Data Development												
1.1	Identify Data Needs (Data Request)												
1.2	Data Collection												
1.2	Data Validation												
1.3	Summarize the validated data to rate cells and service categories												
1.4	Develop base data adjustments												
1.5	Produce Base Data Book and Report												
1.6	Rates Kickoff Meeting with MCOs (optional)												
2	Actuarial Assumption Development												
3	Draft Rate Development												
4	Final Rate Development												

Step	Task Description	Rate Development Time Period (Month)											
		1	2	3	4	5	6	7	8	9	10	11	12
5	Ongoing Support												

Step 1: Base Data Development

A critical part of developing capitation rates is base data development. Ensuring that we have quality base data available to develop rates will require rigorous data validation and extensive communication between the Lewin-Aon Team and applicable stakeholders, including managed care organizations and BMS' fiscal agent, Molina. Our team has an established data collection and validation process to help identify and produce the best data available for rate setting in an efficient and budget effective manner to BMS. This process will leverage existing data collection and validation tools used to develop the current capitation rates, enhanced by additional insight, tools and expertise.

The following base data development tasks will be performed:

1.1 Identify data needs
1.2 Collect and validate the needed data
1.3 Summarize the validated data to rate cells and service categories
1.4 Develop base data adjustments
1.5 Produce base data book and report
1.6 Rate kickoff meeting with MCOs

1.1 Identify data needs

We expect to continue to collect similar data to what has been used in the past for existing populations to develop appropriate base data for rate development. For new programs or populations, such as when West Virginia implements a managed LTSS program (as noted in the RFQ), additional FFS data will be needed to create a credible base data set for rate development. The potential data sources are listed in Exhibit 4-3.

Exhibit 4-3: Potential Data Sources

Data Source	Use
West Virginia Medicaid fee-for-service data	Base data for populations and services currently in FFS but transitioning to managed care
MCO encounter data	Base data for populations and services currently in managed care
MCO financial data	Validation of encounter data and administrative load development
MCO sub-capitation data	Supplement base data with costs for subcontracting vendors via capitated payments
BMS enrollment data	Determine eligible members to filter claim data and for use in per capita rate development

1.2 Collect and validate the needed data

We will leverage existing data requests, revised and updated as needed, to request data from BMS, the fiscal agent, and the MCOs after all data needs are determined. Claims and enrollment data requests will specify the incurred periods, paid through periods, and data fields needed for base data development. Financial data will be collected using customized financial data templates for all MCOs to report data consistently in a prescribed manner. Detailed data instructions will be provided along with all data requests.

The Lewin-Aon Team performs multiple analyses to validate data such as:

- Comparison to prior data submissions
- Comparison to reference totals provided by data submitter
- Date of service volume analysis
- Analysis of distinct and missing values

Our data team is made up of experts with intimate familiarity with *all* types of detailed claims and enrollment data. They are also highly experienced in identifying and resolving data issues effectively and efficiently in appropriate consultation with all stakeholders. The data collection process will utilize relational database software, primarily via Structured Query Language (SQL) technologies, to perform data intake, manipulation and analysis. This structure allows the data team to in-file data in nearly any form which provides ideal flexibility in working with the various types of Medicaid data that West Virginia has available. The claims data we collect will include: institutional claims, physician claims, pharmacy claims, mental health claims, LTSS claims and other ancillary service claims.

Our actuaries and data staff adhere to a strict approach to data validation. After receiving relevant data, it will be validated for accuracy, completeness, and consistency, based on all CMS guidance, BMS requirements, and ASOPs. All collected data require validation and signoff for completeness, accuracy and integrity at the data element level. Enrollment data, FFS data and encounter data will primarily be validated by our data team with the actuarial team's guidance. Financial data will be validated by the actuarial team. Encounter data and financial data are compared against each other to identify any potential gaps or inconsistencies. The validation process is an iterative process between the actuaries, BMS, the MCOs and/or the fiscal agent. If data issues are identified during validation, a meeting with BMS and the appropriate data providers is held to determine a corrective action plan.

1.3 Summarize the validated data to rate cells and service categories

The Lewin-Aon Team will collaborate with BMS to finalize the rate cohort structure to include factors such as population, age, gender, and geography, in order to distribute the risk appropriately.

After the base data is validated, rate cell assignment logic and service category bucketing logic (including global kick payment claims identification) will be applied to summarize the validated data in a structure consistent with the rate cells used by each program. The existing coding logic for rate cell assignments and service category bucketing will be utilized as a starting point. Updates to the logic will be discussed and confirmed with BMS each year to consider if changes are required. In this step, the validated data will be summarized as unadjusted base data by region, rate cell, and service category.

1.4 Develop base data adjustments

Once the base data is summarized, a series of calculations will be performed to develop the appropriate base data adjustments. Typical adjustments which may be needed for raw base data include:

- Incurred But Not Reported (IBNR) factors to reflect the incurred but not paid claims
- Under-reported encounters or claims
  - Payments made outside the encounter system
    - Settlement payments made outside the FFS data system
    - Applicable pass through lump sum payments paid to specific providers
    - Removal of costs for value-added services

Other adjustments may be needed if there is a rate cell structure change or benefit addition or removal. The goal of base data adjustment is to develop a base data representative of the covered benefits and covered populations in the contract period.

1.5 Produce base data book and report

The various data adjustments will be applied to the unadjusted base data in a customized base data book model to develop the final base data for rate development. The base data book and its corresponding report documenting the data sources and adjustments will be provided to BMS as an interim deliverable for rate development. BMS can choose whether it is beneficial for the rate development process to share this base data book and its report with participating MCOs.

1.6 Rate kickoff meeting with MCOs

BMS can choose whether it is beneficial for the rate development process to share this base data book and its report with participating MCOs and/or whether to host a rate development kickoff meeting with the MCOs to discuss the base data book.

Step 2: Actuarial Assumptions Development

Actuarial assumptions are developed and used to adjust and project the base data to reflect expected conditions during the contract period. There are eight primary types of actuarial assumptions needed for rate development:

1. Trend factors
2. Fee schedule adjustment factors
3. Managed care savings factors
4. Program change factors
5. Administrative expense and margin allowance
6. Quality and performance measure impact factors, if applicable
7. Risk scores and risk sharing arrangements, if applicable
8. For applicable populations, appropriate population mix assumptions

Trend factors

Trend factors are used to project the base data to the contract period by estimating the impact of changes in case complexity, health care provider practice patterns and utilization of services.

The Lewin-Aon Team has extensive expertise with rate setting trend development. Our general approach is to derive historical based trend factors when credible managed care data is available. Absent the availability of credible managed care data, we rely on collected trend studies and other states' comparable experience for trend development. For West Virginia's programs, there is some flexibility in data choices for trend development given that there is still a significant portion of the population in (or recently in) FFS. Therefore, FFS data can be used as either an alternative data source or a benchmark resource for specific program trend development efforts, if needed. Typically, adjustments are needed when FFS data is used for trend development to reflect the anticipated differences between FFS delivery system results and managed care delivery system results.

In the last five years, Aon's Medicaid team has developed and certified numerous sets of capitation rates for various Medicaid Managed Care programs. Our rate development experience includes all populations currently included in the State of West Virginia's Managed Care program and also the populations that West Virginia may include in its future Managed Care programs:

- TANF children and adults (similar to Traditional TANF, Medically Needy, and Pregnant Women in Mountain Health Trust program)
- ACA expansion adults
- ABD Non-Dual members (similar to SSI members)
- LTC eligible members (similar to the MLTSS population indicated for future implementation)
- Medicare and Medicaid dual eligible members
- Foster care and adoption assistance children
- Intellectually and developmentally disabled members

Fee schedule adjustment factors

To allow for changes in unit cost, fee schedule adjustments are developed by determining the impact of any Medicaid fee schedule changes that occurred in the base data time period or are anticipated between the base data period and the contract period. This may be done by evaluating the impact of the fee schedule changes to derive a factor to be applied to the claims.

In some cases Medicaid capitation rates are developed using a limit on the percent of the Medicaid fee schedule that will be reimbursed to MCOs. For example, in the development of the capitation rates, unit costs may be limited to 102% of the Medicaid fee schedule. This serves two purposes: 1) helps contain Managed Care program unit costs within a specified percentage of FFS unit costs; and, 2) provides incentives for the MCOs to contract efficiently with their providers.

Managed care savings factors

Managed care savings factors are developed to reflect the expected improvement of managed care efforts leading to cost savings to the program. Programs recently moved to managed care, such as the West Virginia SSI population, will use FFS data as the base data for rate development until the SSI encounter data is credible to use. Managed care savings factors are developed and applied to the FFS base data to reflect the estimated savings of moving to a managed care environment. When specific in-state data is not available, these factors are usually based on our experience with other states' manage care savings programs.

For programs having credible managed care data as the basis for rate development, a moderate level of managed care savings is expected to continue due to improvement in care management efforts. In these programs, comparative efficiency analyses among participating MCOs and specific efficiency benchmarks are used in determining the expected incremental managed care savings. These savings may reflect anticipated improvements in things such as

the prevalence of Emergency Department (ED) uses for non-ED needs, generic drug dispensing rate, and hospital readmission rate, among other benchmarks. Analyses of these items are performed to identify improvement areas and quantify an appropriate range of incremental managed care savings for the programs.

Program change factors

Program change factors are typically treated as separate factors from trend to explicitly quantify the impact of one-time program adjustments. Such changes include the addition or removal of certain benefits, reimbursement approach changes for certain providers, member enrollment process changes, managed care contractual changes, and additional CMS compliance requirements. In developing program change factors, we will continue to work closely with BMS and our managed care oversight team to collect all program change information. Relevant experience data is then used to quantify the anticipated impact of the program changes. In most cases, the appropriate approach is to develop factors at the region, rate cell and service category level to ensure that the developed rates at each level are actuarially sound.

Administrative expense and margin allowance

Medicaid capitation rates must include an allowance for appropriate MCO administrative expense and margin. This allowance is developed based on historical MCO administrative expenses, as reported by MCOs in financial statements, as well as industry benchmarks. The administrative allowance includes an adjustment for the Health Insurer Fee, when applicable. The margin allowance amount is included to reflect both experience fluctuations from year-to-year, as well as contribution to capital.

The Lewin-Aon Team offers 10 credentialed actuaries to assist BMS

Russ Ackerman, ASA, MAAA, FCA

Chris Bach, ASA, MAAA, FCA

Colby Schaeffer, ASA, MAAA

Sterling Felsted, ASA, MAAA

Nicholas Gersch, ASA, MAAA

Michael Halford, FSA, MAAA

Betsy Hanson, FSA, MAAA

Mike Morrow, FSA, MAAA

Don Wakefield, ASA, MAAA

Jeff Yang, ASA, MAAA

Quality and performance measure impact

Final rates need to be adjusted for any quality or performance withhold provisions. As part of the recent Final Rule regulations from CMS, States' actuaries can now forecast how much of a withhold an MCO may earn back by estimating how many of the measures a plan is expected to reasonably achieve in a rating period. Aon has recent hands-on experience working with the State of Georgia on this type of analysis for a sub-set of their Medicaid capitation rates.

Risk scores and risk sharing arrangements

For Managed Care programs using a risk adjustment methodology, risk scores are calculated using the selected risk adjustment approach. We understand that BMS is considering incorporating a risk adjustment methodology into the capitation rates. Our team has successful experience helping states design and implement risk adjustment approaches for both acute care populations and long term care populations. Lewin recently performed a risk score analysis for the State of Minnesota to determine the impact of social determinants on health care costs. In addition, Aon recently worked with the State of Georgia and participating Medicaid managed care plans to implement a risk adjustment process for its core Managed Care program. The data and actuarial teams were able to successfully manage requests from the plan and come to an agreed-upon methodology that satisfies the State's budget neutrality needs as well as the

plans' concerns over budgeting and timing. If requested, we are prepared to help BMS compare, analyze, select and develop a risk adjustment approach appropriate for their program.

The Lewin-Aon Team has extensive experience in risk adjustment including different risk adjustment grouper software packages, including:

- Optum's Symmetry Episode Risk Groups (ERGs)
- UCSD's Chronic Illness and Disability Payment System (CDPS+MedRx)
- Johns Hopkins Adjusted Clinical Groups (ACGs)

Some Medicaid programs also include risk sharing agreements between the State and the MCOs. If applicable, the impact of the risk sharing arrangement can be modeled using different scenarios to understand potential impact to the participants.

Population mix factors

Where applicable for blended LTSS rates, a nursing home (NH) versus home and community based services (HCBS) population mix assumption is vital. For managed LTSS programs, we generally recommend states use a blended rate structure. Under a blended rate structure, participating MCOs are paid with the same regional capitation rates for all long term care eligible members, regardless of their service settings (NH or HCBS). Since it is usually more cost effective to deliver LTSS in community settings than in nursing homes, the blended rate structure creates a strong incentive for MCOs to keep members out of nursing homes. Such rate structures require an appropriate NH versus HCBS mix assumption to reflect past and current program-specific NH versus HCBS mix improvement experience under managed care, and desired mix improvement goals for the contract period.

Step 3: Rate Development and Communication

After the development of base data and actuarial assumptions is complete, the next step is to use a customized actuarial model for rate calculation. In general, actuarial rate models consist of input tabs and calculation tabs. Recognizing quick turnaround is often required when changes need to be made to base data or assumptions, automatic features are built into the customized model to allow for quick rate updates, while at the same time ensuring very high quality results through both automated and (where necessary) manual peer review formula checks.

All formulas and calculation mechanics built into the model go through a robust peer review process, which includes both technical checking and consultative review processes to ensure error-free rate calculation and high quality results. This peer review process is mandatory for all of our team's actuarial work and provides a strong quality control mechanism, resulting in a history of exceptionally high quality work.

The actuarial model performs all calculations necessary to produce projected rate ranges based on the base data and actuarial assumptions included. BMS then selects capitation rates within rate ranges to ensure payment rate actuarial soundness. The selected risk neutral capitation rates can then be used to calculate risk adjusted payment rates, if applicable, for each MCO using their own risk scores calculated for the applicable contract period. Finally, the final capitation rates are compared to previous capitation rates so the revenue impact to the MCOs and fiscal impact to the State can be calculated.

Once the initial rate development is complete, in accordance with applicable ASOPs, CMS rate setting guidance and the Final Rule, rate development documentation including all data, assumptions, and calculation steps necessary to allow users to replicate rate calculation from base data to payment rates is developed. The documentation describes the base data choice,

itemized base data adjustments, each actuarial assumption, data and methodology used to develop each assumption, and resulting rates or rate ranges according to the documentation requirements established by CMS and required by applicable ASOPs. The calculated rates will then be communicated to BMS in a rate development presentation with rate exhibits, which summarizes the information in the rate development report. We meet first with BMS either in person or via conference call to walk through the rate presentation, and then with the MCOs and BMS together through on-site meetings. Any issues or adjustments identified during rate meetings with BMS will be addressed before final materials are sent to the MCOs.

Our transparent approach to rate development, along with our detailed documentation and rate certifications, makes the CMS rate review process very smooth for our Medicaid clients.

Upon BMS review and approval, final materials are sent to the MCOs prior to the on-site combined BMS and MCO rate meeting. The on-site meeting with the MCOs generally begins by discussing the rate presentation, followed by MCO questions and discussion. Our team is prepared to answer questions from MCOs that arise during the on-site rate meeting. For any outstanding questions posted by MCOs during the meeting (or upon BMS discretion, after the meeting), we will prepare written responses for BMS to share with the MCOs. If any inconsistencies in the use of data or assumption development surfaces during the MCO meeting, we discuss the new information with BMS and determine if any revisions to the initial rates would be appropriate to reflect the new information.

Step 4: Prepare Final Rate Package

The Final Rule requires states to submit MCO rate certifications concurrent with the review and approval process for MCO contracts to CMS for review and approval. The Lewin-Aon Team will work with BMS to finalize the rates and the MCO contract concurrently. Once BMS agrees that rates are final, we will prepare a final rate package in electronic format for BMS. The final rate package is then submitted to CMS for review and approval. CMS may have questions related to the rate setting process and certifications, and when needed, our team will assist BMS in answering any questions.

The rate certification is often the main document or narrative included in final rate packages. It includes a detailed narrative of the rate development process consisting of data, assumptions, methodologies and results. It also a detailed rate exhibit as an appendix which allows the reviewer to replicate the entire calculation from base data to payment rates. CMS performs a formal rate review process for all Medicaid managed care capitation rates. To facilitate CMS rate review, our rate certifications are structured to exactly align with CMS checklists and guidance, and also include a crosswalk, mapping each documentation requirement in the applicable CMS rate development guide to each specific section within the rate certification.

The Lewin-Aon Team has worked closely with CMS to obtain approval for various items, including capitation rates and waiver submissions. This includes completion of required forms, preparing written answers to questions, and participating in conference calls.

Other documents included in final rate packages typically include plan specific payment rate schedules for contracting purposes, payment rate spreadsheet to load into the capitation payment system, an estimate of Health Insurer Fee payment for state budgeting purpose, and any other needed calculations based on the final rates as requested by BMS. As part of final rate package, we also provide all other relevant reports, data sets, documents and analysis used in setting the capitation rates as requested by BMS to meet their documentation requirements.

Our capitation rate ranges have historically complied with all Actuarial Standards of Practice, annually released CMS Medicaid Managed Care Rate Development Guides, the Medicaid and CHIP Managed Care Federal Rule, and applicable state laws. We will assist BMS in responding to all rate review questions from CMS. Our team's experience has been excellent, ***ultimately resulting in 100% CMS approval for all of our Medicaid capitation rate certifications.***

Step 5: Ongoing Support

The above represents our understanding of the rate development process based on our long-standing experience in setting capitation rates in West Virginia. It also includes anticipated changes and improvements in the rate setting process. We will adjust the process when necessary as West Virginia's program continues to develop and change. ***We have a deep appreciation for the fact that every State Medicaid program is different and requires specific processes in developing capitation rates.*** Our team is proactive in refining our rate setting methodology to meet evolving state and federal requirements, and promote partnership among all stakeholders. We are responsive to the needs of all stakeholders and remain alert to changes in the capitation rate development environment. For example, we have worked extensively with BMS to develop the Directed Payment Program methodology to simplify the process while meeting CMS approval. Our team is also working proactively with Kentucky, Kansas, Tennessee and Georgia for the upcoming compliance needs including the CMS required pass through payment phase-out and MLR reporting, and IMD inclusion as scheduled in the Final Rule. In addition, we proactively initiated reviews of cost differences for the managed Intellectual and Development Disability (IDD) populations at the MCO level for Kansas. This was necessary because IDD risk corridors consistently resulted in a significant payout to the same MCO each year. Being responsive to program needs, we promote a partnership between the State and the MCOs that allow Medicaid programs to thrive. Being alert to environmental changes, we are able to build our credibility with CMS and make the rating approval process easier and quicker to our States.

We look forward to discussing the above detailed description of our actuarial work process and methodology for rate development. Our approach highlights our attention to detail and our collaborative approach to actuarial modeling. Our actuaries, data analysts, and policy consultants have significant expertise in this area, as well as a long-standing history of program oversight and rate setting for the West Virginia program. Our specific West Virginia knowledge, along with the additional insight, expertise and resources added to our proposed team, will result in an innovative, efficient and accurate rate setting process for West Virginia's Medicaid program. In addition, we will continue to rely on the knowledge and insight of BMS to collaboratively work towards the success of the program.

Ongoing Quality Control and Project Management

Our approach to quality is incorporated in our client service model, which embodies our commitment to providing clients with performance satisfaction aligned with their expectations. This quality assurance program consists of established professional standards that enable us to meet and exceed these expectations.

The Lewin-Aon Team's Approach to Quality Control includes:

- Mandatory peer review for all professional services provided to our clients. Peer review plays an active role in our work process. Because actuarial work is calculation intensive and peer review will help to minimize error and omissions, we require that all consultants abide by our mandatory peer review requirements. Each consultant must solicit the comments, observations, and expertise of associates during the day-to-day preparation

of client work. When preparing work plans, consultants must incorporate a reasonable amount of time for peer review.

- We have professional Practice Councils that set standards and guidelines for project tasks. These national in-house groups routinely meet to review and update these guidelines.
- We maintain local training programs at all staff levels to ensure that all employees possess updated knowledge and skills that conform to current regulations. We also hold regular in-house practice meetings for our staff. Many of our consultants also attend national professional conferences and seminars.

Our team members have been involved in the early review process of Medicaid Managed Care regulations and have a deep understanding of the new Final Rule, its timelines for implementation, programmatic impacts and how it strengthens actuarial soundness. Our team already has directly applicable experience with such requirements as the pass-through payments phase-out, directed payments implementation, Medicaid IMD reimbursement policy, MLR and encounter data standards for each client.

Our client service model provides the:

- Discipline, support tools and measurements needed to achieve quality
- Structure for setting performance metrics in concert with our clients
- Means for establishing a partnership that is built on expectation, performance and routine measurement via stewardship meetings, conference calls and daily interactions
- Standards for collaborating with our clients to achieve mutually agreed upon goals and overall value and benefit the client's programs

Our actuaries are fully compliant with all of the following rate certification and submission requirements per the Final Rule:

- Actuarial soundness, 42 CFR §§438.4(a) and (b)
- Actuarial certification to capitation rate per rate cell, 42 CFR §438.4(b) (4)
- Capitation rates adequate to meet 42 CFR §§438.206, 438.207, 438.208
- Ability to increase or decrease certified capitation rate (per rate cell) by 1.5 percent without revised rate certification, 42 CFR §438.7(c)(3)
- Rate development standards, 42 CFR §438.5 (data, trend, non-benefit component of the rate)
- Risk adjustment standards, 42 CFR §438.5(g)
- Special provisions related to payments, 42 CFR §438.6 (incentive arrangements, withholds, IMD, pass through prohibition, etc.)
- CMS approval process changes of the rate certification, 42 CFR §438.7(a)
- Medical Loss Ratio standards, 42 CFR §438.8
- Encounter data, 42 CFR §438.818
- Corresponding CMS guidance
- 2017 Managed Care Rate Development Guide

The Lewin actuarial services and program oversight teams will follow the same general project management approach as described in response Section 4.1.6. In order to manage the timeline of complex projects like Medicaid managed care rate setting, we will work with BMS to establish appropriate project timelines and key tasks as a management tool to interactively track and continually improve our progress and ensure on-time delivery of rates.

Task 4.1.1.2 Develop capitation rate ranges

The Lewin-Aon Team will develop high, mid, and low capitation rate ranges for review.

As stated in Task 4.1.1.1, our rate setting process results in actuarially sound rate ranges as well as point estimates for rates, the latter of which are required by recent federal rule for rating periods beginning after July 1, 2018.

Upon BMS' determination of the final payment rates within rate ranges, the selected risk neutral payments rates will be used to calculate risk adjusted payment rates, if applicable, for each MCO using their own risk scores calculated for the applicable contract period. Finally, the payment rates are compared to previous payment rates so we can calculate the revenue impact to the MCOs and fiscal impact to the State. All formulas and calculation mechanics built into the model go through our robust peer review process, which includes both technical checking and consultative review processes to ensure error-free rate calculation and high quality results. This peer review process is mandatory for all of our actuarial work and provides a strong quality control mechanism resulting in a history of exceptionally high quality work.

Task 4.1.1.3 Develop managed care rates at the individual MCO level

The Lewin-Aon Team will develop Managed Care rates at the individual MCO level, should the Bureau choose to develop MCO-specific rates based on risk.

Aside from risk adjustment (see response to Task 4.1.7.2), the Lewin-Aon Team is accustomed to developing MCO-specific rates as needed. Examples of this include SFY2016-2017 capitation rates for Georgia which required differences in reimbursement as part of the Inpatient Provider Payment System (IPPS) methodology. Because of differing mix of risk profiles for their members and utilization at hospitals, the IPPS methodology would impact each Medicaid plan differently and they were required to be reimbursed appropriately for those differences.

For West Virginia, Lewin developed MCO-specific capitation rates for:

- Health Insurer Fee Allocation
- DPP increase

Aon has also developed rate differently for MCOs based on differences in place of service such as a site of service adjustment that was implemented for TennCare's CHOICES program. This adjustment would pay MCOs differently based on their mix of members that are residing in nursing facilities versus in a home and community-based setting.

One critical thing about MCO-specific rates is ensuring appropriate dissemination of rate information to the MCOs. Our team achieves this by presenting rate exhibits, data books, and other materials to MCOs that show the rates that are equivalent to the budget-neutral rates for all MCOs combined. Follow-up information via email or SFTP delivery to each MCO results in the receipt of their MCO-specific rates.

Task 4.1.1.4 Participate in and support rate setting discussion

The Lewin-Aon Team will participate and provide support in rate setting discussion and meetings as needed, and provide supporting documentation, including but not limited to: presentations, rate workbooks, Excel files, and rate memos, as requested by Bureau staff for meetings.

The response to Task 4.1.1.1 represents our approach, and outlines the steps our team expects to follow when building actuarially sound rates for West Virginia's comprehensive Medicaid programs, including appropriate supporting documentation and rate methodology discussions with BMS, CMS and the MCOs. Our rate development documentation includes all data, assumptions, and calculation steps necessary to allow users to replicate rate calculation from base data to payment rates is developed. The documentation describes the base data choice, itemized base data adjustments, each actuarial assumption, data and methodology used to develop each assumption, and resulting rates or rate ranges according to the documentation requirements established by CMS and required by applicable ASOPs. The calculated rates will then be communicated to BMS in a rate development presentation with rate exhibits, which summarizes the information in the rate development report.

Upon BMS review and approval, final materials are sent to the MCOs prior to the on-site combined BMS and MCO rate meeting. The on-site meeting with the MCOs generally begins by discussing the rate presentation, followed by MCO questions and discussion. Our team is prepared to answer questions from MCOs that arise during the on-site rate meeting. For any outstanding questions posted by MCOs during the meeting (or upon BMS discretion, after the meeting), we will prepare written responses for BMS to share with the MCOs. If any inconsistencies in the use of data or assumption development surfaces during the MCO meeting, we discuss the new information with BMS and determine if any revisions to the initial rates would be appropriate to reflect the new information.

Task 4.1.1.5 Work collaboratively with Department staff to improve accuracy and efficiency of data sources

The Lewin-Aon Team will work collaboratively with Department staff to improve the accuracy and efficiency of the existing data sources and new data sources used for rate development, and the methodologies used in the rate setting process. Our Team's collaboration will include attending meetings, conference calls, and other requests that the Bureau deems necessary and we will provide new and innovative ideas around the rate setting process and efficiencies of such.

The actuarial team is involved in all steps of the process from data collection and validation to rate calculations to ensure that the data is appropriate for rate development and is used correctly in the rate development. Our actuaries and consultants adhere to a strict approach to data validation. All analyses require validation and signoff of data for completeness, accuracy and integrity at the data element level. If data issues are identified in the initial validation step, a meeting with the client and data suppliers is held to determine a corrective action plan or workarounds to any data issues.

The following are steps we take to gather and validate the data:

1. Rate setting cycle kickoff meeting and data request
2. Obtain, summarize and review eligibility and claims data by rate categories

3. Validate data and prepare actuarial models
4. Meet with BMS to discuss identified data issues and explore alternatives

1. Rate setting cycle kickoff meeting and data request

During our initial meetings, typically as a part of our standing weekly meetings, we review the draft project plan and confirm timelines and deliverables. Through these collaboration efforts, we develop an understanding of the expected program design including who is covered under the program, eligibility criteria, what benefits and services will be included in the program, where the data for these claims are housed today, and how the data will be transferred to us. Additionally, we will discuss the encounter data with BMS to determine whether alternative methods are needed to develop unit costs, how accurate the historical utilization information has been, and other approaches that may be considered in using encounter data in rate development.

Shortly after our initial meeting and subsequent discussions, our team will submit a detailed data request, similar to the current detailed data request, to include multiple years of claims and/or encounter data, enrollment, plan design, policy changes, waiver documents, invoices or accounting records, financial reports, reimbursement history, and any specific information on new data sources.

2. Obtain, summarize and review eligibility and claims data by rate categories

We typically load at least 36 to 48 months of claims and encounter experience in order to thoroughly review past experience. Upon receipt of the data, our data team compiles all the information. This includes creating a unique database to house all the various encounter, claims and eligibility information. The data management team builds a subset of our Medicaid database system to be dedicated to each State's data. We have the flexibility to receive data in multiple formats from multiple vendors. We have adapted to the various data formats, at no cost to states, with the understanding that these formats must contain and maintain all the critical data elements needed to support the development of actuarially sound rates.

As part of the rate development process, we also capture and add any reported non-system claims into the data summaries. We will discuss with BMS if anomalies in utilization and costs should be expected. Upon final review, we will work with BMS to verify that the data loaded into the system is an accurate representation of the program.

We use eligibility files to develop member months that correspond to the claims data. Members are flagged in the data files by potential rate cell characteristics, so they can be split into population groups that are also aligned with the Medicaid eligibility groups used. The data will also be reviewed to consider the potential need for additional rate cell breakouts that may be needed to ensure actuarially sound rates. In addition, members with claims but no eligibility records are flagged for further investigation. Any intricacies of the eligibility data are determined through conversations with the state agency partners about the current administration of the program.

We are committed to taking every possible precaution to safeguard the confidentiality of all Protected Information received, maintained and/or transmitted on electronic media and our security policy specifically addresses the receipt, storage, delivery, disposal and reuse of electronic media that currently or previously contained Protected Information. We prefer to transmit electronic data through a secured FTP (SFTP) sites but can receive data using external drives, CDs, or DVDs using encryption software meeting our security standards.

3. Validate data and prepare actuarial models

To validate utilization and financial data received, it is first and foremost necessary to understand appropriate data and benchmarks so variations or potential errors can be easily identified. We analyze the data received against summary totals to determine high level issues.

