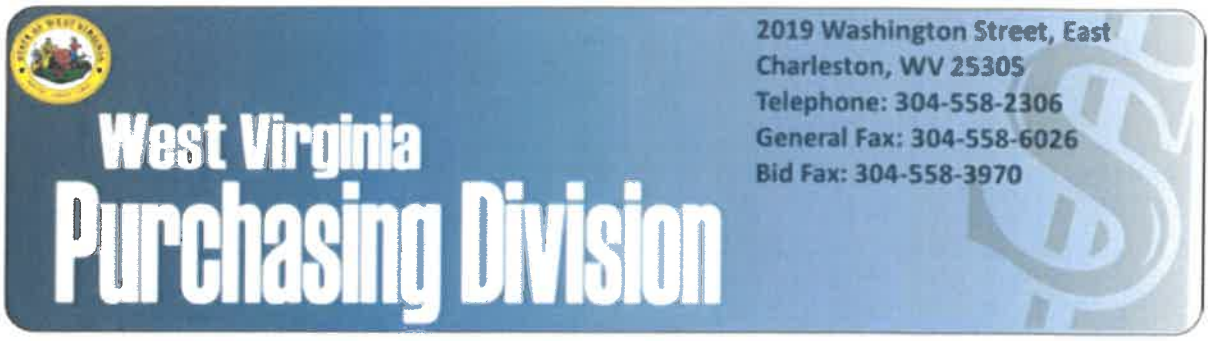
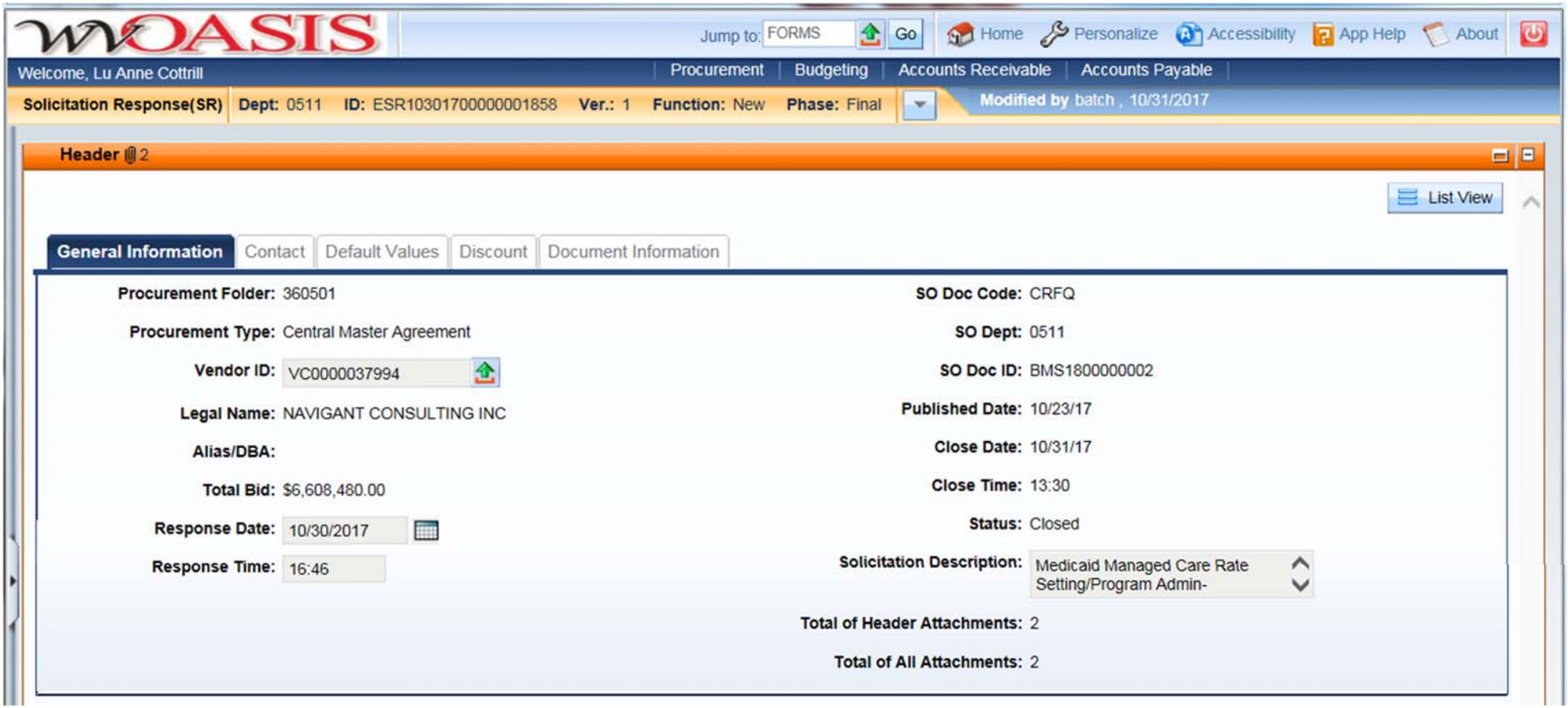


The following documentation is an electronically-submitted vendor response to an advertised solicitation from the *West Virginia Purchasing Bulletin* within the Vendor Self-Service portal at ***wvOASIS.gov***. As part of the State of West Virginia's procurement process, and to maintain the transparency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


WVOASIS
Jump to: FORMS Go
Home
Personalize
Accessibility
App Help
About
Welcome, Lu Anne Cottrill
Procurement
Budgeting
Accounts Receivable
Accounts Payable
Solicitation Response(SR) Dept: 0511 ID: ESR10301700000001858 Ver.: 1 Function: New Phase: Final
Modified by batch , 10/31/2017
Header 2
List View
General Information
Contact
Default Values
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Document Information
Procurement Folder: 360501
Procurement Type: Central Master Agreement
Vendor ID: VC0000037994
Legal Name: NAVIGANT CONSULTING INC
Alias/DBA:
Total Bid: $6,608,480.00
Response Date: 10/30/2017
Response Time: 16:46
SO Doc Code: CRFQ
SO Dept: 0511
SO Doc ID: BMS1800000002
Published Date: 10/23/17
Close Date: 10/31/17
Close Time: 13:30
Status: Closed
Solicitation Description: Medicaid Managed Care Rate Setting/Program Admin-
Total of Header Attachments: 2
Total of All Attachments: 2

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

State of West Virginia
Solicitation Response

Proc Folder : 360501

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

Proc Type : Central Master Agreement

Date issued	Solicitation Closes	Solicitation Response	Version
	2017-10-31 13:30:00	SR 0511 ESR10301700000001858	1

VENDOR

VC0000037994

NAVIGANT CONSULTING INC

Solicitation Number: CRFQ 0511 BMS1800000002

Total Bid : $6,608,480.00 **Response Date:** 2017-10-30 **Response Time:** 16:46:53

Comments:

FOR INFORMATION CONTACT THE BUYER

April Battle

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

Signature on File **FEIN #** **DATE**

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
1	Lead Actuary Services				$624,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

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

Comments: Hourly rate $300

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
2	Staff Actuary Services				$1,872,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

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

Comments: Hourly rate $225

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
3	Managed Care Program Oversight Services				$2,107,380.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description :
Managed Care Program Oversight Services Annual Cost

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
4	Ad Hoc Services Managed Care Oversight Projects				$645,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

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

Comments: Hourly rate $129

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
5	Technical Support Staff (Non-Actuary)				$364,000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

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

Comments: Hourly rate $175

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
6	Clerical Support Staff				$10,400.00

Comm Code	Manufacturer	Specification	Model #
93151507			

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

Comments: Hourly rate $5

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
7	Ad Hoc Services Actuarial Services Projects				$985,700.00

Comm Code	Manufacturer	Specification	Model #
93151507			

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

Comments: Hourly rate $197.14

NAVIGANT

Proposal for:

Medicaid Managed Care Rate Setting and Medicaid Managed Care Program Administration

Presented to:

West Virginia Purchasing Division, on behalf of
West Virginia Department of Health and Human Resources
The Bureau for Medical Services
2019 Washington Street East
Charleston, West Virginia 25305-0130

Technical Proposal

October 31, 2017

Presented by:

Anne Jacobs
Managing Director
1200 19th Street NW, Suite 700
Washington, DC 20036
202.973.3124
ajacobs@navigant.com

navigant.com

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NAVIGANT

October 31, 2017

April Battle
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, West Virginia 25305-0130

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

Dear Ms. Battle:

On behalf of Navigant Consulting, Inc. (Navigant), I am pleased to provide our proposal for the above captioned CRFQ entitled, Medicaid Managed Care Rate Setting and Medicaid Managed Care Program Administration, to the State of West Virginia Department of Health and Human Services and The Bureau for Medical Services. It will be a privilege and a pleasure to support the success of the State of West Virginia in this important work.

Please do not hesitate to reach out if you require clarification to any of the information provided herein.

Sincerely,

Anne Jacobs

Anne Jacobs
Managing Director

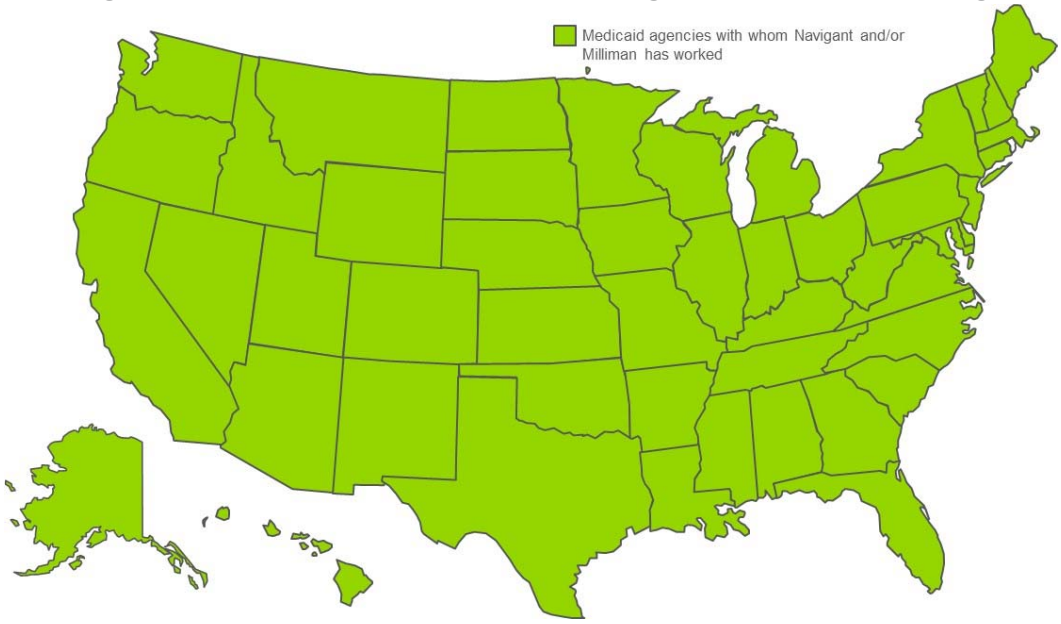
Section I Our Understanding of Your Needs and Attestation of Capabilities to Perform the Work

The West Virginia Bureau for Medical Services (BMS) provides healthcare services through its Medicaid program for more than 550,000 West Virginians every year, 75 percent of whom are enrolled in the State's Medicaid Managed Care program. The State is seeking a vendor to support its managed care program by: 1) Providing oversight and administrative support; and 2) Assisting with the development and review of risk-based capitation rates.

In response, Navigant has partnered with Milliman (together, referred to as "the Navigant team" in this proposal) to provide BMS with the most qualified team of experts, equipped with unparalleled knowledge of state Medicaid managed care program oversight and capitated rate setting. Navigant and Milliman will work together by leveraging our unique skill sets and capabilities to provide a comprehensive solution that meets the needs of BMS. As independent companies, both Navigant and Milliman have the flexibility to offer BMS the full scope of services required under this CRFQ, and will provide BMS individualized attention and support. We further introduce Milliman on the following page.

This comprehensive team is well positioned to assist BMS with Medicaid managed care program administration and oversight services and actuarial services. We have provided support to state and Federal government entities for more than 25 years. Our professionals bring "real world" experience, since many of our consultants have worked within health plans in top leadership and operational positions and in executive positions within various state governments and federal agencies. We have assisted state Medicaid agencies in every phase of designing, implementing, monitoring, and supporting managed care and waiver-based programs for various population groups, and frequently work hand-in-hand with Medicaid staff, as an extension of a state's team. In addition, members of the Navigant team have been developing capitation rates for more than 20 years and are sought out by the industry to contribute to prominent and current topics impacting Medicaid programs. Together, we pride ourselves on being flexible and responsive to our Medicaid clients' changing needs.

Figure 1: Navigant and Milliman's Experience Working with State Medicaid Agencies



The Navigant team will have a strong local presence on this engagement. For example, both the Program Management / Policy Analyst and the Program Integrity Analyst will operate on-site at the BMS offices on a full-time basis. Other team members will travel to Charleston as needed to attend meetings with BMS staff and the MCOs, deliver presentations, and conduct trainings.

We understand that BMS plans to transition other populations to managed care in the future, such as dual eligibles, children receiving foster care, and other specialized populations. We have assisted and are currently assisting state Medicaid agencies with these types of program developments and expansions, including designing program components specific to individuals receiving long-term care services and working with states to develop and implement managed care programs that consider the unique needs of children in foster care. We are therefore well positioned to assist BMS with similar program expansions and will bring our knowledge of best practices and common challenges that arise.

Milliman, our actuarial partner, has been a leader in actuarial consulting since 1947. Milliman will support Navigant by providing the actuarial services requested by BMS in the CRFQ. Milliman has extensive experience providing actuarial support to states and healthcare organizations and is well equipped to assist BMS in developing, reviewing, and setting capitation rates for the Medicaid managed care program. In addition, Navigant and Milliman have a history of successfully working together on managed care engagements, having partnered over the course of the last two decades on Medicaid initiatives in Indiana and Illinois as well as conference presentations and proposal efforts.

Navigant, including our proposed subcontractor, attests that we meet and exceed the mandatory requirements listed in Sections 4.1.1 through 4.1.7 of the CRFQ. In the following sections, we provide a comprehensive overview of our qualifications and proposed staff, which highlights our ability to provide BMS with the highest level of support.

Section II Qualifications and References

Overview of Our Capabilities Relative to the CRFQ

Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global professional services firm that helps clients take control of their future. Navigant's professionals apply deep industry knowledge, substantive technical expertise and an enterprising approach to help clients build, manage, and protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the firm primarily serves clients in the healthcare, energy, and financial services industries.

Navigant can draw on experts from all areas within Navigant's healthcare practice to respond to its clients' needs. Navigant's healthcare professionals include individuals with experience as public policy experts; hospital, physician practice, life sciences, health plan, Federal and State government, and healthcare operations professionals; finance executives; healthcare analysts; and clinical professionals.

Navigant brings together a team of 600 seasoned consulting professionals and industry thought leaders to support clients in designing, developing, and implementing solutions that create high-performing healthcare organizations.

We take a unique interdisciplinary approach to our clients' challenges. This means we work as one team with one goal, leveraging the strengths and expertise of our senior-level consulting professionals in the delivery of integrated solutions.

