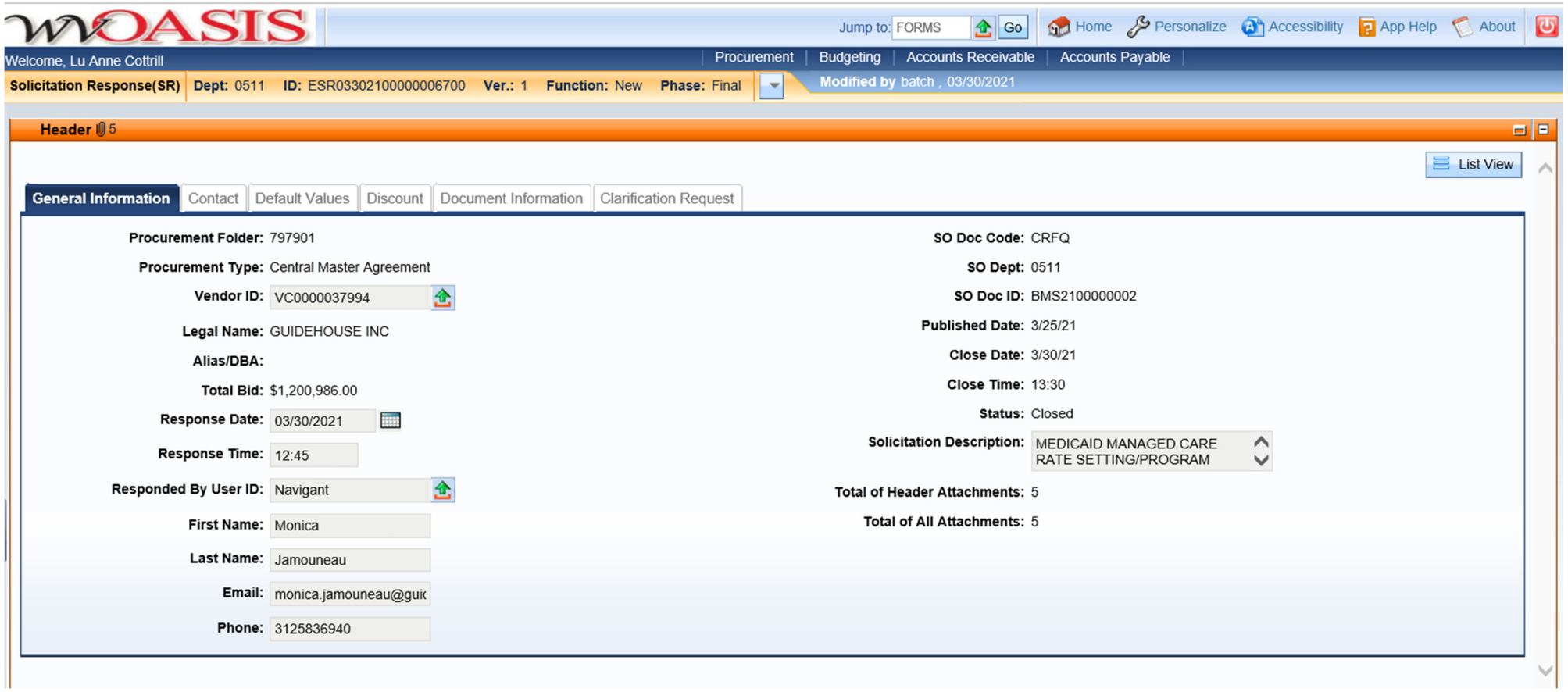
The following documentation is an electronically-submitted vendor response to an advertised solicitation from the *West Virginia Purchasing Bulletin* within the Vendor Self-Service portal at ***wvOASIS.gov***. As part of the State of West Virginia's procurement process, and to maintain the transparency 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.


OASIS
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: ESR03302100000006700 Ver.: 1 Function: New Phase: Final
Modified by batch , 03/30/2021
Header 5
List View
General Information
Contact
Default Values
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Document Information
Clarification Request
Procurement Folder: 797901
Procurement Type: Central Master Agreement
Vendor ID: VC0000037994
Legal Name: GUIDEHOUSE INC
Alias/DBA:
Total Bid: $1,200,986.00
Response Date: 03/30/2021
Response Time: 12:45
Responded By User ID: Navigant
First Name: Monica
Last Name: Jamouneau
Email: monica.jamouneau@guic
Phone: 3125836940
SO Doc Code: CRFQ
SO Dept: 0511
SO Doc ID: BMS2100000002
Published Date: 3/25/21
Close Date: 3/30/21
Close Time: 13:30
Status: Closed
Solicitation Description: MEDICAID MANAGED CARE RATE SETTING/PROGRAM
Total of Header Attachments: 5
Total of All Attachments: 5