We reconcile the data provided to data resources using the mutually agreed upon data reporting and financial management reports to validate the reporting of costs. Through interactive discussions with those (MCOs and supporting vendors) who submitted the actual data, we reconcile or bridge any deviations to ensure baseline data is complete, accurate and adheres to outlined definitions. We compare the data reports to state expenditure reports, MCO financial reports, reconciliation reports, invoices, or accounting records to determine if all data is accurately captured for the covered program and population. As a validation step, we will reconcile with BMS any deviations that arise. We typically summarize the data by region and expected rate cell and reviews the summarized data for reasonableness.

At this point, we have reviewed the results for reasonableness, tied the results to available reports, and looked at historical rates and trends. Through this entire process, data anomalies that may have emerged will have been corrected or explained. Any data fluctuations and anomalies generated by the disparate data sources have been smoothed out and normalized to create a consistent and complete data set. The validated data set will then be loaded into the actuarial model for adjustment and development of per member per month capitation rates by rate cell.

4. Meet with BMS to discuss identified data issues and explore alternatives

If data problems persist, we will generate a detailed write-up of the issue and work with BMS, the MCOs and/or the fiscal agent to uncover the root cause. We send a detailed data problem report and then bring our team to discuss alternatives and solutions. By the end of early meetings, the project team should have adequate information and direction to correct any issues and complete the data validation and preparation.

During each of these steps, we will review all data and assumptions with BMS for completeness, appropriateness and accuracy. This description outlines all efforts to constitute best practices, meeting all professional and client requirements in preparation for the next steps in the rate development process.

We will work proactively with BMS to determine areas where data and/or rate development efficiencies can be considered. BMS will benefit from our experience in rate development in many other states where we employ many different types of data collection and validation processes and varying rate setting methodologies.

Task 4.1.1.6 Provide the Bureau with reports and calculations

The Lewin-Aon Team will provide the Bureau with reports and calculations in the formats specified by the Bureau, including all formulae, databases, data sets, and other documents as requested on an as needed basis in an agreed-upon standard format compliant to the data being requested.

The Lewin-Aon Team will continue to provide monthly program reporting through our updated and automated Mountain Health Trust Information Resource Center (MHT Information Resource Center (IRC) – see response Section 4.1.6 for further discussion of the MHT IRC). As indicated in Task 4.1.1.4, our actuarial team will provide thorough documentation to BMS and other stakeholders, as needed. This includes data book exhibits (which include formulas and

underlying data summaries) in addition to methodology documentation. All reports and data visualizations generated by the actuarial team will be incorporated into the IRC. These actuarial reports and visualizations can be custom-tailored and are often built dynamically when engaging in consultative dialogue with our clients and we will work with BMS on the design of MHT specific data visualizations. These reports help illustrate data that is otherwise inadvertently unknown or overlooked.

Task 4.1.1.7 Rate uniformity

The Lewin-Aon Team will assist the Department in identifying where rate uniformity needs to occur to ensure payments are made consistently across all bureaus by conducting a rate uniformity workgroup and analysis of all rates currently administered in a schedule to be coordinated between Lewin and Department. The analysis will identify inconsistencies and recommendations to the Department for improving its rate setting process and helping align areas that are not in uniformity.

The Lewin-Aon Team has experience in making sure there is consistency and transparency among sister agencies within health and human services departments. Upon BMS request, we will facilitate a rate uniformity workgroup and perform an analysis of all rates being administered by various Bureaus within the Department, setting long-term strategies for rates consistency. The analysis will identify inconsistencies, suggest improvements and operational solutions to align rates, and, in cases where complete alignment is not possible, identify the cause of the differences in order to maintain transparency among the Bureaus.

Workgroups can be an opportunity to efficiently improve a part of the reimbursement process in a transparent and well-documented manner. It is also an opportunity to identify factors and data elements that should be considered in the rate setting processes across delivery systems agencies (e.g., demographics, costs of labor, social determinants). Our actuaries have worked with MCOs, providers, and State agencies in a number of different workgroups concerning reimbursement and rate uniformity. Examples of these workgroups include our actuaries working in Massachusetts to ensure behavioral health rate consistency as well as working with TennCare to develop the ECF CHOICES reimbursement model utilizing feedback from ASO plans, the State, and providers. Through these, there were both short-term needs and long-term strategies that were addressed. Strategies have focused on fiscal needs of the State, potential savings funds, economic impacts, quality improvement, and phase-in based on geographical and demographic differences.

Task 4.1.1.8 Provide capitation rates based on data, pricing trends, and state/federal requirements

The Lewin-Aon Team will develop actuarially sound capitation rates based on claims and financial data, cost and pricing trends, and federal and/or state requirements. We will certify the rates.

The Lewin-Aon Team's approach to capitation rate development is discussed in detail in Task 4.1.1.1. The approach is based on the collection and validation of appropriate base data and application of actuarial assumptions that are reflective of the contract year that rates are being set for. This approach will also be compliant with both BMS and CMS policy at the time of rate development.

The Lewin-Aon Team will leverage the data sources used in the past but will also determine if there are additional sources that can be leveraged. After collection of the data, we will employ a comprehensive data validation process to ensure that the data is appropriate for rate development. The data will require sign-off before use in rates.

After the base data is validated and summarized, The Lewin-Aon Team will apply actuarial assumptions to project the data to the contract period. These include the following adjustments:

1. Trend factors to project changes in utilization
2. Fee schedule adjustment factors to project changes in unit cost
3. Managed care savings factors to project the impact of managed care on populations and services that were in FFS during the base data period.
4. Program change factors to project changes in covered benefits and other program requirements that were not reflected in the base data
5. Administrative expense factors to provide an allow for MCO administrative expense and margin

The Lewin-Aon Team will leverage its expertise with the West Virginia Medicaid program and health care landscape to develop meaningful and appropriate adjustments that accurately reflect trends and other changes specific to West Virginia.

The adjustments listed above will be dependent on BMS policy. At the onset of rate development, the Lewin-Aon Team will submit a request to BMS to determine, what changes, if any, will need to be considered in the rates. We will also request fee schedule information for use in developing the fee schedule adjustment mentioned above.

The Lewin-Aon Team will also send a data request to the MCOs for additional financial data to supplement the encounter and claims data used for rates. This will include additional costs not in the encounter data, such as sub-capitated costs and breakdown of administrative costs. We will also collect the annual Office of the Insurance Commissioner (OIC) filings for use in the administrative cost development.

The capitation rates developed by the Lewin-Aon Team will reflect the federal requirements in place during the contract period. During the rate development process, we monitor for policy changes that will impact the rates or rate development process. This includes the most recent changes to the Final Rule, which we researched and incorporated in our process. We follow and complete the Rate Setting Checklist and provide to CMS with the final rates and documentation. We then work with CMS to ensure that all of their questions are answered completely and in a timely manner to expedite their review and approval process.

Task 4.1.1.9 Develop and successfully implement a Data Transition Plan

The Lewin-Aon Team will develop and successfully implement a plan to transition all data, methodologies, documentation, and ongoing projects to the next succeeding vendor, at least thirty (30) calendar days in advance of the contract end date.

The Lewin-Aon Team understands that transitions do occur and will be prepared as such. Upon notification of a transition, we will collaborate with the new vendor to establish a project plan to include key tasks and milestone dates. Tasks will include meetings with BMS and the new vendor, delivery of process documentation, and transfer of historical data. The project plan will

target completion prior to 30 days before the end of our contract. We, along with the new vendor, will monitor the project plan, and will inform BMS of our progress.

The Lewin-Aon Team will maintain communication with the new vendor throughout the transition. We will hold weekly status calls with them and will answer questions through e-mail. We will also document all questions and answers.

The Lewin-Aon Team will provide the new vendor with a summary of the validated base data and any actuarial assumptions that had been developed to date. We currently develop transparent documentation of the rate setting process which we distribute to BMS, CMS, and the MCOs. MCOs have used this documentation in the past to recreate our process. As a result, we feel that, combined with the summarized data and assumptions that it will be adequate for the new vendor to recreate our process. We will develop similar documentation for any other analyses that we performed.

The Lewin-Aon Team will also transition the raw base data files used in rate development to the new vendor. This will include MCO encounters, FFS claims, and enrollment data. Since the data does contain personally identifiable information and protected health information, we will utilize our existing SFTP solution to ensure that all sensitive data is transferred securely.

We have recent experience in transferring data, as part of our current contract with BMS:

- With the transition of FFS populations to managed care, the Lewin-Aon Team utilized FFS claims data from Molina as base data. To allow the MCOs the ability to recreate our rate setting process for these populations, we provided the detailed FFS data to each MCO through our SFTP site.
- BMS moved the task of MCO encounter data collection, validation, and storage from Lewin to Molina. To prepare for this, Lewin prepared process documentation, including a task outline and data dictionaries, and sent it to Molina. We then held a series of calls and also replied to e-mails from Molina. We researched individual questions as they arose. We, and Molina, both collected and processed the data in parallel. After Molina developed a test data set using their process and data they collected, we compared the results to data that we already collected. There were discrepancies in the comparison, which were resolved through back and forth with Molina. After resolution of these discrepancies, we signed-off on the accuracy of Molina's data almost two months prior to the final transition.

Task 4.1.1.10 Coordinate with the State's fiscal agent

The Lewin-Aon Team will coordinate with the State's fiscal agent to ensure accurate encounter, claims, and eligibility data is used for rate setting. Our team will also review encounter data for completeness and/or inconsistencies as part of rate setting process, and provide a summary report of any inconsistencies to the Bureau for review on an ad hoc basis in a format agreed upon between Lewin and the Bureau.

Gathering accurate and complete data is foundational for developing the utilization, cost and administration estimates of the rates. Ensuring that we have the best data available to develop the rates requires extensive communication and interaction between the Lewin-Aon Team, BMS and/or BMS' fiscal agent, the MCOs, and DHHR.

Task 4.1.1.5 provides a description of our thorough approach to data collection and validation. This includes a summary report of inconsistencies that will be provided to BMS on both an annual and ad hoc basis. Behind this approach is our industry leading data management team. The data team lead for rate setting and data analytics activities has more than 15 years of experience in programing systems and loading and analyzing managed care and other health care data. Our team today intakes, manipulates and analyzes multiple data sources from multiple vendors for our clients. We develop capitation rates using multiple sources of data including but not limited to eligibility files, encounter data, FFS claims data, and financial data. Each year Aon intakes over ***one billion records*** from various sources on ***more than four million members*** and manipulate that data to develop actuarially sound, CMS approved capitation rates. Our team is flexible and does not require a standard file format to upload the data.

Lewin worked directly with the State's Fiscal Agent to:

- Collect and validate claims and eligibility data used for rate setting
- Analyze discrepancies with the data
- Transition the collection, validation, storage, and downstream reporting of MCO encounter data

We also worked with the Fiscal Agent to collect and validate claims, eligibility, and provider data for claims sampling as part of the CMS PERM project.

Task 4.1.1.11 Work with the fiscal agent to ensure completeness of reporting

The Lewin-Aon Team will work with fiscal agent to ensure completeness of any and all reports used for state and federal reporting, as requested by the Bureau.

Typical reports gathered by the State and actuaries for rate development would be MCO reconciliation templates (MRTs). These are critical in reconciling underlying encounter data to MCO-attested financials and ensure both a transparent and validated rate setting process. We will also leverage MRTs to comply with BMS and CMS MLR reporting requirements.

As the MCOs return the populated MRTs, our team reviews them for completeness. Additionally, we reconcile the MRT data with the MCO financial statements. Based on these reviews and reconciliations, questions may arise that need to be addressed by the fiscal agent and the MCOs.

These questions can range from a confirmation that two data elements are mutually exclusive (no double counting) to seeking understanding about abnormal patterns in the administrative expenses. We will compile these questions and work with the state's fiscal agent and the MCOs to receive appropriate responses to verify the integrity of the data collected. This will likely be an iterative process, and typically will happen independently with each MCO.

Task 4.1.1.12 Gather, process, validate, and analyze Managed Care encounter and claims data

The Lewin-Aon Team will gather, process, validate and analyze Managed Care encounter and claims data, including carved out services and provide technical assistance to the Managed Care organizations on data issues.

As described in Task 4.1.1.1, we will gather, process, validate and analyze encounter and claims data during the rate setting process. Our team will work with the MCOs and the fiscal

agent to address differences in the underlying encounter data and reports such as the aforementioned MRTs. Our actuaries recently provided technical assistance to an MCO in Georgia to address a gap we were observing between the encounter data and their financials. While we typically load an underreporting factor, this gap was too significant to rely on that factor alone. Either encounter data was missing or something was being reported wrong. Through a special data request to that MCO, and working with the MMIS vendor, Aon was able to validate the encounter data and have an appropriate base of data for rate setting. Furthermore, all of this information was made transparent to the State throughout the entire process.

While encounter data is a critical element in setting capitation rates and understanding cost and utilization trends within a Medicaid population, encounter data alone cannot provide a complete picture of the financial standing of a Medicaid Managed Care program. Encounter data needs to be supplemented and cross-validated with MCO financial reports and filings. To this end, our team works with MCOs to collect needed data elements with sufficient granularity to allow proper analysis. We also acquire public MCO filings (i.e. NAIC filings) to provide another view of the MCO data.

Task 4.1.1.13 Provide assistance in Directed Payment Program

The Lewin-Aon Team will provide assistance in development of methodologies for calculating Directed Payment Program amounts or other supplemental payments.

With the release of the Final Rule, CMS reinforced that actuarial soundness requires the capitation rates to cover only appropriate and attainable costs that are required to provide services under the contract and associated administrative costs. CMS moved to phase-out supplemental payments not meeting the definition of actuarial soundness. As an alternative, Final Rule 42 CFR 438.6(c) provides flexibility to implement delivery system and provider payment initiatives under the various risk arrangements. Specifically, 42 CFR 438.6(c)(1) describes types of payment arrangements that states may use to direct expenditures under the managed care contract. Many states are seeking approval for various innovative arrangements to preserve access for members and secure funds.

Lewin is currently working with BMS to develop DPP methodology to comply with the Final Rule and gain CMS approval while not generating a severe disruption to provider revenue. The DPP will allow continued payments to certain hospitals tied to utilization amounts. In developing this methodology, we utilized the Final Rule standards regarding innovative payment arrangements, building on the following key concepts:

- Payments are based on the utilization and delivery of services for enrollees covered under the contract
- Payments are provided to a certain category of providers
- Direct expenditures proportionately, using the same terms of performance for each provider

Similarly, Aon is currently working with Tennessee on their DPP that would allow continued payments to categories of hospitals tying those payments to performance and utilization rather than unreimbursed costs. To preserve access for TennCare Members to high quality and appropriate care, the directed payment will provide a uniform percentage payment increase for hospitals included in the eligible class. There will be a percentage adjustment made to the reported inpatient and outpatient costs based on actual claims payments submitted by

TennCare's MCOs. In its design, Aon complied with the new Federal Rule standards regarding innovative payment arrangements:

- DPP is based on the utilization and delivery of services for enrollees covered under the contract
- Fall within a certain category of providers
- Direct expenditures equally, using the same terms of performance
- Advance at least one of the goals and objectives in the quality strategy
- Assure that such goals were met
- Does condition network provider participation
- Not renewed automatically

Assisting TennCare with practical implementation, Aon has provided technical assistance to the program by ensuring the use of directed payments would be actuarially sound and compliant to CMS within the rate development process. The result of this was similar to how the HIF is reimbursed by the State, in which an add-on amount is incorporated into the rate in the event that payments need to be made.

Together, the Lewin-Aon Team brings these experiences, along with experience in several other states to support BMS in developing supplemental payment amounts.

Task 4.1.1.14 Perform actuarial analysis for transitioning of populations

The Lewin-Aon Team will perform actuarial analysis and valuation of the costs or savings established by implementing programmatic changes, including, but not limited to, the transitioning of populations from FFS to managed care or alternate coverage options.

The Lewin-Aon Team is fully prepared to assist the state with analysis of any program changes and their impact on the program and its costs. We have assisted BMS in analyzing the benefits, consequences and impact of the transition of both populations and benefits to or from managed care. Examples of this include Lewin's analysis of moving the West Virginia SSI population from FFS to managed care, and whether to carve pharmacy benefits in or out of the Managed Care program.

We will continue to work closely with BMS and our program administration experts as needed to analyze the impact of potential program changes, and new regulations and requirements. We will also work with BMS to understand how any changes may impact the program and the MCO costs to avoid unintended consequences. We feel it is critically important to conduct these analyses before a program change is put into effect so that all stakeholders within a State have a clear understanding of the potential costs of a program change. This approach will allow the Lewin-Aon Team to support BMS in being proactive rather than reactive and in ensuring budget transparency.

In addition to the standard capitation rate development, some of the actuarial analysis and valuation of the program costs that the Aon Team has recently provided to various State Medicaid agencies include:

- Integrating 1915b and c waivers under 1115 waiver design
- Calculating impact of the various 1115 waiver initiatives

- Modeling per capita caps and block grant impacts
- Developing MCO payment methods for newly required ACA provisions
- Designing a payment methodology for a Care Coordination and Medical Home program
- Developing the cost component of an MCO renewal RFP
- Developing state budget savings estimates and preparing budget projections for entire Medicaid programs
- Modeling cost-sharing options for various populations
- Analyzing the impact of federal and state health care legislation
- Developing non-capitation reimbursement arrangements, such as ASOs, to cover small and unique populations (such as IDD) for both medical and non-medical services
- Evaluating directed payments that are made to MCOs outside of capitation
- Advising on the cost and benefits of carving in or carving out pharmacy services from managed care and the impact of PBM-MCO relationships
- Conducting feasibility studies of a particular initiative
- Completing research and analysis of a complete array of health care issues

Aon also reviews underlying data and financial reports from MCOs (as well as states for FFS populations) throughout each fiscal year. This is important for an actuarial team to provide to states as monitoring of the data and sharing that information will ensure better monitoring of a program and that the right questions are asked.

One way that we do this is through our use of MCO reporting. The Lewin-Aon Team is at the very forefront in innovative ways to help our clients monitor and improve encounter data. Our expert actuarial and data team offer our Medicaid agency clients an MCO reporting tool to monitor data. These dashboards provide interactive, real-time and at- fingertip visual representation of various data items for self-service department-based analytics. Using these robust dashboards, the State can also mitigate the need for interdepartmental requests to the State's own internal analytic departments. These dashboards are custom-designed for the State specifications. The State is then able to internal data-dives and drilldowns without programming knowledge.

Furthermore, the MCO reporting tool allows our actuaries to spend less time pulling and cleaning data and then more time on identifying savings opportunities. Between variation/outlier analysis and reports from the State and MCOs, incremental managed care savings factors are developed to reflect the expected ongoing improvement of managed care efforts leading to incremental cost savings to the program. For programs recently implemented in which FFS data is used as the base for rate development, usually material managed care savings factors are needed and developed. Where more specific in-state data is not available, these factors are usually based on our experience with other states' manage care savings programs. For programs having a longer established history, such as West Virginia, in which to rely on managed care data as the basis for rate development, a moderate level of managed care savings is still expected. In determining incremental managed care savings, comparative efficiency analysis among participating plans and specific efficiency benchmarks are used. These may include the prevalence of ED uses for non-ED needs, generic drug dispensing rate, readmission rate, etc. Analyses of these are performed to identify improvement areas and quantify an appropriate range of incremental managed care savings for the programs.

Finally, program changes that are considered for potential cost savings or additional budget needs. We are fully prepared to assist the state with analysis of any program changes and their impact on the program and its costs. We utilize our policy experts as needed to interpret new regulations and requirements and our actuarial and data staff expertise to produce analysis of the impacts of the requirements. We also work with BMS to understand how the changes impact the program and the MCO costs given that the implementation and operations of the new requirements may impact the MCO costs in ways not anticipated due to contracting and state mandated requirements. The Lewin-Aon Team feels it is critically important to conduct these analyses before a program change is put into effective policy. The reason for this is so that all stakeholders within a State have a clear understanding of the potential costs of a program change. This allows our actuaries to be better partners for our state clients by being proactive rather than reactive and ensuring budget transparency.

Managed Care Program Administration

4.1.2. Waivers (RFQ 4.1.2.1 – 4.1.2.6)

For more than 25 years, Lewin has helped design and implement large-scale health programs for Medicaid agencies. ***Lewin has been a partner to BMS since the design of the first Medicaid managed care 1915(b) waiver and has successfully developed materials to support nine consecutive renewals and numerous amendments.*** The Lewin-Aon Team is knowledgeable about ongoing CMS developments in the waiver submission process, including the combined 1915(b) waiver form and requirements, and are able to quickly and efficiently draft waivers that meet federal requirements and minimize the degree of back-and forth needed in the federal approval process. Lewin has also prepared applications to modify existing waivers. For example, in West Virginia, Lewin prepared a waiver amendment to bring a new Provider-Sponsored Network into the Managed Care program. For this amendment, Lewin not only updated the waiver preprint but also provided documentation of network adequacy and compliance and kept CMS up-to-date on readiness activities that were essential to securing their approval. Most recently, Lewin updated the biannual waiver renewal application to carve pharmacy services out of managed care.

Lewin has developed waivers or portions of them (e.g., prospective and retrospective cost effectiveness analyses) for several states in addition to West Virginia, including Connecticut, Delaware, District of Columbia, Florida, Iowa, Kansas, Louisiana, Massachusetts, Montana, New York, and New Mexico.

Task 4.1.2.1 Assist with current and new programs developed and operating under new waivers or waiver renewals

The Lewin-Aon Team will assist with current and new programs developed and operating under new waivers or waiver renewals, including the tasks outlined in response Section 4.1.2.

Through our close work with BMS, Lewin is well positioned to provide continued support for West Virginia's 1915(b) waiver. We are an experienced partner in the waiver process and have substantial experience working with the State of West Virginia.

The Lewin-Aon Team also brings substantial federal experience critical to successful waiver development including extensive subjective matter expertise in the intricacies of Medicaid, Medicare, and the waiver process, as well as a solid working relationship with CMS. We have

worked with federal, state and local governments to evaluate and implement several 1915(b) waiver models and 1115 waivers.

Task 4.1.2.2 Assistance with drafting waiver applications

The Lewin-Aon Team will assist with drafting waiver applications.

The Lewin-Aon Team will continue to work with BMS to prepare reports and waiver applications that will be submitted to CMS in a timely fashion and will be available to discuss findings with or answer questions from CMS staff. Lewin brings historic knowledge and an extensive repository of programmatic and related information to support swift and complete responses to any CMS inquiries. Furthermore, our current relationships with CMS (both in the central and regional offices) contributes to our long term success in effectively navigating states' interests with CMS.

Task 4.1.2.3 Developing correspondence related to waivers

The Lewin-Aon Team will assist with developing correspondence, such as waiver applications, letters to federal entities, etc. related to waivers.

Working directly with BMS, the Lewin-Aon Team will continue to develop correspondence, such as waiver applications and letters to federal entities. Throughout the lifespan of the State's 1915(b) waiver, Lewin has quickly responded to questions from CMS to facilitate timely approvals. Lewin has developed waivers for a number of states, including 1915(b), 1115, and Health Insurance Flexibility and Accountability (HIFA) waivers, and has worked with CMS to obtain approval for a number of innovative and unique program designs. Our strong working relationships with CMS staff in the central and regional offices benefits states that rely on our assistance to gain federal approval for state-sponsored initiatives.

Task 4.1.2.4 Conducting financial analysis of waiver programs

The Lewin-Aon Team will assist with conducting financial analysis of waiver programs and developing recommendations for improving effectiveness and efficiency of waiver programs.

The Lewin-Aon Team will continue to prepare the biannual Cost Effectiveness portion of the MHT 1915(b) waiver renewal. This analysis, a requirement for each renewal, is used to demonstrate to CMS that the waiver is providing cost savings. Lewin has performed this task multiple times over the course of our work with BMS. In doing this, we calculate retrospective waiver cost using enrolment, claims, capitation, and administration data and then project that cost to future periods, similar to tasks involved in rate setting. The analysis compares waiver performance over time, as the current retrospective data is compared to the projected data from the previous renewal. The Lewin-Aon Team will submit the analysis to CMS and perform any follow-up analysis as a response to CMS questions.

For BMS, Lewin performed an analysis of Managed Care pharmacy costs, compared to projected FFS costs, which showed potential saving in FFS. As a result, BMS decided to remove the pharmacy benefit from capitated managed care.

Lewin has performed analysis in order to gauge the efficiency of the existing MHT program and provide estimates of the impact of changing the services and populations included in it. As part of the annual MHT Report, we calculate estimated savings

resulting from the MHT Managed Care program as compared to FFS costs. We also built additional savings analyses to bring in additional populations by estimating a managed care rate and comparing to FFS costs. This has been done for the West Virginia Health Bridge expansion program and the SSI program, which have both been subsequently moved into managed care.

We have performed additional financial analysis of the MHT waiver and the Lewin-Aon Team will continue to do so. This includes collecting financial reports from the participating MCOs, analyzing them, and creating a dashboard to illustrate the financial performance of the waiver as a whole and compare the performance of each MCO. Through collaboration with BMS, this information can be used to identify dips or spikes in cost that need to be addressed.

Task 4.1.2.5 Developing an annual report on waiver programs

The Lewin-Aon Team will assist with developing an annual report on the Bureau for Medical Services waiver programs, including a financial, service, and demographic overview of the programs.

Lewin has been assisting BMS with the development of the MHT Annual Report since 1995 and will continue to do. The MHT Annual Report focuses on many important aspects of the MCO program, which has established a multi-dimensional partnership between BMS, the federal government, enrollees, providers, and the MCOs that participate in the program. The MHT program has implemented a range of initiatives to coordinate and integrate care beyond traditional managed care, focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care. These initiatives and related outcomes are captured in the annual report that is distributed to the community, enrollees, state Legislators and the MCOs.

The MHT Annual Report addresses:

- Enrollee experience with the program
- MCO enrollment
- Program cost savings
- MCO programs, outreach, and education
- Quality, access, and timeliness of care

Task 4.1.2.6 Assistance with activities related to 1115 waiver for Substance Use Disorder

The Lewin-Aon Team will assist the Bureau with activities related to its 1115 waiver for Substance Use Disorder, including but not limited to, federal reporting requirements and financial analysis, as needed, which will be administered under the managed care organizations.

Assisting BMS with activities related to its 1115 waiver for Substance Use Disorder through our continued collaboration with the MCOs and provider networks will permit Lewin to develop a robust reporting system. The Lewin-Aon Team has a highly qualified team of experts with many years of experience to consult with state and subject matter experts to increase the understanding of how states use the 1115 waiver to serve high risk populations (e.g., individuals with mental health and substance use needs) and to identify ways that states could use the 1115 waiver as a tool to support broader system transformation.

The Lewin-Aon Team has completed multiple projects with federal and state clients with a focus on services and supports needed for high risk populations. These projects include supporting

the policy development and evaluation of programs for persons with Alzheimer's, children with autism, Medicare/Medicaid enrollees, and persons with psychiatric disabilities and chemical and substance use disorders. Lewin assisted New York in the design and implementation of SNPs to serve Medicaid-eligible individuals with HIV/AIDS under the state's broad 1115 demonstration. Activities ranged from supporting the procurement to examining the financial stability of the SNPs.

Lewin will synthesize the financial data and additional data/information from the substance use disorder project to meet federal and state reporting requirements.

4.1.3. Analysis (RFQ 4.1.3.1 – 4.1.3.4)

Task 4.1.3.1 Provide policy impact analyses and support

The Lewin-Aon Team will provide policy impact analyses and support to the Bureau, including, but not limited to, reviewing and analyzing policy options, developing documents for review, fiscal analysis and programmatic impact, conducting federal regulatory review, developing presentations, and assisting with implementation of adopted strategies (i.e. preparation of work plans, facilitation of meetings, monitoring, and evaluation).

The objective of Task 4.1.3.1 is to identify and assess potential policy changes to improve the efficiency and quality of care of the West Virginia Medicaid program. Lewin has performed this task through multiple situations over the life of our current engagement with BMS. Based on our experience and knowledge of existing Medicaid policy and the health care infrastructure in West Virginia, we are prepared to continue such policy analysis going forward.

For the New York State Department of Health, Lewin assisted in implementing a statewide mandatory Medicaid Managed Care program. Our work included:

- Designing program modifications to support the enrollment of the SSI population
- Development of quality assurance standards for MCOs
- A Program monitoring plan
- Facilitating a statewide task force to consider various design issues, including those related to quality assurance and performance improvement
- Investigating the experiences of other states that have enrolled SSI adults and children

In order to improve the health outcomes and overall quality of care for Medicaid managed care enrollees in West Virginia, Lewin worked with BMS to develop multiple versions of a pay-for-performance program for MCOs participating in the MHT Managed Care program. This program provided monetary reward to MCOs based on improvements in quality measure scores. While the initial version featured a percentage bonus on top of the capitation paid, the later version withheld a percentage of capitations which the MCOs had the opportunity to earn back. We developed the scoring methodology to determine the percentage payout and the actual payout amount. We developed presentations to illustrate both the methodology and results. There were payouts made to multiple MCOs, indicating improvement in their quality scores.

Lewin worked with BMS to carve-in services and populations to the MHT program, in order to lower cost and improve quality and efficiency. Services included pharmacy, dental, and behavioral health. Populations included West Virginia Health Bridge Medicaid Expansion and

SSI. Lewin developed estimates of cost savings that could be realized as a result of each carve-in service or population. These estimates were reviewed by BMS, who in turn, determined to proceed with the carve-ins. We collaborated with BMS, MCOs, CMS, and stakeholder groups (i.e. West Virginia Hospital Association) to develop a project plan to manage each carve-in. We managed the project plan through implementation, which included readiness reviews of each MCO and identification of key MCO deliverables.

Lewin is currently leading the state's cutting-edge approach to bridging Upper Payment Limit funds to managed care. In that capacity, Lewin manages negotiations with the state Hospital Association, West Virginia and Marshall Universities, the state's four Medicaid MCOs, and the CMS Office of the Actuary. The result is an approach that stakeholders support and CMS considers a model for other states.

Our team will continue to employ a mix of study strategies to identify and assess policy options. ***In addition to our extensive knowledge of the health care landscape in West Virginia and the issues that define it, we leverage our experience with other health care delivery programs to determine options to consider.*** We will look for best practices across payers, including other state Medicaid programs and Medicare, to help BMS identify the best policy options to consider. This will include identification and tracking of best practices and determining how they can be applied to West Virginia.