Our primary solutions are in three areas:

Strategic Advisory	Operations Management and Implementation	Outsourcing and Technology Solutions
Navigant provides healthcare executives with objective, practical, results-oriented assistance to set strategic directions that enable long-term growth through the ever-changing industry.	Navigant has extensive experience, and a successful track record, helping healthcare organizations implement solutions to improve financial, operational, and quality performance.	Navigant provides outsourcing and technology solutions to improve efficiency and help clients make more informed decisions based on better information management.
Health Systems Physician Groups Payers State and Government Health Agencies Life Sciences		

Navigant continues to build a strategic platform for payers and providers and supports the development and implementation of solutions and tools that enable our clients to achieve what the Institute for Healthcare Improvement (IHI) calls the "Triple Aim":

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care.

On the following pages, we detail our specific experience related to the subject areas of this CRFQ.

Milliman is among the world's largest providers of actuarial and related products and services. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe. It is owned and managed by its principals—senior consultants whose selection is based on their technical, professional, and business achievements. Milliman serves the full spectrum of business, financial, government, union, education, and nonprofit organizations. In addition to consulting actuaries, Milliman's body of professionals includes numerous other specialists, ranging from clinicians to economists.

- *Milliman will perform the Actuarial Services portion of this project, as a subcontractor to Navigant. Navigant and Milliman have a history of successfully working together on managed care engagements, having partnered over the course of the last two decades on Medicaid initiatives in Indiana and Illinois as well as conference presentations and proposal efforts.*

Managed Care Program Oversight Qualifications and References

Navigant has been assisting states Medicaid managed care program administration and oversight for more than 25 years – we have experience with Medicaid programs in more than 45 states. We partner with states on Medicaid managed care program planning and implementation, contract and procurement development, monitoring and oversight, quality management, and program evaluation. Additionally, Navigant regularly works with states to help them understand and comply with Federal regulations, policies, and recent or proposed legislative changes. Navigant monitors Federal and state healthcare initiatives and reputable government and industry information sources to identify potential impacts on our state clients' healthcare programs and operations.

As a leader in Medicaid consulting, our firm is recognized for hands-on experience in Medicaid managed care programs and delivery systems. Our consultants bring deep knowledge and experience to each project, since many have worked in executive positions within various state governments and in top leadership and operational positions within health plans.

Highlights of our Medicaid managed care experience include:

- Assistance with waiver design (both new and renewal waivers), implementation, evaluation, and feasibility analyses
- Development of policy impact analyses, including options assessments to inform programmatic decision-making
- Design of processes and tools to monitor fraud, waste, and abuse in a managed care environment
- Development of managed care contracts that comply with federal regulations and support improved outcomes and quality of care for members

- Assistance with ongoing monitoring activities including developing monitoring procedures and tools to evaluate managed care contract performance and compliance
- Design of managed care quality strategies and managed care contracting strategies devised to help states achieve quality and savings targets
- Development of dashboard reports and performance scorecards that present a meaningful set of measures in a format that frames pertinent information and better positions state Medicaid agencies to manage risk, drive improvement, and shape the future of their programs
- Design of programs and program expansions tailored to meet the unique needs of Medicaid subpopulations, such as dual eligibles and children receiving foster care

In Figure 2 below, we provide a summary of our experience in selected states across the key focus areas associated with this engagement. As illustrated in this table, we meet the CRFQ requirement to have at least 10 years of experience in providing Medicaid managed care program administration and oversight across numerous states. This table includes the three states serving as references for our managed care program oversight services (i.e., Alabama, Illinois, Pennsylvania) for this CRFQ. This table summarizes our experience providing managed care services represented in this CRFQ; however, it is not an exhaustive list.

Figure 2: Navigant's Experience in Medicaid Managed Care Program Administration by State

State *Years of Service*	**AL** *2013-pres.*	**AZ** *1993-pres.*	**GA** *2011-2015*	**IA** *2015-2016*	**IL** *1992-pres.*	**IN** *1992-2008*	**KS** *1994-1996; 2015-pres.*	**MS** *2010-2017*	**PA** *2001-2013*	**TX** *1996-1998; 2005-2016*
Compliance with Federal Regulations	✓	✓	✓	✓	✓		✓	✓	✓	✓
Dashboard / Scorecard Development	✓		✓	✓	✓	✓	✓	✓	✓	✓
Data Analysis	✓		✓	✓	✓	✓	✓	✓	✓	✓
Managed Care Contracts	✓	✓	✓	✓	✓	✓		✓	✓	✓
Managed Care Monitoring	✓		✓	✓	✓	✓	✓	✓	✓	✓
Managed Care Procurements	✓	✓	✓	✓		✓	✓	✓	✓	✓
Network Adequacy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

State *Years of Service*	AL *2013-pres.*	AZ *1993-pres.*	GA *2011-2015*	IA *2015-2016*	IL *1992-pres.*	IN *1992-2008*	KS *1994-1996; 2015-pres.*	MS *2010-2017*	PA *2001-2013*	TX *1996-1998; 2005-2016*
New Delivery or Payment Methodologies	√	√	√		√		√		√	
Program Integrity	√							√	√	√
Quality Management	√		√	√		√	√	√	√	
Readiness Reviews	√		√	√		√		√	√	√
Special Populations (e.g., foster care, long-term care)	√	√	√	√	√		√		√	√
Waivers	√	√	√		√		√			√

Below, we provide three examples of state Medicaid programs for which we have provided managed care program administration services. These three states also serve as Navigant's references for managed care program oversight services for this CRFQ. For each state, we highlight examples of activities that demonstrate our experience with the managed care program administration mandatory requirements for this engagement.

Reference No. 1: The Commonwealth of Pennsylvania	
Name	**Erin Brady** **Pennsylvania Department of Public Welfare (DPW)**
Address	625 Forster St Harrisburg, PA 17120
Telephone Number	717.705.8340
Email Address	ebrady@state.pa.us
Years of Service	2001 – 2013
Proposed Staff Who Worked on this Project	Anne Jacobs, Tamyra Porter, Lee-Lin Wang
Services Provided	Navigant provided technical assistance to the Commonwealth of Pennsylvania in all facets of the implementation and operation of HealthChoices, the

Reference No. 1: The Commonwealth of Pennsylvania	
	mandatory Medicaid managed care program. We performed many of the same services for Pennsylvania as are required under the engagement for West Virginia, as illustrated below. **Dashboard / Scorecard Development** • Assisted in developing public reports like the HealthChoices Annual Report • Developed Consumer Guides and HealthChoices Trending Reports using Healthcare Effectiveness Data and Information Sets, Consumer Assessment of Health Plans, and specific Pennsylvania performance measures to profile the performance of MCOs **Data Analysis** • Performed complex data analyses to evaluate readiness of the managed care program to expand to additional population groups / services and evaluate provider capacity • Analyzed the financial impact of the Health Information Exchange on projected savings for multiple payers including Medical Assistance, Medicare, and commercial insurers **Managed Care Contracts and Procurements** • Developed RFPs and contracts for procurement of MCOs, enrollment broker services and administration of the Primary Care Case Management program and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services **Managed Care Monitoring** • Developed internal activity reporting and external MCO reporting • Created automated, electronic monitoring tools, protocols, and tracking systems • Assisted in restructuring the Contract Team Monitoring process to streamline MCO monitoring and trained staff on how to conduct ongoing monitoring and data analysis **Network Adequacy** • Designed and developed a Provider Network Database, which allowed operations staff to monitor provider network adequacy; the database allowed users to generate reports of provider-to-member ratios, provider counts, and provider additions and deletions **Quality Management** • Developed a strategy to implement a HealthChoices value-based purchasing framework; identified program goals and developed a process to communicate MCO performance

Reference No. 1: The Commonwealth of Pennsylvania	
	• Assisted with the design of Pennsylvania's Performance-based Contracting Program, which measured and rewarded MCOs for high-quality performance • Developed a managed care quality assessment and performance improvement strategy **Program Integrity** • Provided ongoing support to Bureau of Program Integrity regarding oversight and monitoring of HealthChoices contract • Annually reviewed and updated oversight standards and reports for HealthChoices MCOs **Readiness Reviews** • Assisted with readiness reviews of MCOs by developing readiness tools and databases, conducting desk reviews, and participating in on-site reviews **Special Populations** • Supported the State in program planning and design for a managed long-term care program • Evaluated the reimbursement system for Medicaid HCBS waiver programs and developed new reimbursement methodologies **Waivers** • Assisted with the development of a 1915(b) waiver renewal for the HealthChoices program and the primary care case management program • Assisted in the development of a Section 1115 waiver application to request CMS approval to implement premium requirements for consumers participating in the Commonwealth's Medicaid for Children with Special Needs program • Assisted with the review of HCBS waiver programs

Reference No. 2: State of Alabama	
Name	**Stephanie Azar** **Alabama Medicaid Agency (AMA)**
Address	501 Dexter Avenue, P.O. Box 5624 Montgomery, AL 36103-5624
Telephone Number	334.242.5126
Email Address	stephanie.azar@medicaid.alabama.gov
Years of Service	2013 – present

Reference No. 2: State of Alabama	
Proposed Staff Who Worked on this Project	Tamyra Porter, Caroline Deneszczuk, Elizabeth Hataway, Joohee Lee, Scott Mackie, Lee-Lin Wang
Services Provided	Navigant has a five-year contract with AMA to implement a provider-based Regional Care Organization (RCO) model, design and implement a managed long-term care program [referred to as the Integrated Care Networks (ICN) program], and assist AMA in other managed care program design and administration activities. Navigant has supported and/or is currently supporting over 30 task orders for AMA. Of particular interest to this engagement with BMS are the following activities: **Data Analysis** • Analyzed State performance on population health and health services utilization to identify specific objectives and targets for a delivery system improvement initiative • Analyzed long-term care cost and population trends to inform the design of a new managed long-term care program • Analyzed data to determine the potential impact of managed care on community mental health center reimbursement rates **Managed Care Contracts** • Assisted AMA in developing a comprehensive contract for both the RCO and ICN programs; both contracts include federal requirements and best practices from other states, while incorporating provisions unique to AMA's specific objectives • Incorporated required elements of the 2016 Medicaid and CHIP Managed Care Final Rule • Facilitated discussions with CMS regarding the approval of the RCO contract **Managed Care Monitoring** • Developed a Reporting Manual that detailed the instructions and reporting templates for the RCOs to use when submitting reports to AMA • Created standard operating procedures for AMA staff to use when reviewing RCO reports • Developed a monitoring manual for AMA to use to support effective oversight of the RCOs • Provided numerous training sessions to AMA staff to build monitoring skills and capacity **Managed Care Procurements** • Developed procurement materials for the managed-long term care procurement

Reference No. 2: State of Alabama	
	• For an enrollment broker procurement, reviewed other states' contracts to identify common requirements and services, drafted key program design considerations, and facilitated a work group charged with developing the design • For an external quality review organization (EQRO) procurement, provided research on other state EQRO contracts and drafted the scope of work for the RFP • For a Health Home procurement, assisted in developing procurement materials, including a Health Home RFP • For a dental managed care procurement, assisted in review of the RFP, including providing subject matter expertise on compliance with federal regulations **Network Adequacy** • Developed network adequacy standards for the RCO and ICN programs and assisted AMA in developing baseline analytics as well as protocols for ongoing evaluation of RCO network submissions **New Delivery or Payment Methodologies** • Assisted AMA to transition from an inpatient payment model based on per diem payments to an All Patient Refined Diagnosis Related Group (APR-DRG) methodology **Program Integrity** • Assisted AMA in drafting managed care contractual requirements regarding program integrity • Assisted program integrity unit in preparing for the transition from fee-for-service oversight to managed care; developed RCO reporting requirements and initiated work with program integrity unit for collection and analyses of RCO reported data **Quality Management** • Supported AMA's process to identify quality measures for both the RCO and ICN programs • Assisted AMA to develop a methodology for distribution of incentive payments, based on satisfactory reporting and achievement of outcome and quality targets • Assisted AMA in developing a managed care quality assessment and performance improvement strategy, which defined Alabama's goals and objectives for its managed care programs and described its approach to facilitate improvements in performance **Readiness Reviews** • Developed readiness assessment reporting templates, governance structure, and timelines for AMA and RCOs • Developed a readiness assessment tool, which identified the specific requirements that the RCOs must meet

Reference No. 2: State of Alabama	
	• Conducted desk and on-site reviews • Developed corrective action plans (CAPs) that were used to monitor the RCOs **Special Populations** • Assisted AMA in developing a managed long-term care program for individuals in nursing facilities and individuals receiving HCBS, including dual eligibles **Waivers** • Assisted with the development of AMA's 1115 demonstration waiver, approved by CMS in February 2016; drafted the demonstration waiver, managed the public comment process, developed the Special Terms and Conditions, and supported AMA in its negotiations with CMS • Assisted AMA in the design of its Delivery System Reform Incentive Payment (DSRIP)-like program, approved under the 1115 demonstration waiver • Drafted a 1915(b) waiver for a: – Proposed dental managed care program – Managed long-term care program • Assisted AMA with the consolidation of three 1915(c) waivers

Reference No. 3: State of Illinois	
Name	**Dan Jenkins** **Department of Healthcare and Family Services**
Address	201 South Grand Avenue East Springfield, IL 62704
Telephone Number	217.524.7500
Email Address	dan.jenkins@illinois.gov
Years of Service	2010 – present
Services Provided	Navigant has worked with Illinois for more than 20 years on back-to-back competitively bid contracts, including assisting the State with preparations for the implementation of expanded Medicaid managed care programs and developing managed care monitoring processes and tools. Relevant projects include: **Dashboard / Scorecard Development** • Developed executive summaries and dashboard reports to communicate Medicaid managed care performance to Agency leadership, sister agencies and other stakeholders