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

State of West Virginia
Solicitation Response

Proc Folder:	797901
Solicitation Description:	MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN
Proc Type:	Central Master Agreement

Solicitation Closes	Solicitation Response	Version
2021-03-30 13:30	SR 0511 ESR03302100000006700	1

VENDOR

VC0000037994
GUIDEHOUSE INC

Solicitation Number: CRFQ 0511 BMS2100000002

Total Bid: 1200986 **Response Date:** 2021-03-30 **Response Time:** 12:45:29

Comments:

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor
Signature X **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				275.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Lead Actuary Services
$_____Per Hour X 5,000 Hours Annually

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
2	Staff Actuary Services				190.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Staff Actuary Services
$_____Per Hour X 20,000 Hours Annually

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
3	Technical Support Staff (non-actuary)				175.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Technical Support Staff (non-actuary)
$_____Per Hour X 5,000 Hours Annually

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
4	Clerical Support Staff				1.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Clerical Support Staff
$_____Per Hour X 5,000 Hours Annually

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
5	Managed Care Program Oversight Services				1200000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Managed Care Program Oversight Services Annual Cost
All-Inclusive Fixed Annual Amount (Inclusive of 12 Months)

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
6	Managed Care Oversight Ad Hoc Services				145.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Managed Care Oversight Ad Hoc Services
$____ per hour X 5,000 hours Annually

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
7	Actuarial Services Ad Hoc Services				200.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

Actuarial Services Ad Hoc Services
$____ per hour X 5,000 hours Annually

Guidehouse

Proposal for:

Medicaid Actuarial Services and Managed Care Program Administration

CRFQ BMS2100000002

Presented to:

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

Technical Proposal

March 30, 2021

Presented by:

Russell H. Ackerman, FCA, ASA, MAAA
Partner
150 North Riverside Plaza, Suite 2100
Chicago, Illinois 60606
602.698.4366
russ.ackerman@guidehouse.com

guidehouse.com

Guidehouse

March 30, 2021

Buyer: Crystal Hustead
State of West Virginia
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

RE: Medicaid Actuarial Services and Managed Care Program Administration, CRFQ BMS2100000002

Dear Ms. Hustead:

Guidehouse Inc. ("Guidehouse" or “we/us/our”) appreciates the opportunity to provide the West Virginia Department of Health and Human Resources ("Department”, "Company" or "you/your") with this proposal agreement (the “Agreement”) for Medicaid Actuarial Services and Managed Care Program Administration.

Guidehouse is pleased to have an opportunity to build upon our current, strong relationship with BMS to advance its Medicaid managed care programs. We know that a seamless approach to consulting and program operations is highly important to BMS for both efficient and effective results, and as such we continue to be fully at the service of you and your staff to most efficiently serve the State. You will see that our proposal, in combination with the work we currently perform for West Virginia, complies with all RFQ requirements and exceeds expectations in a way that uniquely positions us to continue serving the State.

It will be a privilege and a pleasure to continue to support the success of BMS in this important work to improve the health of Medicaid managed care members. Please do not hesitate to reach out if you require clarification to any of the information provided herein.

Sincerely,

Russell H. Ackerman

Russell H. Ackerman, FCA, ASA, MAAA
Partner

Table of Contents

Section 1 Executive Summary

The RFQ sets forth minimum qualifications for potential vendors, related to years of experience and required staff. For your convenience, we have provided an excerpt of RFQ requirements along with Guidehouse's demonstrated compliance in this section. **Section 2** provides additional details on our vendor qualifications, and **Section 3** describes individual staffing qualifications.

In addition, you will see that our cost proposal is in full and complete compliance with all RFQ instructions, with a rate as required for each actuarial and ad hoc category / commodity for lines 1-4 and 6-7, with a fixed fee annual amount for commodity line 5, wherein our understanding of the requirements and instructions from RFQ Section 5.2 is that vendors must complete the Pricing Page (Exhibit "A") in its entirety. We are confident you will find our proposal reflects a great value for the scope of services required and our commitment to BMS.