We will use a team-based research and review process to ensure that all output is thorough, well-documented, and accessible to target audiences. Depending on the goals and requirements of a specific request, our approach to policy analysis will draw upon a wide range of data collection and analytic methods which may include the following:

- Identify and clarify the policy issue to be examined, including clarification of the project scope, in consultation with BMS
- For BMS review, draft work plan and timeline and detailed project approach, including study period, outcome and process measures, and required deliverables
- Engage with stakeholders to gather input on project design, as appropriate
- Conduct an initial review of relevant research to understand factors including state and national context, policy options under consideration, research findings and recommendations, and Federal and State current policies and guidance
- Develop initial evaluation criteria for policy options to assist BMS in prioritization and decision-making
- Determine what combination of qualitative and quantitative sources would best address the policy analysis goals and issues (e.g., surveys or interviews of subject matter experts, stakeholders and state/federal agency staff, benchmarks derived from related policies, program-specific performance measurement or outcomes data, CMS or state program data)
- Determine best methodology for analysis, recognizing resource/data availability and timeline for completing the task
- Develop and submit data request, data use agreements, interview protocols, or other information collection tools as needed
- Perform data preparation and cleaning, and begin initial analysis

- Build an actuarial model, in order to project the impact of the policy change on multiple measures, such as enrollment, cost and utilization
- Develop assumptions used to model the projection (e.g., cost trend, enrollment increase factor)
- Using the model, apply assumptions to the data to arrive at results
- Perform technical peer review of all calculations
- Identify subject matter experts and benchmarks to validate data and findings
- Finalize analysis and information synthesis, including identifying major pros and cons of policy options or models based on BMS' priorities
- Develop presentations to explain the methodology used and the results found to BMS and stakeholder groups, including CMS, MCOs, and provider associations.
- Draft final report and/or briefs based on findings and make recommendations to BMS

If multiple options are being considered, we will work with BMS to identify criteria that can be used to evaluate the policy options and inform decision-making. Exhibit 4-4 shows an example of how multiple initiatives could be reviewed for feasibility.

Exhibit 4-4: Sample Prioritization of Potential Initiatives, At-a-Glance (excerpt)

	Planning Timeline	Impact	Staff Resources	Evidence Base
Potential Initiative #1	Short term	Low	Need to hire additional staff	Strong evidence base to support initiative
Potential Initiative #2	Short term	High	Have necessary staff	Strong evidence base to support initiative
Potential Initiative #3	Medium term	Medium	Can leverage contractors	Limited evidence base to support initiative
Potential Initiative #4	Short term	High	Have necessary staff	Strong evidence base to support initiative
Potential Initiative #5	Long term	Low	Need to hire additional staff	Strong evidence base to support initiative

Task 4.1.3.2 Revision of analyses

The Lewin-Aon Team agrees to revise all analyses based on future releases or revisions of information at the state or federal level within an agreed upon timeframe between the vendor and Bureau.

The objective of Task 4.1.3.2 is to ensure that all analyses and reports delivered to BMS are based on the most up to date specifications and data at the time of analysis and can be revised or refreshed with updated data.

Prior to performing any analysis, the Lewin-Aon Team will confirm the specific requirements with BMS. These requirements include the source and timeframe of the data, assumptions applied to the data, specific output fields and format. We also rely on our own knowledge and experience to ensure that we are performing the analysis accurately, based on the agreed requirements. After finalization of the requirements, we will perform the analysis and provide results to BMS.

Using this process, and barring significant changes in scope, we will successfully meet the timelines agreed upon for analyses.

However, there are situations in which requirements may change or more recent data has become available. Upon identification of any such change, Lewin will determine the materiality, feasibility and timing associated with making that change. We will collaborate with BMS to determine whether or not to proceed with the change and develop an agreed-upon timeframe. We use standardized programming and models in its analyses, so that changes to data or assumptions can be made without having to recreate the code. When an analyses needs to be refreshed due to a change in a key variable (i.e., study period), we can make the change in the code, and repopulate models with updated data. We will review the code outputs, like we would with any analysis.

Lewin conducted several analyses for BMS, including cost savings estimates, in which we re-ran the analysis based on updated data. We have also re-run rate setting analyses and delayed the delivery date, in order to include the most up-to-date data to provide greater credibility in rate development.

Task 4.1.3.3 Monitor federal regulations and requirements

The Lewin-Aon Team will monitor federal regulations and requirements for potential changes and provide analysis on program impact on an ongoing basis.

The objective of Task 4.1.3.3 is to regularly monitor changes in federal policy that may impact the MHT program and estimate the changes necessary to comply.

Lewin has expertise in federal policy through our work with federal agencies, including CMS. We regularly monitor CMS Bulletins and the Federal Register. We participated in public webinars, conference calls, and other CMS meetings in which changes were announced or explained. One recent change was the new Managed Care Rule, which provided wholesale changes to the capitation rate development and approval process. Upon announcement of this rule, Lewin actuaries and subject matter experts reviewed the proposed changes in order to determine their impact on the program. We also participated in calls regarding these changes. As a result, we were able to incorporate several changes to our rate setting methodology. Lewin also incorporated significant changes required under the new regulations into the MCO contract.

Lewin works directly with CMS to gain guidance and/or approval of prospective changes. This includes the DPP, in which additional monies paid in FFS were incorporated into managed care capitation rates. Lewin participated in several calls with BMS and the CMS regional and central offices. We then drafted a methodology, based on the feedback received. Lewin incorporated CMS feedback and eventually received approval from CMS. The methodology was then implemented. Our team will continue to monitor available feeds, in order to capture the most recent federal updates. We will then disseminate these changes to BMS, and assist in development of a compliance solution. Along with BMS, we will communicate with the appropriate CMS areas in order to get approval of any proposed solution.

Task 4.1.3.4 Program integrity

Lewin will provide a full-time program integrity analyst to assist with oversight of managed care fraud, waste and abuse reporting and improvement in recouping Medicaid funds.

The objective of Task 4.1.3.4 is to provide an onsite program integrity analyst, who will work with West Virginia's Medicaid MCOs and the BMS Office of Program Integrity in the identification of fraud, waste, and abuse (FWA) in the Medicaid program. This individual will also collaborate with the MCOs to improve both reporting on FWA activity to BMS and recoupment of monies found as a result of FWA investigations.

Program integrity is a key component of Medicaid program administration to prevent the loss of public dollars to FWA. Lewin has experience with FWA analysis, including in West Virginia. In response to CMS Medicaid Integrity Group (MIG) audits, we worked with BMS to implement solutions to address areas of concern. For example, we trained MCO staff on updated requirements on disclosures and provider screenings and implemented expanded MCO reporting on FWA activities. We also led the creation of a Managed Care program integrity work group to develop new and improve existing processes related to the three key program integrity prevention elements: provider enrollment and screenings, program exclusions and credible allegation of fraud. The workgroup brings together BMS managed care and program integrity staff, the Medicaid Fraud Control Unit, Office of the Inspector General, and the MCOs.

The Lewin-Aon Team's program integrity analyst chosen for this engagement will have experience with program integrity systems and analyses and will be prepared to assist BMS immediately. The analyst will examine current West Virginia program integrity procedures, including predictive modeling and detection algorithms, and will look for areas for improvement. They will also familiarize themselves with the existing reporting and collaborate with BMS in order to make it more effective. The program integrity analyst brings a strong understanding of Medicaid regulations and will be prepared to ensure that new requirements being sought by CMS are met by BMS and participating MCOs.

4.1.4. Operations Plan (RFQ 4.1.4.1 – 4.1.4.5)

The Lewin-Aon Team will develop an Operations Plan within the first 30 calendar days of contract that addresses compliance with the program requirements and services in response Section 4.1.4.

BMS requires an experienced partner to support the effective and efficient administration of West Virginia's MHT program, including support in the development of a robust Managed Care Operations Plan to track progress in achieving goals and managing risks. As a trusted partner since 1995, Lewin's ability to support BMS' Managed Care program in the development of an Operations Plan is unmatched. We understand well the progress West Virginia has already made on its Managed Care program and know the primary players and stakeholders; having worked with them over the years to achieve BMS' goals. West Virginia has a strong record of Managed Care contracting and Lewin is eager to continue working with BMS in incorporating innovative strategies to further enhance the existing program. Moreover, Lewin has the substantive experience and qualifications to deliver on all of the tasks within the Operations Plan and can hit the ground running on all components of the plan.

Key components of this plan are Managed Care contract development, contract maintenance, maintenance of provider enrollment, readiness evaluation, reporting, and ongoing monitoring of

MCOs and their performance. Lewin has repeatedly demonstrated our expertise in the following areas with our clients and especially with West Virginia:

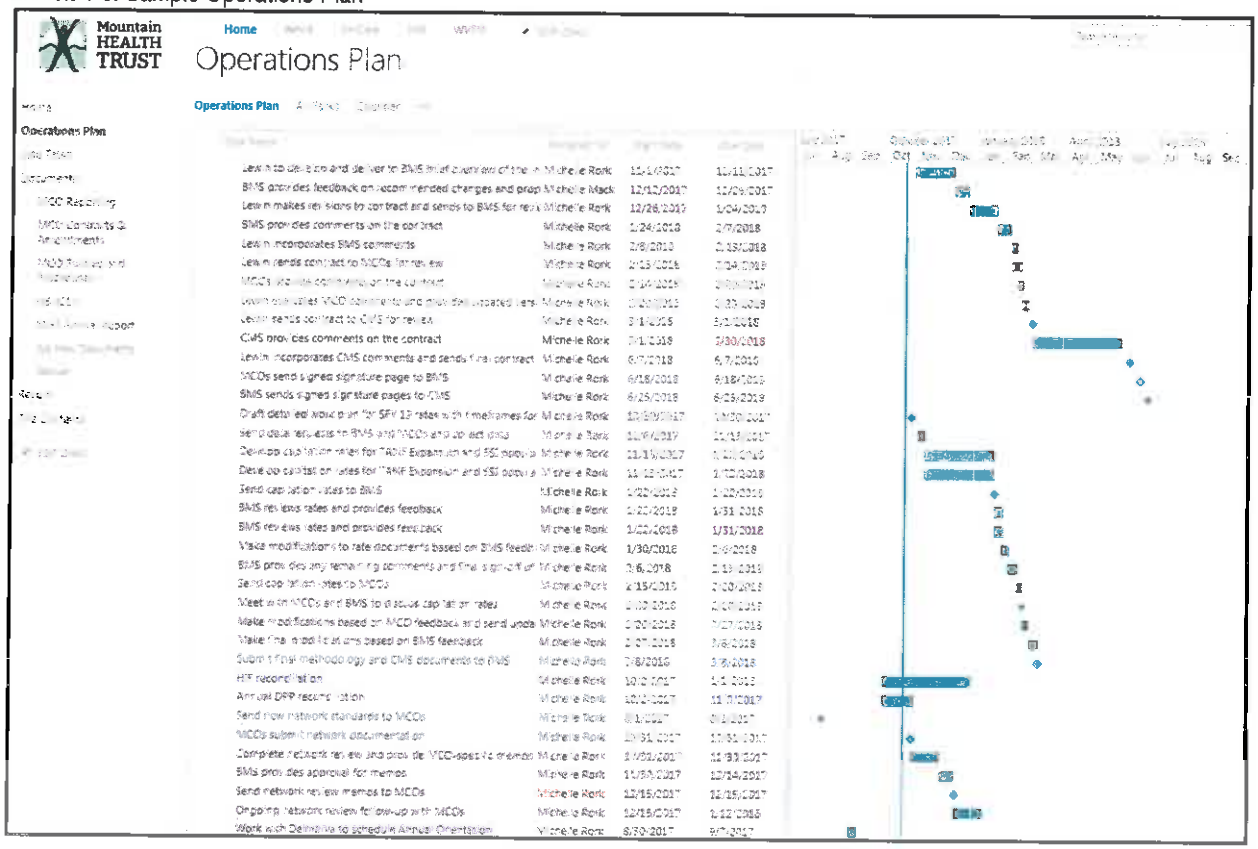
- Policy Analysis
- Managed Care Waiver Applications and Responses
- Managed Care Contract Development, Procurement, and Maintenance
- MCO Readiness and Desk Reviews
- MCO Compliance and Performance Monitoring
- Provider Payment Reform
- Stakeholder Engagement
- State and Federal Reporting

We bring a unique breadth and depth of experience of working with the Centers for Medicare and Medicaid Services on Medicaid Managed Care initiatives and a deep understanding of West Virginia's dynamic Managed Care program to successfully support all management and program operations.

An important part of a successful Operations Plan is ensuring that key stakeholders are engaged at the right times throughout the plan's implementation life span. While we thoroughly understand the current requirements to be included in the Operations Plan, we will meet with BMS to establish any new goals they would like to promote in the Managed Care program. For example, we know that increasing program integrity activities are on the horizon for SFY 2019. Lewin will collaborate with BMS, the MCOs, and other relevant stakeholders to integrate any new activities into the Operations Plan. Lewin has the direct experience working with West Virginia's managed care stakeholders needed to successfully support BMS' goals for continuing the transformation of the MHT program.

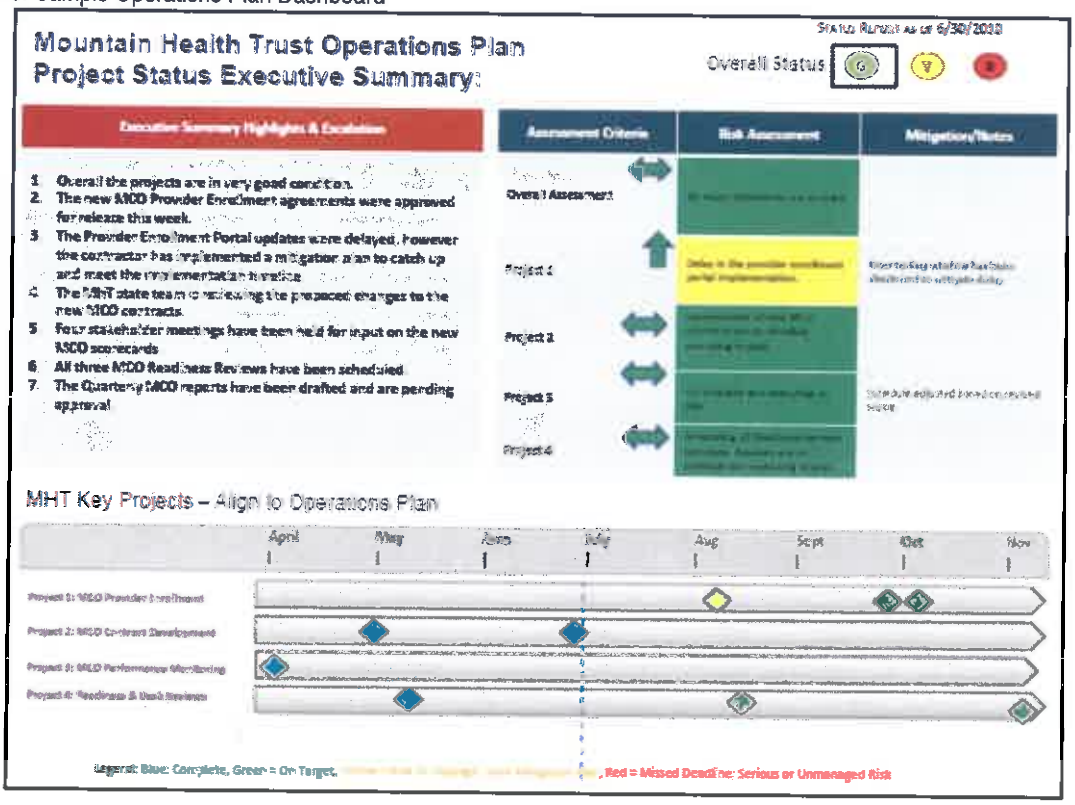
These unique sets of experience will be leveraged to develop a tailored Managed Care Operations Plan for BMS within the first 30 calendar days of the contract. Led by Ryan Benson, PMP, the Operations Plan will provide the MHT operations team a critical tool for implementing BMS' strategic plan for managed care and will serve as a cornerstone document at operations meetings and ensure that the team is on track to meet upcoming milestones and to manage risks. The plan will document the MHT projects, associated tasks, task owners, implementation timelines, and key milestones. The initial Operations plan will be accessible through the MHT IRC. While the initial Operations Plan, similar to the one shown in Exhibit 4-5, will be submitted within the first month, the Operations Plan will be a living document that Lewin will revise as BMS' program needs and priorities evolve.

Exhibit 4-5: Sample Operations Plan



In addition, to provide a high level, quick summary of upcoming project milestones and to manage project risks, Lewin will also provide an Operations Plan Dashboard, similar to the one shown in Exhibit 4-6, to augment the Operations Plan. Lewin will work with Bureau staff to design a dashboard that provides Executives and Operations staff both a quick status update on key MHT projects and a tool for prioritizing resources and for triggering any necessary escalations and mitigation plans.

Exhibit 4-6: Sample Operations Plan Dashboard



Task 4.1.4.1 Development and maintenance of provider enrollment and Managed Care contracts and agreements

The Lewin-Aon Team will develop an Operations Plan that includes development and maintenance of provider enrollment and Managed Care contracts and agreements.

One of the key components of the Operations Plan is the implementation of the Managed Care Report Review and Compliance Dashboard that will be used for managing the MCO contracts, contract amendments, policies and procedures documents, quality metrics and report cards, network adequacy and readiness review documents, grievance and appeals, and training as outlined in response Section 4.1.6. Lewin will also use our experience with the MHT program to document in the Operations Plan, the critical managed care contracting milestones throughout the year.

One of the new requirements under the final Medicaid and CHIP rule is to screen, enroll, and periodically revalidate all MCO network providers. Lewin will work closely with BMS and BMS' Fiscal Agent to identify the tasks and key milestones in the Operations Plan for developing any new provider agreement content, performing stakeholder outreach, and screening and enrolling all managed care network providers who are not already enrolled in the State's FFS system to meet these new CMS requirements. New provider agreement content may include additional monitoring requirements and reports, outreach and member services requirements, staffing ratios, or hiring requirements if additional populations or services are carved into the managed care contracts.

Task 4.1.4.2 Coordinating with state staff on the development of the Managed Care contract

The Lewin-Aon Team will develop an Operations Plan that includes coordinating with state staff on the development of the Managed Care contract.

Development of Managed Care contracts is another key component within the Operations Plan. Building on West Virginia's successful Managed Care program, Lewin will work closely with BMS staff to design and develop new performance-based contracting options for current populations as well as contracts tailored to meet the special needs of any future populations such as dual eligibles, youth in foster care, and individuals receiving long term services and supports.

For BMS, Lewin has:

- Developed managed care contracts and amendments since 1996
- Created a MCO provider application
- Conducted readiness reviews for MCOs
- Determined MCO readiness related to three new benefits and two new populations

Lewin has expertise in both designing Managed Care contract content and supporting the state's Managed Care contracting procurement process, and has worked with BMS through two iterations of federal Medicaid Managed Care regulations and implementation of the ACA. Lewin understands BMS must have a managed care strategy that promotes competitive managed care contracting in largely rural areas of the state and that also stimulates MCO performance improvements in key areas while continuing to support West Virginia's safety net and traditional Medicaid providers. One critical decision the State must make is to determine how many MCOs in the program are optimal for the projected membership with the recent inclusion of the SSI population and any future Medicaid coverage changes. Lewin understands this delicate balance. Too few MCOs may overtax the existing network capacity and result in inadequate access to care, improper delivery of services, and poor health outcomes. Too many MCOs could result in insufficient enrollment to sustain efficient operations, leading to unnecessary pressure to increase capitation rates or, ultimately, MCO withdrawal from the program. Lewin staff have worked with a number of state Medicaid programs to develop criteria to determine the ideal number of MCOs to participate in the program to strike a balance between providing sufficient enrollee choice and efficient program operations. The Lewin-Aon Team has extensive experience with states in designing procurement provisions to meet the state's goals, including MCO RFP development, the use of a competitive bid strategy, and scoring. We will work closely with state staff to ensure that the Operations Plan includes both the regularly expected annual updates to the existing managed care contracts as well as adequate time for new procurements or development of any new requirements related to new populations or benefits as discussed in Task 4.1.5.12. As part of this component, stakeholder involvement, rate setting, review by CMS, and related system changes will be addressed in the Operations Plan.

Task 4.1.4.3 Analysis and monitoring of Managed Care contract performance

The Lewin-Aon Team will develop an Operations Plan that includes analysis and monitoring of Managed Care contract performance.

Lewin understands West Virginia must ensure participating MHT MCOs meet contract performance criteria including network adequacy and quality standards not only prior to contracting, but also throughout the contracting year. Thus, analysis and monitoring of the Managed Care contract performance is another key component of the Operations Plan. Lewin will work closely with BMS and other partners such as BMS' External Quality Review Organization (EQRO) to develop a comprehensive quality and performance monitoring plan as well as to monitor things like the network adequacy and utilization of important medical services by MCO as described in response Section 4.1.5. Lewin will also evaluate encounter data as well as track the timeliness of and review required MCO reports. Key milestones of this quality and performance monitoring plan will be included in the Operations Plan.

Task 4.1.4.4 Development of MCO performance scorecards and annual MCO performance reports

The Lewin-Aon Team will develop quarterly MCO performance scorecards for public distribution and an annual report on MCO performance and compliance with contractual obligations within 30 calendar days of the end of the reporting period. The annual report will also address program enrollment, services available, cost savings resulting from the program, performance on key quality indicators, MLR overview, improvement strategies implemented, program goals, and other information as requested by the Bureau.

A significant component of the Operations Plan is to produce quarterly MCO performance scorecards (also referred to as an "MCO quality metrics and report card" as described in Task 4.1.6.4) and annual MCO performance reports. These reporting tools are critical to monitoring and managing the MHT program. From our work over the years with the MHT program, we understand the audiences for these reports and scorecards. Lewin currently supports BMS in producing reports such as the MHT Annual Report shown in Exhibit 4-7, analyses, legislative briefs, and other communications tools around cost savings analyses and policy enhancements that support BMS' program messaging and promotes buy-in from key legislators and policy makers.

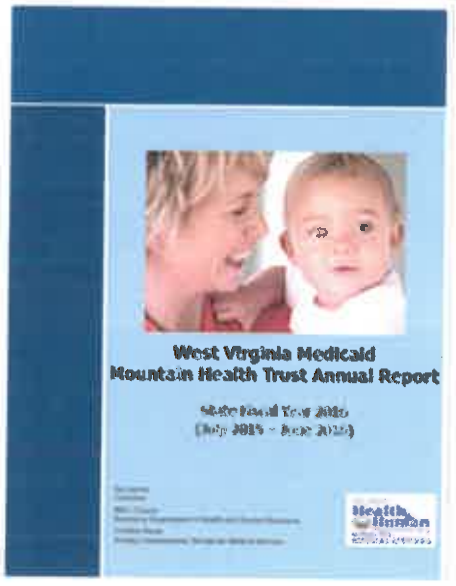


Exhibit 4-7: MHT Annual Report

Lewin will produce the MCO performance scorecard one month after the end of the quarter while the annual report will be produced one month after the end of MCO contract year. The scorecard will be designed to highlight each MCO's performance in areas such as:

- Average monthly enrollment by coverage group
- Network adequacy measurement

- Quarterly EPSDT screening and treatment rates as measured by the CMS 416
- Quarterly dental screening and treatment rates as measured by the CMS 416
- Number of ED visits
- Numbers of grievances, appeals, and resolutions
- Annual HEDIS scores
- Annual CAHPS scores

Since these performance scorecards need to be available for public distribution, Lewin will work with BMS to build in additional levels of review and approval into the Operations Plan. It will also be important to include stakeholder involvement in the initial development and design of the scorecard to create buy-in before public distribution. The MCO performance scorecards will be updated quarterly. Lewin can provide guidance in interpreting results to the enrollment broker, Medicaid eligibility workers, advocacy groups and others that may assist Medicaid enrollees in making MCO choices.

The annual report will include information on each MCO's compliance with contract requirements, MHT program goals, outcomes of improvement strategies implemented over the reporting year, MHT program enrollment, program cost savings information, current managed care quality indicators such as HEDIS scores, Medical Loss Ratio overview, and other information requested by BMS.

Task 4.1.4.5 Conduct program readiness document and desk reviews for managed care entities

The Lewin-Aon Team will conduct program readiness document and desk reviews, as needed, for an undetermined number of managed care entities, dependent upon entry into the West Virginia Medicaid program. Reviews will also be provided on an on-going basis for existing MCOs in the event the Bureau would add a new population or benefit to the MCO contract, and such review was warranted to ensure continued network adequacy compliance and readiness to meet Medicaid standards.

Conducting program readiness and desk reviews for managed care entities is a final key component of the Operations Plan. The assessment of a contracting MCO's readiness to provide health care to MHT plan enrollees is performed both prior to the start of actual operations and on an ongoing basis to monitor health plan performance. The ongoing aspects are timed to reflect the critical nature of the item subject to review (e.g., Policy and Procedures are reviewed as they are updated, whereas, Fraud and Abuse Compliance Plans are reviewed on an annual basis). Review and evaluation of an MCO's readiness to begin operations and serve MHT enrollees includes the following major steps:

- Coordination with BMS for Medical Services
- Development of a schedule of deliverables
- Review of provider networks and primary care physician availability
- Desk review of MCO's policies and procedures to assess compliance
- Onsite health plan visits
- Coordination with CMS as they conduct a review of readiness processes to evaluate health plans compliance with rules and readiness to commence operations

In the case of a program expansion, Lewin would initiate a similar review process to determine a participating MCO's readiness to provide a new benefit or serve a new population. Under our current engagement with BMS, Lewin has assessed readiness for pharmacy, behavioral health, and children's dental services as well as the addition of the ACA Expansion and SSI populations. For previous program expansions, we conducted a desk review of policies, procedures and staffing plans to assure the MCOs' preparedness as well as compliance with program requirements. New network standards were developed and plan networks were also evaluated. The results of these reviews were submitted as part of the 1915(b) waiver to obtain CMS approval.

Program readiness and desk reviews can require a significant investment of time, depending on the scope of the deficiencies identified and MCO's response time. Lewin has a number of staff with health plan experience and has conducted high visibility readiness reviews for a both state and federal clients. For example, Lewin conducted extensive readiness reviews for health plans participating in the Financial Alignment Initiative Demonstration, the first ever opportunity to blend both Medicare and Medicaid funding streams to serve Medicare-Medicaid enrollees in a single delivery system. Lewin has the experience to complete these reviews in a timely manner, has existing relationships with the MCO staff that will facilitate shorter response times, and has a flexible team that can dedicate staff time as needed to successfully complete the reviews.

Lewin has assessed readiness for numerous MHT expansions:

- SSI
- ACA Expansion
- Behavioral Health
- Children's Dental
- Pharmacy
- Provider-Sponsored Network
- MCO Service Area Expansions

4.1.5. Evaluation of Network Adequacy (RFQ 4.1.5.1 – 4.1.5.13)

Task 4.1.5.1 Analyses and ongoing monitoring of MCO provider networks

The Lewin-Aon Team will perform analyses and ongoing monitoring of MCO provider networks, and conduct quarterly analyses of the MCOs' networks against program requirements. Our Team will also develop MCO-specific reports and maps showing providers, clinics, and hospitals by specialty and location. This information will be submitted within 10 calendar days of request, unless otherwise noted.

Lewin is equipped to assess the availability and capacity of West Virginia's MCO provider network to provide adequate access to MHT enrollees. Members of our project team have over two decades of experience, serving as leads in the development of reasonable and reliable network criteria by which provider networks are evaluated. Our expertise with new and expanding Medicare Advantage plans, including developing network adequacy standards, and annually reviewing provider networks, uniquely positions our team to assist BMS with network monitoring. We understand the necessity of provider networks that accommodate the full range of specialty types and geographic variants in the delivery of care. With this understanding and deep knowledge of the Affordable Care Act, CMS requirements, the insurance industry, provider practice patterns, consumer perceptions, West Virginia's geographic makeup, and the MHT program, our team is prepared to make recommendations for network considerations and engage in network reviews.

With the new federal rule governing Medicaid managed care, Lewin's substantive regulatory knowledge and familiarity with the status of West Virginia's network standards lends itself to

efficient and effective implementation and evaluation. Lewin will assist BMS to evaluate factors such as:

- Expected utilization of services
- Characteristics of the population's health care needs
- Number and types of providers to deliver Medicaid services, including safety net providers
- Anticipated Medicaid enrollment
- Number of providers not accepting new patients
- Geographic location of providers and enrollees
- Means of transportation ordinarily used by enrollees
- Ability of providers to communicate with enrollees with limited English proficiency
- Reasonable accommodations for enrollees with physical or mental disabilities

Lewin's proposed technical approach to evaluate provider networks is focused on these considerations to ensure network adequacy standards are met. Our network adequacy model accounts for the minimum number of providers required to serve enrollees, and for the maximum time and distance permitted for travel to those providers. After we thoroughly analyze utilization data and establish network standards, we will provide detailed guidance and reporting templates to each MCO. Our data visualization tool, HealthView allows us to perform network evaluations. HealthView facilitates consistency across reviews, enabling Lewin to analyze the data for deficiencies and identify areas for improvement. It also shows geographic mapping of network providers. MCOs can request exceptions to network requirements when they are unable to meet specific criteria. Lewin's Medicaid experts will collaborate with BMS and the MCOs to provide actionable suggestions to improve access for MHT enrollees.

With the MCO quarterly report submissions, our team will monitor changes in provider networks to ensure enrollees have appropriate access. Lewin will also perform ongoing spot checks on the data submitted to verify that the individual, group, or facility listed is operating at the given address and is practicing in the specialty indicated by the MCO. Member materials, such as provider directories, will also be reviewed and monitored to ensure that the MCO provides members with accurate network information. Annual and quarterly information will be submitted within 10 calendar days of request, unless otherwise noted.