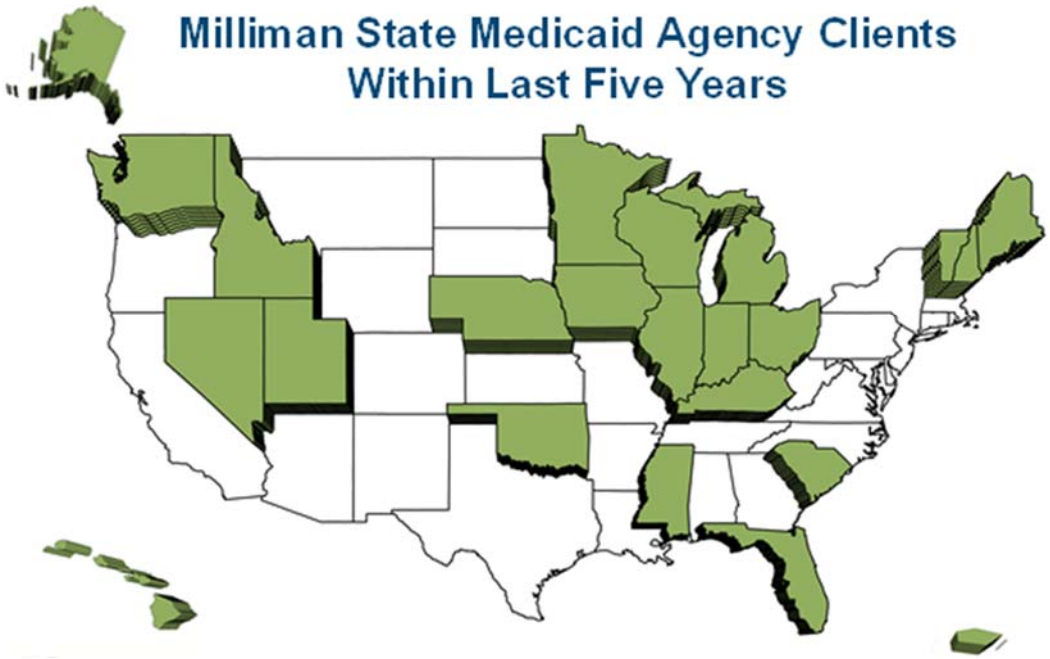
Reference No. 3: State of Illinois	
	Data Analysis • Simulated the fiscal impacts of the inpatient and outpatient payment systems using historical Medicaid-specific claims data • Developed budgetary impact analyses that required significant financial, actuarial, and public and commercial insurance benefits plans expertise and complex analyses of data describing State population demographics, employer healthcare spending, and the cost and availability of a wide variety of public and commercial benefit packages **Managed Care Contracts and Procurements** • Assisted with review of MCO contracts for the Integrated Care Program, Medicare-Medicaid Alignment Initiative, and Family Health Plan / Affordable Care Act Medicaid Expansion programs, and provided recommendations to strengthen contract language and align requirements across programs • Developed RFPs and contracts for a Client Enrollment Broker and Primary Care Case Management Program Administrator **Managed Care Monitoring** • Assisted with refining the managed care monitoring and performance improvement process to integrate analysis of program operations and quality data, lessons learned and best practices, and ongoing dialogue with MCOs to improve individual MCO and overall program performance • Evaluated MCO contract reporting requirements, including inventory, review, standardization, and enhancement of current reports and development of standard operating procedures for analyzing reports • Trained program staff on Medicaid managed care, data analysis, report reviews, and MCO monitoring to support ongoing performance improvement efforts **New Delivery and Payment Methodologies** • Worked closely with Illinois since 2010 in launching its Hospital Rate Reform Initiative to restructure and modernize the payment methodology for Medicaid fee-for-service inpatient and outpatient hospital rates • Assisted with transitioning the Medicaid inpatient prospective payment system to an APR-DRG payment model and its Medicaid outpatient prospective payment system to an Enhanced Ambulatory Patient Group payment model • Developed a hospital potentially preventable readmissions policy, which resulted in significant state savings via payment reductions for providers with excess readmissions **Special Populations** • Assisted with developing a monitoring approach for the State's Integrated Care Program for seniors and individuals with disabilities

Reference No. 3: State of Illinois	
	• Assisted with the implementation plan for the State's Balancing Incentive Program (BIP) grant from the federal government • Helped streamline consumer intake into nine 1915(c) waiver programs by reducing duplicative effort, streamlining information systems and data, and working to develop conflict-free case management protocols and policy recommendations to comply with federal regulations

Actuarial Services Qualifications and References

The Milliman Medicaid Consulting Group includes more than 40 senior actuaries focused on Medicaid state agencies with a supporting staff of more than 100 individuals. **Milliman has been developing capitation rates for 20 years – with more than 20 states in the most recent 5 years.** Milliman's Indianapolis office is currently the actuary for six Medicaid agencies (Illinois, Indiana, Iowa, Michigan, Ohio, and South Carolina), three of which have been clients for more than 15 years. The foundation of Milliman's Medicaid Consulting Group is the experience of its consultants and actuaries with developing client-focused solutions to Medicaid rate-setting while helping guide regulatory oversight and ensuring compliance within each project. In addition, Milliman's actuaries are sought out by the industry to contribute to prominent and current topics impacting Medicaid programs.

Figure 3. Milliman State Medicaid Agency Clients Within Last Five Years



In addition to these Medicaid clients, the Milliman Indianapolis office provides actuarial consulting services to a wide array of healthcare organizations including pharmaceutical companies, hospitals, and insurance companies. Milliman's Medicaid experience is frequently supplemented by learning from consultants who specialize in these other markets, as pricing benefits has certain basic principles that extend across payers and emerging trends often affect multiple markets. For example, new specialty pharmacy products are having a large impact to all healthcare payers, and emerging information is shared among Milliman consultants from different markets to understand the consistencies and variances among programs and states to provide the best expertise to clients.

Below, we provide three examples of state Medicaid programs for which Milliman has provided actuarial services. These three states also serve as references for actuarial services for this CRFQ.

Reference No. 1: State of Indiana	
Name	**Paul Bowling** **Indiana Family and Social Services Administration**
Address	402 W. Washington St, Rm 461 Indianapolis, IN 46204
Telephone Number	317.233.4451
Email Address	Paul.bowling@fssa.in.gov
Years of Service	2000 – present
Proposed Staff Who Worked on this Project	Jeremy Cunningham
Services Provided	• Develop and certify managed care capitation rates for the State Medicaid agency for 17 years (since 2000) • Provide risk adjustment, including customized weights, duration adjustment, carve-out adjustments, or any other modifications appropriate to the program • Conduct encounter data quality review and lead a workgroup to improve quality • Perform medical loss ratio review • Pay for outcomes: Review metrics and calculation of bonus and withhold payments • Analyze and develop new program designs, including the Healthy Indiana Plan • Develop 1915(b) waiver cost neutrality exhibits • Conduct 1115 waiver budget neutrality calculations for the Healthy Indiana Plan and substance use disorder program benefits, including expansion of institutions for mental diseases (IMD) utilization

Reference No. 1: State of Indiana	
	• Worked with clinicians in the Department of Mental Health and Addiction to develop a substance use disorder program in compliance with American Society of Addiction Medicine (ASAM) guidelines • Analyzed of the impact of a pharmacy carve-out, or alternatively, instituting a strict preferred drug list (PDL) requirement or specific pharmacy benefit manager • Worked to achieve rate uniformity • Develop supplemental managed care payments for physicians and government ambulance providers • Integrated hospital upper payment limit (UPL) payments into the managed care rates, using the required minimum reimbursement methodology in §438.6(c)(1)(iii) • Develop rates for the Program of All-Inclusive Care for the Elderly (PACE) and non-emergency medical transportation (NEMT) programs • Prepare Medicaid budget forecast used in the State appropriation, and monthly monitoring of variance from budget • Assessed of financial risk related to various policy proposals • Provided home- and community-based waiver and rebalancing support

Reference No. 2: State of Michigan	
Name	**Penny Rutledge** **Michigan Department of Health and Human Services (MDHHS)**
Address	400 S. Pine Street Lansing, MI 48933
Telephone Number	517.284.1191
Email Address	rutledgep@michigan.gov
Years of Service	1997 – present
Proposed Staff Who Worked on this Project	Jeremy Cunningham
Services Provided	• Develop and certify acute care capitation rates for the State Medicaid agency for 20 years • Develop capitation rates for the Specialty Services Waiver for mental health, substance abuse, and 1915(c) waiver services • Calculate risk adjustment scores for the managed care health plans to reflect the Chronic Illness and Disability Payment System risk adjustment methodology • Assist in the preparation and development of cost effectiveness filings for the State of Michigan's programs associated with 1915(b) waivers for the managed care program

Reference No. 2: State of Michigan	
	• Participate in discussions with CMS related to waiver filings and assist the State with evaluating and estimating the fiscal impact of policy and program proposals and their impact on budget neutrality • Prepare and develop the budget neutrality filings for Michigan's Healthy Michigan 1115 waiver and subsequent updates since program inception • Prepare 1915(c) cost effectiveness calculations for the 1915(c) HCBS waiver filings • Provide budget forecasts that are relied upon by the State of Michigan's department of Health and Human Services in their submission to the State Budget Agency • Estimate the impact of proposed reimbursement and benefit policy changes. This includes fee schedule changes (APR-DRG, RVU updates, etc.), along with payment structure changes • Advise the State on alternative reimbursement structures such as graduate medical education, supplemental payments, and provider taxes • Assist MDHHS with analysis on a number of projects regarding health policy including Medicaid expansion, pharmacy carve-out, analyzing the impact of changing pharmacy patterns, policy and program changes, expansion of eligibility, transition of populations into managed care, and other initiatives pursued by State • Assist the State in performing encounter data quality review and work directly with the health plans to improve the reporting and accuracy of data being submitted to the State • Develop and review rates for the PACE program • Formulate and implement various risk mitigation strategies for different managed care programs and the calculating the outcomes following implementation of the strategies; these methods have included risk corridors, medical loss ratios, and risk pools for various programs throughout the State

Reference No. 3: State of Ohio	
Name	**Al Dickerson** **Ohio Department of Medicaid**
Address	50 West Town St. Suite 400 Columbus, OH 43215
Telephone Number	614.752.3050
Email Address	al.dickerson@medicaid.ohio.gov
Years of Service	July 2015 – present

Reference No. 3: State of Ohio	
Proposed Staff Who Worked on this Project	Jeremy Cunningham
Services Provided	• Develop and certify managed care capitation rates for the State Medicaid agency for two years • Calculate risk adjustment scores for the managed care health plans to reflect the Chronic Illness and Disability Payment System risk adjustment methodology • Provide budgetary support including the development of prospective trends on a five-year rolling basis • Provide federal reporting support for enhanced FMAP reporting of preventative and family planning services • Participate in meetings with CMS and State officials to review capitation rates and other actuarial certifications and analysis • Perform encounter data quality review and work directly with the health plans to improve the reporting and accuracy of data being submitted to the State • Perform medical loss ratio review • Prepare and develop the budget neutrality filings for the Healthy Ohio 1115 waiver • Develop 1915(b) waiver cost neutrality exhibits • Analyze the impact of a pharmacy PDL • Provided new program development support for managed long-term services and supports • Facilitate monthly meetings with managed care plans to discuss future program changes and other rate setting issues • Develop PACE rates

Section III Engagement Team

Navigant's committed resources are healthcare professionals with numerous years of hands-on managerial and subject matter experience. Both the Program Management / Policy Analyst and the Program Integrity Analyst will be on-site at the BMS offices Monday through Friday from 8:30am-4:30pm. In addition, Navigant team members will have a local presence to fulfill the requirements of the contract, such as attending meetings, delivering presentations, and conducting trainings, among other activities.

Although specific resources are contingent upon timing of the engagement and resource availability, we expect that the following professionals will lead Navigant's efforts in respective functional areas:

Name	Role	Relevant Experience
Managed Care Program Oversight		
Tamyra Porter Director	*Engagement Director*	• Nearly 17 years of experience working on the design, implementation, and oversight of Medicaid programs and initiatives • Expertise in assisting clients in oversight and monitoring of the performance of their managed care programs • Assists states with waiver development, procurement, and contracting • Assists states with addressing reform and innovation to better manage long-term care programs including stakeholder engagements, development of quality measures, waiver support, and cost analyses • Develops and manages various readiness assessment and oversight tools for Medicaid managed care oversight • Holds a Bachelor of Science in Public Health, Health Policy, and Administration
To Be Determined After Contract Award	*Program Management Lead* **KEY STAFF**	• At least five years of experience with large-scale, complex projects within Medicaid • Certified Project Management Professional • Experience overseeing development of quality deliverables • Experience facilitating communication with internal and external parties • Holds a Bachelor's degree

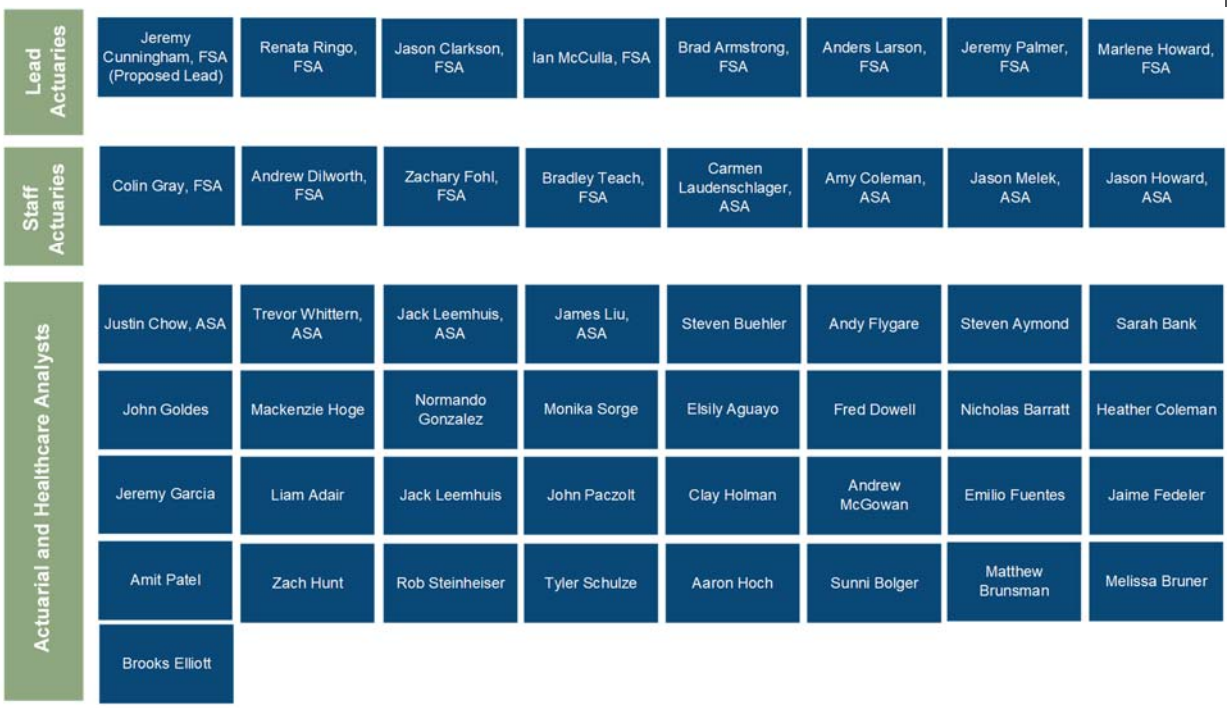
Name	Role	Relevant Experience
Caroline Deneszczuk Senior Consultant	*On-site Program Management / Policy Analyst* **KEY STAFF**	• Five years of experience with Medicaid and Medicaid managed care • Experience in healthcare demonstrations and waiver policy, healthcare access, dual eligible individuals, program operations, and evaluation • Deep understanding of Federal health regulations, guidelines, and standards related to Medicare, Medicaid, State Children's Health Insurance Programs (SCHIP), and other Federal and state programs • Holds a Masters of Public Health in Health Policy
Nari Yoon Managing Consultant	*On-site Program Integrity Analyst* **KEY STAFF**	• More than eight years of experience in reviewing Medicaid fraud, waste, and abuse cases and issuing recovery notices • Certified Fraud Examiner • Has conducted review of CMS' HCBS waiver applications to assess program integrity • Expert in the HCBS regulatory environment and creating compliance programs by reviewing the Code of Federal Regulations and state code • Holds a Bachelor of Arts in Accounting
Lee-Lin Wang Managing Consultant	*Senior Consultant*	• Twenty years of experience in program management and evaluation, research, and health policy analysis, with seven years of experience working with state Medicaid programs • More than 10 years of experience with multi-year, multi-million dollar engagements and timely and quality completion of deliverables for complex engagements • Significant project management expertise and skills • Experienced working with Medicaid managed care program design, contracting, readiness review and monitoring, and strategic planning

Name	Role	Relevant Experience
		• Holds a Master of Business Administration and Master of Social Work in Health Policy
Elizabeth Hataway Senior Consultant	*Junior Consultant*	• Has more than two years of experience working with state Medicaid agencies, including conducting both policy and quantitative analysis to improve and transform government programs and payment structures • Holds a Master of Business Administration
Joohee Lee Senior Consultant	*Junior Consultant*	• Has more than three years of experience working with state Medicaid agencies, assisting with managed care program design, research, and analysis of healthcare policy, and performance monitoring • Holds a Master of Public Health in Health Management and Policy
Julie Saha Consultant	*Research Analyst*	• Has more than two years of experience working with state Medicaid agencies, with a focus on Medicaid managed care program implementation and administration • Holds a Master of Public Health in Health Policy
Scott Mackie Senior Consultant	*Research Analyst*	• Has nearly four years of experience working with state Medicaid agencies • Experience with Medicaid quality programs and optimization of fraud, waste, and abuse prevention and detection units • Holds a Bachelor of Arts
Gage Kaefring Consultant	*Research Analyst*	• Has more than two years of experience working with state Medicaid agencies • Experience with Medicaid data analytics and modeling, including developing payment systems to incentivize efficient and quality patient care and reductions in preventable readmissions • Holds a Bachelor of Science
Pam Vahle Coordinator	*Support / Clerical Staff*	• Has provided administrative support for multiple year-long Medicaid managed care engagements of similar complexity

Name	Role	Relevant Experience
Actuarial Services		
Jeremy Cunningham, FSA, MAAA Actuary	*Lead Actuary* **KEY STAFF**	• More than six years of experience providing actuarial support to state Medicaid agencies including capitation rate settings, financial impacts of policy and program changes, and other Medicaid functions • Possesses both FSA and MAAA credentials • Significant technical expertise including raw data processing and manipulation, cleaning, and quality review • Holds a Bachelor of Science in Actuarial Science and Statistics

In addition, as illustrated in Figure 4 below, Milliman's Indianapolis office has a deep team of lead actuaries, staff actuaries, and actuarial and healthcare analysts, which can be drawn upon to support BMS' needs.