Addressing Pressing Health Issues with Innovative Solutions and Execution

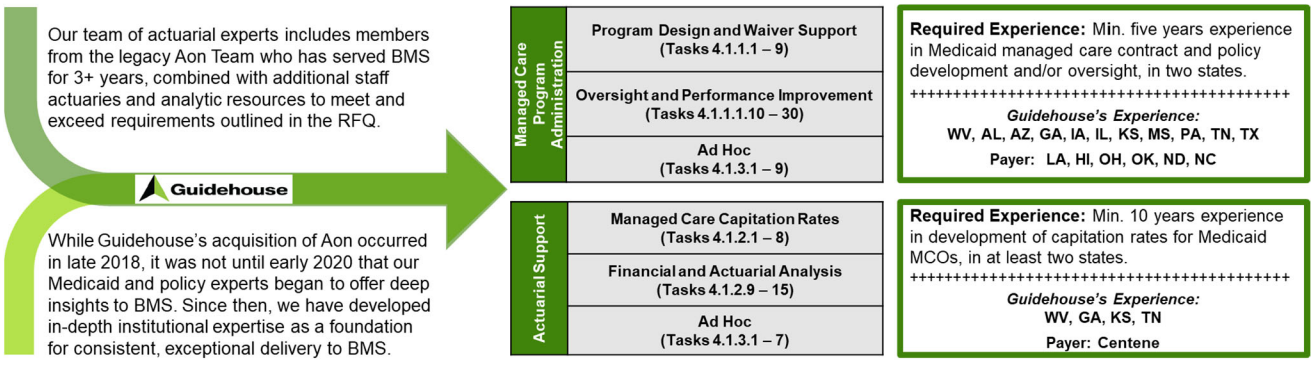
West Virginia Department of Health and Human Resources' Bureau for Medical Services (BMS) looks to build on the prior successes of the Mountain Health Trust (MHT) and Mountain Health Promise (MHP) programs. This procurement is critical for the MHT and MHP programs' future success – to build on historical successes and support BMS' aspirations for improvement. BMS has significant interest in addressing social determinants of health, health disparities and equity issues, and common chronic conditions that persist in the State due to cultural norms.

We understand that the RFQ requirements should be addressed in the context of the current and future healthcare landscape and support BMS' mission, values, and priorities. The number of issues that BMS must consider simultaneously and sequentially (constant regulatory change) can sometimes seem infinite – from basic blocking and tackling of member enrollment and provider payment to the latest hot topics such as the opioid crisis, the future of rural and critical access hospitals, and health equity. **As we execute the requirements of this RFQ and all other needs arising throughout the contract, we will advise and support BMS as it tackles these larger issues to obtain high value from its managed care platform. You have been the beneficiary of this high level of support throughout Guidehouse's current contract supporting BMS' Medicaid programs.** We are excited to continuing serving as BMS' trusted advisor and vendor.

Your Guidehouse Team: A "One-Firm" Resource

Guidehouse will build upon our strong relationship with BMS to advance its Medicaid managed care programs. **We are one of the few truly full-service Medicaid consulting firms that houses both program and policy support alongside our highly reliable and robust actuarial practice, without requiring subcontracting arrangements**. A seamless approach to consulting and program operations is highly important to BMS for efficient and effective results, and as such we continue to be fully at the service of you and your staff to best serve the State.

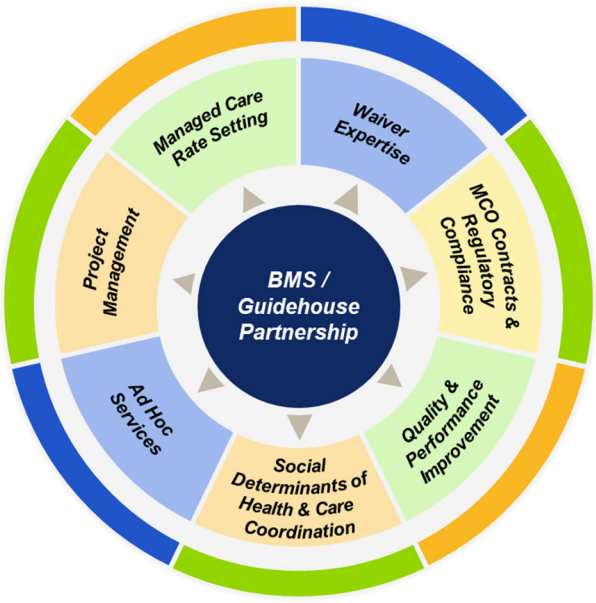
We are proud to bring you ONE firm approach to meet both your actuarial and managed care program administration needs.