Task 4.1.5.2 Work plan and project timeline

The Lewin-Aon Team's Operations Plan will include a work plan and timeline for project.

Lewin's proposed Network Adequacy Evaluation timeline is outlined in Exhibit 4-8, based directly on our current experience in network reviews. Lewin brings unmatched knowledge with the MCO provider networks, and understands known issues with limited provider supply (e.g., limited OB/GYNs and ENTs, and DME provider shortages) and can work with MCOs to address these network challenges. Furthermore, this knowledge, in addition to our relationships with the MCOs, leads to a more efficient network adequacy evaluation process.

Annually, Lewin will develop a detailed work plan, which includes an annual, comprehensive analysis of each MCO's provider network. On a quarterly basis, Lewin will perform a network

review to ensure MCO contract and federal regulatory compliance for the existing MHT health plans.

Exhibit 4-8: Lewin's proposed Network Adequacy Evaluation timeline

Schedule of MCO Provider Network Evaluation 2018 – 2019	February 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018	January 2019	February 2019
1. Send Network Standards and Templates to MCOs							X						
2. MCOs Submit Data and Documentation									X				
3. Complete Annual MCO Network Evaluation									X	X			
4. *Provide MCO Specific Memos to BMS*										X			
6. *BMS Provides Approval for Memos and Maps*										X			
7. *Send Memos and Maps to MCOs*										X	X		
8. *Ongoing Follow-up with MCOS*											X	X	
9. *Quarterly Provider Network Review*		X			X			X			X		

Task 4.1.5.3 Comprehensive reporting calendar

The Lewin-Aon Team will work with the Bureau to develop a comprehensive reporting calendar for the MHT program that complies with federal, state, and bureau-specific reporting requirements as currently defined by the managed care contract.

Keeping track of report due dates is essential for efficient operation of the MHT program. As reports are received by BMS, a reliable system to keep track of them is necessary. Lewin has significant experience assisting states in the ongoing management of Medicaid Managed Care programs. Our most important engagement has been assisting BMS for Medical Services with the ongoing management of MHT. Since 1995, Lewin has partnered with Bureau staff, representatives from other Department of Health and Human Resources agencies, the enrollment broker, the external quality review organization, the Medicaid fiscal intermediary, and other stakeholders in the MHT program.

Lewin-Aon Team members developed the current reporting calendar as part of their MCO and will work with BMS to maintain and update as required. This reporting calendar will be integrated into our Project Management System as described in response Section 4.1.6. From the system, BMS and the Lewin-Aon Team will be able to monitor upcoming deliverables, track each MCO's compliance, and retrieve submitted reports.

This tenure and deep understanding of West Virginia's performance monitoring methods and data intricacies, coupled with our national knowledge of best practices, is unique to Lewin. It enables us to design a comprehensive monitoring plan that leverages existing monitoring activities to develop systematic feedback loops for continuous program improvement and to support reporting to CMS as needed.

Task 4.1.5.4 Identify and comply with federal regulations

The Lewin-Aon Team will identify and comply with all federal and state Medicaid laws, regulations, and policies, as outlined by the Centers for Medicare and Medicaid Services and the Bureau for Medical Services.

The objective of Task 4.1.5.4 is to support BMS in complying with externally-driven changes to programs and requirements, including any state or federal laws, rules, and regulations. Lewin will continue to support BMS, as we have done for two iterations of managed care regulations. Our approach will include addressing the potential impact of the repeal of the ACA and other state or federal requirements as they may arise so that the MHT program continues to be in full compliance with all regulations and requirements, while providing quality care to its enrollees.

Lewin has demonstrated our understanding of the intricacies of federal legislation by providing analysis of national and state-level estimates of the impact of the ACA and the Health Care and Education Reconciliation Act (HCERA). Using Lewin-developed modeling techniques, we estimated key areas related to health reform coverage and insurance market reforms.

To complete this task, the Lewin-Aon Team will analyze and assess key health reform components that are likely to impact BMS and its stakeholders, track and evaluate several health-reform related funding opportunities, and provide analytic and modeling support for BMS. We have extensive of experience needed in addressing and planning for state and federal changes in law, rules, and regulations. For example, Lewin completed a project with the NYS Health Foundation to address opportunities for containing health care costs throughout the New York State health care system. The goal of the engagement was to identify up to 10 specific cost containment scenarios that could be modeled to determine the potential for future cost containment and health care system improvement. The project was modeled after the highly successful "Bending the Curve" national analysis conducted by Lewin and The Commonwealth Fund and was the first-of-its kind state-level endeavor.

To support BMS' continued compliance with the evolving state and federal regulations, Lewin-Aon will provide additional services including implementation support, as needed. Services may include assistance with policy development impact analysis, requirements definition and testing activities, and support in developing proposals for health reform-related planning and implementation funding opportunities. We will also continuously monitor best practices in the field so that we can provide innovative recommendations to BMS to stay ahead of the curve in lessons learned in managing externally-driven changes. Lewin's long history working with West Virginia uniquely qualifies our team to highlight and prioritize key areas of interest and importance to BMS and its stakeholders, and enables us to make valuable and actionable recommendations that best meet West Virginia's needs.

Lewin currently has a dedicated staff person responsible for tracking and performing impact analysis on all federal regulations and grant opportunities surrounding the ACA, and will continue this effort going forward, with close attention to changes in Federal health reform and other initiatives or regulations. Our staff has access to a wide range of federal resources that provide same-day health reform updates and tracks this information using an internal Lewin database to assist staff in better understanding reform implications for our clients.

Task 4.1.5.5 Analyze EPSDT service provisions, prepare federal and state reports

The Lewin-Aon Team will analyze Early Periodic Screening, Diagnosis and Treatment (EPSDT) service provisions and prepare federal and state reports on methods to improve the efficiency, effectiveness, coordination and quality of those services in West Virginia as needed, in an agreed upon format and submission standard between the vendor and the Bureau.

The objective of Task 4.1.5.5 is to provide BMS with analysis and reporting of EPSDT service utilization to help ensure the provision and quality of these services. These services are preventive in nature and can help maintain positive enrollee health status and prevent illness. They are also monitored by CMS. As a result, BMS needs to closely monitor these services and take corrective action, if necessary.

Lewin has considerable experience with EPSDT programs from both analytic and operational perspectives, especially in West Virginia. Using MCO and FFS claims data, we worked with BMS to develop, test, and revise the annual CMS-416 EPSDT Participation Report. We also collected EPSDT metrics directly from MHT MCOs to develop utilization and quality reporting. As a result, we are extremely knowledgeable of the data needed for EPSDT reporting as well as the current EPSDT programs in West Virginia. We developed EPSDT reporting, including the CMS-416, for other states as well. In addition to serving in an analytic capacity, we have also modeled the impact of proposed reimbursement rates on EPSDT services.

To perform this task, the Lewin-Aon Team will meet with the appropriate BMS staff to determine the level of support required. Based upon those discussions, we will design, implement, test, and produce data extracts and reporting tools that measure EPSDT program performance. These reports are created to respond to state and federal requests for information. We will identify EPSDT services from both fee-for-service and MCO encounter data. If required data elements are not included in the data, we will develop a methodology to collect it. We will summarize the data and calculate utilization and cost metrics across multiple variables, which will allow us to identify factors that impact service use. This includes the development of the CMS-416 report, in addition to other agreed-upon reports. Data from the CMS-416 reports will also be used to calculate EPSDT quality measures.

Task 4.1.5.6 Ad-hoc reports

The Lewin-Aon Team will provide ad-hoc reports upon request on information including, but not limited to, comparisons of the Managed Care program with the fee-for-service program to improve the efficiency, effectiveness, and quality of the Managed Care program within the timelines established for each project as outlined by the Department.

The objective of Task 4.1.5.6 is to provide ad-hoc reporting on the MHT program as requested by BMS, the legislature, and other interested stakeholders. This information will be used to answer questions regarding the Managed Care program and how to improve it. We have responded successfully to similar requests throughout our 25 years working with BMS, as a trusted partner in monitoring and refining the MHT program.

In our current role, Lewin has provided several ad-hoc analyses to BMS, including:

- Assessment of increased pharmacy costs after the migration of West Virginia Health Bridge enrollees from FFS to managed care
- Potential cost/savings of carving out pharmacy benefits from managed care

- Estimation of savings achieved by managed care versus FFS for the current managed care population
- Estimation of projected savings by managed care should certain populations and services be carved-in to managed care
- Cost and utilization for newborns diagnosed with Neonatal Abstinence Syndrome (NAS)

To perform this task, we will meet with BMS to clearly understand the goal of each ad-hoc request and the expected output. The Lewin-Aon Team will determine the data and tools necessary to produce that output. Both MCO encounter data and FFS data will be analyzed, based on the request. We will develop a model to summarize and apply assumptions to the data to estimate the desired end-state. The final output to BMS could be a memo, Excel spreadsheet, or Tableau workbook. We will thoroughly review all data collection and modeling prior to release.

> Lewin has analyzed the impact of changes to managed care capitation rates, including:
>
> - Impact of market conditions on pharmacy costs
> - Cost and utilization of high-cost Hepatitis C drugs
> - Impact of changes to Federally Qualified Health Center and Rural Health Center reimbursement changes.

Task 4.1.5.7 Analysis tool for use in identifying medical service utilization patterns

The Lewin-Aon Team will provide a data visualization tool for use in analyzing medical service utilization and cost patterns by category of service for all MHT populations.

In order to provide robust and customizable reporting for utilization and cost analysis, The Lewin-Aon Team will provide our data analytics solution, HealthView to BMS. This solution integrates data from multiple sources, including MCO encounters, FFS claims, enrollment, and provider data and provides enhanced and summarized data via interactive visualizations using Tableau software. These visualizations provide information on specific subject areas and allow for quick drill-down. This, in turn, can provide insight into service utilization and cost trends, by helping to identify key drivers critical for managed care administration and oversite. HealthView is currently in use by multiple state clients.

The Lewin-Aon Team will leverage the detail data from the Fiscal Agent to populate HealthView. We will enrich the data with a number of value-added variables that transform the data into critical intelligence. These enrichments include the following:

- Categorization of clams in to service categories based on procedure code and revenue code data
- Calculation of risk scores for each member
- Identification of disease prevalence for each member
- Categorization of ED visits into avoidable or non-avoidable categories

Once enriched, the data will be summarized to build the different visualizations.

The HealthView visualizations are included in Tableau workbooks, based on specific topics. These workbooks will be accessible on the MHT IRC discussed in detail in response Section

4.1.6. Users would simply need to download the workbook they are interested in and open it via Tableau Reader, which can be downloaded at no additional cost. Within Tableau Reader, the users will be able to manipulate key dimensions, such as category of service, eligibility group, and key demographic indicators, in order to drill down across multiple factors.

The Lewin-Aon Team will collaborate closely with BMS to identify the HealthView visualizations that will best serve BMS' needs and interests. This could include modification of existing visualizations or development of new ones. We will continue to innovate and evolve HealthView by adding targeted analytics that are required to evaluate emerging health care issues and areas of focus.

The following sample HealthView visualizations are highlighted in the remainder of this section:

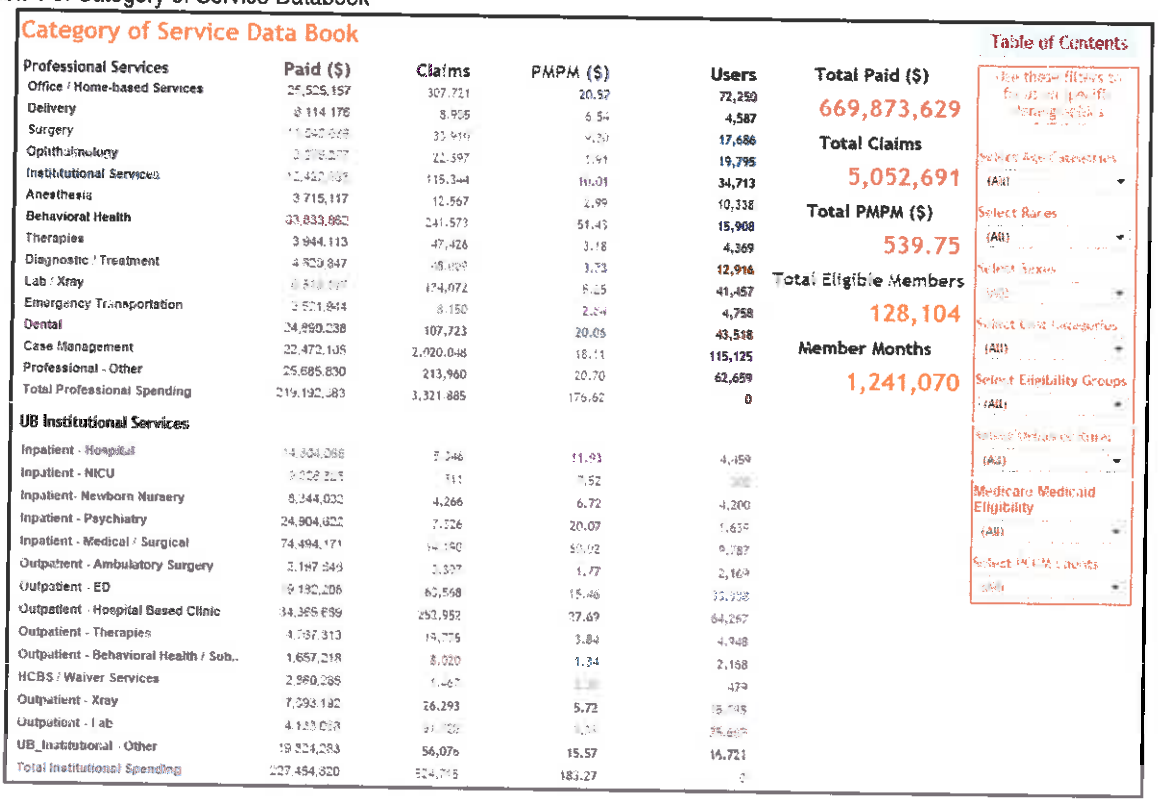
- Per member per month (PMPM) service cost and utilization data book
- Geographic visualization of cost and risk scores
- Provider performance visualization
- Opioid utilization patterns
- ED utilization

PMPM Service Cost and Utilization Data Book

As part of the data enrichment process mentioned previously, we categorize claims based on procedure and revenue codes in the data. We use this categorization to develop our Category of Service Databook workbook. This workbook shows the PMPM service cost and utilization of health care services by service category for the total population with the ability to drill down to populations (e.g., WVHB, TANF, SSI) and demographic characteristics. We will further customize this visualization to include other variables, such as the MCO. For example, BMS could easily see whether there are notable differences in member acuity by MCO.

An example of the Category of Service Databook is shown in Exhibit 4-9.

Exhibit 4-9: Category of Service Databook



Category of Service Data Book

Professional Services	Paid ($)	Claims	PMPM ($)	Users
Office / Home-based Services	25,525,157	307,721	20.57	72,250
Delivery	8,114,176	8,955	6.54	4,587
Surgery	[illegible]	[illegible]	[illegible]	17,686
Ophthalmology	[illegible]	22,597	1.91	19,795
Institutional Services	[illegible]	115,344	[illegible]	34,713
Anesthesia	3,715,117	12,567	2.99	10,338
Behavioral Health	33,833,962	241,573	51.45	15,908
Therapies	3,944,113	47,426	3.18	4,369
Diagnostic / Treatment	4,929,847	[illegible]	3.73	12,916
Lab / Xray	[illegible]	174,072	5.25	41,457
Emergency Transportation	3,571,844	8,150	2.84	4,758
Dental	24,990,238	107,723	20.05	43,518
Case Management	22,472,105	2,020,048	18.11	115,125
Professional - Other	25,685,830	213,960	20.70	62,659
Total Professional Spending	219,192,283	3,321,885	176.62	0
UB Institutional Services				
Inpatient - Hospital	[illegible]	[illegible]	51.93	4,459
Inpatient - NICU	[illegible]	[illegible]	[illegible]	[illegible]
Inpatient- Newborn Nursery	8,244,032	4,266	6.72	4,200
Inpatient - Psychiatry	24,904,822	[illegible]	20.07	[illegible]
Inpatient - Medical / Surgical	74,494,171	[illegible]	60.02	[illegible]
Outpatient - Ambulatory Surgery	[illegible]	[illegible]	1.77	2,169
Outpatient - ED	[illegible]	60,568	15.46	[illegible]
Outpatient - Hospital Based Clinic	34,369,699	252,952	27.69	64,267
Outpatient - Therapies	[illegible]	[illegible]	3.84	[illegible]
Outpatient - Behavioral Health / Sub..	1,657,218	8,020	1.34	2,168
HCBS / Waiver Services	2,980,286	[illegible]	[illegible]	479
Outpatient - Xray	7,093,182	26,293	5.72	[illegible]
Outpatient - Lab	[illegible]	[illegible]	[illegible]	[illegible]
UB_Institutional - Other	19,324,283	56,076	15.57	16,721
Total Institutional Spending	227,454,320	924,795	183.27	[illegible]

Total Paid ($)	Total Claims	Total PMPM ($)	Total Eligible Members	Member Months
669,873,629	5,052,691	539.75	128,104	1,241,070

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Use these filters to find out specific information

Select Age Categories: (All)

Select Race: (All)

Select Sexes: (All)

Select Care Categories: (All)

Select Eligibility Groups: (All)

Select Medicare Risk: (All)

Medicare Medicaid Eligibility: (All)

Select PMPM Charts: (All)

Geographical Visualization of Cost and Risk Scores

HealthView includes visualizations that enable BMS to analyze cost and utilization from a macro perspective (e.g., by population and geography) and an individual recipient perspective (e.g., risk score). These multiple perspectives allow users to drill down to determine factors that impact cost and quality of care.

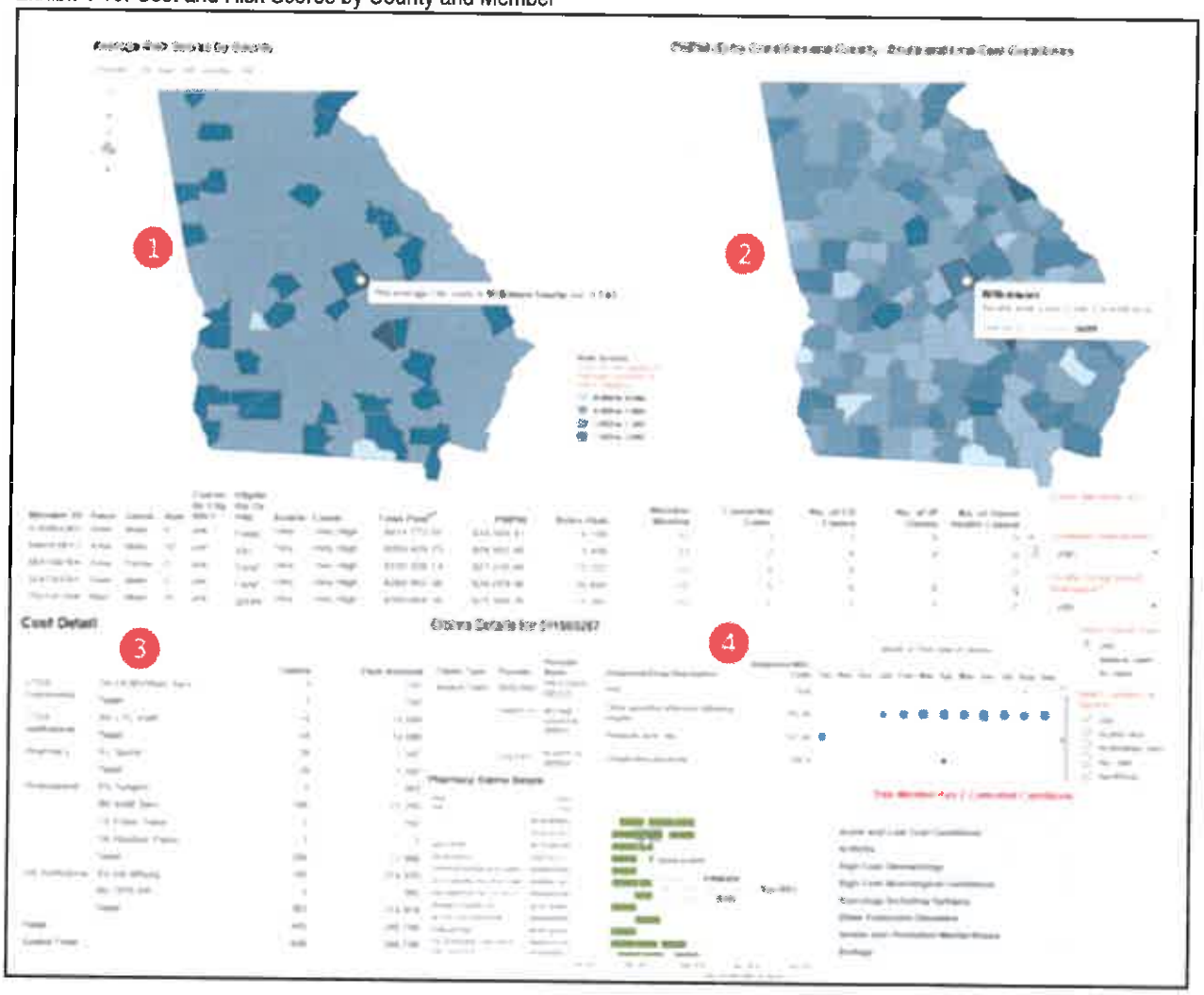
The Lewin-Aon Team with stratify the data by risk scores, in order to measure the acuity of a population. We are experienced with various types of episodic-grouper risk adjustment software packages, including Optum's Symmetry Episode Risk Groups (ERGs), University of California San Diego's (UCSD) Chronic Illness and Disability Payment System (CDPS+MedRx) and Johns Hopkins Adjusted Clinical Groups (ACG). Using a grouper, each member will be assigned a risk score. The member risk scores can then be aggregated to show average risk score across a population segment.

Exhibit 4-10 shows the geographical views/member characteristics that can be used to drill down and identify drivers of utilization and cost. This information can be used to inform MCO contracting, program design and monitoring. Using Tableau, we are able to visually show metrics by county. The user can hover over a certain county, and see the metrics for that county.

Graphics 1 and 2 show the PMPM and risk maps by county respectively, allowing the user to identify the counties and individual conditions contributing towards high cost and high overall risk. The user can drill down to further stratify members by geography, condition and other demographic factors. This detailed view could be used to support the identification of members for care or disease management.

Graphics 3 and 4 show how the views allow further drilling down into a particular member of interest to understand the member's claim, risk, and cost profiles. This can also be used to analyze the member's diagnosis and drug usage pattern to identify gaps in care or potential inappropriate utilization.

Exhibit 4-10: Cost and Risk Scores by County and Member

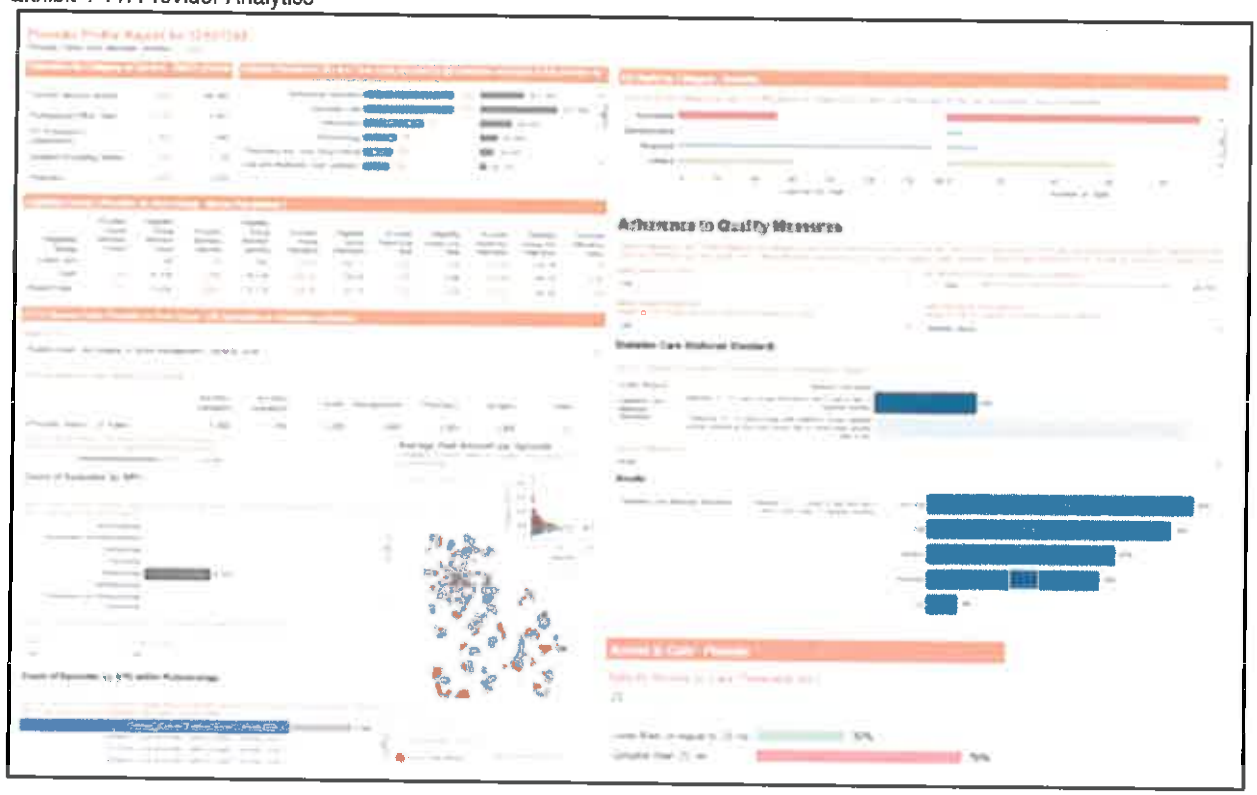


Provider Performance Visualization

HealthView includes visualizations for analyzing provider performance using key cost drivers, avoidable utilization, and network access. Exhibit 4-11 depicts our Provider Analytics visualization that shows the key utilization characteristics with comparison average, member disease prevalence, risk-adjusted PMPMs, provider efficiency, and cost ratio for any episode of care.

This type of visualization facilitates analysis of quality adherence and access to care, and the ability to drill into any Episode Treatment Groups (ETGs) average paid amount by zip code, which is color-coded and compared to the statewide median cost. BMS could look at performance across the four MCOs to help ascertain whether cost of care differentials are being driven by provider practices and missed care management opportunities. Further drill down into actionable reports is available to address member care opportunities and high risk/cost member cohorts.

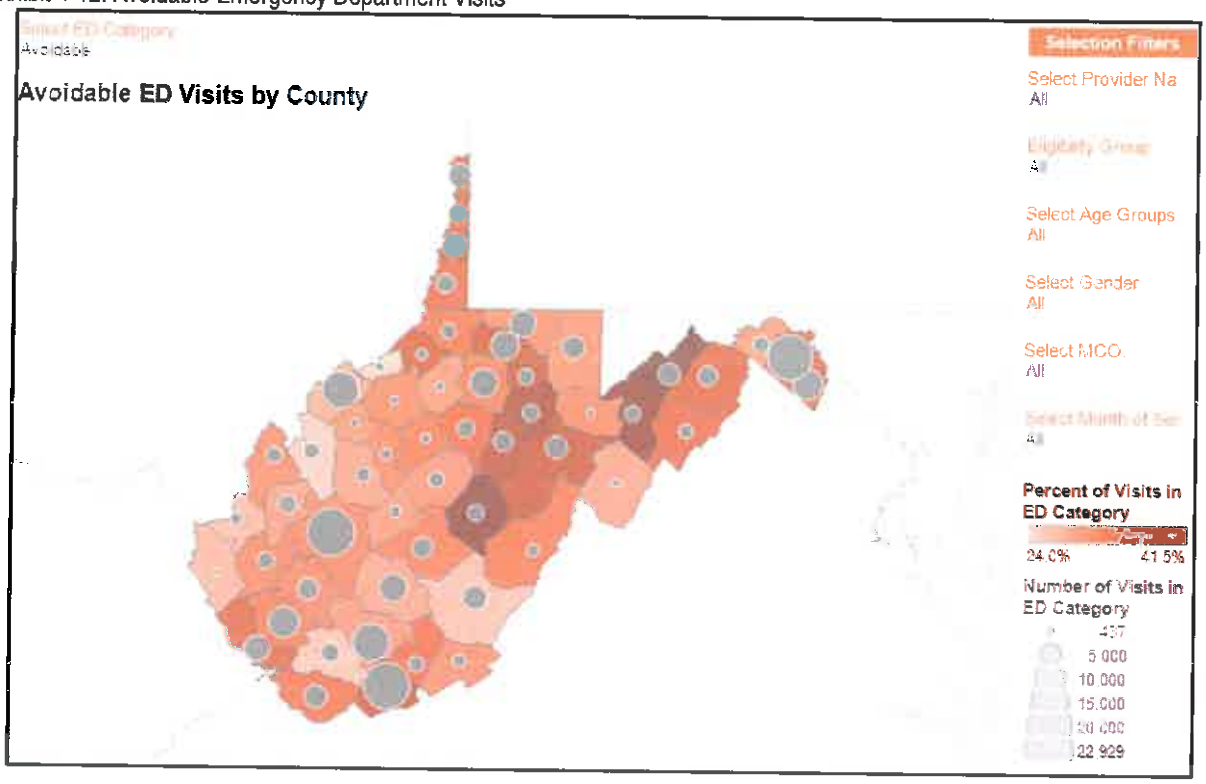
Exhibit 4-11: Provider Analytics



Emergency Department (ED) Utilization Patterns

HealthView includes visualizations that allow users to analyze emergency department utilization. This includes categorizing visits as avoidable or non-avoidable, based on the condition treated. To do this, the Lewin-Aon Team leverages a study by New York University (NYU) and runs each claim through an algorithm which classifies that visit into a specific avoidable or non-avoidable category. Exhibit 4-12 shows a West Virginia-specific example of an ED visualization, based on claims data from our current engagement.