Figure 4. Milliman Medicaid Consulting Group – Indianapolis



This team described above may also be complemented by practice leaders and directors, subject matter specialists, nurses, physicians, analytical support staff, and other resources as necessary to ensure successful achievement of our mutually defined outcomes. For example, we can draw on experts from all areas within Navigant's healthcare practice to respond to BMS' needs, including individuals with experience as public policy experts; hospital, physician practice, life sciences, health plan professionals; and finance executives, among others.

Detailed professional resumes for our **Key Staff** can be found in **Appendix A.**

Detailed professional resumes for all other **Non-Key Staff** can be found in **Appendix B**.

Appendix A Key Staff Resumes

Please see full professional resumes for our key staff on the following pages.

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PROJECT MANAGEMENT LEAD

Required Experience

- Five or more years of experience assisting states with Medicaid managed care program oversight
- Five or more years managing large-scale engagements
- Experience developing work plans and budgets for ad hoc requests
- Experience performing Medicaid monitoring activities
- Experience developing Medicaid policies and updating contracts, waivers, etc.
- Superior written and oral communication skills
- Experience collaborating with other teams or contractors related during engagements
- Excellent research and quantitative analysis skills
- Excellent time management skills and ability to prioritize multiple tasks
- Extensive knowledge of Microsoft Suite - Word, Excel, PowerPoint, and Access

Responsibilities

- Manages the day-to-day performance of the engagement
- Communicates regularly with BMS leadership and other necessary parties
- Acts as the point-of-contact to BMS including delivering regular project status reports
- Responsible for managing project risk including notifying BMS when issues are identified that could impact budget or schedule and developing “work-around” recommendations and options for BMS
- Develops work plan(s) and budget estimates
- Operationalizes the work plan(s) for the engagement
- Delegates work plan tasks and assignments to the team
- Directs team efforts to meet and exceed BMS expectations
- Oversees that all project deliverables are met according to agreed-upon standards and timelines
- Oversees quality control and reviews of deliverables
- Organizes and leads meetings with BMS project staff
- Travels as necessary

Education

- *Minimum qualifications for education:* A Bachelor’s degree in a related discipline

Certifications and Licensures

- Certified Project Management Professional

NAVIGANT

Caroline Deneszczuk, MPH

Senior Consultant

caroline.deneszczuk@navigant.com
Washington, D.C.
Direct: 202.973.3277

Professional Summary

Caroline Deneszczuk is a Senior Consultant with Navigant's Government Health Solutions practice, specializing in health policy research, project management, and data analysis. Caroline has significant experience working with government entities and legislative groups to conduct research and support health reform initiatives and has five years of experience working with Medicaid and Medicaid managed care. Her areas of focus are health insurance coverage and access, healthcare demonstrations and waiver policy, managed care policy, operations and performance, dual eligible individuals and, home- and community-based settings. She has served in positions in Washington, D.C. that have afforded her a deep understanding of Federal health regulations and reform in the United States; as well as, worked with multiple state agencies on designing, operationalizing, and evaluating healthcare programs and reforms.

Caroline has performed reviews of Federal regulations, guidelines, standards, and recommendations related to Medicare, Medicaid, State Children's Health Insurance Programs (SCHIP), and other Federal and state programs, and worked as a liaison to congressional offices, the Congressional Budget Office, the Department of Health and Human Services, state officials, and health advocacy groups.

Areas of Expertise

- Analysis of healthcare policy issues and development of reports, issue briefs, and other deliverables.
- Healthcare program redesign including the waiver approval process, conducting readiness reviews, and site visits to assess health plan readiness to serve Medicaid members and development of standard operating procedures for future monitoring and operations.
- Facilitation and training of elected officials, healthcare executives, and other stakeholders on state and Federal policy-related issues and the healthcare delivery system.
- Expertise in stakeholder engagement through developing, scheduling, and conducting stakeholder interviews, focus groups, and surveys.
- Assess Medicaid program operations and workflows to optimize efficiency and effectiveness to the benefit of state staff and Medicaid beneficiaries.

NAVIGANT

Caroline Cay Deneszczuk

Senior Consultant

Professional Experience

Medicaid Managed Care

- Managed teams to conduct readiness reviews of Medicaid managed care organizations in Texas, New York and California, and well over 30 plans. Led staff through the readiness review process by providing training, guidance, and expertise. Planned, staffed, and conducted desk reviews and site visits to all three states and led discussions on care coordination, appeals and grievances, and staffing.

- Led drafting of the Alabama Medicaid Agency (AMA) Managed Care Quality Strategy and establish a framework for collecting and analyzing quality data to reflect managed care organization and state performance.

- Leading drafting of 1915(b)/(c) combo waiver to implement an integrated managed long-term care program in the State of Alabama including consolidating language from several existing 1915(c) waiver programs, drafting 1915(b) waiver language and documenting key decisions regarding the managed care design. Confirming the proposed program complies with all Federal and State regulations regarding managed care.

Medicaid Reform

- Served as the assistant project manager for a Federal 1115 waiver demonstration management and evaluation project. Provided policy and evaluation recommendations to CMS regarding Medicaid 1115 waivers throughout the United States. Aided CMS and states in improving reporting requirements and adherence to Standard Terms and Conditions (STC). Reviewed quarterly and annual reports of providers participating in the Delivery System Reform Incentive Payment (DSRIP) program. Determined providers' achievement of milestones necessary for performance payment in the DSRIP program.

- Aided Wyoming to identify gaps and provide recommendations to improve the State's Adult Protective Services system and improve communication and collaboration across agencies, advocates, the judicial system, and business leaders that serve vulnerable adults.

- Aided in the development of the State Innovation Model (SIM) Plan in Washington, D.C. Led stakeholder engagement efforts by conducting consumer interviews and focus groups, provider surveys, and assisting in advisory committee and workgroup activities. Led research and drafting efforts of several sections of the State Healthcare Innovation Plan (SHIP) including the environmental scan, stakeholder engagement, and building connections between social and medical services.

NAVIGANT

Caroline Cay Deneszczuk

Senior Consultant

Medicaid Performance Management

- In collaboration with subject matter experts within Navigant and Alabama Medicaid Agency, develop standard operating procedures regarding program governance, key staffing roles, monitoring of subcontractor agreements, and provider certification to collaborate with the State.

- Led efforts to monitor and evaluate the performance of managed fee-for-service demonstrations in Washington State and Colorado. Developed all annual reports to CMS regarding process and outcomes measures reported by the states. Selected the questions and administered a demonstration-specific Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey during each year of the monitoring and evaluation effort.

Federal Initiatives

- Provided subject matter expertise to the Centers for Medicare and Medicaid Services (CMS) regarding Medicare and the Dual Eligible population. Assisted CMS is implementing healthcare demonstrations for this population through the Financial Alignment Initiative. Aided in the readiness review of contracted health plans and the ensuing implementation and monitoring of the demonstration in Washington, Colorado, Texas, New York, and California.

- Assisted in the qualitative and quantitative evaluation of federal healthcare innovation grants awarded by the Centers for Medicare and Medicaid Innovation (CMMI). Planned and conducted site visits for seven awardees and performed analysis on this data collection. Led the drafting process for quarterly and annual reporting requirements throughout the evaluation. Provided research and knowledge regarding home- and community-based services, assisted living and independent living facilities, end-of-life care policy, and palliative care policy.

Long-term Care

- Assisting the Alabama Medicaid Agency with its planned transition to managed LTSS delivery system. Responsibilities include leading the development of the Section 1915(b) and 1915(c) Medicaid waiver applications, developing a concept paper for public comment, and analyzing results of a survey of LTSS consumers, caregivers, providers, and advocates.

- Assisted Colorado with streamlining case management service delivery and redesigning reimbursement methodology for the State's ten 1915(c) home- and community-based services waivers. Researched and interviewed case management experts to determine best practices that offer choice in case management providers, eliminate conflicts of interest, establish a framework for fair reimbursement, and increase provider capacity.

NAVIGANT

Caroline Cay Deneszczuk

Senior Consultant

Other Relevant Experience

- Assisted Navigant's Healthcare Revenue Cycle practice to support healthcare systems implement and refine coding and billing procedures using Epic Software®. Worked with the University of Texas Medical Branch (UTMB) to conducted research and devise strategies and procedures to prevent claim denials and avoidable write-offs.
- Served as Monitoring Task Lead for a Financial Alignment Initiative Operation Support Contract.
- Served as awardee cohort lead for the Health Care Innovation Award Evaluation: High-Risk and Complex Patient Populations Project, at NORC at the University of Chicago.
- As Health Policy Fellow for a congressman's office, assisted in drafting legislation regarding a single-payer system, primary care workforce reform and gaps in Medicare / Medicaid coverage.
- Performed research related to legislative trends for aging individuals, in the areas of managed care, caregiving, health insurance exchanges dual eligible, and Medicaid waiver programs.

Work History

Senior Consultant, Navigant	2015 – Present
NORC at the University of Chicago	2013 – 2015
Office of Congressman Jim McDermott	2012– 2013
American Association for Retired Persons	2011 – 2012

Education

Masters of Public Health, Health Policy	The George Washington University
Bachelors of Science, Psychology	The Ohio State University

Selected Recent Presentations and Publications

- Lupu, D., Deneszczuk, C., Leystra, T., McKinnon, R., and Seng, V. (December, 2013). Few U.S. Public Health Schools Offer Courses on Palliative and End-of-Life Care Policy. Journal of Palliative Medicine. 16(12); 1582-7.

NAVIGANT

Nari Yoon, CFE

Managing Consultant

nari.yoon@navigant.com
Washington, DC
Direct: 202.481.8545

Professional Summary

Nari is a Managing Consultant with Navigant. She has more than ten years of experience in Medicaid home- and community-based services (HCBS) related to compliance, rate setting, claims data analysis, and fraud, waste, and abuse (FWA) prevention program design. She has managed many long-term services and supports (LTSS) compliance reviews, Program Integrity (PI) audits, Payment Error Rate Measurement (PERM) eligibility case reviews, and program implementation planning of conflict-free case management (CFCM).

Areas of Expertise

- Expertise in the evaluation of HCBS program compliance with federal and state regulations.
- Adept at examining various HCBS programs to determine FWA vulnerabilities and make recommendations to the State agencies to prevent further FWA instances in the program.
- Experience in evaluating Electronic Visit Verification systems and evaluation of such systems against the existing state policies and procedures.
- Extensive experience in creating compliance and audit programs for Program Integrity reviews and 1915(c) waiver application reviews.
- Experience in developing training programs for 1915(c) waiver programs involving rate setting, FWA prevention, detection strategies, and litigation support for various law enforcement agencies.
- Expert project manager, experienced at managing multiple deliverables, deadlines, and individuals from varying backgrounds of clinical, technical, and compliance.
- Extensive experience in Program Integrity reviews and fee-for-service claims data analysis for a multitude of provider types. Experience in data analysis and creating dashboards for Medicaid expenditures, projections, and state trends.
- Knowledgeable in state Medicaid eligibility rules for Permanent Error Measurement Review (PERM). Experience in reviewing state eligibility files and determining eligibility and technical errors.
- Experience in CFCM implementation plan development.

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Nari Yoon, CFE

Managing Consultant

Professional Experience

Federal Initiatives

- Managing project with the CMS Centers for Medicaid and CHIP Services (CMCS) to design and conduct CMS 1915(c) Rate Review and Compliance assessment for state HCBS waiver applications, renewals, and amendments. Oversee team responsible for assessing states' compliance with Federal and State regulations related to the 1915(c) applications. Perform the data analysis using the existing 1915(c) waiver applications to determine utilization trends, common issues that occur in the waiver application reviews, and personal care services oversight trends in all 50 states. Using results of the data analysis and waiver application reviews, create and conduct training for CMS and the states for rate setting methodologies, fiscal integrity, using 372(s) reports, cost and utilization estimation for the waiver applications, and HCBS quality and oversight measures.
- Assisting the CMS Centers for Medicaid and CHIP Services (CMCS) with enhancing HCBS Quality Improvement Systems (QIS) of the 1915(c) waiver programs by improving the existing QIS reporting and evaluation systems for CMS and State agencies. Create models of quality improvement system (QIS) reporting tools to be used by State. Using existing performance measures, conduct research and data analysis to determine the core performance measures to be used for the States and CMS. Develop 1915(c) and 1915(i) waiver quality measure analysis tools for CMS Central and Regional Office analysts.

Long-term Care

- Examined current landscape of case management services for Colorado. Conducted cost surveys and analyzed data to calculate individual and broad financial impact on Community Centered Boards to keep the state in compliance with CMS requirements related to conflict of interest. Recommend to the state legislature the best approach to implementing Conflict Free Case Management based on financial and programmatic impacts.
- Oversaw, reviewed, and performed more than 300+ annual Medicaid post-payment reviews including Personal Care Services (PCS) and Home Health (HH) with a focus on identification of overpayment and FWA risk. Reviewed medical files, employee records, claims data, and determined if the facility provided care in accordance of the service plans, whether the facilities met Medicaid provider manuals and state and federal guidance. Evaluated various agencies' EVV systems against state policy as part of Program Integrity review. Provided recommendations to states on how to improve processes, control waste and abuse and suggested regulation updates. Uncovered multiple frauds and referred them to State Medicaid Fraud Control Units (MFCU) Assisted MFCU and FBI agents to prosecute fraudulent providers. The review team recovered over $40 million in five years for one state Medicaid agency and improved agency's oversight of various Medicaid services by recommending process improvement.