Guidehouse Offers Continuity Along with a Fresh Perspective

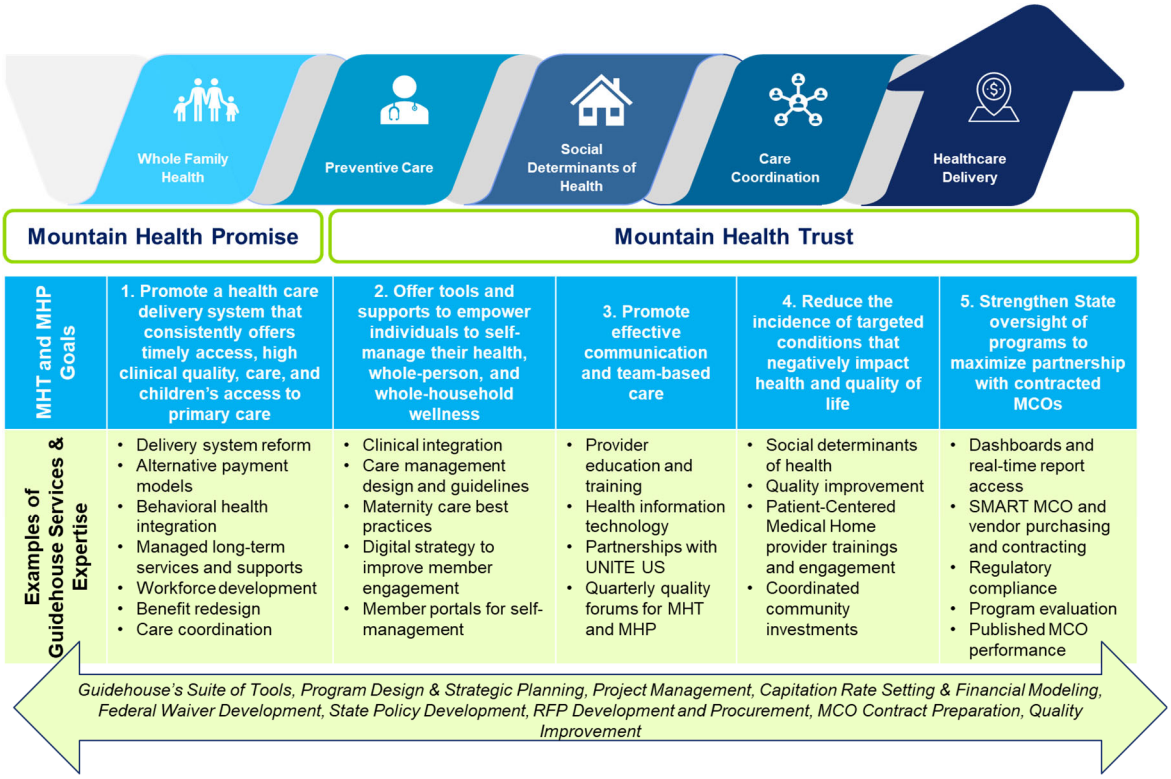
Guidehouse offers proven, consistent delivery of requested services and deliverables combined with strategic insights. Over the course of our contract, we quickly hit the ground running on MHT and MHP program administration and actuarial tasks. We are now very familiar with managed care program history, BMS team members, the State's political environment, and MCO strengths and weaknesses. We can continue supporting BMS to navigate through sensitive and challenging issues that arise and bring in national best practices.

Beyond our project management expertise, we offer meaningful and actionable takeaways to strengthen programs and services. Over the last several years, we have helped BMS with:



- **Program management:** We developed and maintain detailed work and operations plans to meet BMS' increasingly complex needs due to MHT / MHP program changes.
- **Managed care rate setting:** Our collaborative and nationally-informed approach, especially with the complexity of COVID-19 challenges, has helped BMS meet CMS requirements and achieve value from the MHT and MHP programs.
- **Waiver expertise:** Our thorough and expedient approach has put BMS on a smooth path to CMS approval.
- **MCO contracts & regulatory compliance:** We completed a Compliance Review in 2020 to help confirm that MCOs are meeting contractual and federal requirements. This review serves as the basis for continued performance improvement activities. We also prepared a number of contractual enhancements around care coordination, reporting requirements, EPSDT, and marketing to promote health outcomes and the member experience for MHT and MHP.
- **Quality and performance improvement:** We supported BMS in "refreshing" its Quality Strategy to more accurately describe BMS and WVCHIP's aspirations for managed care programs, and to resonate more strongly with stakeholders. We also enhanced and streamlined MCO reporting to drive meaningful operational improvements from MCOs.
- **Social determinants of health and care coordination:** Through the Quality Strategy and MCO Contract, we recommended meaningful enhancements to require MCOs to assess and coordinate critical services for vulnerable MHT and MHP members.
- **Ad hoc services:** Our team has been available to respond to any ad hoc issues, legislative questions, policy requests, or budgeting support – from pharmacy high-risk pools to Drug Free Moms and Babies.