Exhibit 4-12: Avoidable Emergency Department Visits



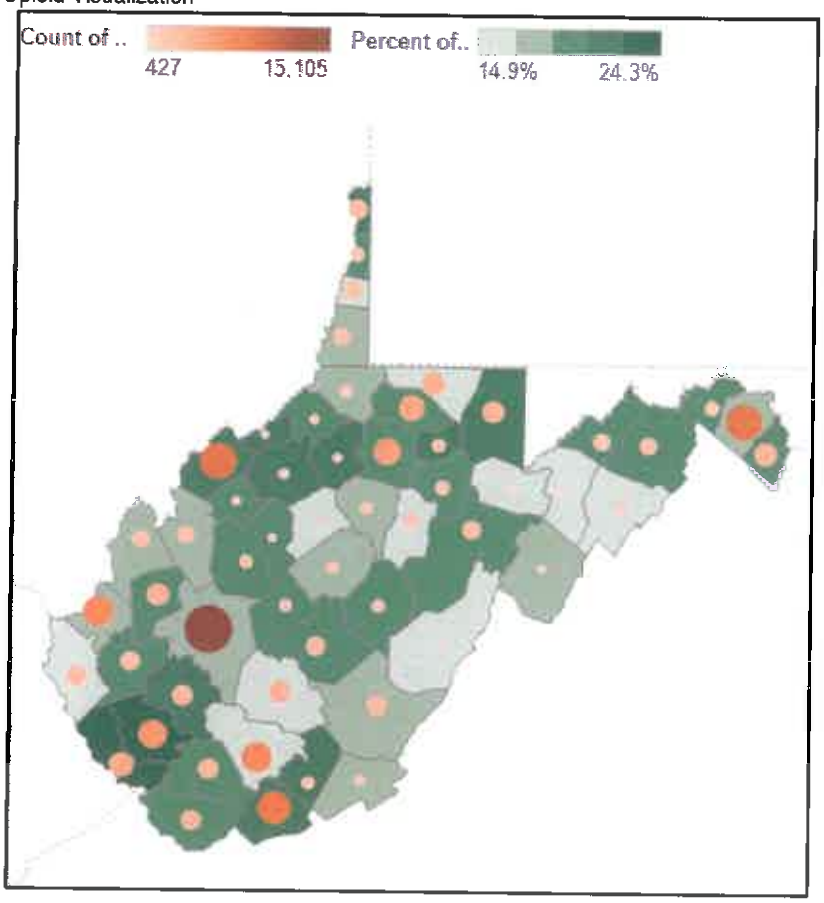
Opioid Utilization Patterns

In the midst of the current Opioid crisis across the country, the Lewin-Aon Team has developed HealthView visualizations to specifically address opioid utilization. We incorporate the most recent published research by CMS to evaluate and predict opioid usage, addiction and abuse, provider prescription patterns and member utilization and quality reporting patterns.

HealthView allows a user to drill into a specific provider type and then into an individual provider to analyze opioid prescription patterns. The user can also drill down into a specific member's opioid usage pattern over time. This is another example of the ability to visually navigate from a macro view of data down to a specific entity in order to identify trends that may require action or further investigation.

Exhibit 4-13 shows a West Virginia-specific example of an Opioid visualization based on claims data from our current engagement. This visualization shows Opioid use by county which can be used to identify potential Opioid abuse.

Exhibit 4-13: Sample Opioid Visualization



Task 4.1.5.8 Respond to Legislative, Federal, State, Budgetary, Provider or Advocacy requests

The Lewin-Aon Team will provide all data, program and regulatory analyses required to respond to, but not limited to, Legislative, Federal, State, Budgetary, Provider or Advocacy requests.

When called upon to assist BMS in responding to requests, the Lewin-Aon Team will follow the process outlined in response Section 4.1.3.1 to develop an analysis approach. All materials used in developing the response will be made available to BMS. Under our current engagement, Lewin provided talking points and drafted correspondence in response to legislators' inquiries around such diverse aspects of the Managed Care program including member lock-in provisions and MCO profitability. We performed cost saving analyses and regularly assisted BMS in responding to advocacy and provider group questions around the transition of new benefits into managed care. Recognizing that many responses, particularly during the legislative session, require a quick turnaround, the Lewin-Aon Team will draw on their in-depth knowledge of BMS' programs and data to meet any requests rapidly. With this and other data-related tasks, Lewin will make certain that all data released are HIPAA compliant.

Task 4.1.5.9 MCO contracting strategy

The Lewin-Aon Team will develop a strategy for MCO contracting, including options for performance targets, use of incentives and/or penalties, modifications to program requirements, implementation and oversight of a Managed Care MLR, and others as requested.

Lewin has experience drafting entire contracts and contract amendments for fully- and partially-capitated Medicaid health plans, as well as other alternative arrangements (e.g., a consortium of community health centers, special needs plans). For the States of West Virginia, New Mexico, and New York, Lewin worked with State staff to prepare Medicaid managed care contracts, ensuring that contract language complied with federal regulations and guidelines and State requirements. Lewin also participated in discussions with CMS staff, incorporating their comments as needed.

Our detailed understanding of BMS' goals and the current strengths and shortcomings of the MCOs' performance in West Virginia, as well as the strong relationships we have developed with the participating MCOs, have been especially critical in our approach. Lewin created a pay-for-performance program to incentivize the MCOs to improve HEDIS scores on key program indicators. While the pay-for-performance program did produce results, BMS determined it needed to hold the health plans more accountable. After researching potential approaches and discussing the pros and cons of each with the BMS, Lewin developed a performance-related withhold program.

Under the provisions, five percent of capitation payments were withheld from the MCOs. To earn the money back, the MCOs had to meet defined performance targets that are benchmarked to national performance standards. One of the most important components of the performance incentive approach is the MCOs' confidence in the measurement system and how it will be applied. Lewin's credibility with the MCOs, our reputation for analytic quality and objectivity in our work in West Virginia and elsewhere, and our collaborative approach were important strengths that we brought to the task.

For both performance initiatives, Lewin also helped BMS benefit from experiences in other states by conducting a literature review and leveraging our prior experience in other states to identify additional best practices and lessons learned, avoiding approaches that may be unsuccessful. We review service encounter data, MCO quarterly reports, and provider networks to evaluate beneficiary access to services and identify areas for improvement. Lewin also tracks and evaluates the timeliness of required MCO reports. Our experience and research findings helped develop performance targets, incentives, and penalties for MCOs tailored to West Virginia's specific needs.

Exhibit 4-14 shows a sample of performance withhold results.

Exhibit 4-14: Sample Performance Withhold Results

Metrics	MCO A	MCO B	MCO C
Adult BMI Assessment	X	X	X
Annual Monitoring for Patients on Persistent Medications – Total	X	X	X
Medication Management for People with Asthma: Medication Compliance 75% Total	X	X	X
Immunizations for Adolescents - Combination 1	X	X	X
Prenatal and Postpartum Care - Post Partum Care	X	X	X
Adolescent Well-Care Visits	X	X	X
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	X	X	X
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers to Quit	X	X	X

KEY

X	Compared favorably to the National Medicaid Average (NMA) for MY 2015
X	Did not compare favorably to the NMA for MY 2015

In 2015, Lewin updated the contract language to establish the minimum Medical Loss Ratio targets and corresponding rebate methodology. This strategic contracting approach came in advance of federal requirements for minimum Medicaid MLRs placing West Virginia on strong footing for the future. Measuring MCO efficiency through the MLR in combination with the quality withhold program leads to a more unified approach in performance measurement and greater quality assessment of the Managed Care programs. Lewin used long-established relationships with the MCOs participating in the Managed Care program to get their buy-in into new program initiatives.

Lewin's CMCS Managed Care Oversight Guide includes:

- Tools to help CMCS to better oversee and manage the delivery systems
- Curriculum to support CMCS review of Managed Care programs that conveys all applicable statutory, regulatory and policy guidance as well as program norms and best practices.

Lewin is recognized by CMS as a leading authority on oversight and operations of Medicaid Managed Care programs. We recently wrote the training manual for Center for Medicaid, CHIP, and Survey and Certification (CMCS) staff on oversight of state Medicaid managed care delivery systems. The oversight guide curriculum addresses regulatory requirements, state program norms, and state best practices in 12 areas: enrollment, enrollee services, service provision, provider access, coordination and continuity of care, grievance, appeals and fair hearing processes, quality, information systems, program integrity, encounter data, financial oversight and third party liability.

In addition, we were invited by the National Governor's Association (NGA) to prepare guidance for states on Medicaid purchasing. The NGA Compendium on Healthcare Purchasing is an important resource for states evaluating how best to meet growing Medicaid program costs under budgetary restraints. Patrick Finnerty, former Virginia State Medicaid Director and a proposed SME for this engagement, co-authored a chapter in the compendium.

The Lewin-Aon Team has experience developing performance-based contracting strategies in numerous states. We make certain that the areas of focus are measurable and meaningful to both the state and the contractor.

While it is often tempting to include all of the various types of behaviors or health system and status improvements in the incentive system, a long list of measures and goals can dilute the particular reward associated with any one of them. Lewin's experience in Massachusetts and Florida focused on financial incentives tied to improving performance rather than merely meeting stated goals as a way of encouraging continuous progress and minimizing gaming of the system.

In Connecticut, Lewin developed a system to reward health plans with auto-assignment for providing additional services. In Minnesota, we worked closely with State staff, its contractors, and the MCOs to develop a performance contracting system. We spent considerable time gathering best practices from MCOs in other states and meeting with the MCOs and with state staff to develop a program tailored specifically for Minnesota.

Lewin has assisted BMS in bringing the MCO contract into full compliance with significant changes in federal laws and regulations coming out of the ACA and the Medicaid and CHIP Managed Care Regulations finalized in 2016. As further changes on the federal level loom, Lewin is ready to assist BMS in understanding the impact and operationalizing any future changes to the Medicaid program. In addition, Lewin's strong relations with the MCOs and other Medicaid vendors, as well as the Philadelphia Regional Office of CMS (responsible for monitoring MHT), will help BMS gain approval of contract changes and amendments.

Lewin's experience with performance-based contracting will help BMS develop a strategy that meets the combined challenges of promoting a competitive managed care contracting system while simultaneously encouraging MCO performance improvements in key areas and supporting traditional Medicaid providers as important elements of West Virginia's health care delivery system and safety net. As contracting strategies change over time, our team is prepared to work with BMS to understand current best practices in the field and to tailor these to West Virginia's needs.

Task 4.1.5.10 Quality Strategy

The Lewin-Aon Team will develop a comprehensive quality assessment and performance improvement strategy, that complies with federal regulations, Quality Improvement Systems for Managed Care (QISMC), CMS standards, other quality review programs, and input from enrollees, advocates, MCOs, and other stakeholders to identify options and recommendations for monitoring and evaluating the quality and appropriateness of care and services to enrollees.

The Lewin-Aon Team has helped states develop revised quality strategies to take into account changes in federal guidance (such as the introduction of CMS's Quality Improvement Standards for Managed Care, which replaced the earlier Quality Assurance Review Initiative guidelines) and changes in state-of-the-art managed care oversight. For example, the Lewin-Aon Team has helped states, including West Virginia, redefine performance standards to comply with Medicaid HEDIS and CAHPS protocol.

Lewin assists BMS using the results from national performance measures to target areas for intervention and improvement. For example, MCOs use the results of their annual CAHPS survey to develop an action plan for areas identified as in need of improvement and provide quarterly updates to BMS on implementation of the action plan.

The final managed care regulations adopt further changes to federal quality monitoring, including expanded External Quality Review activities and the implementation of a managed care rating system similar to the Medicare Star ratings.

Most important to this task, however, is Lewin's strong understanding of program needs and BMS' and MCOs' capabilities, which will facilitate further development of this plan. Lewin drafted the state's original Quality Strategy in 2008 and numerous updates to comply with changes in federal standards, such as the 2012 Quality Strategy Toolkit for States released by CMS, as well as changes in the scope of services offered in MHT.

For example, new goals and performance measures were included when pharmacy, children's dental and behavioral health services were transitioned to managed care. Lewin supports BMS in its frequent contact with numerous stakeholders, including advocates, legislators, providers, other State agencies, the MCOs, the enrollment broker, and the EQRO. We have prepared materials to present to the Medicaid Services Fund Advisory Council which advises BMS on a range of issues, including the development and revision of the Quality Strategy. These groups provide feedback on quality activities and programs on an ongoing basis both formally and informally.

As part of its ongoing assistance with the operation of the MHT program, Lewin has continuously worked with BMS to ensure the program's compliance with the final Medicaid managed care regulations. Lewin has also helped BMS prepare numerous documents for CMS, such as the State's plan for ensuring quality and access for children with special health care needs (CSHCN) and the State's Strategy for Assessing and Improving Managed Care Quality. Lewin's strong experience with the MHT program and other states' MCO programs provide a strong foundation to assist BMS in developing an innovative and flexible approach to a variety of quality initiatives and program changes.

West Virginia Quality Strategy Approach

Monitoring

- Monitors MCOs for compliance with its managed care quality standards.

Assessment

- Analysis of a variety of health care data to measure performance and identify focus areas for improvement, including indicators for specific diseases and populations.

Improvement

- Implement interventions that target priority areas to maximize the benefit for MHT enrollees.

Lewin has assisted many states, including California, Connecticut, Maryland, Montana, New Mexico, New York, and West Virginia in developing Medicaid managed care quality oversight and improvement programs. Lewin worked with state and MCO staff, stakeholders, and CMS to develop quality and reporting requirements that met state needs for monitoring and oversight and complied with federal policies and regulations.

In Connecticut, Montana, New York, and West Virginia, Lewin developed the initial standards for quality assurance programs and reviewed MCO quality plans. We then developed options and recommendations for strategies to monitor and evaluate the care and services provided to enrollees, including specific monitoring tools and data reporting requirements. We have also worked directly with local and national MCOs in many states and are familiar with innovative strategies.

We bring significant expertise to the development of performance measures for evaluation. Lewin and Optum (Lewin's parent organization) are industry leaders in quality measurement and recognize that evidence-based quality metrics are an essential standard for state Medicaid

agencies building quality programs. Select SMEs from across our organization are supporting a number of states in the development of the Adult Medicaid Quality Measures, including Arizona, Iowa, Massachusetts, Montana, and Vermont.

Through analysis of various program components (e.g., health outcomes, enrollee satisfaction, quarterly reports, network access, CMS feedback, bi-annual beneficiary survey results), Lewin detected areas for improvement. We also work closely with the EQRO regarding performance monitoring. Our experience will continue to inform work with BMS in identifying and prioritizing program improvement opportunities and implementing the necessary program modifications.

Task 4.1.5.11 Meetings

The Lewin-Aon Team will meet with the State's Managed Care entities, provider groups and other parties as determined necessary by BMS at locations to be determined dependent upon availability of space.

The Lewin-Aon Team will meet with the State's managed care entities, provider groups, and other parties as deemed necessary by BMS; we agree to meet at such locations determined by BMS. With two full-time staff onsite, members of the Lewin-Aon Team will be readily available to attend meetings as needed to support BMS. As meeting needs are identified, appropriate members of the team will be available to attend established meetings, such as the annual rate setting review and MCO workgroups, as well as ad hoc meetings. Currently, Lewin participates in biweekly MCO meetings and the annual EQRO orientation, attend the Medical Services Fund Advisory Committee, and regularly meet with provider groups, such as the West Virginia Hospital Association.

Lewin's parent company, Optum, maintains a Charleston office which can be accessed if BMS needs additional meeting space.

Task 4.1.5.12 Program Expansions

The Lewin-Aon Team will assist in developing options for program expansion and assist in implementation of program expansion, including preparation of documents outlining options for program expansions, including cost savings, policy considerations, risks, issues, agency and bureau coordination requirements, and legal constraints, etc.

West Virginia and Lewin's 20+ year collaboration has resulted in significant growth and enhancement of the Managed Care program increasing access, quality of care, and providing the State with budget predictability.

- Since 2014, managed care has expanded to include the ACA expansion and SSI populations, and has also expanded covered services to provide Medicaid enrollees comprehensive coverage with the inclusion of pharmacy, children's dental and behavioral health services
- Medicaid enrollees now have a choice of four MCOs statewide
- Managed care has become the dominant delivery system for West Virginia Medicaid covering over 80 percent of the Medicaid eligible enrollees

We have been a critical partner in bringing these expansions of services and populations to fruition. Lewin assisted in all phases of the expansion including:

- Helping with the preparation of implementation timelines

- Communicating with MCOs and key stakeholders
- Reviewing managed care networks
- Conducting operational readiness reviews
- Preparing cost impact analyses to determine whether and how to approach expansions and related program changes
- Answering questions MCOs have about expansions prior to going live
- Supporting BMS by handling ad hoc requests
- Performing ongoing monitoring and oversight
- Monitoring changes to federal regulations and determining if there is any impact on expansion plans

Lewin has helped design and implement large-scale health programs for Medicaid agencies across the country. Our experience in States such as West Virginia, Montana, Kansas, Kentucky, Maryland, and New Mexico has provided us with an understanding of the specific issues that rural states face in the expansion of Medicaid managed care systems. Lewin staff have expertise developing innovative methods for managed care arrangements to increase access and coordination of care in rural areas. The goal of these innovative arrangements is to take advantage of existing delivery systems and encourage cooperation between public and private health care provider organizations, which often feel at odds over such issues as access and finance.

Based on our experience in West Virginia and other states, Lewin has found that there are five key components to successfully implementing program changes. We will work with BMS to tailor these components to each specific task order awarded:

- Project management
- Communication strategies and plan
- Data and operational system infrastructures
- Readiness reviews and support
- Learning and diffusion trainings

The Lewin-Aon Team will identify areas of concern through quarterly monitoring efforts, surveys and focus groups, and analyzing complaints and grievances by enrollees. Working together with BMS and the MCOs, we will develop solutions to mitigate problems found with the expansions.

We will help with post-implementation assessments of the success of the program expansions along with areas for improvement. We will conduct beneficiary focus groups and surveys and getting feedback from MCOs and other key stakeholders. The Lewin-Aon Team will create separate summary briefings for BMS on each expansion effort and also will report findings to CMS. Our experience and knowledge of the Managed Care program will help ensure that upcoming expansion implementations will be successful.

Task 4.1.5.13 House Bill 4217

The Lewin-Aon Team will assist with the development of reports for WV House Bill 4217.

During 2014, the West Virginia Legislature passed House Bill 4217 requiring Medicaid to report on the performance of its MCOs. As a result of this legislation, Medicaid began to publish an MCO report card on its Website using national reporting standards such as CAHPS and HEDIS. An abbreviated report card is sent to potential MCO enrollees to assist them in making choices based on quality and performance.

House Bill 4217 requires an annual report containing information about Medicaid managed care be provided to the Legislative Oversight Commission on Health and Human Resources Accountability (LOCHHRA). Lewin will compile data from the MCOs to develop a comprehensive report to be submitted to the West Virginia LOCHHRA. The report will be produced annually on or before May each year. The report will include the 24 outlined categories and subcategories as required by state statue.

4.1.6. Project Management Systems (RFQ 4.1.6.1 – 4.1.6.8)

The Lewin-Aon Team will provide an electronic tool that serves as a program compliance dashboard and at a minimum will allow the Bureau to track program compliance. Our Team will work with the Bureau to further refine the program compliance dashboard requirements.

Project management systems need to grow in tangent with programs in order to continue to sustain the program's progress to date and to support ongoing goals for improvement and continued expansion. This applies to the project management systems required to support MHT, which grew from an enrollment of just over 170,000 members at the end of SFY13 to over 425,000 members at the close of SFY17.

The Information Resource Center (IRC) will assist the State by providing a document repository for

- All documents submitted by the MCOs
- Policies and procedures
- Managed care contracts
- Quality metrics and report cards
- Network adequacy documentation and readiness reviews
- Grievance and appeals reports
- Other documents necessary to facilitate management of the program.

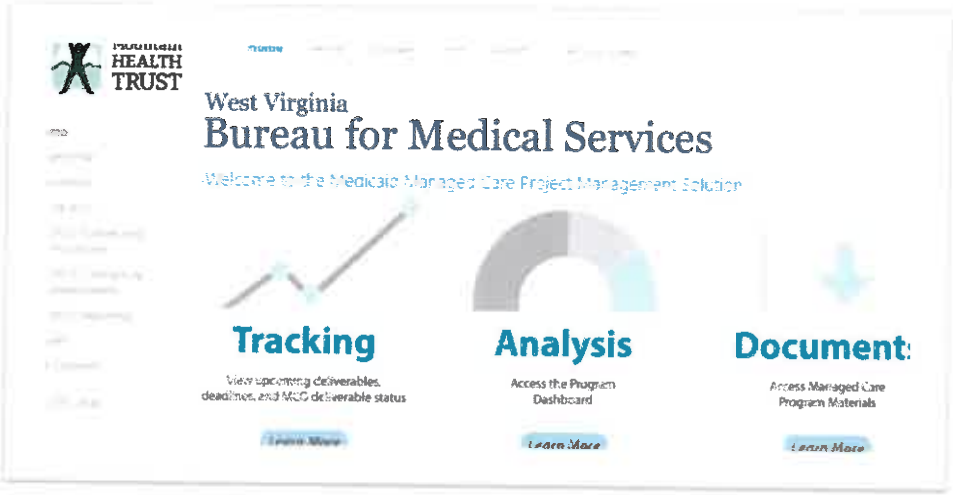
Lewin has substantial experience with developing custom project management solutions to support data collection, tracking and reporting. We have maintained and hosted data collection tools that require security controls for sensitive data for over a decade and have annual security control assessments with CMS to certify that our systems are secure and reliable. Lewin builds project management solutions ourselves and has also worked with vendors to build portals. We understand well what is needed to build, stage, and bring a project management solution to production. We also understand the user experience stage of data collection in which individuals reporting data require education and technical assistance to effectively and efficiently use the system.

For BMS, we will maintain the MHT IRC: a centralized project management solution which provides easy access to project deliverables, MCO documentation, and MHT reports. Our project management expertise can be applied directly to assist the BMS team in its efforts to develop

and maintain a project management solution. The Lewin-Aon Team knows how to identify the tasks that are required to complete the scope of work, and the challenges and issues that are likely to emerge. We ask the right questions and provide ready guidance to those tasked with maintaining the IRC. Our intimate knowledge of the many reports, documents, and resources associated with the Managed Care program will enable us to curate the IRC and meet BMS' needs.

The IRC is designed to provide an organized and intuitive approach to managing deliverables and maintaining project documentation. From the home page of the IRC, BMS can access the three key areas; a deliverable tracking schedule, analytic reports, and Managed Care program documentation. Exhibit 4-15 shows the home page of the IRC.

Exhibit 4-15: MHT's IRC



Task 4.1.6.1 All deliverables

The Lewin-Aon Team's electronic program compliance dashboard will track all deliverables submitted by the MCOs as outlined under the Managed Care contract.

The MHT IRC allows the Lewin-Aon Team and BMS to track each MCOs deliverables, submission of data and reports using a Gantt Chart (see Exhibit 4-16). The IRC can be configured to send reminders to staff as deliverable dates approach. The IRC is organized to track each MCO's documentation and data/reports individually and will indicate when each required report or data submission is received and the task is completed.

Exhibit 4-16: Tracking MCO Deliverables using Gantt Charts

The IRC organizes MCO reports, policies, quality metrics, and program dashboards by MCO and type of document. The site is customizable, and we will work with BMS to further design the document management component on the solution to assist BMS in maintaining organized and consistent documents

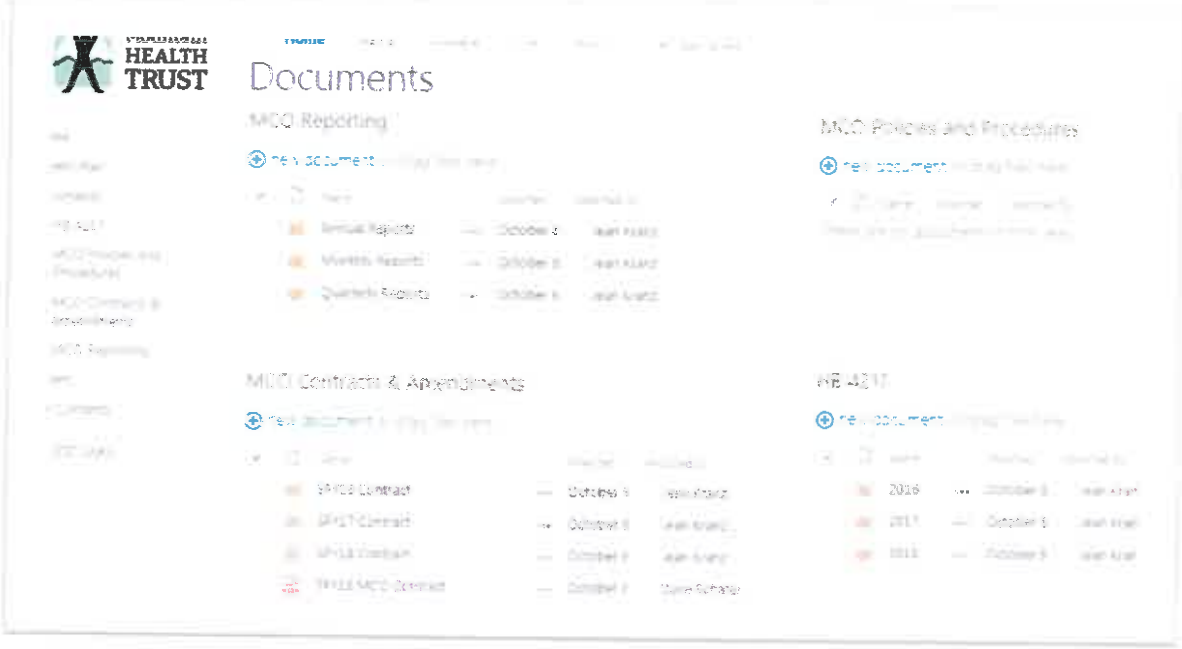
across each MCO. This collaborative effort ensures that BMS can organize documents in collection libraries.

Task 4.1.6.2 MCO policy tracking

The Lewin-Aon Team's electronic program compliance dashboard will track the MCO policies and procedure documents.

Historically, policy tracking has been an important deliverable for the MHT program. Lewin has assisted with this process since the program's inception and will continue to refine our approach to policy tracking to meet the dynamic needs of BMS and reflect current technologies. The Lewin-Aon Team will assist BMS to incorporate a library for each MCO providing services to the MHT enrollees. There is no limit to the number of document libraries included. The document library will be a platform that will allow BMS or the managed care vendor to create, store or update files. Each library type displays a list of files and key information about the files, such as the last person to modify the file and the date of the modification. Exhibit 4-17 shows the Policy and Document Library in the IRC.

Exhibit 4-17: Policy and Document Library in IRC



Task 4.1.6.3 Contract and amendment language and version control

The Lewin-Aon Team's electronic program compliance dashboard will track contract and amendment language and version history.

In the case of MCO contract language, the IRC will offer a centralized location to store the contract from each State Fiscal Year and any amendments. Red-lined versions can be retained as well to allow users to easily see changes in language from one year to another. Monitoring changes to the MCO contract over time in a single location will help BMS easily identify trends and document the rationale for MCO contract provision changes. The IRC can also be used to track changes to the MCO contract for the upcoming fiscal year. Specific elements of the

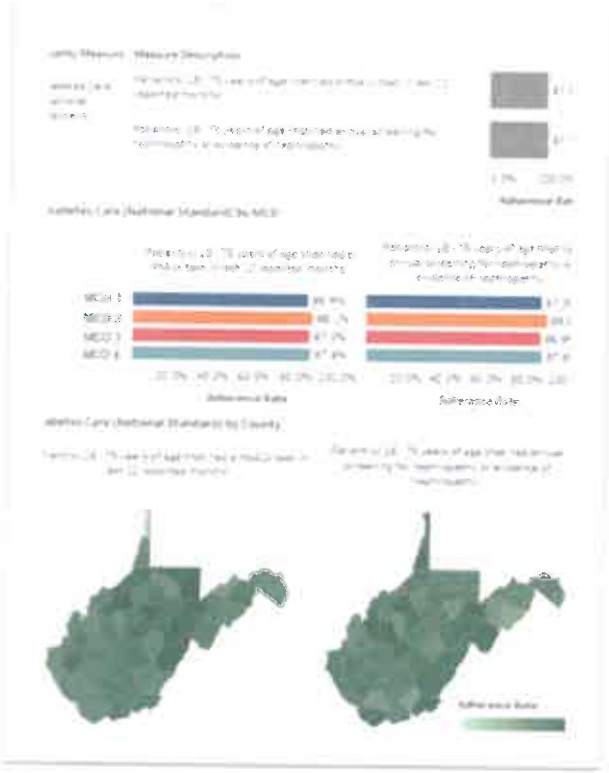
database will include, but may not be limited to, contract reference (e.g., section, paragraph), previous contract language, revised contract language, rationale for change, and requestor.

Task 4.1.6.4 MCO quality metrics and report card

The Lewin-Aon Team's electronic program compliance dashboard will track MCO quality metrics and produce report cards.

Having ready access to quality measures is essential to monitoring Managed Care program performance. The IRC will enable BMS to easily track the submission, and data provided, for all required quality metrics. This will include metrics such as annual HEDIS scores, quality metrics gleaned from the MHT quarterly reports, CAHPS results and quarterly action plans, CMS Core measures, and any additional quality data.

Exhibit 4-18 Quality Measures used to improve system performance



BMS and the Lewin-Aon Team will work collaboratively to develop MCO specific report cards to inform consumers and provide incentives for the health plans to continually improve performance. The report cards will inform members in their managed care plan selection and foster competition among MCOs to improve the quality of services offered. The managed-care report card will be based on data provided by the MCOs and patient surveys, such as HEDIS and CAHPS results. The report cards will be updated quarterly with current and previous versions maintained on the IRC. Using the data available on the IRC, the Lewin-Aon Team will coordinate with BMS and the External Quality Review Organization to work with the MCOs on opportunities to improve their performance. Exhibit 4-18 illustrates how visual reporting of quality measures can be used to compare health plan performance.