Government Payment Transformation

- Designed, reviewed, and performed annual FWA prevention training and compliance review rules training for 30 provider types, including personal care services and home health agencies, conducted internally.

NAVIGANT

Nari Yoon, CFE

Managing Consultant

- Completed audits for Virginia Department of Medical Assistance Services' (DMAS) cost reports and operational Disproportionate Share Hospitals (DSH) and Intergovernmental Transfer (IGT) data. Reviewed low to medium risk hospitals and examined the uninsured patient billing / claims data files to determine if the hospitals accurately reported the cost of uninsured care. Audited nursing home and intermediate care facilities' cost reports and determined if the cost reports filed are in compliance with state and federal regulations.
- Performed PERM Reviews for DMAS. Evaluated 250 long-term care and Children's Health Insurance (CHIP) eligibility case files for both technical and eligibility errors. Assist in creation of the initial list of eligibility and technical error listing development. Prepared the client to be ready for the PERM review cycle by creating a list of commonly occurring technical and eligibility errors.

Work History

Managing Consultant, Navigant	2014 – Present
Manager, Myers & Stauffer	2006 - 2014

Certifications, Memberships, and Awards

Certified Fraud Examiner

Education

Bachelor of Arts – Accounting	University of Maryland

Selected Recent Presentations and Publications

- CMS Division of Long-term Services and Supports (DLTSS), Disabled and Elderly Health Programs Group (DEHPG) State Operations and Technical Assistance (SOTA) Webinar Series
  - Monitoring Fraud, Waste, and Abuse in HCBS personal Care Services, February 2016
  - Increasing Fiscal Protections for Personal Care Services, April 2016
  - Protecting Self-Direction Rights, June 2016
  - Fee Schedule for HCBS Rate Setting: Developing a Rate for Direct Care Workers, July 2016
  - Financial Accountability, September 2016
  - Financial Accountability Q&A, October 2016
  - Rate Sufficiency Strategies, November 2016
  - HCBS Billing Validation Methods, December 2016
- National Association for States United for Aging and Disabilities (NASUAD) Home and Community-Based Services (HCBS) Conference Presentations with CMS DLTSS
  - Increasing Fiscal Protections for Personal Care Services
  - Rate Methodology in HCBS Fee-For-Service Structure

Jeremy A. Cunningham
FSA, MAAA
Actuary

Summary

Jeremy Cunningham is an actuary with Milliman's Indianapolis Health Practice. He joined the firm in 2011, and has over 6 years of experience providing actuarial support to state Medicaid agencies including capitation rate settings, financial impacts of policy and program changes, and other Medicaid functions.

Mr. Cunningham has a great deal of technical expertise including raw data processing and manipulation, cleaning, and quality review. He led the development of the DRIVE™ tool that evaluates the quality of the underlying encounter data supporting the capitation rate development. Lastly, he has experience using GitHub, which is a version control software that enhances Milliman's comprehensive peer review process.

Experience

- **Managed Care Services**
  - **State of Michigan, Department of Health and Human Services**: Development of capitation rates for specialty services managed care program, including evaluation of encounter and financial cost data, monitoring of eligibility changes, evaluation of risk adjustment variables (2011 to present)
  - **State of Ohio, Department of Medicaid**: Development of capitation rates for acute care managed care program, including TANF, Disabled, and ACA Adult populations, including risk adjustment calculations, encounter data validation, and analysis of policy changes (2015)
  - **State of Illinois, Department of Healthcare and Family Services**: Development of capitation rates for acute care and long-term supports and services (LTSS) for TANF, Disabled, and ACA Adult populations, including risk adjustment, encounter data validation, and analysis of policy changes (2016)
  - **State of Indiana, Family and Social Services Administration (FSSA):** Development of NEMT capitation rates for populations not already covered in managed care, including encounter data validation, evaluating of program changes, managed care efficiency adjustments, and development of non-benefit expense assumptions (2016)

- **Encounter Data Quality and Financial Reporting**
  - **State of Michigan, Department of Community Health**: Implemented encounter data monitoring and quality improvement process for specialty services managed care program, including the deployment of the DRIVE™ tool to facilitate the sharing of encounter data summaries between managed care entities and the Department (2013 to present)
  - **State of Illinois, Department of Healthcare and Family Services**: Supported improvement in encounter data and financial reporting by working with HFS' managed care encounters team, including the implementation of a comprehensive process to reconcile Encounter Utilization Monitoring (EUM) reports to managed care organizations' financial statements (2016 - present)

- **Budget and Forecasting**
  - **State of Indiana, Family and Social Services Administration (FSSA):** Development of annual budget estimates for an 1115 demonstration providing comprehensive substance abuse services (2016)
  - **State of Michigan, Department of Health and Human Services**: Development of 1115 demonstration budget neutrality projection and narrative for the state of Michigan's transition of their managed behavioral health and HCBS program from a 1915(b)/(c) to an 1115 waiver, which included incorporating other waiver populations which were previously covered on a fee-for-service basis benefit (2016)

Jeremy A. Cunningham
FSA, MAAA
Actuary

Milliman

- **State of Alaska, Department of Health and Social Services**: Development of 1115 demonstration budget neutrality projection and narrative for the state of Alaska's behavioral health transformation. Perform health care reform financial projections related to recent healthcare reform legislative proposals (2017)

- **Taxes, Fees, and Supplemental Payments**
  - **State of Michigan, Department of Health and Human Services**: Adjust capitation rates for applicable taxes and supplemental payments, including use tax, claims tax, and pass-through payments (2011 – present)

- **Additional Financial Analysis**
  - **State of Michigan, Department of Health and Human Services**: Evaluation of incentive payment methodology to improve outreach to foster children with serious emotional disturbances (2012 – present)
  - **State of Michigan, Department of Health and Human Services**: Assess revenue impacts to MCOs participating in managed care specialty services program resulting from changes in the risk adjustment methodology used in the capitation rate development process (2011 – present)

Selected Publications and Presentations

- *Encounter data standards: Implications for state Medicaid agencies and managed care entities from final Medicaid managed care rule,* Milliman White Paper, May 2016
- *Expansion of ASD treatment to a Medicaid EPSDT benefit*, Milliman White Paper, May 2015
- *Encounter Data: Managed Care Rule and the Encounter Quality Dashboard (EQD),* 2016 Medicaid Enterprise Systems Conference
- *Encounter data standards: Implications for state Medicaid agencies and managed care entities from final Medicaid managed care rule,* 2017 Medicaid Innovations Conference
- *Data Analytics Required to be Successful in Managed Care,* 2017 State Healthcare IT Connect Summit

Education/Credentials

- Bachelor of Science, Actuarial Science and Statistics with a minor in Management
  Purdue University, 2011, *Summa cum laude and honors*
- Member, American Academy of Actuaries (MAAA), 2013
- Fellow, Society of Actuaries (FSA), 2014

Appendix B Non-Key Staff Resumes

Please see full professional resumes for our supporting staff on the following pages.

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NAVIGANT

Tamyra Porter

Director

tporter@navigant.com
Washington, DC
Direct: 202.973.3138

Professional Summary

Tamyra Porter is a Director within Navigant's Government Healthcare Solutions practice. She has nearly 17 years of experience working on the design, procurement, implementation, readiness, and oversight of Medicaid programs and initiatives in many states including Alabama, Pennsylvania, North Carolina, Indiana, Mississippi, Texas, the District of Columbia, Maryland, Kansas, Ohio, Iowa, Illinois, and Georgia. Tamyra has worked on designing various managed care systems such as provider-sponsored, medical homes, full-risk MCOs, and integrated service models, including long-term care. One of Tamyra's key areas of expertise is in assisting clients in oversight and monitoring of the performance of their managed care programs. She provides operational strategy guidance to our state clients as they oversee their managed care programs while also providing similar oversight as the project manager for many of our practice's most complex engagements.

Areas of Expertise

- Assists states with evaluating options to better manage their Medicaid programs including waiver development, procurement and contracting, and developing internal infrastructure to monitor and drive quality improvements.
- Assists states with addressing reform and innovation to better manage long-term care programs including stakeholder engagements, development of quality measures, waiver support and cost analyses.
- Develops and manages various readiness assessment and oversight tools for Medicaid managed care oversight
- Provides strategic consultation in program design assisting states in exploration of new model options including Medicaid ACO, provider-sponsored health plans, health homes, etc.
- Develops and deploys solutions to improve the use of Health Information Technology and data analytics assisting states in their goals for transparency and accountability through dashboards and other technology solutions

Professional Experience

Medicaid Managed Care

- Supported and directed various aspects of program design and implementation. Roles in this area have included concept paper development, internal stakeholder facilitation, development and drafting

of waiver applications (1915 b and c, as well as 1115), updating and drafting state plans and developing and reviewing budget neutrality calculations. Tamyra has also assisted states in coordination and meeting with CMS to usher through the waiver approval process. Supported Pennsylvania and Alabama in these aspects of program design implementation.

- Directed and supported the development of procurement and reprocurement tools, including state administrative code development, RFPs, proposal evaluation resources, and contracts. Provided support with an eye towards ongoing operations and oversight incorporating principles of value-based purchasing. Provided such support for Pennsylvania, Mississippi, Georgia and Alabama for full-risk managed care programs, provider-sponsored managed care programs, EPCCM programs, Enrollment Broker contracts, EQRO contracting, Pharmacy Benefits Managers, Specialty Pharmacy contracting, ADA compliance audits, and public outreach campaigns.

- Directed and supported the development of various readiness review tools for a variety of state Medicaid managed care programs including Indiana, Pennsylvania, Mississippi, Alabama, and Iowa. Has assisted in training state and contracted staff in the use of designed tools and providing ongoing support and dashboarding of readiness tools throughout the readiness process. Served as a subject matter expert with emphasis on systems readiness, network adequacy, reporting, long-term care, and special needs populations. As a subject matter expert, she participates and leads desk reviews and participates in site visits related to the readiness process. Worked with states to leverage the readiness efforts as a seamless transition to ongoing monitoring, including evaluation and assessment of national and local Medicaid health plans such as Centene, Amerigroup, United, AmeriHealth Mercy, Molina, and also provider-sponsored entities who have partnered with groups such as Blue Cross Blue Shield, Sentara, Viva, and others.

- Works with a variety of states to evaluate and support their monitoring and oversight of state programs. Worked on targeted efforts to evaluate provider network access and availability, ADA accessibility, care management evaluations, compliance with grievances and appeals, and maternity care programs. Worked with state clients in multi-year engagements and one-time GAP analyses to develop Monitoring Boot Camp trainings, provide automated tools to facilitate monitoring, provide oversight documentation, and develop reporting requirements and tools to read and aggregate vendor reporting for state dashboarding and oversight. Her approach to monitoring includes the use of existing resources and development of automated tools to more efficiently document and complete oversight functions. Has directed the development of various tools that have been created to support state agencies in all aspects of program operations. Provides support through entire software development process including development of UAT, user guides, and training, whether directing the development for clients or working as the business analyst for the client and interfacing with state-staffed developers.

NAVIGANT

Tamyra Porter

Director

- Directed an engagement for Texas Health and Human Services Commission to support compliance with Corrective Action Orders specific to the Consent Decree in *Frew v. Hawkins* and mandate to provide adequate supply of healthcare providers..

- Assisted states in the development or renewal of their state quality strategy. Worked with Pennsylvania, Mississippi, and Alabama in crafting the quality strategy as a foundational component of their overarching approach to value-based monitoring and oversight and as a means of aligning state program goals and objectives with the national quality strategy.

Medicaid Performance Management

- Conducted various reviews of internal state oversight functions and provided technical assistance and recommendations for performance improvements in several states including Indiana, Pennsylvania, Texas, Alabama, Mississippi, Louisiana, and North Carolina. Provided clients with various technical, customized database solutions to better track and document monitoring activities, report on these functions and improve oversight. Recommended monitoring review steps, sources for obtaining required data and guides for measuring and evaluating performance. Developed detailed standard operating procedures to support the ongoing monitoring efforts and transitioned these tools to the assigned staff for ongoing use. Provided detailed training manuals and conducted classroom trainings to support staff in these efforts. The monitoring tool also connects compliance decisions to contractor performance reporting.

- Designed and directed the development of a state training institute to assist clients in program transitions from fee-for-service to managed care and to provide ongoing staff development resources. Directed the development of various e-learning solutions to be packaged and hosted on state platforms or hosted for our state clients.

Long Term Care

- Assisting states in their design and development of program reforms for their long-term care programs. Working with state clients to develop concept papers, stakeholder engagement efforts, waivers and state plan modifications. Coordinating efforts with legislative mandates and affiliated workgroups. Assistances also includes payment transformation and leveraging managed care designs to transition to alternative payment models. Recent efforts have focused on provider-led initiatives where provider groups would gradually assume risk for the long-term care population.

- Assisted Pennsylvania's Bureau of Home and Community Based Services (HCBS) with ongoing analysis of its current Individual Service Planning and service plan approval process. Assisted the Commonwealth in evaluating process for automating the service planning and approval process. Conducted research and support for the evaluation of uniform needs assessment tools to aid in the development of individualized budgets for HCBS waiver services. Expanded this research to include

a full spectrum of public welfare services including the critical services for dual eligibles and those who may qualify for long-term care and support.

- Researched and developed a bed-needs study for Ohio. Compared the number of nursing facilities available across the state to occupancy rates and unused beds for each area of the State. Compared findings with trends in nursing home usage in other states, as well as nationally, in context to recent Federal requirements related to rebalancing and nursing home transitions. Prepared summary reports and presented findings to Ohio's Office of Jobs and Family Services.

- Developed and conducted a training institute for HCBS waiver providers and service planners to fulfill training requirements for enrollment as a qualified provider with the Commonwealth of Pennsylvania.

- Provided initial support for an automated audit tool to assist state clients in their quality improvement and audit functions of HCBS providers.

Government Payment Transformation

- Assisted North Carolina with an evaluation of its Medicaid Disproportionate Share Hospital and supplemental payment programs. Revised the State's model that calculates Disproportionate Share Hospital or supplemental payments. Assisted with the payment calculations. Analyzed the validity of hospital-reported data used in calculating interim payments and in final cost settlement. Trained State staff in the use of the model.

- Assists states in moving monitoring programs to that of compliance to align with more robust development of value-based purchasing (VBP) concepts. Facilitates planning sessions related to program goals and outcomes, data analytics to support benchmark data as well as to guide ongoing performance evaluation. Instrumental in the development of Quality Strategies and tools to support the state's aims for value-based purchasing and program oversight. Provides assistance in the operational assessments to determine strength and capacity of internal resources to execute VBP goals. Assisted with these efforts in Mississippi, Pennsylvania, and Alabama while providing some project consultation in Illinois.

- Assisted Alabama with various aspects of its quality withhold program and related exercise in developing quality measures with the states Quality Assurance Committee, coordination with the Medicaid Quality Strategy, and coordination with the RCO's Provider Standards Committee.

Medicaid Reform

- Serves as a liaison between state staff and CMS in the development of state waiver programs (1115), corrective action plans or other program design considerations. Assists senior state health and human services officials a state to identify and develop major reform initiatives including reforms to

NAVIGANT

Tamyra Porter

Director

Medicaid, social services, reforms required under the ACA and other public welfare benefits. Develops options, white papers, presentations, talking points, and meeting and training materials to facilitate the decision-making process. Assisted states including Pennsylvania and Alabama through various wavier development exercises and discussions with CMS.