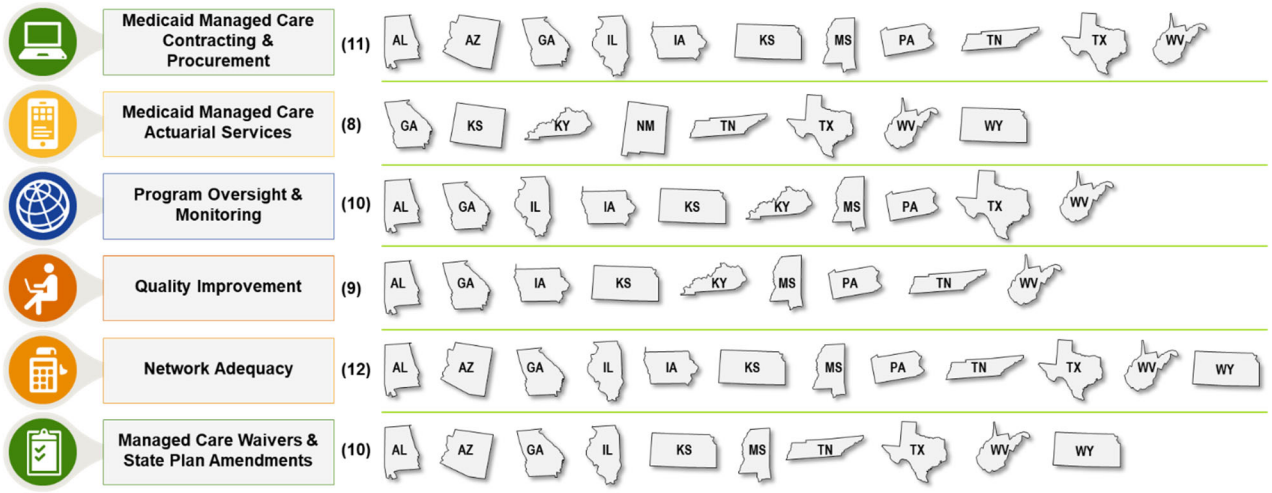
Our team is always prepared to further add value with additional services and expertise that are ready to deploy. Following we provide examples to support each of the Managed Care Quality Strategy goals identified. **We are confident that with our expertise and tools, we can help BMS re-imagine and enhance the MHT and MHP programs, all the while continuing to meet compliance-related milestones.**



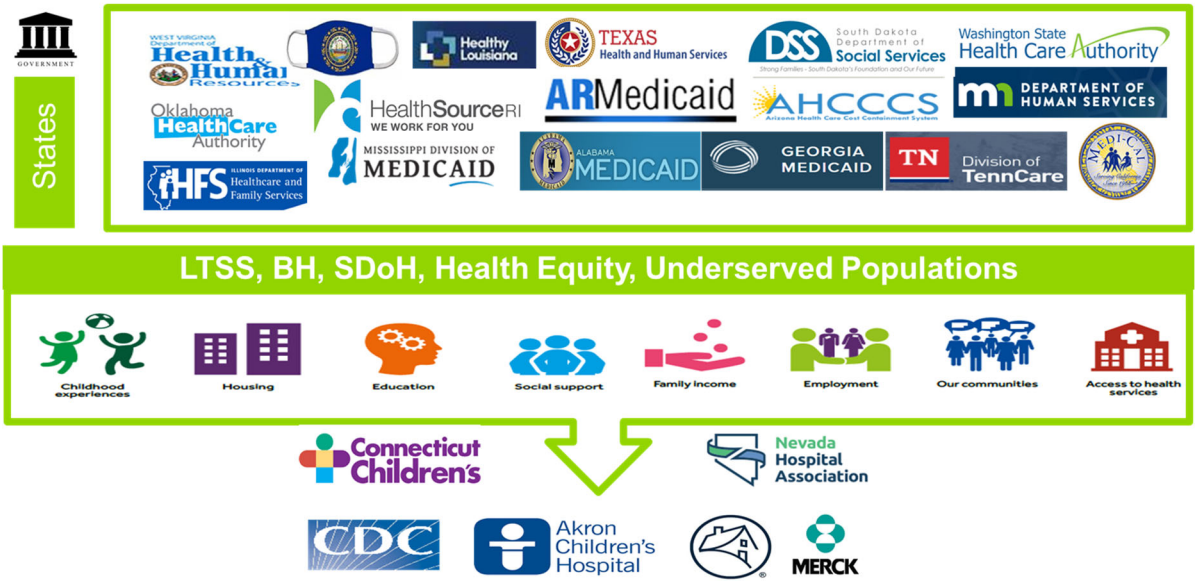
Guidehouse Brings A National Medicaid Perspective