Task 4.1.6.5 Network adequacy documents

The Lewin-Aon Team's electronic program compliance dashboard, the MHT IRC, will track network adequacy documents and readiness review materials.

BMS conducts an annual review of each MCO's provider network to determine their individual adequacy to provide necessary services to the enrollees of the MHT program. Lewin will collect the comprehensive list of providers contracted with each MCO on an annual basis or in the instance of a program expansion. The MCO provided files will be reviewed against network standards to assure the Medicaid enrollees have access to the care they need in a timely manner. All MCO materials provided during network adequacy reviews will be loaded onto the

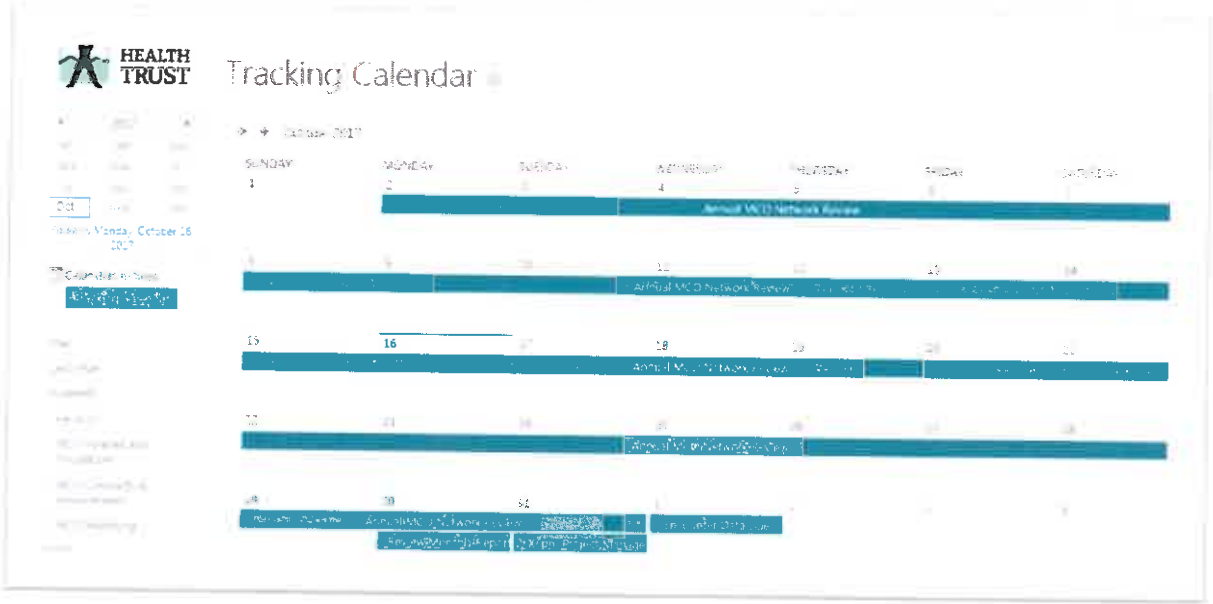
program management site. BMS will be able to track and review the status of each iteration of the MCO's network submissions and review.

Along with network review results, other relevant measures of access such as reports on availability of provider appointments and 24/7 access can be added to the project management system.

The IRC will also facilitate any readiness reviews that may be required under this engagement. The site will be a repository for the voluminous amounts of information resulting from a readiness review, such as:

- Readiness review tools
- MCO document submissions
- Correspondence
- Review findings
- Tracking calendar (Exhibit 4-19)

Exhibit 4-19: The IRC tracks MCO tasks/deliverables including readiness reviews



Task 4.1.6.6 Grievances and Appeals

The Lewin-Aon Team's electronic project management solution will track grievances and appeals.

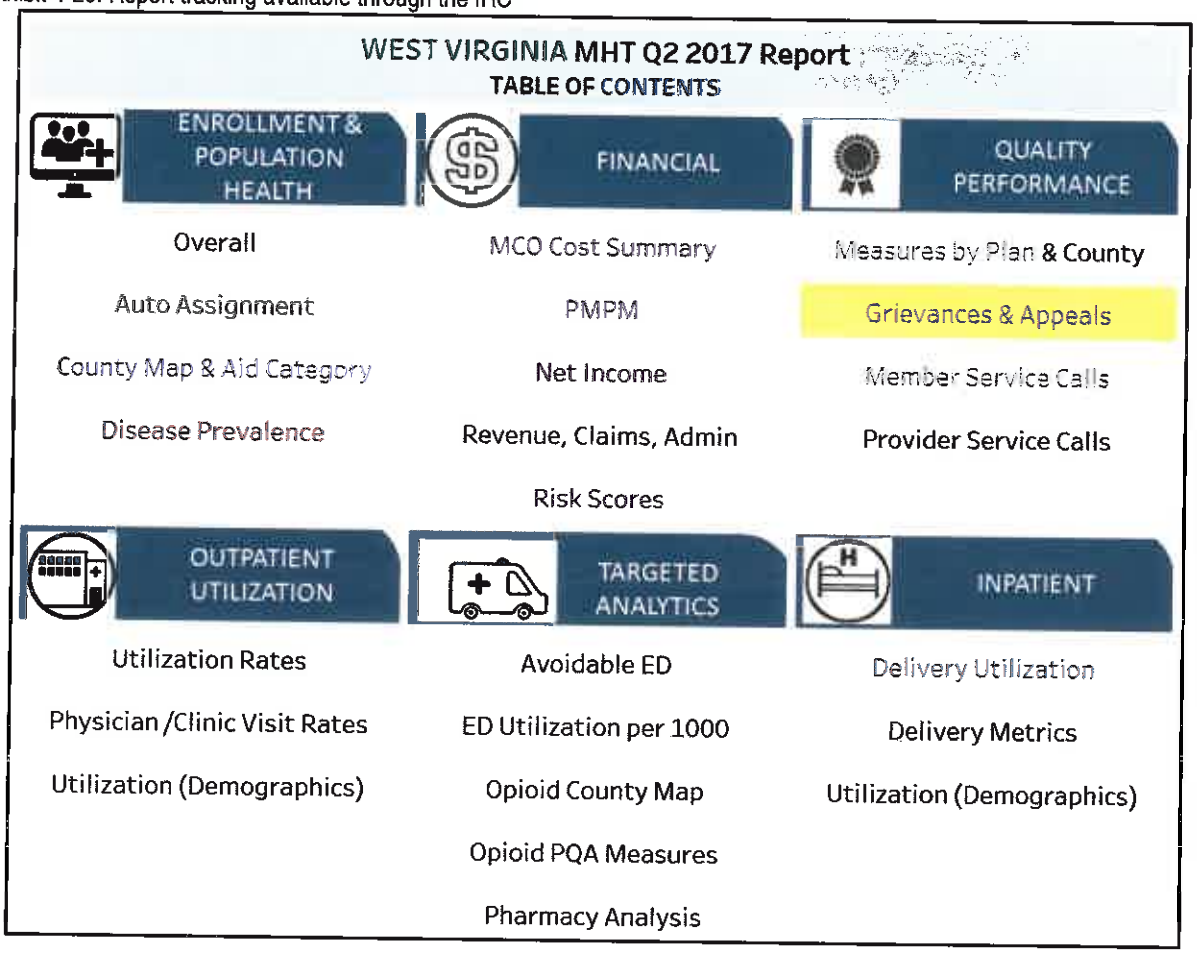
MCO enrollees are encouraged to use the customer or enrollee services department to resolve service issues. When this cannot be done to the enrollee's satisfaction, the enrollee can file a formal grievance or appeal with the MCO. As part of the MCO's contractual agreement with the State they are required to inform enrollees about the complaint, grievance and appeal process available within the MCO and at the State level.

The Lewin-Aon Team will collect the grievance and appeals reports from the MCOs on a quarterly basis and ongoing as necessary. We will analyze the reports to determine that all needed information has been provided to determine that a thorough review or investigation of

the complaints has taken place. We will inform BMS of how the complaints are resolved on a quarterly basis.

Furthermore, we track the number and content of the grievances and appeals over time, as a barometer for health plan issues. We will drill down through the data, and work with an individual MCO as necessary to determine whether a change in grievances and appeals signals an actual issue for monitoring (e.g., enrollee complaints about lack of access to a specific type of provider or service might trigger an ad-hoc review of the provider network). The documentation and tracking will be available through an analytic report contained in the IRC as shown in Exhibit 4-20.

Exhibit 4-20: Report tracking available through the IRC



Task 4.1.6.7 Classroom led training

The Lewin-Aon Team will provide classroom-led training to staff on utilizing the project management system and maintain a training manual for reference.

The use of technology is sometimes intimidating to "non-technical" individuals. Our technical support experts will train the onsite project lead as a "Super User" of the IRC so that ongoing support will be readily available. The onsite project lead will conduct regular classroom-led training for BMS for Medical Services program users at the request of BMS. The onsite project lead will be a source of ongoing technical support for IRC users.

Task 4.1.6.8 Multiple users and configurable settings

Lewin will host the platform for the electronic program compliance dashboard, the MHT IRC and will allow access for up to ten (10) users at any time. The settings will be configurable to meet state needs.

BMS staff will have an opportunity to provide input into the site configuration that most accurately reflects their data storage and manipulation needs. The program management site will serve two primary purposes: tracking compliance and storing program documents. An overall compliance dashboard will be easily accessible from the main page so that BMS can easily track upcoming deadlines and status of required program submissions. Compliance can also be tracked individually for each MCO. The site offers the user the option of viewing deliverable timeframes in either a calendar or Gantt chart format. In addition, the program management system will serve as a repository for program documents. The IRC will be available to multiple users simultaneously.

CMS Technical Assistance Medicare and Medicaid Eligible (TAMME)

Lewin developed a portal to provide technical assistant to providers who care for dual eligibles of Medicare and Medicaid. The portal (https://www.resourcesforintegratedcare.com/) is largely a repository of resources that we have created, supported, or collected for providers.

It supports plans and providers in their efforts to deliver more integrated, coordinated care to Medicare-Medicaid enrollees, specifically in the context of intellectual and developmental disabilities, physical disabilities, and serious mental illness.

4.1.7. Ad Hoc Services (RFQ 4.1.7.1 – 4.1.7.8)

Task 4.1.7.1 Analyze accurate payments and reimbursements related to the ACA or other regulations

The Lewin-Aon Team will analyze accurate payments and reimbursements related to changes under the ACA or other federal or state health care and/or payment provision rules, regulations, laws, or codes.

The Lewin-Aon Team is prepared to implement and comply with all regulatory provisions related to payments, including incentive arrangements, performance withholds, IMD, MLR, pass-through payments prohibition, as well as the any changes under the state plan amendments or federal waivers or state laws that may arise.

We have already started implementation and calculations of the pass-through payments phase-out for West Virginia, as well as Kentucky, Kansas and Tennessee. Lewin is currently working with BMS to develop a methodology for implementing the DPP program for West Virginia hospitals. In addition, Aon is working with Tennessee to implement their DPP as approved under their 1115 waiver. CMS requires a specific approach when phasing out hospital payments. The total amount of pass-through payment paid by MCOs to hospitals during a contract year may not exceed a percentage of the "base amount" calculated for that year, beginning with 100 percent for contracts starting on or after July 1, 2017 and decreasing by 10 percentage points each successive year. The base amount must be calculated on an annual basis and must be recalculated annually. CMS has not promulgated specific phase-out language for the physicians or nursing facilities unlike for the hospital providers. In addition, the rule does not stipulate what would be the pass-through payment cap per contract year. It

specifies a timeframe of five years to accomplish a phase-out. Our team has experience recommending a phase-out approach individually tailored to each state agency based on non-hospital providers receiving pass-through payments as part of the capitated rates to MCOs.

Lewin has assisted BMS in developing quality withhold arrangements with the MCOs. In addition, Aon has also designed and calculated quality incentive arrangements for Kentucky and Georgia. Prior to the announcement of the Final Medicaid and CHIP Managed Care Final Rule, the Georgia Families 360° program had already included a capitation withhold arrangement, which declared that the plan would be paid at a fixed percentage above the low end of the developed rate range. The amended Medicaid and CHIP Managed Care Final Rule states that a withhold arrangement must be structured such that the capitation payment, minus any portion of the withhold that is not reasonably achievable, must be actuarially sound. This necessitated a change in the methodology used to determine the amount withheld from the rates. Aon's policy and actuarial teams guided Georgia's Department of Community Health (DCH) through revising the withhold formula to comply with the language in the Final Rule.

Our team has prepared a number of briefs for all state clients regarding implementation of the Medicaid IMD reimbursement policy, an example of which is included as Attachment B.

While the MLR standards became a required component of CMS reporting effective this year, West Virginia has had this requirement in place for the past few years. We have worked with BMS to develop MLR templates and monitor results during that time. In addition, our team has worked with multiple states to develop reporting briefs and templates compliant with the new requirements and timelines. Our team provides ongoing reviews of MCO MLRs for West Virginia, as well as Medicaid clients in Georgia, Kansas, and Tennessee on monthly or annual bases to determine the appropriateness of ongoing contract rates, and develops summaries of the results.

Medicaid reform, transformation and innovation is a key priority for West Virginia and vital for the continued success of the program. Our team recently provided Georgia with fiscal modeling of different scenarios for how the State's budget would be impacted by potential legislative changes to federal Medicaid funding. Our models relied on sensitivity testing of long-term assumptions regarding potential growth in Georgia's Medicaid costs as well as the national medical consumer price index. The findings were presented to members of the Governor's budget office. In addition to the modeling per capita caps by enrollee group (for current and ACA Expansion populations), the presentation included variations in Federal Medical Assistance Percentages. Also this year, we provided memorandums to both New Jersey's Treasury Department and West Virginia's Department of Health and Human Resources regarding fiscal impacts of similar Medicaid reform.

Task 4.1.7.2 Provide analysis in the development of a risk-adjusted payment model

The Lewin-Aon Team will provide analysis and other consultation services as needed in the development of a risk-adjusted payment model.

Lewin has been working with BMS to understand the value of adding a risk adjustment payment methodology to the capitation rate development. Our actuarial team will continue to assist BMS in determining next steps in the process. Exhibit 4-21 describes our team's approach in calculating risk adjusted rates using CDPS+MedRx. The methodology would be similar if different risk adjustment software were used.

Exhibit 4-21: The Lewin-Aon Team's approach to calculating risk adjusted rates using CDPS+MedRx

Task	Task Description	Risk Adjustment Time Period					
		Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
1	Identify Data Needs (Data Request)						
2	Calibration of weights						
3	Application of risk adjustment						
4	Internal peer review						
5	Communication and monitoring of results						

Task 1: Identification of data needs, selection of risk adjustment model, and development of assumptions

Our actuarial team members will work with BMS to design the optimal risk adjustment approach for each population. We will then identify data elements needed to apply risk adjustment, and discuss the results with BMS. We will first determine the base period used to score members, and the membership period used to attach risk scores from the scoring period. Once BMS has approved the proposed approach, we will request encounter data and eligibility data to kick off the risk adjustment process.

Assumptions will be discussed with BMS before settling on a final methodology including:

- The risk adjustment model
- Category of service exclusions
- Eligibility exclusions
- Supplemental data allowance
- Number of diagnosis codes allowed
- Ordering of diagnosis codes
- Concurrent versus prospective weight development
- State-based versus national-based weights (may depend on strength of available encounter or claim data)
- Minimum eligibility requirements
- Unscored members
- Rate cell versus Category of Aid scoring
- Limitations on the percentage impact
- Risk adjustment of non-medical cost, where appropriate

Task 2: Calibration of weights

BMS may choose to use national or local weights in the application of risk adjustment. For example, the CDPS+MedRx software includes weights that are calculated based off of data that spans multiple states. National weights may be used when there is not enough relevant

experience to develop local weights. However, it may be the case that national weights are not suitable for West Virginia's Medicaid populations, in which case our team will calculate local weights based off West Virginia's own encounter data.

Our actuarial team members will also help BMS assess whether concurrent or prospective weights are more suitable for the population in question. Prospective weights are developed by regressing one year's conditions on a subsequent year's costs, tend to capture more chronic conditions, and are associated with individual-based payments. Concurrent weights are developed by regressing one year's conditions on the same year's costs, have better predictive power, and are associated with aggregate-based payments. Each method presents its own advantages, and because every population's situation is different, we will help BMS assess and select the weighting approach that is most appropriate for the situation.

Task 3: Application of risk adjustment

While the development of risk adjustment factors is actuarial in nature, the implementation is heavily data driven, which results in a need for an integrated understanding of both the data elements and the actuarial assumptions to most accurately develop risk adjusted rates. The Lewin-Aon Team offers the unique advantage of having in depth West Virginia specific knowledge, along with a team of actuaries and data consultants who work hand-in-hand to complete all areas within the rate setting and financial management process. Risk adjustment is no exception to that standard.

The first step in calculating risk adjusted rates is to filter the data down to the categories of services and eligible individuals applicable for risk adjustment. Once this step is complete, the data is formatted for the grouper and run through the risk adjustment model. For example, with CDPS+MedRx this involves categorizing diagnosis codes and national drug codes into classification systems, and ultimately outputting member level risk scores. The process leading up to the development of member level risk scores is technical and nuanced in nature. It is essential that actuaries and data consultants work together to ensure that the intended designs are captured in the modeling.

Member level risk scores are then placed into Excel, where further modeling is done. The methods will vary depending on the assumptions, but all methods should yield results that are budget neutral to the state. Task 1 includes a list of additional assumptions that may be taken into consideration here.

Task 4: Internal peer review

All deliverables that goes out to external stakeholders follow our robust peer review process, where results are reviewed both for technical accuracy and overall reasonableness. All elements of risk adjustment will be peer reviewed before delivered to BMS.

Task 5: Communication and continued monitoring of results

Once risk adjusted rates are finalized, results will be delivered to BMS. As determined appropriate by BMS, the results may be shared with the MCOs, and upon discussion and agreement, our team can modify methodologies where warranted.

Depending on the population and the program structure, risk adjusted rates may be revised on an annual, semi-annual, or even quarterly basis.

Task 4.1.7.3 Provide assistance in development of payment methodologies for other programs

The Lewin-Aon Team will provide assistance in development of payment methodologies for other programs, including, but not limited to, long-term care, nursing home, waiver programs, etc.

The Lewin-Aon Team not only works with State Medicaid agencies on capitation rate development but also other types of payment methodologies. A recent example of this is Aon's work with Tennessee on their Employment and Community First (ECF) CHOICES program. With ECF, Tennessee became the first state in the country to develop and implement an HCBS program that coordinates all health and long-term services and supports, aligning incentives toward promoting and supporting integrated, competitive employment and independent living as the first and preferred option for people with IDD. Through this, our actuaries modeled expected administrative costs for ECF CHOICES. It was established as a new ASO arrangement for managing both medical and support care coordination costs for ID/DD populations, by taking into account MCO estimates, State feedback, and our clinical staff input.

For the BMS, Lewin recently developed a new system of determining individualized budgets for members who access Intellectual/Developmental Disability Waiver Services. The system takes into account seven different living settings and nine levels on the Inventory of Client and Agency Planning (ICAP), a standardized assessment tool to determine appropriate budgets for waiver enrollees.

Our team has significant experience with alternative payment methodologies including those that were part of SIM initiatives in Idaho, Massachusetts, and Vermont. Other states we have worked with for various similar projects include Georgia, Minnesota, and Tennessee. The projects have included multi-payer ACOs with shared savings programs and Patient Centered Medical Homes (PCMHs) with reimbursement tied to quality performance. Our actuaries developed target cost savings, validated data, and evaluated experience to determine what additional payments, if any, needed to be made as well as calculated the value of savings to the states. These projects required working with a variety of different stakeholders including state health departments, insurance companies, and provider groups. We designed a vendor payment methodology for a Care Coordination and Medical Home program for Georgia's Medicaid program. We also worked with clinicians to ensure appropriate development of the care coordination component of PCMH costs and how those impact Medicaid capitation rates.

Task 4.1.7.4 Assist with programmatic activities, including State Plan Amendments (SPAs)

The Lewin-Aon Team will provide assistance with programmatic activities associated with the Medicaid program, including SPA, contract amendments, and regulatory changes.

We are prepared to assist BMS with programmatic activities associated with the Medicaid program, including SPA, contract amendments, and regulatory changes. Our approach will begin by reviewing the change requirements, researching other states' actions where applicable, and determining best practices. Based on our review and our extensive knowledge of federal regulatory approaches, we will recommend the optimal federal authority for planned program changes.

Our team will assist BMS with the preparation of any necessary SPA requests. As the first step in preparing to develop a SPA request, we will gather relevant information on the BMS' goals and objectives. We will help BMS document and demonstrate compliance with all the terms and conditions required by CMS. Following discussions with BMS staff, we will submit a complete draft of the SPA request to BMS for review and comment. The Lewin-Aon Team will prepare the necessary documentation and any required cost-effectiveness analysis and work with BMS to submit the amendment request to CMS, modify the request if necessary, and obtain approval of the change. Lewin has assisted BMS in obtaining SPAs. We are familiar with the process of working with CMS to modify or add to existing SPAs.

In our experience, a well-prepared SPA that features clear and concise descriptions of the requested changes, accompanied by documentation reflecting a thoughtful and comprehensive financial analysis of the program, will reduce the number of questions CMS will have for BMS. Nonetheless, there will be some questions and requests for clarifications from CMS staff. The Lewin-Aon Team will assist BMS in any way necessary to respond quickly. We will draft responses to CMS questions and participate in meetings or conference calls with BMS and federal officials as needed.

Task 4.1.7.5 Analyze proposed adjustments to provider reimbursement rates

The Lewin-Aon Team will analyze proposed adjustments to provider reimbursement rates.

The Lewin-Aon Team is experienced with addressing the impact of adjusting provider reimbursement rates, as demonstrated in our approach to fee schedule changes (Task 4.1.1.1), directed payments (Task 4.1.1.13), MCO-specific rate development to account for special provider reimbursement (Task 4.1.1.3), or alternate payment methodologies (Task 4.1.7.3).

Following are additional examples to provide more background on our actuarial experience with provider reimbursement rates.

- For Tennessee, Aon's actuarial team members employed the use of rate variation and low-to-high corridors based on utilization patterns ensuring safety net providers including rural area hospitals and critical access hospitals received equitable payments from MCOs and the State. The providers and the rate variation arrangement was an agreement between TennCare and the Tennessee Hospital Association.
- For Georgia, Aon's actuaries took into account differences in reimbursement as part of the Inpatient Provider Payment System (IPPS) methodology. Because of differing mix of risk profiles for their members and utilization at hospitals, the IPPS methodology would impact each Medicaid plan differently and they were required to be reimbursed appropriately for those differences.
- We have also provided support to our state clients when provider groups approach them with negotiations. To do this, our actuaries use a data-driven approach to determine the best interest to the State (measuring fiscal impact) and the beneficiaries.

Task 4.1.7.6 Conduct research and recommend approaches in key areas

The Lewin-Aon Team will conduct research and recommend approaches in key areas of chronic care/disease management, pharmacy, eligibility and coverage, quality improvement, improved rural health delivery, provider networks, and others as requested.

The Lewin-Aon Team is prepared to conduct research and recommend approaches in key areas of interest that will assist BMS in improving the efficiency, effectiveness, and quality of Medicaid services. Research areas, which will be determined by BMS or the legislature, may include, but are not limited to: chronic care/disease management, profiles of specific disease states, pharmacy, eligibility and coverage, quality improvement, innovative reimbursement models, improved rural health care delivery, and provider networks. We will also continuously monitor best practices in the field so that we can provide innovative recommendations to BMS to stay ahead of the curve in lessons learned. Our research and work in this task area will enable BMS to draw from the work and experience of other states and other health care related organizations to improve overall program performance, enhance beneficiary access, and develop innovative approaches to maximize efficiency and increase quality.

Upon a request from BMS, we will convene a conference call with BMS and/or other staff to discuss the request in detail. During this call, participants will discuss the objectives, potential uses of findings by BMS or legislature, anticipated methods, and timeframes. We will then develop a draft work plan to accomplish the objective(s) with recommended strategies and methods. This includes rationale for those approaches, clearly defined products, concrete milestones for activities, and assigned staff with the appropriate experience and expertise to complete the research request. The Lewin-Aon Team will share and discuss the draft work plan with BMS and/or Legislative staff and will revise it as necessary.

Our team brings significant experience and expertise with several research strategies that would very effectively meet the diverse research needs of BMS and state legislature, including surveys, literature searches, stakeholder interviews, focus groups, and analysis of utilization, expenditure, and claims data. Research tools and protocols will be revised based on the requestors' input. As a component of developing protocols and tools, we will identify potential data sources, both maintained by BMS and from outside sources, and their validity. We also have a vast library of resources and work products developed in projects for other states on various Medicaid topics as well as an extensive collection of data and knowledge staff, which we may leverage to meet West Virginia's needs with minimal cost to BMS.

We will then conduct the research and provide BMS and/or Legislative staff periodic updates on the progress of research activities. Once completed, our team members will prepare an informed, objective report, memo or written deliverable of research findings and submit it to BMS for review. Reports will provide an overview of the research activities, describe key findings, identify critical issues and key decisions, and describe available alternatives. We will provide a complete assessment of advantages, disadvantages, and possible consequences of all recommended program modifications or actions, as needed. If requested, we will review the report with BMS and Legislative staff to answer questions, and obtain feedback. The report will be revised as necessary.

Task 4.1.7.7 Provide assistance to DHHR in responding to information requests

The Lewin-Aon Team will provide assistance to DHHR in responding to various information requests from the Governor's Office or Legislative leadership. Our Team's

assistance may include, but is not limited to, development of written correspondence, preparation of presentation materials, attending meetings, and presenting upon request and on an as needed basis at a location to be determined by the meeting organizer.

Many of our proposed project team members have years of experience working directly with the DHHR, including working with West Virginia Medicaid stakeholders and other BMS contractors to implement large policy changes, providing us with an understanding of the West Virginia Medicaid program. We are well-suited to assist DHHR in responding to various information requests from the Governor's Office or Legislative leadership.

Lewin-Aon skilled consultants have years of experience preparing professional written correspondence, leading dynamic and informative presentations and developing accompanying materials for in person or virtual events. Our capabilities include WebEx services, enabling interactive communication from a number of locations.

Our approach begins with discussing the information request with DHHR in order to come to a clear understanding of what is required. We will then gather information and conduct research, using our resources as well as those of DHHR when appropriate. Understanding that requests from the Governor's office or state legislature are usually very time sensitive, we will move quickly to create draft documents (correspondence, power point presentation, or other media as requested) for review by DHHR. Final products will be developed with feedback and input from DHHR and assistance with delivering or presenting will be provided, as requested.

Task 4.1.7.8 Assist with the development of procurement materials

The Lewin-Aon Team will assist with the development of procurement materials, including Request for Proposals, Requests for Quotations, and Requests for Information related to any service covered under this procurement.

The Lewin-Aon Team brings extensive experience designing and managing procurements and has worked with numerous states, the federal government, and several private-sector organizations on various procurement tasks, including developing overall procurement strategies, drafting RFPs, RFQs and RFIs, developing scoring criteria and review guides, training state evaluation teams, participating in proposal review, analyzing provider networks, developing site visit protocols, and conducting site visits to MCOs. Our team members also assist our clients in other purchasing activities, such as conducting market analyses and negotiating with selected contractors.

Lewin developed the original RFP for the West Virginia MHT program, managed the procurements of MCOs for the program, and developed the revised MCO contracts that serve as the basis for future procurements. We have supported BMS in efforts to encourage additional MCOs to participate in the MHT program, and have developed cooperative relationships with key decision-makers at several of these plans.

Lewin has developed RFPs and managed procurements for other contractor types as well, such as enrollment broker, external quality review organization, Medicaid FFS claims processor and others.

Attachment A – Resumes

Key Personnel

RYAN A. BENSON, MA, PMP 2

RUSSELL H. ACKERMAN, ASA, MAAA, FCA 4

COLBY SCHAEFFER, ASA, MAAA 7

G. JEAN FISHER-KRANZ, MS, MBA 10

YELENA BARZILLA, B.L., M.L., CHC 13

Consulting and Research Staff

LESLIE A. WEEMS, MSW 16

NEIL MCCRAY, MPP 19

JULIA TRUELOVE, RN MSN 21

HEATHER FENG 23

CHANDLER GRAY 24

SAM KALLMAN 26

Actuarial Team Members

NICHOLAS GERSCH, ASA, MAAA 29

JEFF YANG, ASA, MAAA 30

DONALD WAKEFIELD, ASA, MAAA 32

STERLING FELSTED, ASA, MAAA 34

ELIZABETH (BETSY) A. HANSON, FSA, MAAA 36

RYAN A. BENSON, MA, PMP

Project Management Lead

Ideally Suited for West Virginia Medicaid Managed Care Leadership

- Certified Project Manager Professional
- Led implementation of Maryland's expanded Medicaid Family Planning Program during his tenure with the Maryland Department of Health and Mental Hygiene
- Eight years of project management and leadership experience with large, complex Medicaid projects
- For West Virginia, supported efforts related to Medicaid managed care improvement plan, site visits to participating MCOs, and analyzed dental network adequacy
- Managed several large, complex Medicaid projects, including operations support and policy development for the Vermont and Rhode Island Health Benefit Exchanges and a strategic policy analysis for South Dakota Medicaid

PROFESSIONAL EXPERIENCE

The Lewin Group **August 2013 - Present**

Senior Consultant

West Virginia Medicaid Managed Care Program

- Analyzed dental network adequacy for the State's Medicaid managed care program
- Supported stakeholder engagement efforts related to integration of behavioral health services into Medicaid managed care.

South Dakota Medicaid

- Led the development of a series of policy papers analyzing Medicaid expansion options in South Dakota. Assisted the State in weighing design alternatives for Medicaid expansion, including design features such as health savings accounts, work referral programs, co-pays, and premium assistance.

District of Columbia Department of Human Services, Medicaid

- Served as project manager for the implementation of a customer relationship management system for the District's Medicaid consumer contact center.
- As part of this role, Mr. Benson led various work streams including stakeholder engagement, business requirement collection, and user training.