Health Information Technology

- Assisted the States of Pennsylvania, Kansas, Maryland, and the District of Columbia in the design and planning for the Medicaid HIT provider incentive payment program. Assisted in the development of various planning sessions and the drafting of the SMHP for CMS review and approval. For the District of Columbia, assisted in the drafting of a statement of work the District would use to procure support for the ongoing operations of its incentive program.

- Directed engagements related to encounter data requirements and validation. Projects have included development of contract requirements, evaluation of readiness, assistance with encounter data production testing. Developed various encounter data studies to look at timeliness and completeness and determine opportunities for efficiencies and other studies comparing HEDIS scores for administrative measures comparing results from encounter data calculations to audited HEDIS reports.

- Developed MCO contract requirements related to promoting use of HIT by providers requiring adoption and use for inclusion in provider networks for certain high-volume provider types.

- Assisted states in considering data warehousing requirements for potential procurements to support better use of data gathering, storage and reporting.

Healthcare Compliance

- Assisted on various healthcare litigation projects related to billing disputes. Evaluated all aspects of claims life cycle to determine billing errors and to quantify related damages. Evaluated claims for inpatient, outpatient, pharmacy and durable medical equipment (DME).

Work History

Director, Navigant	2016 – Present
Associate Director, Navigant	2006 – 2016
Manager, Navigant	2004 – 2006
Manager, Tucker Alan Inc.	1999 – 2004
Web Developer, University of North Carolina Hospitals	1998 – 1999
Assistant to the Chair of Obstetrics and Gynecology	

NAVIGANT

Tamyra Porter

Director

Education

Bachelor of Science in Public Health, Health Policy and Administration with Highest Honors

University of North Carolina at Chapel Hill, School of Public Health

Selected Recent Presentations and Publications

- "Innovative Approaches to Measuring Outcomes for HCBS Participants" NASUAD (2016)
- "Moving the Outcomes Needle – Integrating the Dually Eligible" NASUAD (2016)
- "Improving Your Purchasing Power – Procurement Opportunities" HSFO (2016)
- "Monitoring the Shift to Managed Care. Why is Monitoring Important?" World Congress Medicaid Managed Care Summit Presentation (2012)
- Readiness Review Trainings – Commonwealth of Pennsylvania Bureau of Managed Care Operations (Spring 2012)
- Monitoring Boot Camp - Commonwealth of Pennsylvania Bureau of Managed Care Operations (Fall 2012)

NAVIGANT

Lee-Lin Wang, MSW, MBA

Managing Consultant

lee-lin.wang@navigant.com
Chicago, Illinois
Direct: 312.583.2104

Professional Summary

Lee-Lin Wang is a Managing Consultant with Navigant Healthcare and has 20 years of experience in program management and evaluation, research and health policy analysis, and seven years of experience working with state Medicaid programs. She is experienced working with Federal, state, and local governments and public and private entities on healthcare reform issues, Medicaid managed care program design, contracting, readiness review and monitoring, healthcare disparities, strategic planning, and cross-cultural understanding and collaboration.

Areas of Expertise

- Leads development and review of state Medicaid managed care contracts in consideration of compliance with state and Federal regulations, often in coordination with multiple stakeholders.
- Supports states with conducting and managing readiness reviews and monitoring the ongoing compliance of managed care organizations.
- Assists state Medicaid agencies and other organizations in the development, design, and evaluation of healthcare staff training.
- Supports work on multi-year, multi-million dollar engagements and guiding timely completion and demonstrable value of complex engagements.

Professional Experience

Federal Initiatives

- Assisted the Centers for Medicare & Medicaid Services (CMS) and the Center for Consumer Information and Insurance Oversight (CCIIO) with activities related to the Outreach and Collections for the Transitional Reinsurance Program. Supported identification and outreach efforts of entities required to contribute towards stabilizing premiums in the individual market.

- Supported the Consumer Operated and Oriented Plan (CO-OP) Program of CMS and CCIIO on the creation of qualified nonprofit health insurance issuers in multiple states. Drafted market research profiles, provided technical and administrative support, and conducted onsite visits to states to determine readiness for operations and compliance with state and Federal regulations.

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Lee-Lin Wang, MSW, MBA

Managing Consultant

Medicaid Reform

- Assisted with survey development, analysis, and evaluation for North Carolina's Family Planning Waiver and provided recommendations to increase enrollment with Waiver services and support continuity of enrollee participation in annual screenings.

- Provided internal Navigant assistance and collateral development of Federal Healthcare Reform implications and needs for appropriate state positioning and preparedness for compliance with Medicaid provisions of the Patient Protection and Affordable Care Act of 2010.

Medicaid Managed Care

- Serving as project manager for the Arkansas Department of Health Services' (DHS) reorganization of five Divisions into the newly created Division of Provider Services and Quality Assurance (DPSQA). Assisting DPSQA with the evaluation of personnel reallocation, policy review and promulgation, contract review and assessment, and provider education, support and training. Leading ongoing communications with client, tracking timely completion of deliverables against project work plan, and managing budget and invoicing.

- Providing subject matter expertise to a commercial health plan in its proposal submission to the State of Florida, Agency for Health Care Administration to provide Statewide Medicaid Managed Care Program services. Reviewing and scoring drafted responses against state evaluation criteria.

- Assisted the Arizona Department of Corrections with procurement review and evaluation between two potential healthcare vendors. Developed comparison analysis of vendors' proposed staffing plans and considerations for further assessment.

- Assisted the Alabama Medicaid Agency (Agency) on the statewide transition to risk-based, community-led, regional care organizations (RCOs) to coordinate the health care of the State's Medicaid beneficiaries in each of five designated regions in the State.

  – Led development of a risk-based contract for use between the Agency and RCOs. Working with the Agency and CMS on contract language revisions and final contract approval and execution.

  – Assisted the Agency with conducting readiness assessments of eleven RCOs to determine their respective readiness to provide services to Medicaid beneficiaries in accordance with the RCO contract and State and Federal regulations. Developed review criteria, interview questions, onsite review schedules and agendas, and risk mitigation strategies. Drafted final Readiness Assessment report for submission to CMS.

  – Managed development and implementation of healthcare related trainings for Agency employees.

  – Supported drafting Alabama Medicaid Administrative Code Rules to implement the RCO program.

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Lee-Lin Wang, MSW, MBA

Managing Consultant

- Assisted with the Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)'s readiness reviews of four selected MCOs for the IA Health Link program. Conducted desk and onsite reviews of each MCO's ability to provide high quality, accessible care to Iowa Medicaid beneficiaries. Assisted with drafting final reports that documented findings and recommended mitigation steps for identified deficiencies.

- Supported Pennsylvania in the development of an e-Learning Institute for State employees, provided recommendations for course content, timing, and roll-out. Managed the transformation of PowerPoint presentations into individual web-based training sessions, facilitated review, and edit of course content along three course tracks: Medicaid 101, Health Reform and Special Topics, and Leadership Development. Developed corresponding knowledge checks and resource guides for the e-Learnings.

- Conducted desk reviews of Coordinated Care Organizations' (CCOs) ability and readiness to provide services for the Mississippi Division of Medicaid's Coordinated Care Program called Mississippi Coordinated Access Network. Assessed alignment with requirements from the CCO contract and Request for Proposals (RFP). Determined for each operational area if the materials submitted satisfied contract requirements. Identified follow-up items related to any deficiencies found and identified questions to ask during pre-site and on-site reviews.

Government Payment Transformation

- Assisted Wyoming with the development of its annual Medicaid Benchmarking Study, a report analyzing Medicaid fee schedules for various services. The report serves as a reference and planning document with comparisons to other state Medicaid reimbursement rates, commercial fees and Medicare reimbursement. Researched Wyoming current and historical payment methodology, analyzed expenditure data, and presented options for future reimbursement directions.

- Provided Massachusetts's Delivery Model Advisory Committee with research and analysis of Medicaid service delivery systems and fee schedules to evaluate MassHealth, the State's Medicaid program. Assisted in development of a briefing book, summaries of interviews with representatives from various state Medicaid programs and recommendations of innovative Medicaid payment and delivery system models and design features.

- Provided assistance to the Illinois Department of Healthcare and Family Services with potential modifications to the Medicaid fee-for-service inpatient prospective payment system (IPPS). Assisted in development of evaluation criteria for reimbursement system re-design. Researched utilization of Resource Utilization Groups within the national landscape for nursing facility reimbursement.

Medicaid Performance Management

- Assisted the Iowa Department of Human Services, Iowa Medicaid Enterprise (IME) with development of a performance report for the State Legislature of the IA Health Link program's participating MCOs' first quarter performance. Provided review and data analysis of submitted monthly and quarterly data reports for contract compliance and assessment of care provided to members.

NAVIGANT

Lee-Lin Wang, MSW, MBA

Managing Consultant

- Assisted the Pennsylvania Department of Public Welfare (DPW) with updating performance reports of outcomes for MCOs participating in the HealthChoices program. Reviewed the Department's data repository and performance profile reports developed from HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data from the National Committee for Quality Assurance. Assisted with review and recommendations for the Department's Annual Report, Consumer Guide and other publications.

- Assisted the Illinois Department of Healthcare and Family Services with development of monitoring tools and standard operating procedures for tracking and evaluation of MCO performance reporting.

Health Information Technology

- Supported the District of Columbia Department of Health Care Finance's design, planning and implementation of its State Medicaid Health Information Technology Plan (SMHP). Assisted in the development of provider and hospital surveys.

- Assisted the Pennsylvania DPW Office of Medical Assistance Programs with health information technology efforts including the design, development and implementation of its SMHP and Implementation Advanced Planning Document (IAPD). Assisted with evaluation of the eHealth Pod Pilot to increase secure data exchange among long-term care and behavioral health providers with other provider partners.

Long-term Care

- Assisting the Alabama Medicaid Agency with assessment and redesign of medical care services delivery for the State's elderly and disabled Medicaid beneficiaries. Supporting review and development of requirements for governance and operations through a statewide integrated care network.

- Assisted in restructuring efforts of long-term care supports and services for a state Medicaid population. Provided technical assistance, research, and national best practices. Developed options analysis, briefings, and state presentation materials. Reviewed guidance on Federal waiver process for state application.

Health Insurance Studies

- Provided assistance to the North American Medical Management (NAMM) of Illinois – an Aveta Company to create Regional High Performance Networks (HPN) for Chicago. Applied cost analysis model to analyze 13 hospital claims data against a peer grouping. Assessed each hospital's potential cost savings on a per case basis, potentially avoidable one-day admissions, avoidable emergency room visits, and avoidable readmissions. Assisted in development of a hospital shared savings model. Conducted research on MCOs to assist development of competitive market assessments and strategic recommendations.

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Lee-Lin Wang, MSW, MBA

Managing Consultant

Other Relevant Experience

- Designed and convened multiple Chicago city-wide listening sessions for research and assessment of racial and ethnic disparities related to access to breast health screening and treatment. Assisted in the development and publication of report addressing quality improvements and reducing disparities in breast cancer mortality in Metropolitan Chicago.

- Assessed health conditions and standards of incarcerated and formerly incarcerated girls in Chicago. Provided policy and programmatic recommendations on the health of incarcerated girls to the Illinois Department of Juvenile Justice.

Work History

Managing Consultant, Navigant	2011 – Present
Graduate Assistant, Center for Supply Chain Management and Logistics University of Illinois at Chicago	2010 – 2011
Teaching Assistant, Department of Managerial Studies University of Illinois at Chicago College of Business Administration	2010
Consultant, Metropolitan Chicago Breast Cancer Task Force Sinai Urban Health Institute	2007, 2009
Program Director, Illinois Women's Health Coalition and Senior Policy Analyst, Health and Policy Research Group	1996 – 2007

Certifications, Memberships and Awards

Beta Gamma Sigma

Member, Women's Leadership and Mentoring Alliance (WLMA)

Member, Project Management Institute (PMI) Chicagoland Chapter

Education

M.B.A., Entrepreneurship, Marketing, and Management	Liautaud Graduate School of Business University of Illinois at Chicago
M.S.W., Health Policy	University of Pennsylvania School of Social Policy & Practice (formerly the School of Social Work)
A.B., Political Science	Bryn Mawr College

NAVIGANT

Elizabeth Hataway, MBA

Senior Consultant

elizabeth.hataway@navigant.com
Suwanee, Georgia
Direct: 334.538.5498

Professional Summary

Elizabeth Hataway is a Senior Consultant in Navigant's Government Healthcare Solution Practice. Elizabeth has an extensive background in healthcare and has worked with state Medicaid agencies, hospitals, providers, and healthcare consumers over the past seven years. Her most recent experience includes assisting with Medicaid managed care program design and implementation, readiness assessments, risk identification and mitigation strategies, communications, and health plan monitoring. Prior to her role at Navigant, she helped develop industrial medicine programs for hospitals, educated employees on their health insurance benefits, and promoted health and wellness among community members.

Areas of Expertise

- Works with state Medicaid agencies on managed care program design and implementation, including readiness reviews and assessments.
- Experience serving as a liaison between managed care entities and state Medicaid agencies.
- Works with state Medicaid agencies on transitioning to managed care, including creating dashboards and other tools utilized for performance monitoring.
- Assists with developing training materials including standard operating procedures, project dashboards, and PowerPoint presentations for staff.

Professional Experience

Medicaid Managed Care

- Assisted the Alabama Medicaid Agency on the statewide transition to risk-based, community-led, regional care organizations (RCOs) to coordinate the health care of the State's Medicaid patients in each region.
- Provided support to state Medicaid clients such as Alabama in assessing readiness for transition to Medicaid managed care. Served as a liaison between the managed care entities and the State. Conducted weekly technical assistance calls. Assisted with onsite reviews of managed care organization's readiness to go-live with the program.

NAVIGANT

Elizabeth Hataway

Senior Consultant

- Developed materials and trained agency staff in areas such as Managed Care 101, Medicaid 101, and Readiness Assessment preparation. Presented on these topics for the state managed care team. Assisted with developing standard operating protocols and instructional guides delivered to staff.

- Assisted with identifying potential risks for managed care transition and related mitigation strategies. Developed Corrective Action Plans to monitor contract compliance. Presented findings to Executive team.

Medicaid Performance Management

- Developed standard operating procedures, tracking tools, and dashboards to monitor case management and prior authorization activities. Trained staff on use of these tools to drive system performance.

Work History

Senior Consultant, Navigant	2017 – Present
Consultant, Navigant	2015 – 2017
Corporate Health Consultant, Jackson Hospital	2013 – 2015
Marketing Manager, 2WR, Inc.	2012 – 2013
Creative Marketing Assistant, Private	2011 – 2012
Sales Representative, Atomos Spine / R8 Medical	2011 – 2011

Certifications, Memberships, and Awards

Chair Member, Jubilee Community Center

Former President of the Junior Executive Board for the Montgomery Museum of Fine Arts

Phi Beta Kappa

Education

Master of Business Administration	Auburn University at Montgomery
Bachelor of Arts, Interdisciplinary Studies	University Alabama – Tuscaloosa

NAVIGANT

Joohee Lee, MPH

Senior Consultant

joohee.lee@navigant.com
Washington, DC
Direct: 202.481.7387

Professional Summary

Joohee is a Senior Consultant with Navigant in the Government Healthcare Solutions (GHS) practice. She works with state Medicaid agencies, assisting with managed care program design, research, and analysis of healthcare policy, strategic planning, and performance monitoring. She also has extensive experience leading grassroots level health intervention projects resulting in increased access to health education and services. Joohee specializes in needs-finding assessments to make evidence-based recommendations.