Guidehouse is a national firm backed by a long history supporting ***states, Federal agencies, and commercial payers with similar tasks – combining our legacy knowledge of West Virginia with national best practices.***

Please see below for more detail on how Guidehouse has more than 10 years of experience in developing capitation rates for Medicaid MCOs and over five years of experience in Medicaid managed care contract and policy development and/or oversight. **Appendix D** lists Guidehouse proven tools we have developed based on our experience in other states. These tools are ready for deployment to support the MHT and MHP programs.



On any issue that BMS faces, we can draw upon our more than 1,000 healthcare consultants to provide the required subject matter expertise. Following is a sample of our national client base that BMS will have insights from as we execute on BMS' priorities.



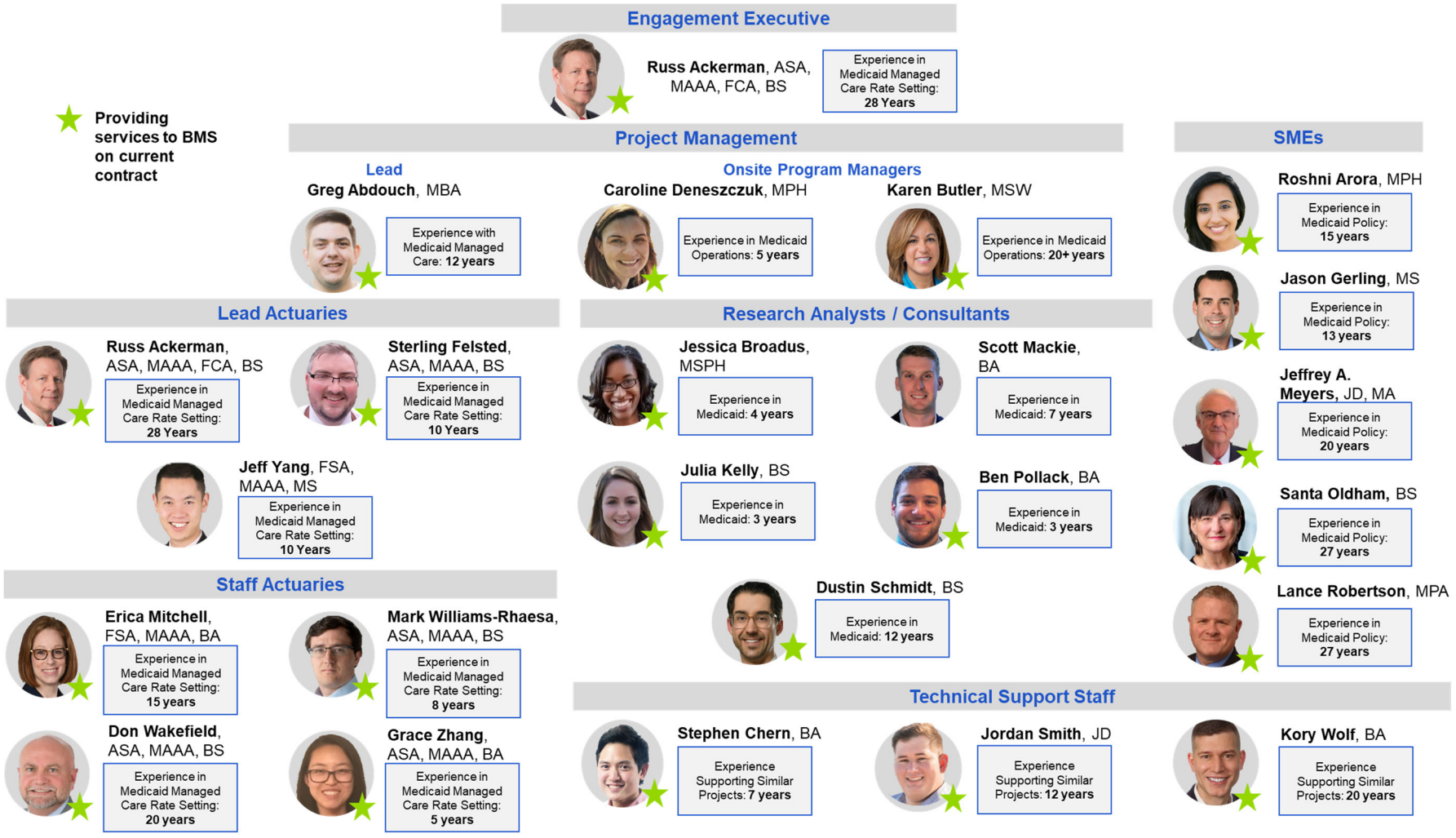
Your Guidehouse Team Meets and Exceeds All Required Staffing Requirements