HealthSource Rhode Island

- Led a team of consultants in making operational enhancements to the Rhode Island Health Benefit Exchange, including process mapping and process improvement focused on Medicaid and Qualified Health Plan enrollment.

Massachusetts Health Connector

- Supported the operation of the Commonwealth's health exchange by providing ongoing quantitative analysis and predictive models of application volumes.

- Led efforts to improve the operation of the consumer contact center, including implementing enhancements to the center's case management tool.

Vermont Health Connect

- Led a team of 15 consultants to provide process mapping, operational support and business process improvement services.

Maryland Department of Health and Mental Hygiene **2009 - 2013**
Health Policy Analyst

- Served as project manager for the expansion of the Medicaid Family Planning program. Led the development of regulations, implementation of eligibility systems and outreach efforts to newly-eligible beneficiaries. The expanded program increased enrollment from 20,000 to 25,000 Marylanders over the course of 2012.
- Served as project manager for a stakeholder workgroup charged with planning the integration of behavioral health services. Managed a diverse set of over 75 stakeholders, including payers, physicians, hospital systems and community organizations.
- Developed and implemented enhancements to the Medicaid value-based purchasing program, enhancing quality monitoring of a $3 billion dollar managed care program servicing over 800,000 Marylanders.
- Supported reforms to Medicaid eligibility policies in preparation for the ACA
- Prepared policy analyses of the State's substance abuse treatment programs.
- Supported activities under the Medicaid State Innovation Model Planning Grant.
- Performed fiscal and policy analyses of Medicaid legislation in the Maryland General Assembly.
- Assisted in the implementation of the State's Electronic Health Records Incentive Program.

Johns Hopkins University Institute for Policy Studies **2008 – 2009**
Student Consultant and Teaching Assistant

- Designed an evaluation of substance abuse treatment access to assist a quasi-governmental organization that leverages funding for family-support programs.
- Supported public policy students in econometrics and statistics courses by giving lectures, providing tutoring services, and leading workshops in STATA and Excel.

EDUCATION

M.A., Public Policy, Johns Hopkins University, Baltimore, MD
B.S., Mechanical Engineering, Tufts University, Medford, MA

TECHNICAL SKILLS

- MS Project
- STATA
- Visual Basic (Excel macro programming)

RUSSELL H. ACKERMAN, ASA, MAAA, FCA

Lead Actuary

Ideally Suited for West Virginia Medicaid Managed Care Actuarial Analysis

- More than 25 years of consulting and MCO pricing/rate setting experience, including more than 12 years working with numerous state Medicaid programs, exceeding RFQ qualification requirements
- Prior experience leading the development of a study for West Virginia including pharmacy analysis to compare states who have carve-in versus carve-out programs
- Client leader, project director, and/or certifying lead actuary for multiple states, including Georgia, Idaho, Kansas, Kentucky, Massachusetts, Ohio, and Tennessee, having provided subject matter expertise to other states
- Prior experience includes chief actuary of a large health plan that was the largest Medicaid carrier in the state of Minnesota

PROFESSIONAL EXPERIENCE

Aon **2014 - Present**

Senior Vice President and Medicaid National Practice Leader

- Leads all activities related to Medicaid.
- Responsible for executive, management, actuarial, pricing, reserving, underwriting, and financial consulting.
- Strategy and actuarial leader specifically for Georgia, Tennessee, Kansas, and Kentucky Medicaid programs.
- Managed care, state agency, legislative, and other stakeholder facilitation.
- Oversight of all pricing/rate-setting, financial management, analytics, policy, and operations for all Medicaid clients.
- Involvement in and support of State Innovation Model (SIM), 1915b, c, and combo waivers, 1115 waivers, ACO, and PCMH strategy, analysis for alternative.
- Experience consulting with a variety of states on public exchanges, analysis of rural health programs, behavioral health programs, and various disability programs, both for physically disabled and developmentally disabled populations, primarily in the managed care environment, but also in fee for service.
- Medicaid rate setting strategy, health care reform consulting, state innovation model strategies, waiver development, and development and implementation of ACOs and PCMHs and associated alternative payment methodologies to serve Medicaid and other higher risk populations.

Mercer **2012 - 2014**

Principal and Client Leader within Company's Government Human Services Consulting Practice

- Client leader, with primary client and actuarial responsibility for Massachusetts managed care, Ohio financial analytics and healthcare reform, and Idaho SIM grant application oversight, strategy and development.

- Practice leadership over all SIM and public exchange business.
- Assisted states in developing strategies and applications to CMS for SIM grants, implementation of approved SIM funded programs, and development and implementation of various waiver demonstrations.
- Actuarial leader for various clients, including Massachusetts rate setting.

Medica **2005 - 2012**

Financial Department Leader, with Chief Actuary Responsibility

- Corporate leadership and oversight over all government sponsored, commercial, and retail lines of business, including Medicaid, Medicare Cost and Medicare Advantage, Individual, Large and Small Group.
- Built actuarial department from ground up.
- Developed strategy and implemented company-wide improvements affecting all actuarial, reserving, capitalization, pricing, underwriting, financial reporting, and operations across all corporate lines of business.

Deloitte **2003 - 2005**

Consultant

- Consulted health insurers, third party administrators, and managed care organizations including various for-profit and Blue Cross and Blue Shield not-for profit organizations nationally and in various states).
- Responsible for executive, management, actuarial, pricing, reserving, underwriting, and financial consulting.

Aon **2001 - 2003**

Assistant Vice President and Actuarial/ Underwriting Consultant

- Responsible for consulting large corporations on benefit design, pricing, underwriting activities, and healthcare funding mechanisms.

PacifiCare Health Systems (now United HealthCare) **1995 - 2000**

Corporate leader for National and Major Accounts

- Responsible for pricing and underwriting activities for the company's National accounts.
- Responsible for California Major Accounts underwriting.

Watson Wyatt (now Willis Towers Watson) **1992 - 1995**

Consultant

- Responsible for consulting large corporations on benefit design, pricing, underwriting activities, and healthcare funding mechanisms.

EDUCATION

B.S., Brigham Young University, Provo, UT

CERTIFICATIONS

Associate of the Society of Actuaries (ASA)
Member of the American Academy of Actuaries (MAAA)
Fellow of the Conference of Consulting Actuaries (FCA)

Society of Actuaries Directory – Credentials and Compliance Printout

Russell H Ackerman

Personal Information
Russell H Ackerman
Senior Vice President
Aon Hewitt
1900 16th Street
Suite 1000
Denver, CO 80202
United States

Tel: +1(480)318-9390
Email: russ.ackerman@aonhewitt.com

Designations
ASA 2007
MAAA 2007
FCA 2015

SOA Continuing Professional Development Requirement
Compliant(2015-2016)

Academic Degrees
B.S.

Other Professional Designations

Industry
Consulting

Primary Area of Practice
Health

Specializations
Capital Management
Financial Reporting
Product Pricing/Development
Public Systems/Social Insurance
Regulatory
Risk Management

Society of Actuaries Sections
Entrepreneurial & Innovation
Health
Marketing & Distribution
Social Insurance & Public Finance

COLBY SCHAEFFER, ASA, MAAA

Lead Actuary

Ideally Suited for West Virginia Medicaid Managed Care Leadership and Actuarial Analysis

- More than 10 years of consulting and MCO pricing/rate setting experience, including more than 6 years working with numerous state Medicaid programs
- Client leader, project manager, and/or certifying lead actuary for multiple states, including Georgia, New Hampshire, Tennessee, Vermont, and West Virginia having provided subject matter expertise to other states
- Direct experience in all facets of rate setting for West Virginia Medicaid from 2012 to 2015 including involvement in certifying rates that were submitted timely to BMS and accepted by CMS and the participating MCOs during a period that covered rapid expansion of the Mountain Health Trust program (carve-in of pharmacy, dental, and behavioral health services and inclusion of Medicaid Expansion population)
- Prior experience includes all actuarial activities for what was the largest Medicaid health plan (Missouri) at Coventry (now part of Aetna) in addition to supplemental Medicare plan valuation.

PROFESSIONAL EXPERIENCE

Aon **June 2015 - Present**

Assistant Vice President

General Role

- Assisting in the management of Medicaid activities at Aon and overseeing large pricing/actuarial engagements for both Georgia and Tennessee. These projects have covered many needs for state agencies including Medicaid managed care pricing/rate setting, health reform modeling, budget analyses, IBNR valuations, value-based payment methodologies, fiscal analyses of policy changes, and data analytics presentations.

Georgia Department of Community Health

- Project manager and client lead overseeing rate development process and ad hoc projects.
- Signing actuary for SFY17-18 rates for CMO rate development that saw implementation of value-based purchasing initiatives and risk adjustment.
- Developed NEMT rates for transportation brokers.
- Assisted modeling and review of annual IBNR valuations.

Tennessee Division of Health Care Finance & Administration

- Signing actuary for CY15-18 capitation rates, which included LTSS population and HCBS rates.
- Peer reviewed all elements of project including State budget forecasts, risk adjustment, and annual reports.

- Led the development of modeling administrative expense needs for insurance plans participating in ASO arrangement for IDD kids called ECF CHOICES.

The Lewin Group **2012 - 2015**
Senior Consultant

West Virginia Bureau for Medical Services: Medicaid Managed Care Administration Oversight

- Project manager for actuarial modeling, capitation rate setting (SFY13-16), and MCO quarterly monitoring reports.
- Developed and modified monitoring reports on Medicaid plans' utilization, cost, and access to care, grievances and appeals, and call center volume.
- As both a consultant and signing actuary, oversaw rate development through several transformations of the project.

Centers for Medicare & Medicaid Services (CMS), Office of Financial Management: Payment Error Rate Measurement (PERM)

- Data Manager role involved reviewing quality and reasonability of data through data submission (universe).
- Became lead details manager conducting final review of claim extracts for all States, including Virginia, prior to submission.

Vermont Green Mountain Care Board

- Project manager for actuarial side of State Innovation Model grant project that kicked off July 2014.
- Developed share savings models for Medicaid and Commercial Accountable Care Organizations that included exchange premium modeling and risk adjustment.

State of New Hampshire

- Modeled expansion population costs for Medicaid agency.
- Projected membership and costs through 2020 and included scenarios to price new essential health benefits for mental health.

Colorado CHIP

- Provided actuarial support including analysis and modeling of SFY13 CHIP rates.
- Assisted in pulling together provider network contact data.

Coventry Healthcare (now Aetna) **2010 - 2012**
Actuarial Analyst

Missouri Medicaid (Healthcare USA plan)

- Actuarial analyst assigned to plan to perform all actuarial modeling functions including SFY12 rate setting modeling, Fee Schedule analysis, Medical Home MLR targets, Provider Contract Analysis for SSM, CY11 Budget Refresh, CY12 Budget, FY12 PDR, and RFP support.

Virginia Medicaid

- Conducted monthly reserve analysis for health plans' claims that have been incurred but not received.

Lynchval Systems Worldwide **2009 - 2010**
Actuarial Analyst

- Bridged actuarial and developer departments as actuarial programmer.

- Consulted on post-retiree Medicare supplemental plans.
- Developed enhancements to software for stochastic modeling, cash balance plans, and medical plans.

John S. Agatston Actuarial Services **2007 - 2009**
Actuarial Analyst

- Redesigned valuation system based on research of new regulatory requirements under the Pension Protection Act of 2006.
- Analyzed expected future costs through plan valuations.

EDUCATION

B.S. Mathematics, State College, PA

CERTIFICATIONS

Associate of the Society of Actuaries (ASA)
Member of the American Academy of Actuaries (MAAA)

G. JEAN FISHER-KRANZ, MS, MBA

On-Site Program Management/Policy Analyst

Ideally Suited for West Virginia Medicaid Managed Care Program Management

- Current West Virginia on-site Program Management/Policy Analyst
- NCQA Patient Centered Medical Home Content Expert Certification
- More than six years of experience working with Medicaid Managed Care delivery systems
- Coordinated quality improvement efforts for providers serving Medicaid and CHIP children through managed care delivery systems in Oregon and Alaska, to include eight MCOs.
- Liaison between the Bureau for Medical Services' and the managed care organizations to build and delegate work plans, and communicating progress to the client executives
- Supported WV BMS with contracting, rate setting, directed payment program, network adequacy, monitoring and evaluation for the program as well as preparing federal waiver materials for CMS preparing federal waiver materials for CMS

PROFESSIONAL EXPERIENCE

The Lewin Group **July 2015 – Present**

Senior Consultant

West Virginia Managed Care Program

- Serves as the onsite project manager assisting with the administration of the Medicaid managed care program
- Support the state with contracting, rate setting, network adequacy, monitoring and evaluation for the program as well as preparing federal waiver materials to submit to CMS
- Assists the WV Medicaid managed care program, facilitating team and client project meetings, bridging client and vendor relationships, and directing and implementing managed care systems for the Bureau for Medical Services'
- Serves as a liaison between the Bureau for Medical Services' and the managed care organizations to build and delegate work plans, communicating progress to the client executives
- Provide centralization of all managed care activities, oversight for implementation of managed care guidelines, implementation and coordination of managed care reporting and related activities, to include corrective action plans
- Assist in conducting system-wide managed care activities and in arranging affiliation relationships with other healthcare and healthcare-related organizations, while providing oversight for affiliation relationships

West Virginia Health Improvement Institute **2011 – 2015**

Project Director, Tristate Children's' Health Improvement Consortium

- Guided quality improvement efforts across three states, serving children through a managed care delivery system for quality improvement, that included eight health plans
- Provided technical direction to an alliance between the Medicaid/CHIP programs of Alaska, Oregon and West Virginia, formed with the goal of markedly improving children's health care quality as part of a Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Demonstration Project
- Coordinated quality improvement efforts for providers serving Medicaid and CHIP children through managed care organizations in Oregon and Alaska
- Developed within each state an enhanced capacity to report and use the Child Core Set of quality measures for children, including the Consumer Assessment of Healthcare Providers and Systems surveys (CAHPS); developing and enhancing health information technology to improve quality of care, reduce cost and increase transparency; and developing and expanding provider-based care models
- Supported provider practice transformation to the patient-centered medical home model; care management entities, which aim to improve services for children and youth with serious emotional disorders and school based health centers
- Assessed current patient centered care measurement across the partner states and identified common state or site specific measures of implementation and impact for collecting and reporting quality measures
- Worked with the project subcontractor to facilitate the administration of the CAHPS survey across the providers in the health plan networks

Highmark Health Services **2013 – 2014**

Clinical Transformation Consultant

- Guided health plan providers to assist with administrative coordination of and complex technical assistance to the Highmark network providers and to facilitate practice transformation in various strategic care delivery models
- Worked directly with the network of providers to assist the practice team with the day to day execution of projects, initiatives and significant work streams related to provider transformation and performance excellence in various health care delivery settings
- Served as the primary catalyst for developing standards for identifying and facilitating major systems change in the form of industry standard evidence-based best practice improvement opportunities to accelerate the achievement of goals related to clinical operations excellence and sustained quality patient care as manifested by patient outcomes

West Virginia Primary Care Association **2009 – 2011**

Director, Clinical Quality

- Provided technical assistance to Federally Qualified Health Centers (FQHC) and Rural Health Clinics in West Virginia to support clinical/performance improvement, for community health center personnel
- Assisted in the development and maintenance of policies, procedures and methods to improve provider network function
- Assisted Association members to develop and test state-wide emergency preparedness policies and procedures

Wheeling Jesuit University **2009 – 2010**
Adjunct Faculty (on-line)

- Conducted online learning sessions for students enrolled in the BA Program

West Virginia Hospital Association **2001 – 2009**
Vice President, Patient Safety and Education

- Worked with hospitals statewide to plan, develop and execute educational workshops for hospital leadership and clinical staff
- Conducted both classroom and virtual programs to provide a cost effective venue for education in a rural state
- Partnered with 40 states to develop an on-line learning platform to assist hospital administrators and education staff to meet clinical competencies required by licensing boards and accreditation agencies
- Technical support for the "super users" of the care Learning platform
- Development of multiple state-wide hospital standardization projects for emergency audible pages, color coding of armbands, patient sitter protocols and a universal protocol for site marking and verification during invasive procedures

University of Charleston **1991 – 2001**
Director of Clinical Education and Mentoring Program Coordinator

- Conducted classroom and clinical education for 2- and 4-year Respiratory Care students
- Planned, coordinated and supervised all clinical laboratory experiences for students in the program
- Delivered didactic instruction in areas of study to include respiratory care, human resource management, business and the "Freshmen Experience"

Healthfocus/Jackson General Hospital **1987 – 1991**
Director of Respiratory Care Department

- Provided respiratory care technical direction in a 50 bed rural West Virginia hospital
- Supervised 10 employees

EDUCATION

MS, Human Resource Management, University of Charleston, Charleston, WV
MBA, Business Administration, University of Charleston, Charleston, WV
BA, Arts, Glenville State College, Glenville, WV

Technical Skills

- MS Map Developer
- Dreamweaver Video Production
- Blackboard Course Design
- Avilar Webauthor

YELENA BARZILLA, B.L., M.L., CHC

Program Integrity Analyst

Ideally Suited for West Virginia Medicaid Managed Care Program Integrity

- Certified Health Compliance Officer
- Ten years of regulatory compliance and program integrity experience, exceeding the minimum qualification. Researched and implemented various federal and state laws and regulations related to health care fraud and abuse issues and Medicaid reimbursement issues
- For West Virginia, developed key contractual provisions, advised on the enforcement, conducted compliance reviews
- For the Office of Inspector General, developed policies, procedures, and compliance strategies to ensure appropriate monitoring, auditing and evaluation of Medicaid program integrity resulting in higher recoveries
- For multiple state agencies, managed CMS Medicaid Integrity Group Comprehensive Program Integrity Reviews, responded to findings, and developed corrective actions
- For CMS, Centers for Medicaid, CHIP, and Survey and Certification (CMCS): Development of Infrastructure for Oversight of Medicaid Managed Care Delivery Systems, served as a lead policy expert and a drafter for the CMS MCO compliance tool

Professional Experience

Aon **July 2016 - Present**

Assistant Vice President

- Medicaid policy lead providing expertise on state health policy and reimbursement issues, particularly Medicaid and CHIP, to states, third party vendors, and Aon actuarial team
- Analyzed regulations, legislation, and program guidance for impact on Medicaid and CHIP programs across the country

The Lewin Group **2012 - 2016**

Senior Consultant

West Virginia Medicaid Managed Care Program

- Policy SME on managed care, eligibility, program integrity and enforcement issues. Supported the state with all aspects of design, administration, monitoring and evaluation of the program.
- Project manager for the MCO readiness reviews and contract compliance reviews.
- Principal drafter for the managed care waiver and MCO contracts (SFY 13-SFY17).
- State policy expert for the CMS MIG reviews.
- Project manager for pharmacy, dental, behavioral, and ACA transitions into managed care.

Centers for Medicare & Medicaid Services (CMS), Office of Financial Management: Payment Error Rate Measurement (PERM) Eligibility Support

- Lead policy expert for the federal eligibility regulations review. Provided ongoing consulting to CMS, through the PERM project, on a variety of issues related to Medicaid and CHIP policy, payment methodology and program integrity.
- Conducted a comprehensive study to evaluate the impact of four proposed Medicaid regulations on each of the 50 states and the District of Columbia for CMS.

CMS, Center for Consumer Information and Insurance Oversight (CCIIO): Marketplace Network Standards Adequacy

- Policy expert on the Medicaid regulatory compliance. Conducted reviews of the state Medicaid contracts to identify provider network and member communication requirements.

Texas Health and Human Services Commission **2007 - 2012**

Managed Care Oversight

- Monitored managed care organization performance to ensure compliance with federal regulations, state laws, contracts and manuals. Updated Texas HHSC contracts and manuals to ensure appropriate monitoring and evaluation of Medicaid/CHIP programs.
- Served as an Office of Inspector General liaison for the program integrity questions.

Office of the Inspector General

- Planned, implemented and evaluated oversight strategies and methodologies for Medicaid providers, recipients and managed care organizations as related to program integrity functions.
- Project manager for 2010 CMS Medicaid Integrity Group Comprehensive Program Integrity Review.

EDUCATION

LL.M., magna cum laude, University of Florida, Gainesville, FL
M.L., Master of Laws, A.B.A., Karaganda State University, College of Law, Russia
B.L., Bachelors of Laws, summa cum laude, (undergraduate law degree), Karaganda State University, College of Law, Russia

Consulting and Research Staff

LESLIE A. WEEMS, MSW

Senior Consultant

Ideally Suited for West Virginia Medicaid Managed Care Program Administration

- More than nine years of Medicaid experience
- Medicaid Reform Specialist for the Colorado Department of Health Care Policy and Financing, supported a wide range of reform projects, including redesign of statewide Community Behavioral Health Program managed care contracts, Accountable Care Collaborative Payment Reform Initiative and implementation of 1115 Demonstration Waiver
- Health Policy Analyst with the Texas Department of State Health Services supported healthcare delivery redesign efforts
- Senior Policy Analyst/Project Manager with Texas Health and Human Services Commission
- Program Specialist, Texas Health and Human Services Commission for the Texas Medicaid and CHIP programs

PROFESSIONAL EXPERIENCE

The Lewin Group **March 2014 – Present**

Consultant

Payment Error Rate Measurement (PERM) Eligibility Support Contractor, CMS

- Serves as project manager for the PERM Eligibility Support Contractor project, which is developing tools and guidelines for PERM measurement of improper payments in Medicaid and CHIP under the Affordable Care Act.
- Leading the development of a methodology to incorporate claim-specific federal matching into the PERM measurement approach.
- Coordinated the planning and implementation of PERM eligibility measurement pilots in three states, managed the efforts of subcontractors performing the reviews, performed analysis on findings, and provided process observations and recommendations for CMS consideration.

Payment Error Rate Measurement (PERM) Statistical Contractor, CMS

- Served as the cycle manager for the PERM Statistical Contractor work for two cycles.
- Responsible for coordinating project work for the PERM federal contract, including the management of relationships with partner contractors, coordination and development of written deliverables, and consultation on process improvement and project management efforts.
- Worked with over 34 states to educate them on the PERM program and CMS requirements while navigating the variations among state Medicaid and CHIP programs and ensuring successful measurements to meet CMS needs.

DHHS Centers for Medicare and Medicaid Services (CMS)

- Supporting an evaluation of the online enrollment assistor community, ***In the Loop***, using qualitative and quantitative research methods.

- Leading the design, facilitation, and analysis of a series of focus group sessions with enrollment assistors to understand the user experience of the online community and to identify opportunities to improve its support of enrollment work across the country. This effort will result in a report to the Centers for Medicare and Medicaid Services (CMS) with evaluation findings.

Colorado Dept. of Health Care Policy and Financing **2011 – 2014**

Medicaid Reform Specialist

- Served as project lead for a number of Medicaid Reform projects and initiatives, including: the re-design of the statewide Community Behavioral Health Program managed care contracts, the Accountable Care Collaborative (ACC) Payment Reform Initiative solicitation, implementation of the 1115 Demonstration Waiver to expand Medicaid eligibility to Adults without Dependent Children (AwDC), and the design of a Section 2703 Health Homes benefit.
- Contributing author on the Round 1 State Innovation Model (SIM) model testing grant proposal and helped with the design of the State Demonstration to Integrate Care for Medicare-Medicaid Enrollees.
- Developed reform efforts to be implemented through the Accountable Care Collaborative (ACC) program, an innovative service delivery system that was implemented in 2011 with the goals of improving health outcomes of Medicaid clients through a coordinated, client-centered system, and controlling costs by reducing avoidable, duplicative, variable and inappropriate use of health care resources
- Managed contracts for Regional Care Coordination Organizations (RCCOs) in three regions of the state and worked with Medicaid primary care providers to enroll them as medical homes in the ACC program.
- Identified core data elements for legislative reporting and ongoing evaluation efforts, and she also efforts to build new systems requirements in the MMIS to accommodate program improvements in the ACC and the planned health homes program.

Texas Department of State Health Services **2011 – 2011**

Healthcare Policy Analyst

- Worked on Healthcare Delivery Redesign efforts in the Center for Program Coordination and Health Policy.
- Facilitated agency leadership's development of a multi-year strategic plan, creating a billing and claims strategy for the agency's Medicaid programs, and producing financial impact analyses for policy changes related to Medicaid-funded programs.

Texas Health and Human Services Commission **2011 – 2014**

Senior Policy Analyst/ Project Manager

- Managed the Health Homes Pilot Project, a statewide strategic initiative to fund pediatric practices across the state and transform them into fully-competent health homes for children.
- Created a data collection and evaluation methodology.
- Managed the $20 million project budget and procurement process, while working with providers across the state on the development of their health homes models.

Texas Health and Human Services Commission **2008 – 2010**
State Plan Coordinator

- Coordinated the development and submission of over 65 state plan amendments, including policy updates and new reimbursement methodologies across the Medicaid program.
- Served as the state liaison to the Centers for Medicare and Medicaid Services (CMS) and provided technical guidance for state plan requirements, federal regulations and statutory requirements for policy development and reimbursement strategies.
- Authored the Drug Utilization Review Program Improvement Reports in 2009 and 2010, which identified strategies to reduce costs and improve effectiveness in the program.

Texas Health and Human Services Commission **2008 – 2010**
Program Specialist

- Researched statutory and regulatory authorities to support program development and policy changes for the Medicaid program.
- Analyzed various sections of the Texas state plan to identify content issues; and researched program options through literature review and examination of other state Medicaid programs.
- Developed records management systems and assisted IT staff with the development of a communications database program.

UT Austin Center for Social Work Research, Austin, TX **2006 – 2008**
Research Assistant

- Managed qualitative data sets for multiple projects, including Hurricane Katrina disaster response studies that resulted in numerous publications.
- Supervised the work of the graduate research team and helped to develop a coding methodology applied to a data set of several hundred recorded interviews and transcripts.

EDUCATION

MSW, Administration and Policy Practice, the University of Texas, Austin, TX
BA, Anthropology, the University of Texas, Austin, TX

NEIL MCCRAY, MPP

Junior Consultant

Ideally Suited for West Virginia Medicaid Managed Care Operations Support

- West Virginia managed care data modeling consultant
- Experienced with Medicaid data analysis, including providing operations support and data analysis for the Maryland Health Benefits Exchange, eligibility and enrollment data analytics, and reporting to CMS and Maryland's Department of Health and Mental Services

PROFESSIONAL EXPERIENCE

The Lewin Group **July 2014 - Present**

Research Consultant

Kansas Medicaid

- Offered technical Excel support, including model design and development, for audit of state's Health Care Access and Improvement Program, under the state's Medicaid agency.
- Assisted with data analysis and with creation of report exhibits.

West Virginia Department of Health and Human Resources

- Provides support with capitation rate setting for managed care organizations (MCOs) for the state Medicaid agency, including analysis of encounter, fee for service (FFS), and sub-capitation data.
- Assists with updating, developing, and creating Excel models for rates development including fee schedule adjustments and rates model.
- Assists with modeling the incorporation of UPL (Upper Payment Limit) directed payments into capitation rates.

Wisconsin Health Information Organization (WHIO)

- Analyzed SAS and Excel output to evaluate the integrity of WHIO data contributors' submissions, including eligibility, medical, pharmaceutical, and facility/professional claims data.

Maryland Health Benefits Exchange (MDHBE)

- Completed monthly Medicaid and qualified health plan (QHP) enrollment and eligibility reports to CMS and DHMH to support eligibility and enrollment reporting.
- Assisted in administration of an IRN matching process in 2014, and later helped to design and implement a new IRN matching process under Maryland's new HBX system.
- Assisted in data management, reporting, and analytics on this project.

American Enterprise Institute for Public Policy Research **2013 - 2014**

Research Assistant

- Provided research support to four health policy researchers specializing in Medicare, Medicaid, long-term care, and health insurance markets.

- Organized and managed health policy publications and events, including promotion and execution of public conferences, private working groups, and numerous articles and papers.

Independent Contractor **2015 - 2014**

- Designed a model to predict political ideology and affiliation using nothing but demographic information, primarily utilizing Stata statistical analysis software and General Social Survey data.

EDUCATION

M.P.P., Public Policy, George Mason University, Fairfax, VA
B.S.S., Public Policy and Philosophy, Cornell College, Mt Vernon, IA

JULIA TRUELOVE, RN MSN

Junior Consultant

Ideally Suited for West Virginia Medicaid Managed Care Operations Support

- On the CMS Financial Alignment Initiative, completed desk reviews of provider data to ensure network adequacy
- For the District of Columbia Department of Human Service, worked on implementation of program redesign and served as the technical lead

PROFESSIONAL EXPERIENCE

The Lewin Group **March 2014 – Present**
Research Consultant

District of Columbia Department of Human Services

- Served as the technical lead for a redesign of the Salesforce system used by the DC Department of Human Service, the state Medicaid agency.
- Primary business analyst for the Salesforce development team, as well as overseeing requirements gathering, and end user demonstrations and testing.
- Responsible for leading all trainings for new staff and refresher trainings for existing staff on the redesigned system.
- Supports reporting and training for the agency.

District of Columbia Health Benefit Exchange Authority

- Assisted in implementing a redesign of the exchange's case resolution process, including serving as a liaison to the Salesforce software development team, developing system testing procedures, and overseeing reporting.
- Currently the primary functional analyst supporting the Salesforce development team, and is responsible for requirements gathering from clients, scheduling and communicating system deployments, and Salesforce reporting.

DHHS Centers for Medicare and Medicaid Services, Financial Alignment Demonstration Initiative

- Assisted with data review for CMS' Financial Alignment Demonstration Initiative.
- Completed desk review of provider data to ensure network adequacy.

U.S. Senate Committee on Health, Education, Labor & Pensions **2015**
Graduate Intern

- Led stakeholder engagement efforts and legislative planning related to nurse practitioner education and workforce issues.
- Assisted with the establishment of a bipartisan staff working group on the topic of campus sexual assault and represented the office in planning a committee hearing on the issue.