Areas of Expertise

- Supports states with conducting managed care program readiness reviews and quarterly program audits for monitoring process improvement and network adequacy
- Research and analysis of healthcare policy, health needs assessment and program design, and health outcomes measurement and evaluation
- Project management and leadership experience having directed multiple health camps and educational programs

Professional Experience

Medicaid Managed Care

- Assisted with the development of Kansas 1115 waiver renewal application and subsequent public information materials (i.e., comment and hearing notices, fact sheets, FAQs, etc.).
- Assisted in implementing organizational improvements in key functional areas for Kansas Department for Aging and Disability Services to enhance oversight and monitoring of MCO performance, including the development of standard operating procedures and agency policies.
- Assisted the Alabama Medicaid Agency on statewide transition to risk-based, community-led, regional care organizations (RCOs) to coordinate the health care of the State's Medicaid patients in different regions. Assisted in developing reporting templates for monitoring quality and performance. Assisted with leading RCO trainings on the readiness review process. Assisted in quarterly audits of Health Homes using random sampling on Real Time Medical Electronic Data Exchange (RMEDE).
- Assisted with the support provided to Illinois Bureau of Managed Care by performing quality checks of health plan performance data analysis.

NAVIGANT

Joohee Lee, MPH

Senior Consultant

Long-term Care

- Assisted the Alabama Medicaid Agency with developing a timeline for the Integrated Care Network (ICN) implementation activities, which will be used in the roll-out of the ICN program.
- Assisted the Centers for Medicaid and Medicare Services (CMS) with creating training materials for states developing Home and Community- Based Services (HCBS) 1915(c) waiver programs.

Other Relevant Experience

- Served as Project Manager for a consulting engagement to recommend best practices and Wholesale Acquisition Cost (WAC) for Agile Therapeutics product market entry. Provided a financial model that considers market insights, Patient Protection and Affordable Care Act (ACA) impact, and payer access.
- Designed and managed public health programs for women and children in inner-city Philadelphia. Provided health education and advocacy services for people with limited resources.
- Conducted community needs assessment and quality improvement for student-led free clinics. Trained medical students in patient advocacy and cultural competence.
- Organized health and dental camps for checkups, eye exams, and teeth extractions for over 100 children and elderly in remote areas of Nepal.
- Volunteered as a Care Coordinator in a free clinic, helping patients set up appointments. Assisted with Spanish medical translation for doctors and patients.

Work History

Senior Consultant, Navigant Consulting, Inc.	2017 – Present
Consultant, Navigant Consulting, Inc.	2014 – 2017
President and Founder, Drexel CHAMPS	2014 – 2015
Foundation Member, Daya Foundation Nepal	2013 – Present

Certifications, Memberships, and Awards

Member of American Public Health Association

2016 September Healthcare Heartbeat Community Award

2015 Public Health Practice Award

Education

Master of Public Health, Health Management and Policy	Drexel University
Bachelor of Science, Business Administration	University of Mary Washington
Minor in Business Spanish	Equatorialis University

NAVIGANT

Julie Saha, MPH

Consultant

julie.saha@navigant.com
Chicago, Illinois
Direct: 312.583.2165

Professional Summary

Julie Saha is a Consultant within Navigant's Government Healthcare Solutions practice. She has more than two years of experience working with state Medicaid agencies and has assisted state Medicaid agencies with conducting both policy and quantitative analysis used to improve and transform government programs and payment structures.

Areas of Expertise

- Analysis of healthcare policy issues and development of reports and issue briefs.
- Analysis of Medicaid payment methodologies and rate reimbursement levels in the context of consistency with Federal requirements and sufficiency of access and quality.
- Assisting with strategic planning, design, implementation, operation, and evaluation of healthcare delivery systems and healthcare reform options.
- Researching Medicare, state, and other websites for regulatory information and healthcare-related databases.

Professional Experience

Medicaid Performance Management

- Evaluated Wyoming Medicaid's Section 1115 family planning demonstration. Developed quarterly and annual reports for submission to the Centers for Medicare and Medicaid Services (CMS), which include information on service utilization, expenditures, and budget neutrality.

Medicaid Managed Care

- Assisted the State of Iowa with implementation of its Medicaid managed care program, IA Health Link. Conducted readiness reviews for four managed care organizations to assess their operational readiness to begin serving members. Reviewed draft Managed Care Organization (MCO) provider agreements to confirm that the Iowa contract is comprehensive.

Government Payment Transformation

- Assisted in evaluating cost report data submitted by Psychiatric Residential Treatment Facilities (PRTFs), Residential Treatment Centers (RTCs), group homes, and Board of Cooperative Education

NAVIGANT

Julie Saha, MPH

Consultant

Services (BOCES) facilities which treat Wyoming Medicaid clients and clients of the Departments of Family Services and Education of Wyoming. Assisting with the monitoring and tracking of data submitted by these facilities in addition to identifying and communicating any issues.

- Assisted in assessing current payment method for Wyoming Medicaid to determine possible impact of modifying the State's payment rules for crossover claims from dual eligible Medicaid beneficiaries. Performed a Lower of Logic analysis to estimate potential saving that could be generated over a two-year period by modifying the allowed amounts paid on crossover claims.

- Provided support and analysis to the WDH to compare current Wyoming Medicaid payment rates and methodologies for hospital, professional, pharmacy, community-based, ambulance, emergency transportation, durable medical equipment, prosthetic, orthotic and supply (DMEPOS), developmental centers, hospice, home health, and other providers to ensure that Wyoming Medicaid is paying for services in a reasonable manner and at comparable rates to Medicare and other states in the same geographic region.

- Currently evaluating cost report data submitted by facilities which treat Wyoming Medicaid clients in combination with inpatient and outpatient claims data to determine the levels of Qualified Rate Adjustment (QRA) payments which will be available to Wyoming providers in SFY 2018.

- Assisted WDH with clinic services UPL demonstrations required by the Centers for Medicaid and Medicare Services (CMS).

Long-term Care

- Assisted in researching and preparing reports for assisted living, adult family home, and nursing facility services for the Washington State Department of Social and Health Services (DSHS). The purpose of these reports was to describe and analyze the current Medicaid payment methodology for these services as well as to evaluate whether payment levels were consistent with Federal requirements that specify payments must consistent with efficiency, economy, and quality of care and are sufficient to ensure access to services. Assisted with researching and gathering data, completing payment-to-cost analyses, analyzing results, and completing the reports for these services.

Litigation Services

- Performed literature research and data collection in order to deliver a report of opinion. The report supported a state attorney general with an evaluation of the reasonableness of proposed reimbursement rates for home health services.

NAVIGANT

Julie Saha, MPH

Consultant

Other Relevant Experience

- Conducted research on health care reform for the Christopher & Dana Reeve Foundation and the Diabetes Hands Foundation and provided strategic guidance that strengthened their policy priorities.
- Provided insights and strategy support for a policy change brief on curbing sugar sweetened beverage consumption.

Work History

Consultant, Navigant	2015 – Present
Health Policy Intern, HCM Strategists	2014 – 2014
Chronic Disease Projects Intern, The National Association of County and City Health Officials (NACCHO)	2013 – 2013
Community Health Worker (AmeriCorps), Santa Maria Community Services	2011 – 2012

Certifications, Memberships, and Awards

The Black Public Health Student Network

Health Policy Scholar

Education

Master of Public Health, Health Policy	George Washington University Milliken Institute School of Public Health
Bachelor of Science, Marketing	Ohio State University
Bachelor of Arts, Psychology	Ohio State University

Selected Recent Presentations and Publications

- "*Physicians' and Hospitals' Varied Responses to Changes in Medicare Payment: Findings from HCFO Research." Changes in Healthcare Financing & Organization.* August 13, 2014.

NAVIGANT

Scott Mackie

Senior Consultant

scott.mackie@navigant.com
Chicago, Illinois
Direct: 312.583.3714

Professional Summary

Scott Mackie is a Senior Consultant with Navigant's Government Healthcare Solutions business unit. He has nearly four years of experience working with state Medicaid agencies. He has experience researching healthcare trends related to government payment transformation and supporting large program implementations. He has conducted organizational assessments of Medicaid programs to improve critical processes to improve the delivery of services. He has also helped develop quality incentive programs aimed at providers and payers, based on research of best practices across the nation. In addition, he has experience evaluating health plan operations, along with an in-depth understanding of how operations relate to the prevention of fraud, waste, and abuse (FWA).

Areas of Expertise

- Operational assessments of Medicaid programs, focusing on internal and external-facing processes
- Development of Medicaid Long-Term Care programs and payments systems
- Analysis of Medicaid funding and payment mechanisms
- Optimization of FWA prevention and detection units in both the public and private sector
- Proficient in Microsoft Office programs such as Excel and Access, as well as SPSS software

Professional Experience

Government Payment Transformation

- Currently assisting Alabama in the implementation of provider-sponsored Medicaid Managed Long-term Care Organizations, "Integrated Care Networks." Coordinated with stakeholders to design the Quality Incentive Program. Facilitated discussions with stakeholders to selected the most appropriate clinical, long-term care, and home- and community-based services quality domains and measures. Formulated the payment methodology to incentivize performance in the selected quality domains. Conducted national best practice research to establish the benchmarks and target goals for the Quality Incentive Program.

NAVIGANT

Scott Mackie

Senior Consultant

- Created a report at the request of the Florida legislature to redesign the State's Medicaid nursing home reimbursement methodology. Proposed a new payment structure to transition the state from a retrospective cost-based system to a prospective price-based system. The report outlined a methodology to disburse $3.5 billion, the current size of the Florida Medicaid nursing facility reimbursement program. Utilized provider cost report data, CMS Nursing Home Compare data, and Minimum Data Set data to design a quality program that created incentives tied to a variety of structure, process, and outcome long-term care quality measures. Conducted meetings with many stakeholder groups across the State to provide updates and request feedback on the new payment methodology. Prepared a final report that Navigant presented to the Florida legislature.

- Created a report at the request of the Centers for Medicare and Medicaid Services (CMS) to do a complete review of the State of Florida's current provider payment and financing system. The study focused on healthcare providers that contribute to and receive funds through Florida's Low Income Pool (LIP) program which offered $2.1 billion in supplemental payments to hospitals and clinics in state fiscal year 2015. The LIP program supplemental payments were designed to reimburse hospitals for Medicaid shortfall and for care of the uninsured and under-insured. Analyzed the adequacy of current payment levels as well as the adequacy, equity, accountability, and sustainability of the State's funding for these payments. Proposed recommendations for the state that would reduce their dependence on intergovernmental transfers and help the transition to statewide Medicaid managed care. With $2.1 billion at risk, Florida used the recommendations outlined in the report and CMS granted an extension of their 1115 waiver.

- Assisted Wyoming in its annual calculations of disproportionate share hospital payments to eligible hospitals and Qualified Rate Adjustment (QRA) analysis. Assisted in the development of a revised approach to calculating the annual Wyoming Disproportionate Share Hospital (DSH) payments to enable Wyoming to use most of its available DSH funds and to minimize administrative resources for both the State and hospitals.

Federal Initiatives

- For a project providing Technical Assistance CMS for the 24 new health insurance Consumer Operated and Oriented Plans (CO-OPs), created as a provision of the Affordable Care Act, developed market research reports to inform CO-OPs of recent healthcare trends within each state, along with competitor analysis and health reform updates. Conducted site-visits to the CO-OPs to assess operations and determine the long-term viability and financial sustainability. Moderated weekly calls between CMS officials and the executives of each individual CO-OP to discuss progress, milestone completion, and potential issues / challenges. Developed regular reports to keep team up-to-date on health reform developments. Created summary material circulated throughout CMS on CO-OP progress and accomplishments.

NAVIGANT

Scott Mackie

Senior Consultant

- As a part of the CO-OP project, developed a manual for the CO-OP to use as a framework to protect against FWA committed by providers, members, or brokers. Determined effective strategies to improve compliance functions related to FWA. Provided data analytic solutions to aid in the prevention and detection of FWA, along with program metrics to determine the effectiveness of the CO-OP's FWA unit.

Medicaid Performance Management

- Conducted an in-depth organizational assessment of the Texas Office of Inspector General (OIG) to improve critical processes related to preventing FWA within the Texas health and human services system. Performed an evaluation of the current functional areas by conducting interviews and gathering pertinent documentation of policies and procedures across the agency. Conducted targeted research to identify best practices in key states of interest to help inform our assessment. Provided key recommendations to increase the agency's return on investment, focused on improving OIG's organization structure, inter / intra-agency collaboration and communication, oversight, and monitoring of the State's managed care organizations (MCOs) and data and technology capabilities.

- Analyzed data from all MCOs in the state of Vermont, on behalf of the Vermont Department of Financial Regulation, to determine compliance with state regulations. Benchmarking program quality and patient outcomes to historic MCO, regional, and national measures, including Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and Healthcare Effectiveness Data and Information Set (HEDIS) measures to identify opportunities for improvement and quality progression for each MCO.

Work History

Senior Consultant, Navigant — 2014 – Present

Education

Bachelor of Arts in Cognitive Science, Case Western Reserve University
Minors in Business Management and Marketing.

NAVIGANT

Gage Kaefring

Consultant

gage.kaefring@navigant.com
Seattle, Washington
Direct: 206.292.4051

Professional Summary

Gage Kaefring is a Consultant with Navigant's Government Healthcare Solutions practice. He has more than two years of experience working with state Medicaid agencies and assists Medicaid agencies with payment transformation projects, including incentivizing efficient and qualify patient care through payment, reducing preventable readmissions, and identifying populations and socioeconomic factors related to better care opportunities. His experience also includes optimizing funding sources across multiple programs and conducting inpatient and outpatient hospital payment modeling.

Areas of Expertise

- Enhanced Federal funding mechanisms for Medicaid services, such as; Certified Public Expenditures (CPEs), provider assessment programs, and inter-governmental transfers (IGTs)
- Analysis using 3M Core Grouping Software (CGS), including Potentially Preventable Readmissions (PPRs) and Clinical Risk Groups (CRGs)
- Medicaid supplemental payment programs, including the determination of provider costs and average commercial rates used as the basis for Upper Payment Limit (UPL) calculations
- SAS data analysis and presentation

Professional Experience

Government Payment Transformation

- Assisting the Washington State Health Care Authority (HCA) with its hospital readmissions policy using 3M's Potentially Preventable Readmissions (PPRs) software to measure readmission rates as one of the key inpatient healthcare outcomes. Assisted with analysis of socioeconomic factors to determine potential variables impact readmissions rates. Additionally, assisted with individual provider hospital reports to provide actionable data to help hospitals reduce preventable readmissions.

- Assisted Washington (HCA) with annual updates to its hospital safety net assessment program. Calculated the assessment owed by each individual provider using Medicaid days, solved for the assessment rates necessary to collect target proceeds and determined the distribution of assessment payments for both fee-for-service and managed care by provider type. Assisted with CMS required

demonstrations needed for Federal approval, including a redistributions test, hold harmless demonstration, and hospital UPL analyses.