Guidehouse's team includes many familiar names and faces that you are already used to working with, along with some additional team members who have experience supporting other state Medicaid agencies. As COVID-19 continues to wane, we look forward to considerably more on-site presence in Charleston by Caroline Deneszczuk and Karen Butler, both proposed as On-Site Program Managers. On our team is also Jordan Smith, who resides in Kenna, West Virginia, which is a short 25-minute drive to Charleston. We also plan for our larger proposed team to be in Charleston more regularly to work directly with the BMS team.

Our team includes seasoned experts such as **Russ Ackerman** (actuarial and financial), **Roshni Arora** (managed care and quality), **Jason Gerling** (MLTSS and behavioral health), **Jeff Meyers** (former Medicaid Director for New Hampshire), and **Lance Robertson** (former U.S. Assistant Secretary for Aging at Health and Human Services' Administration on Community Living) – all of whom are proposed as Lead Actuary and Medicaid Policy Subject Matter Experts. On any issue that BMS faces, we can draw upon our more than 1,000 healthcare consultants to provide the required subject matter expertise.

Please see the following **Figure 1** for more detail on how our team meets all RFQ staffing requirements.

Figure 1. Guidehouse Team Structure and High-Level Qualifications



Section 2 Vendor Qualification and References

Guidehouse is a leading global provider of consulting services to the public and commercial markets with broad capabilities in management, technology, and risk consulting. In addition to the Medicaid consulting we provide to State agencies and programs, we help clients address their toughest challenges with a focus on markets and clients facing transformational change, technology-driven innovation, and significant regulatory pressure.

Across a range of advisory, consulting, outsourcing, and technology / analytics services, we help clients create scalable, innovative solutions that prepare them for future growth and success. Headquartered in Washington DC, the company has more than 7,000 professionals in more than 50 locations. Guidehouse is led by seasoned professionals with proven and diverse expertise in traditional and emerging technologies, markets and agenda-setting issues driving national and global economies. For more information, please visit: www.guidehouse.com.

Our Government Team focuses on the challenges state government agencies and federal agencies face in administering and overseeing publicly financed healthcare systems. Our teams are positioned to address both state and federal challenges and to provide tailored, practical solutions to bridge the gap between these two critical players. **Figure 2** below shows examples of our team members, programs, and services. West Virginia will benefit from a diverse set of perspectives; our staff includes former public health leadership, Medicaid leadership, social services agency leadership, CMS leadership, and managed care and provider leadership.

Figure 2. Examples of Guidehouse's Experience and Services

In the following sections, we detail our specific experience related to all subject areas of this RFQ.

Managed Care Program Administration Qualifications

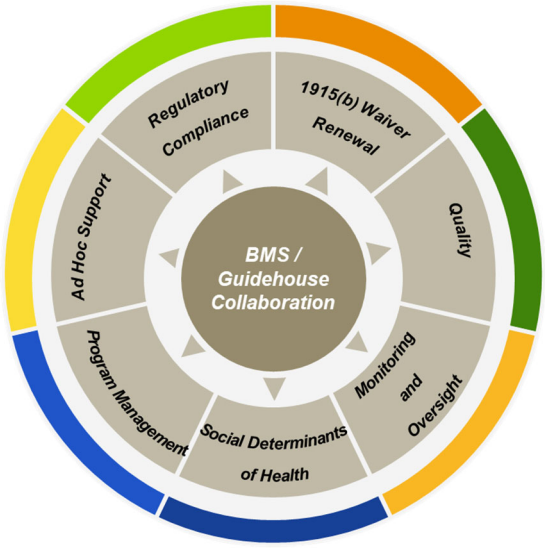
Guidehouse has been assisting states Medicaid managed care program administration and oversight for more than 25 years – we have experience with Medicaid programs in more than 45 states. We work with states on Medicaid managed care program planning and implementation, contract and procurement development, monitoring and oversight, quality management, and program evaluation. In this section, we present our experience that **meets and exceeds the minimum RFQ requirement to have at least five years of experience** in providing Medicaid managed care in Medicaid managed care contract and policy development and/or oversight as the prime contractor across numerous states.