UVA Health System Accountable Care Organization **2014 – 2015**

Research Assistant to Chief Medical Officer

- Conducted research on the integration of community health workers into health system-based care teams.
- Assisted with implementation of a pilot partnership with the local area agency on aging to integrate health coaches into the inpatient setting.

EDUCATION

M.S., Public Health Nursing Leadership, University of Virginia, Charlottesville, VA
B.S., Nursing, University of Virginia, Charlottesville, VA

HEATHER FENG

Research Analyst

Ideally Suited for West Virginia Medicaid Managed Care Research Analysis

- Experienced in evaluation State Innovation Model activities as well as CMS grants for states aimed at care improvement for Medicaid populations

PROFESSIONAL EXPERIENCE

The Lewin Group **July 2015 – Present**
Senior Research Analyst

Evaluation of Demonstration Grant for Testing Experience and Functional Assessment Tools in Community-Based Long Term Services and Supports

- Evaluated CMS grants for eight states to test new quality measurement tools and demonstrate person-centered electronic information exchange in Medicaid community-based long-term services and supports waiver programs. Specific care improvement mechanisms evaluated include an experience of care survey, a universal functional assessment, Personal Health Records, and an electronic LTSS plan for LTSS Medicaid waiver populations.
- Monitored the progress of surveys and assessments, as well as changes to the health-IT landscape in the grantee states.

Maine SIM Evaluation

- Supporting Lewin's work as a strategic partner for the State of Maine in a three year evaluation of its State Innovation Model grant activities.
- Conducts data collection and data analysis using Atlas TI to create a series of evaluation reports. Data for this work included a combination of Medicaid, Medicare, and commercial partners.
- Creates visual representation of her collected data, and writes analyses of stakeholder representation in ME SIM processes.
- Supports research to understand the impact of SIM program interventions and ultimately identify best practices.

Smith, Gildea, & Schmidt **2014**
Intern

- Assisted in change management for the new nursing home litigation practice as employees adjusted to their firm's new practice area.
- Researched state regulations pertaining to nursing homes, such as long-term care regulations, and aging and disability regulations.
- Synthesized the researched information into written communications designed for simplicity, readability, and increased public engagement to drive business development.

EDUCATION

B.A., International Studies, East Asian Studies, Johns Hopkins University, Baltimore, MD

CHANDLER GRAY

Research Analyst

Ideally Suited for West Virginia Medicaid Managed Care Research Analysis

- Supports evaluation of CMS demonstration grants, conducting state-level qualitative research
- For a large CMS project, maintains website for quarterly data submission, including updating data collection tool, exporting the data for analysis, and preparing the data for submission to CMS.

PROFESSIONAL EXPERIENCE

The Lewin Group **November 2015 – Present**

Senior Research Analyst

Evaluation of Demonstration Grant for Testing Experience and Functional Assessment Tools (TEFT) in Community-Based Long Term Services and Supports

- Supporting the evaluation of state programs that have been awarded grants under the TEFT Demonstration program. Involves in-depth understanding of state Medicaid programs and their administration, management of several tasks, and coordination with several agencies.
- Monitoring the progress of the two health IT components of the demonstration: the development of an electronic personal health record (PHR) system for Medicaid LTSS beneficiaries and the development of an electronic long-term services and supports (eLTSS) standard care plan.
- Maintains the website where grantees submit data each quarter by updating data collection tool questions, exporting the data for analysis, and preparing the data for submission to CMS. Updates the Access database used to store this data on a quarterly basis.
- Supports the qualitative analysis and development of quarterly monitoring reports that reflect the progress of the grantees and the drafting of the annual report to CMS, as well as writing grantee-specific reports and profiles.
- For the PHR component of the demonstration, completed a comprehensive literature review of existing PHR solutions and vendors and developed a deliverable on PHR vendor selection criteria.
- Acts as Lewin's representative on weekly calls with the Office of the National Coordinator (ONC) detailing grantee's progress in developing the eLTSS plan and updates Lewin's internal team. Participates on monthly project officer calls with grantees and develops monthly project updates for each project officer call.

Office of U.S. Senator Kay R. Hagan **2014**

Intern

- Submitted informative research reports on various policy issues after utilizing various databases as well as the Congressional Research Service.
- Represented the Senator's office at various policy and issue briefings and hearings and assembled this information into comprehensive reports for the Senator and her staff.

- Communicated effectively with constituents via phone, email, and mail as well as led constituent groups on a tour of the United States Capitol and legislative roles.

EDUCATION

BA, Political Science, Davidson College, Davidson, NC

SAM KALLMAN

Research Analyst

Ideally Suited for West Virginia Medicaid Managed Care Research Analysis

- Supports the WV rate setting task through data analysis and developing code to adjust pharmacy rates
- Works with Medicaid and CHIP claims in numerous states, including West Virginia, Indiana, and others through the Payment Error Rate Measurement (PERM) project to stratify PMPMs and quality outcomes by eligibility groups, including waivers, the Medicaid expansion population, and managed care vs fee-for-service

PROFESSIONAL EXPERIENCE

The Lewin Group — **September 2015 – Present**

Senior Research Analyst

Vermont SIM Statewide Analytics

- Developed code to calculate PMPMs for ME measures, conduct a leaver-joiner analysis, perform an NPI crosswalk to practices for a pilot of practice-level reporting, and perform an ICD 9 to 10 crosswalk for data from the transitioning months.
- Developed code to adjust Vermont's shared savings based on demographic risk scores and on paid amount-to-allowed amount ratio.
- Ran the ACG grouper on Vermont commercial and Medicaid data and assisted in an analysis of the predictive power of various risk groupers on both commercial and Medicaid populations in the state.
- Ran code with SAS to pull samples and perform medical coding assessment for the VT SIM project, as well as extensive data validation for both VT SIM quality and ME measures.

Medicare Care Choices Model

- Developed SAS code to track and create monthly and quarterly reports on enrollment, participation in the model, and discharges in a Lewin-managed web portal, and claims utilization in a CMS claims database, the Chronic Conditions Warehouse (CCW).
- Runs code to prepare data for evaluators and to perform numerous data quality checks, such as the validity of Medicare numbers, NPIs, and ICD-9 and -10 diagnosis codes.
- Identified issues with the web portal and drafted explanations and suggested solutions for the web developers to implement.
- Prepared MCCM data for input into Tableau and assisted in the report design thereof.

West Virginia Medicaid Rate Setting

- Supported the project as a data analyst for all of the rate setting for SFY 18, running code to analyze several eligibility groups and medical, pharmacy, dental, and behavioral health claims over the previous three years.

- Developed code for adjusting the pharmacy rates based on expenditures on opioids and modified behavioral health coding to be more consistent between fee for service and managed care.

MassHealth LTSS and Indiana HCBS Assessment

- Provided reporting support to MassHealth on an LTSS project and to Indiana on an analysis of children in their HCBS waivers and Choice program.

Payment Error Rate Management (PERM) Statistical Contractor

- Supports data analysis and draws statistical samples of Medicaid and CHIP claims in numerous states.

Penn Wharton Public Policy Initiative **2014**

Policy Research and Memo Writing

- Tracked movements in healthcare policy in federal and state governments in a range of issues, including payment model innovation, vaccine costs, access to care, and veteran' s health reform, among others.
- Connected these active policy issues to previous or current research done by Penn faculty, culminating in a half-day panel event in Washington, DC, where Penn faculty presented to congressional staff, industry, and third party researchers.

The Home Depot **2012**

Database Management and Predictive Modelling & Budget Analysis and Data Validation

- Managed a dataset of several million observations. Management included locating and selecting relevant entries from a larger set, verifying records, and creating numerous additional subsets for independent analysis.
- Assessed the impact of shipping charges on online sales and profit for seasonal products, through the creation of a predictive regression model.
- Assisted Supply Chain Finance leadership with second half planning, including evaluating outbound logistics and several proposed sales.
- Performed significant data validation on both a quarterly report and second half planning.

EDUCATION

BS, Economics, University of Pennsylvania, Philadelphia, PA
BA, International Studies, University of Pennsylvania, Philadelphia, PA

TECHNICAL SKILLS

- SAS

Actuarial Team Members

NICHOLAS GERSCH, ASA, MAAA

Staff Actuary

Ideally Suited for West Virginia Medicaid Managed Care Actuarial Analysis

- More than three years of Medicaid consulting experience
- Analyst and led actuarial modeling for multiple states, including Georgia, Kansas, Kentucky, and Tennessee in addition to several employers

PROFESSIONAL EXPERIENCE

Aon **September 2014 - Present**

Actuarial Analyst

Kentucky Department for Medicaid Services (DMS)

- Lead analyst for Kentucky capitation rate-setting. Responsibilities include developing IBNR factors, pricing retrospective and prospective program changes, developing risk adjusted capitation rates, supporting the development of admin and trend assumptions, packaging deliverables, and drafting rate certifications for CMS review.

Georgia Department of Community Health

- Lead analyst for Georgia Non-Emergency Medical Transportation (NEMT) capitation rate-setting.

Kansas Department of Health and Environment

- Involved in several actuarial components of KanCare rates including base data development and adjustments, MCO reporting review, program change analysis, trend analysis, managed care savings analysis, admin cost development, and packaging deliverables.
- Provided support for various ad hoc projects including development of risk corridor for IDD population and projecting HCBS costs under different cost saving scenarios.
- Works with CMS checklists and questions, HIF calculations, Medicaid Final Rules, DRG re-basing, risk adjustment, pass through payment phase-out, and waiver integration.

Tennessee Department of Finance and Administration

- Provides support for Medicaid capitation rate development and risk adjustment. Primary responsibilities include developing IBNR factors, pricing retrospective and prospective program changes, supporting the development of admin and trend assumptions, packaging deliverables, and drafting rate certifications for CMS review.

EDUCATION

B.A., Kalamazoo College, Kalamazoo, MI

CERTIFICATIONS

Associate of the Society of Actuaries (ASA)
Member of the American Academy of Actuaries (MAAA)

JEFF YANG, ASA, MAAA

Staff Actuary

Ideally Suited for West Virginia Medicaid Managed Care Actuarial Analysis

- More than five years of consulting and MCO experience working with numerous state Medicaid programs

PROFESSIONAL EXPERIENCE

Aon **December 2014 - Present**

Senior Consultant and Actuary

Georgia Department of Community Health

- Lead analyst for Georgia Families, Georgia Families 360, and Planning for Healthy Babies capitation rate-setting. Primary responsibilities include processing and tagging encounter data, developing IBNR factors, pricing retrospective and prospective program changes, supporting the development of admin and trend assumptions, packaging deliverables, and drafting rate certifications for CMS review.
- Assumptions development, including completion factors, trend, managed care savings, program changes, administrative loadings, and taxes.
- CDPS risk adjustment. Medicaid expansion analysis. NICU case rate analysis.
- Experience with Medicaid claims and eligibility data, and with large data sets.
- Worked with CMS checklists and questions, HIF calculations, Medicaid Final Rules, DRG re-basing, risk adjustment, and waiver integration.

Kansas Department of Health and Environment

- Lead analyst for KanCare rate-setting. Involved in several actuarial components of KanCare rates including base data development, base data adjustments, MCO reporting review, program change analysis, trend analysis, managed care savings analysis, admin cost development, and packaging deliverables.
- Risk corridor calculation.
- DRG weight and hospital rebasing.
- Critical access hospital rate adjustment.
- LTSS rate risk adjustment with LTSS service setting mix.

Amerigroup **2012 – 2014**

Actuarial Analyst

- Budget/forecasting: Designed and developed the forecast model for the Medicaid line of business and served as the primary point of contact for over a dozen Amerigroup markets.
- Data requests/experience reports: Collaborated with finance and accounting to ensure the financial accuracy of reports.
- Actuarial Pricing: Assisted in formulating rate arguments for NJ Medicaid and TN Medicaid.

- Principal drafter for the waiver and MCO contracts (SFY 13-SFY17).
- Data Processing/Analytics: Familiarity with claims and eligibility data and Amerigroup's databases.
- Other: Medicaid IBNR, seasonality factor development, project management, VBA modeling.

EDUCATION

M.Eng. Financial Engineering, Cornell University, Ithaca, NY
B.S. Mathematics and Economics, College of William and Mary, Williamsburg, VA

CERTIFICATIONS

Associate of the Society of Actuaries (ASA)
Member of the American Academy of Actuaries (MAAA)

DONALD WAKEFIELD, ASA, MAAA

Staff Actuary

Ideally Suited for West Virginia Medicaid Managed Care Actuarial Analysis

- More than 20 years of experience, including 3 years working directly with state Medicaid programs
- Client leader, project manager, and/or certifying lead actuary for multiple states, including Georgia and Kentucky having provided subject matter expertise to other states
- Prior experience included working with health plans and administrators in Massachusetts and Utah

PROFESSIONAL EXPERIENCE

Aon **May 2015 - Present**

Assistant Vice President

Kentucky Department for Medicaid Services (DMS)

- Leadership of rate setting, financial forecasting, data warehouse management, reporting tool development, trend development, and model development efforts for many types of medical plans.

Tennessee Division of Health Care Finance & Administration

- Assisted in review of capitation rate development, analysis of annual budget for the State, and data analyses for Comptroller Report.

North Carolina Office of State Auditor

- Reviewed IBNR models and wrote actuarial report on the estimated Medicaid claims liability for the State.

Georgia Department of Community Health

- Developed NEMT rates for State to pay transportation brokers covering Medicaid population.

Deseret Mutual Benefit Administrators **1999 - 2015**

Assistant to the Chief Actuary

- Enterprise-wide experience monitoring & reporting; business intelligence system lead; and actuarial & analytical support to provider contracting, medical management, and church-related medical plans.
- Created report card system to measure performance of all aspects for multi-billion dollar enterprise (e.g., pension plans' funded status, claims processing efficiency, pricing and reserving accuracy).
- Price benefit changes (ACA/non-ACA related) for medical, behavioral health and dental plans.
- Led vendor search and implementation of healthcare business intelligence system. Subsequently, assumed on-site responsibility for all things related to the business intelligence system.

- Developed reports to identify aberrant provider billing patterns. Multiple cases were identified, and resolution pursued.
- Led inter-departmental Six Sigma project to improve customer experience.

PacifiCare Health Systems (now United HealthCare) **1997 – 1999**
Senior Actuarial Analyst

- Responsible for actuarial analysis of various national contracting initiatives.
- Created MS Excel models to assist regional provider contracting teams in analyzing profitability of facility and physician group contracts.
- Developed and conducted training classes on using provider contracting models.

Blue Cross Blue Shield of Massachusetts **1994 – 1997**
Actuarial Analyst

- Pricing, reserving and forecasting for state regulated individual and Medicare supplement products.
- Quick turnarounds in response to state rate hearing inquiries regarding appropriateness of premium rate proposals.
- Provided actuarial support (pricing, reserving, forecasting) to a fledgling state CHIP program.

Human Affairs International (now Magellan Behavioral Health) **1993**
Quality Management Analyst

- Statistical and analytical support for quality management initiatives in behavioral health space.
- Created quality metrics that quality management staff used, leading to greater system efficiencies and improved patient outcomes.
- Developed, distributed, and analyzed patient satisfaction surveys.

EDUCATION

B.S. Mathematics, Brigham Young University, Provo, UT

CERTIFICATIONS

Associate of the Society of Actuaries (ASA)
Member of the American Academy of Actuaries (MAAA)

STERLING FELSTED, ASA, MAAA

Staff Actuary

Ideally Suited for West Virginia Medicaid Managed Care Rate Actuarial Analysis

- More than seven years of consulting and MCO experience working with numerous state Medicaid programs
- Client leader, project manager, and/or certifying lead actuary for Tennessee and having provided subject matter expertise to other states (Kentucky, Georgia)

PROFESSIONAL EXPERIENCE

Aon **May 2009 - Present**

Senior Consultant and Actuary

Tennessee Division of Health Care Finance & Administration

- Coordinates rate-setting process for Tennessee's Medicaid rate-setting process, including project planning, data aggregation and validation, model development, actuarial assumption development and incorporation, and report creation.
- Provides consultation and financial analyses around Directed Payments Program, both for LTSS and Non-LTSS populations.
- Assists with the evaluation of program compliance with existing and changing Federal / CMS and State regulations, such as MHPA, PPACA.
- Provides actuarial support to respond to CMS questions.
- Processes and models risk adjustment impacts to capitation rates.
- Prepares and signs actuarial rate-setting certifications and other State reports.
- Communicates ad hoc and other financial deliverable results to clients.

Georgia Department of Community Health

- Provides actuarial support to respond to CMS questions.
- Prepares and signs actuarial rate-setting certifications and other State reports
- Communicates ad hoc and other financial deliverable results to clients.

Global Benefits Analyst

- Collected, maintained, and analyzed plan data for several large multinational corporations.
- Analyzed plan performance, estimated future plan costs, and calculated plan prices of global health and benefit programs, including life, accident, disability, medical, DB, DC, and hybrid plans.
- Developed ways of tracking, documenting, and justifying cost savings to clients
- Coordinated the implementation of global broker of record appointments for multinational clients with benefits in over 50 countries.
- Prepared, peer-reviewed, and helped present analyses and deliverables to clients
- Assisted in the preparation of actuarial year-end disclosures.

EDUCATION

B.S. Mathematics, Brigham Young University, Provo, UT

CERTIFICATIONS

Associate of the Society of Actuaries (ASA)
Member of the American Academy of Actuaries (MAAA)

ELIZABETH (BETSY) A. HANSON, FSA, MAAA

Staff Actuary

Ideally Suited For West Virginia Medicaid Managed Care Actuarial Analysis

- More than five years of Medicaid consulting experience
- Iowa, Massachusetts, and New York in addition to several employers

PROFESSIONAL EXPERIENCE

Aon **June 2012 - Present**
Vice President

New York Department of Civil Services

- Managed retiree healthcare pricing for State.
- Setting incurred but unpaid reserves.

State of Massachusetts

- Managed retiree healthcare pricing for State.

Other Organizations (including Hershey, Campbell Soup, Astra Zeneca, and universities)

- Assisting employers in evaluating options associated with the settlement of retiree medical benefit programs.
- Helping clients understand the strategic implications of healthcare reform and acting as an internal subject matter expert on healthcare reform modeling.
- Setting incurred but unpaid reserves.
- Completing actuarial attestations for the Retiree Drug Subsidy.
- Providing support for postemployment and postretirement welfare benefit valuations for both public and private employers.
- Evaluating strategic alternatives for retiree benefit plans, including individual market sourcing strategies for both Medicare eligible and ineligible participants.
- Improving operating procedures for Aon's national Center of Excellence for retiree medical valuation work.

Mercer **2003 - 2012**
Actuary

Milliman **1998 - 2003**
Consulting Actuary

Iowa Department of Human Services

- CHIP capitation rate development and actuarial consulting.

Other State Medicaid Agencies

- Actuarial consultant providing peer review and support of rate development for Medicaid managed care programs.
- Development of risk adjusted rates for a disabled population.

Center for Medicare and Medicaid Services

- Consulted on HIPAA compliance and support.

KPMG **1995 - 1998**
Manager

EDUCATION

B.A. Magna Cum Laude, Alfred University, Alfred, NY

CERTIFICATIONS

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

Final Rule—Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Institution for Mental Disease

September 2016

Executive Summary

Prior to the release of the Medicaid Final Rule, the IMD exclusion prohibited federal payments for services incurred by a Medicaid recipient in an Institution for Mental Disease (IMD). There are a few exceptions to the exclusion, which are outlined on the next page.

The release of the Medicaid Final Rule modified the parameters of the exclusion to allow states to make monthly capitation payments to managed care organizations (MCO) for members aged 21-64 who have short term stays in an IMD. Although this exception does not directly allow for the creation of an eligibility category or rate cell for purposes of obtaining Federal Financial Participation (FFP), it does create an opportunity for state budget improvements and/or potential savings through capitation rate setting when it applies to the IMD services.

Based on our understanding, the following conditions need to be met in order for MCO payments to be covered by federal dollars:

- Short term stay is defined as a stay no longer than 15 days within a month.
  - CMS states that MCO capitation payments are prohibited for months in which a member exceeds the 15 day limit. In such cases, the member's MCO coverage must be retro-adjusted and the capitation payment must be fully recouped.
- The IMD services must meet conditions of the "in lieu of" services provided.
  - Services must be cost effective and authorized by the MCO contract.
- The capitation rates must price IMD at the same cost as the alternative state plan services.
  - Unlike the rate setting approach for other "in lieu of" services, the utilization of short term IMD stays as "in lieu of" services must be re-priced with costs "consistent with the cost of the same services through providers included in the state plan."
  - The actuary may not include the direct IMD costs when setting the rates.
- IMD alternative settings need to be a choice and may not be directed by the state or MCO.
  - A member's choice of the least restrictive settings must be observed by the MCO. Consequently, the MCO contract may not require MCOs to use IMD providers for "in lieu of" services.

Background

The IMD exclusion prohibits federal payments with respect to care or services for any individual who is a patient in an institution for mental diseases.[i] There are a few exceptions to that exclusion. The exclusion does not apply to those over 65 and under 21, to institutions with fewer than 16 beds, and to partial hospitalization and day-treatment programs.

Prior to this year, states had used managed care to pay for IMD inpatient services in the following ways: savings from 1915(b) waivers and a design under 1115 waivers[ii]. Absent those authorities, IMD inpatient care had been covered by various sources, including state dollars, disproportionate share hospital (DSH) and even remained uncompensated.

The 2016 Final Medicaid Managed Care Rule did not remove FFP prohibition on the IMD payments. It created an exception, allowing for a capitation payment during a month with a short term stay for the managed care member, if the short term stay met a number of conditions. Centers for Medicare & Medicaid Services (CMS) indicated that current waiver authorities for IMD coverage are not preserved under the new Rule. The Rule presents "the only permissible approach" for enrollees in an IMD given the statutory prohibition on FFP.[iii] The exact impact on the state waiver authorities is largely unknown (e.g., Texas 1115 waiver does not have 15 days limitation and may require a change).

Final Rule Changes

While the Centers for Medicare & Medicaid Services (CMS) did not repeal the IMD payment exclusion in FFS or for the extended stays[iv], they did change the parameters of this exclusion by permitting a state to make a monthly capitation payment to a managed care plan for a member who is aged 21-64 and has a short term stay in an IMD. Per the Final Rule, the IMD facility must meet general requirements[v] and be a certain type of facility defined as a hospital providing psychiatric or substance use disorder (SUD) inpatient care or a sub-acute facility providing psychiatric or SUD crisis residential services[vi].

The following conditions must be met in order for MCO payments to be covered by federal dollars:

- Short term stay is defined as a stay no longer than 15 days within a month;
- The IMD services must meet conditions of the "in lieu of" services provided;
- The capitation rates must price services at the same cost as the state plan services; and
- IMD alternative setting must be a choice and may not be directed by the state or MCO[vii].

The following sections discuss each of the conditions in more detail.

1. Fifteen Days Limitation[viii]

The managed care IMD payments are limited to short stays lasting no more than 15 days (single or cumulative) per capitation month. CMS states that if an extended stay is necessary at the onset, then the IMD becomes an unlikely provider choice or Medicaid managed care should be discontinued. The MCO must determine if its member meets the medical necessity standard for inpatient care no longer than 15 days prior to the choice of IMD setting. CMS also clarifies that the MCO may cover two stays up to 15 days each for two consecutive months.[ix]

The complexity of the 15 days limitation arises in scenarios where multiple short stays occur per month or when a single episode is extended beyond the 15 days. Comments provided by CMS imply that MCO capitation payments are prohibited for months during which a member exceeds the 15 days limit. Literal interpretation of that response means that Medicaid MCO coverage must be retro-adjusted for a member whose stay exceeds 15 days. A retroactive adjustment would result in a capitation payment recoupment and reclassification of the impacted encounter data. In addition, the MCO would prohibit any claim payments for the services delivered that month by an IMD or by any other provider. For claims already paid (i.e., outpatient pharmacy), the MCO may request a provider payment recovery or a separate state reimbursement. The state would be covering any unpaid claims for that month with state funds. In addition, the MCO must develop a mechanism that informs the MCO and the state of the extended IMD stay. Such notification mechanisms could be achieved through a prior authorization process or through any unique provider action. A state may also consider robust contractual language regarding a member transfer into an alternative setting to avoid extended stays. CMS did not outline any operational requirements, leaving all operational details to the state's discretion. However, CMS did recognize the significant operational burden that this approach would entail.

To demonstrate the operational impact of this limitation, we identified a few scenarios that would occur under the 15 days requirement:

Dates of IMD Stay	Length of Stay	Capitation FFP	Non-IMD Claims	Impact
July 1-15	15 days per month	Covered.	Yes	All claims are paid by managed care.
July 1-5; July 10-14; July 20-24	15 days per month	Covered.	Yes	All claims are paid by managed care.
June 16-July 15	15 days per each month	Covered.	Yes	All claims are paid by managed care.
July 1-August 2	31 days and ongoing	Not covered. Choice of setting is allowed. Alternative setting is covered.	No	Delivery system changes if IMD is the only provider choice; all claims paid by state funds.
July 1-15-20 (episode extension)	20 days per month	Not covered. Choice of setting is allowed. Alternative setting is covered.	Yes	Episode extension triggers retro disenrollment, capitation recoupment and provider claims adjustment.
July 1-10; July 20-25	16 days	Not covered. Choice of setting is allowed. Alternative setting is covered.	Yes	A second short stay triggers retro disenrollment, capitation recoupment and provider claims adjustment.

The transition of care between the delivery systems for inpatient IMD members remains an issue under the new IMD rule. Alternatively, a state can create a separate IMD capitated arrangement funded by state dollars only.[x] This arrangement would allow an IMD member to stay in managed care if the stay exceeds 15 days. However, all services will be paid by state only funds and covered by a state only contract.

2. "In Lieu of" Services

The services provided during a short term stay at an IMD must meet the conditions of the "in lieu of" services. CMS describes "in lieu of" services as an "alternative service or services in a setting that are not covered under the state plan but are medically appropriate, **cost effective** substitutes for state plan services included within the contract."[xi] As long as the "in lieu of" services meet conditions of being cost effective, outlined within the state MCO contract, and occur at the choice of the member and MCO, such services are deemed by CMS as payable under the new Rule.[xii]

3. Implications to Rate Setting

Given that the Rule compliance date is set by CMS as of July 1, 2017, the following adjustments may need to be included in the rate setting process:

- Base data adjustment

  Assuming that the State is currently paying IMD claims outside the capitation rates for Medicaid eligible members age 21-64 and plans to approve short term IMD stays (no more than 15 days per month) as "in lieu of" services under the MCO contracts, the current base enrollment data will need to be adjusted to include the FFS months for members age 21-64 with short term IMD stays. The current base claims data will also need to be adjusted to include the short term IMD utilization of current MCO members and FFS members.

- Re-pricing of short term IMD utilization in the rate calculation

  The Rule does not allow the rates to include the actual costs related to short term IMD utilization. Instead, the utilization must be re-priced with the costs of the same services through providers covered in the state plan. For example, the actual direct cost (assuming $4500) of a 10-day IMD stay cannot be included in the rate calculation without adjustment. Instead, the 10-day stay must be re-priced with the same cost as the replaced state plan service (for example, acute psychiatric service in a non-IMD hospital with an average daily rate of $700) before its inclusion in the rate calculation. In this case, the allowable cost to include in the rate calculation for this 10-day IMD stay will be $7000 instead of $4500. Please note that this approach is different from the current rating approach for the inclusion of "in lieu of" services where the actual costs of "in lieu of" services can be included as a proxy for rate calculation.

4. Provider Choice and Other Operational Considerations

The MCO may not require members to choose an alternative IMD setting. To comply with the Olmstead decision and the Americans with Disabilities Act, a member's choice of the least restrictive settings must be observed by the MCO. Consequently, the MCO contract may not require MCOs to use IMD providers for "in lieu of" services.[xiii] A state can make a contractual determination of what services are approved as "in lieu of" services. Such determination must be in general and must not occur on a case by case basis.

Other operational considerations could include:

- Amending MCO contracts to design terms for the IMD coverage, limitations and payments.
- Examining public and private IMD capacity.
- Reviewing MCO network contracts with IMD.
- Reviewing requirements for voluntary and non-voluntary commitments.

- Developing a mechanism to ensure that the MCO does not receive or make any payments for members with longer than 15 days stay.
- Developing a procedure to ensure appropriate provider payments for members with longer than 15 days stay.
- Developing MCO disenrollment mechanisms for the IMD stays over 15 days.

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[i] SSA 1905(a)(B)
[ii] https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf
[iii] Federal Register / Vol. 81, No. 88 / Friday, May 6, 2016 / Rules and Regulations, p.27560.
[iv] Federal Register /Vol. 81, No. 88 / Friday, May 6, 2016 /Rules and Regulations, p. 27561: "If an enrollee has a length of stay for more than 15 days within the period covered by the monthly capitation payment, no capitation payment may be made for that enrollee under a Medicaid managed care program regulated under 42 CFR part 438."
[v] 42 CFR §435.1010
[vi] 42 CFR §438.6(e)
[vii] 42 CFR §438.6(e)
[viii] CMS used data from the Medicaid Emergency Psychiatric Demonstration. The preliminary evidence suggested that the average length of short stay is 8.2 days
[ix] Federal Register /Vol. 81, No. 88 / Friday, May 6, 2016 /Rules and Regulations, p. 27561
[x] Federal Register / Vol. 81, No. 88 / Friday, May 6, 2016 / Rules and Regulations, p. 27558: "...since services for enrollees with longer stays would not be covered under the Medicaid program, any capitated payment for such individuals with longer stays would not be covered under the Medicaid program, any capitated payment for such individuals would need to be under a separate contract (since the costs for such individuals would have to be accounted for separately in setting the capitation rate and the capitation rate would be paid with state-only funds)."
[xi] Federal Register / Vol. 81, No. 88 / Friday, May 6, 2016 / Rules and Regulations, p. 27556
[xii] 42 CFR §438.3(e)(2) (i-iii)
[xiii] Federal Register / Vol. 81, No. 88 / Friday, May 6, 2016 / Rules and Regulations, p. 27556