- Assisting the Washington HCA with monitoring the budget neutrality of its Medicaid inpatient and outpatient hospital prospective payment systems. For inpatient hospital services, assisted with updates to the State's All Patient Refined Diagnosis Related Group (APR-DRG)-based system, and for outpatient services, assisted with updates to the Enhanced Ambulatory Patient Grouping (EAPG) system. Utilized SAS-based payment simulation models to measure payment changes under the current systems relative to the legacy payment methodologies, and determined payment increases due to improvements in provider documentation, coding, and the migration from ICD-9 to ICD-10.

- Assisted with annual updates to the professional services supplemental payment (PSSP) program through Washington State Medicaid for the University of Washington Medicine and other Washington Public Hospital Districts, in cooperation with the Washington State Health Care Authority. Constructed professional services UPL analysis, as required by Centers for Medicare and Medicaid Services (CMS), to implement the payment program. Collected provider commercial payment data, constructed a master commercial fee schedule, and applied weighted average commercial rates to Medicaid claims data to simulate payments under commercial rates.

- Assisted the State of Minnesota with rebasing its inpatient APR-DRG system, covering multiple inpatient provider types including acute care, rehabilitation hospitals, critical access hospitals, and long-term service providers. Constructed baseline analytical claims dataset based on inpatient paid claims data, used in determining the impact of the new APR-DRG payment system and assisted with an inpatient hospital UPL demonstration.

- Assisted the Wisconsin Department of Health Services (DHS) with its Medicaid fee-for-service inpatient and outpatient hospital prospective payment systems, hospital assessment program, Disproportionate Share Hospital (DSH payment methodology and UPL demonstrations). For inpatient hospital services, assisted with updates to the DRG payment system, and for outpatient, assisted with updates to its EAPG payment system (combined value of over $1 billion in payments).

- Assisted the Illinois' Department of Health and Family Services (HFS) with the design and implementation of eligibility requirements based on assessment of short- and long-term health opportunities in population health, healthcare outcomes, and total medical expenditures in the Illinois Medicaid Health Home program. Implementing program evaluation methodologies to assess the impact of the program and to identify opportunities for generating more positive outcomes using 3M's Clinical Grouping Software to identify PPRs.

NAVIGANT

Gage Kaefring

Consultant

Work History

Consultant, Navigant	2015 – Present
Business Analyst, Target Corporation	2013 – 2015

Education

Bachelor of Science – Marketing and International Business	University of Minnesota

Appendix C Schedule of Proposed Contract Exceptions / Revisions

Please see the following pages for our Schedule of Proposed Contract Exceptions / Revisions.

[Remainder of page intentionally left blank.]

SCHEDULE OF PROPOSED CONTRACT EXCEPTIONS/REVISONS

Navigant Consulting, Inc. respectfully requests that the State of West Virginia consider the following contract exceptions/revisions to the General Terms and Conditions of the RFQ for Medicaid Managed Care Rate Setting/Program Admin:

1. **Please revise Section 8 (Insurance)** by revising the Professional/Malpractice/Errors and Omissions Insurance to an amount of $1,000,000 per occurrence. Please also revise Commercial Crime and Third Party Fidelity Insurance to $1,000,000 per occurrence.

2. **Please delete Section 10 (Litigation Bond).**

3. **Please insert the following language into Section 19 (Cancellation):** Vendor reserves the right to terminate this Contract upon thirty (30) days written notice to the Purchasing Division Director. Upon termination or cancellation for any reason, the State shall pay Vendor for any fees and expenses incurred up to and including the date of effective date of termination or cancellation.

4. **Please include the following language in Section 37 (Indemnification):**

   Notwithstanding the terms of any other provision, the total liability of Vendor and its affiliates, directors, officers, employees, subcontractors, agents and representatives (collectively the "Vendor") for all claims of any kind arising out of this Agreement, whether in contract, tort or otherwise, shall be limited to the total fees paid to Vendor under the Contract in the preceding 12 months. Neither Vendor nor State shall in any event be liable for any indirect, consequential or punitive damages, even if the State or Vendor have been advised of the possibility of such damages. No action, regardless of form, arising out of or relating to this Agreement, may be brought by either party more than one year after the cause of action has accrued, except an action for non-payment may be brought within one year following the date of the last payment due under this Agreement. Vendor shall not be liable for any loss or destruction of any valuable documents provided to Vendor. State shall be responsible for insuring such documents against loss and destruction.

5. **Please revise Section 40 (Conflict of Interest) as follows:**

   Based on Vendor's conflict check procedure, Vendor is not aware of circumstances that constitute a conflict of interest or that would otherwise impair Vendor's ability to provide objective assistance. Vendor's determination of conflicts is based primarily on the substance of its work and not the parties involved. Vendor is a large consulting company that is engaged by many companies and individuals. Vendor may have in the past represented, may currently represent or may in the future represent other clients whose interests may have been, may currently be or may become adverse to State in litigation, transactions, or other matters (collectively "Other Clients"). Therefore as a condition to Vendor's undertaking to provide the Services to the State, State agrees that Vendor may continue to represent, and in the future may represent Other Clients provided however that Vendor agrees that it will not accept retentions by Other Clients that would be adverse to State in the same legal proceeding on the factual matters that are the subject matter of an engagement set forth under the applicable Contract.

Notwithstanding any other provisions herein, State agrees and acknowledges that Vendor is not restricted in any way from providing eDiscovery services to Other Clients.

6. **Please include the following provision regarding third party requests:**

   If access to any of the materials and information in Vendor's possession relating to this Agreement are sought by a third party, or any of its professionals are requested or compelled to testify as a fact witness in any legal proceeding related to this Agreement, by subpoena or otherwise, or it is made a party to any litigation related to this Agreement, Vendor will promptly notify State of such action, and either tender to State its defense responding to such request and cooperate with State concerning Vendor's response thereto or retain counsel for its defense. In such event, State shall compensate Vendor at its standard billing rates for its professional fees and reimburse Vendor's expenses, including reasonable attorneys' fees (internal and external), involved in responding to such action.

7. **Please include the following provision regarding intellectual property:**

   Upon full payment of all amounts due Vendor in connection with this Contract, all rights, title and interest in any information and items, including summaries, documents, reports and portions thereof it provides to State (the "Vendor Deliverables") will become State's sole and exclusive property for use in connection with the professional services set forth in this Agreement, subject to the exceptions set forth below. Vendor shall retain sole and exclusive ownership of all rights, title and interest in its work papers, proprietary information, processes, methodologies, know-how and software, including such information as existed prior to the delivery of the Services and, to the extent such information is of general application, anything that it may discover, create or develop during provision of the Services ("Vendor Property"). To the extent the Vendor Deliverables contain Vendor Property; State is granted a non-exclusive, non-assignable, royalty-free license to use it in connection with the subject of this Agreement. Without the prior written consent of Vendor, in no event shall Vendor's name be mentioned nor shall Vendor Deliverables be disclosed, referenced, used in connection with any offering documents or shared with any third party, except (a) as required by law; (b) as required by any government or regulatory agency with supervisory authority over State; and (c) State's legal advisors and auditors. It is strictly prohibited for the Vendor Deliverables to be disclosed, referenced, filed, or distributed in connection with the purchase or sale of securities, and in connection with any financing or business transaction.

8. **Please include the following provisions applicable to the actuarial services performed under the Contract:**

   (a) Reliance on State and Third Party Data and Work Product – The data and information provided by State to Vendor in furtherance of its performance of the services hereunder and creation of the deliverables hereunder shall be considered "as is" and Vendor will not validate or confirm the accuracy of the data and information provided. State agrees and acknowledges that while material defects in the data or information provided may be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent, this type of detailed, systematic review is beyond the scope of Vendor's work and responsibilities under this Contract. It is further understood that Vendor may be reviewing work product prepared by parties

other than Vendor on behalf of State, and accordingly, State agrees to hold harmless and indemnify Vendor for all claims, damages, demands, liability and costs (including attorney fees as incurred) arising from negligent acts, errors and omissions of the parties who prepared such work product.

(b) Reliance on Projections – State agrees that the actual results may vary from the Vendor projections for many reasons including but not limited to differences from assumptions regarding provider fee schedules, the effectiveness of health care management and other cost savings programs such as fraud detection, as well as other random and non-random factors. Vendor shall have no continuing obligation to update its work product or any projections contained therein or monitor for modifications to rates or changes to cost savings programs after completion of its Services to State.

(c) Actuarial Services Disclaimer – It is acknowledged that Vendor will not be rendering an actuarial opinion nor is Vendor required to have a credentialed actuary to perform the services hereunder. Although Vendor personnel performing services under this Agreement are credentialed actuaries and are members of the American Academy of Actuaries, the services performed hereunder are not services that require the skills of a credentialed actuary, and the deliverables provided pursuant to this Agreement are not actuarial opinions.

Appendix D Required Forms

Please see the following pages for executed versions of the following required forms:

- Designated Contact Certification
- Addendum Acknowledgement Form
- Purchasing Affidavit
- Vendor Preference Certificate
- Ethics Disclosure Form

[Remainder of page intentionally left blank.]

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.

Anne Jacobs
(Name, Title)
Anne Jacobs, Managing Director
(Printed Name and Title)
1200 19th Street NW, Suite 700, Washington, DC 20036
(Address)
Ph: 202.973.3124, F: 202.973.2401
(Phone Number) / (Fax Number)
ajacobs@navigant.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.

Navigant Consulting, Inc.
(Company)

Anne Jacobs
(Authorized Signature) (Representative Name, Title)

Anne Jacobs, Managing Director
(Printed Name and Title of Authorized Representative)

10/30/17
(Date)

Ph: 202.973.3124, F: 202.973.2401
(Phone Number) (Fax Number)

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFQ 0511 BMS1800000002

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

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

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

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

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

Navigant Consulting, Inc.
Company

Anne Jacobs
Authorized Signature

10/30/17
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: Navigant Consulting, Inc.

Authorized Signature: Anne Jacobs Date: 10/30/17

State of Illinois

County of Cook, to-wit:

Taken, subscribed, and sworn to before me this 30th day of October, 20__.

My Commission expires 10/7, 2018.

AFFIX SEAL HERE

OFFICIAL SEAL
JULIA A TERESI
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:10/07/18

NOTARY PUBLIC Julia A Teresi

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 v…our (4) years immediately preceding the date of this certification;

☐ Bidder is a partnership, associat… headquarters or principal place of business continuously in West …e of this certification;

☐ Bidder is a resident vendor pa…nty percent of ownership interest of bidder held by another entit…ement; **or,**

☐ Bidder is a nonresident vendor w…um of one hundred state residents and which has maintained its h…rginia continuously for the four (4) years immediately preceding th…

2. **Application is made for 2.5%…**

☐ Bidder is a resident vendor wh…e at least 75% of the employees working on the project being bi…tate continuously for the two years immediately preceding submis…

3. **Application is made for 2.5%…**

☐ Bidder is a nonresident vendor…s, or a nonresident vendor which has an affiliate or subsidiary w…usiness within West Virginia and employs a minimum of one hu…r distributing the commodities or completing the project which i…the entire term of the project, on average at least seventy-five p…'s or subsidiary's employees are residents of West Virginia wh…diately preceding years and the vendor's bid; **or,**

Not Applicable to Navigant

4. **Application is made for 5% v…**

☐ Bidder meets either the require…nd (3) as stated above; **or,**

5. **Application is made for 3.5%… checked:**

☐ Bidder is an individual resident v…the reserves or the National Guard and has resided in West Virgi…ding the date on which the bid is submitted; **or,**

6. **Application is made for 3.5%… checked:**

☐ Bidder is a resident vendor wh…erves or the National Guard, if, for purposes of producing or distri…the subject of the vendor's bid and continuously over the entire ter…nt of the vendor's employees are residents of West Virginia who …liately preceding years.

7. **Application is made for pref…rity-owned business, in accordance with *West Virginia Co…* §5A-3-59 and West Virginia Code of State Rules.**

☐ Bidder has been or expects to …e 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: Navigant Consulting, Inc. **Signed:** Anne Jacobs

Date: 10/30/17 **Title:** Managing Director

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

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

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

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

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

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

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

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

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

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

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

Contracting business entity: Navigant Consulting, Inc.

Address: 1200 19th Street NW, Suite 700, Washington, DC 20036

Contracting business entity's authorized agent: Anne Jacobs

Address: 1200 19th Street NW, Suite 700, Washington, DC 20036

Number or title of contract: CRFQ 0511 BMS 1800000002

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

Governmental agency awarding contract: West Virginia Department of Health and Human Resources The Bureau for Medical Services

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

Navigant Consulting, Inc.

Milliman, Inc.

Signature: Anne Jacobs Date Signed: 10/30/17

☐ Check here if this is a Supplemental Disclosure.

Verification

State of Illinois, County of Cook:

I, Anne Jacobs, 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.

OFFICIAL SEAL
JULIA A TERESI
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:10/07/18

Julia A. Teresi
Notary Public's Signature

To be completed by State Agency:

Date Received by State Agency: _____

Date submitted to Ethics Commission: _____

Governmental agency submitting Disclosure: _____

NAVIGANT

Proposal for:

Medicaid Managed Care Rate Setting and Medicaid Managed Care Program Administration

Presented to:

West Virginia Purchasing Division, on behalf of
West Virginia Department of Health and Human Resources
The Bureau for Medical Services
2019 Washington Street East
Charleston, West Virginia 25305-0130

Cost Proposal

October 31, 2017

Presented by:

Anne Jacobs
Managing Director
1200 19th Street NW, Suite 700
Washington, DC 20036
202.973.3124
ajacobs@navigant.com

navigant.com

Exhibit A: Pricing Page

Section Actuarial Services
Section Managed Care Oversight
Section Ad Hoc Services

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

Section A: Mandatory Services

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

Actuarial Services*

Staff by Level	# of Hours (total)	Cost Per Hour	Total Cost
Lead Actuary	2,080	300	$ 624,000.00
Staff Actuaries (4)	8,320	225	$ 1,872,000.00
Technical Support Staff (non-actuary)	2,080	175	$ 364,000.00
Clerical Support Staff	2,080	5	$ 10,400.00

*hours are estimated on a per year (2080) hours basis and subject to change. The hourly rate established for each position will carry forward throughout the life of the contract, including any optional renewals and extension awarded. Vendor is responsible for all travel costs.

Managed Care Program Oversight will be billed on a fixed annual amount divided into 12 equal monthly installments and is all-inclusive of all services outlines within that section of the RFQ.

Vendor should provide the annual cost in the higlighted box below for Managed Care Program Oversight.

Managed Care Program Oversight

Total Cost (Annual)	$ 2,107,380.00

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	129	$ 645,000.00
Actuarial Services Projects	5,000	197.14	$ 985,700.00

Total Project Cost (Sum of Actuarial Cost, Managed Care Oversight Cost, and Ad Hoc Costs):
$6,608,480.00

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.

Navigant Consulting, Inc. (Navigant)
(Company)

Anne Jacobs, Managing Director
(Representative, Name, Title)

Ph: 202.973.3124, F: 202.973.2401
(Contact Phone / Fax Number)

10/30/2017
(Date)

CENTRALIZED REQUEST FOR QUOTATION
CRFQ 0511 BMS 1800000002
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: Navigant Consulting, Inc.

Remit to Address: 4511 Paysphere Circle, Chicago, IL 60674

Phone #: 202.973.3124

Vendor Fax #: 202.973.2401

Email Address: ajacobs@navigant.com

Signature: Anne Jacobs Date: 10/30/17