Additionally, Guidehouse regularly works with states to help them understand and comply with Federal regulations, policies, and recent or proposed legislative changes. Guidehouse 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, as many have worked in executive positions within various state governments and in top leadership and operational positions within health plans. Finally, **Appendix D** lists Guidehouse proven tools we have developed based on our experience in other states. These tools are ready for deployment to support the MHT and MHP programs.

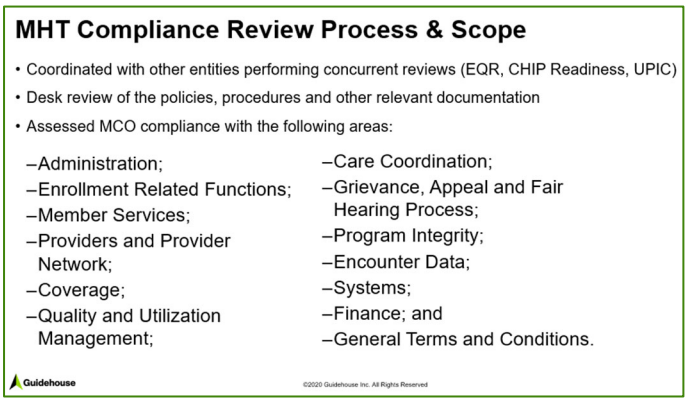
Our Work with West Virginia to Provide Program Administration Services

Since 2018, our Guidehouse team has worked with BMS to oversee, manage, and enhance the State's MHT and MHP managed care programs, initially focusing on actuarial services and currently for all services. Throughout our tenure collaborating with BMS, Guidehouse has served as a trusted advisor and extension of BMS, helping it achieve its mission and managed care program goals. Guidehouse is supporting BMS to make an impact on and stride towards the following:

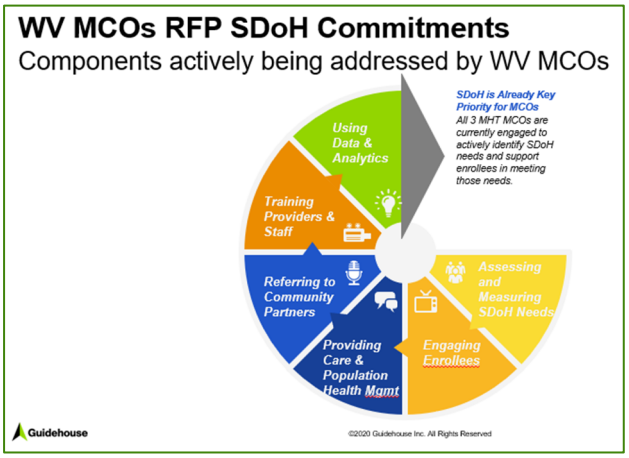


- **Strengthening Regulatory Compliance:** Guidehouse works with State staff to prepare Medicaid managed care MCO contracts and amendments, ensuring not only compliance with federal regulations and State law (e.g., 2020 Medicaid Managed Care Final Rule), but also enhancements to drive performance improvement. For example, we conducted a comprehensive review of federal managed care requirements to confirm all appropriate guidance was included in the MCO contracts. We also prepared a number of enhancements around care coordination, reporting requirements, EPSDT, and marketing to promote health outcomes and the member experience for MHT and MHP.
- **Preparing 1915(b) Waiver Renewal:** We are leveraging our waiver expertise to refresh and populate the Bureau's 1915(b) waivers granting MHT and MHP managed care authority for on-time submission to CMS on April 1, 2021. In the first quarter of 2021,

Guidehouse reviewed and revised 1915(b) waivers for the MHT and MHP programs, summarized new waiver design elements and updated the waiver responses based on policy and MCO contract changes. Guidehouse organized the waiver renewal monitoring plan and results sections for easy and streamlined CMS review and acknowledging BMS' hard work to administer and operate managed care programs responsibly.



- **Enhancing and Streamlining MCO Monitoring and Oversight:** Over the course of our current contract, we monitored and evaluated managed care expansions, including behavioral health and SSI populations, as well as, oversaw the integration of Substance Abuse Waiver, Foster Care, and Institutions for Mental Disease services under the managed care model. We are currently in the process of updating reporting dashboards so they are interactive, dynamic, and can be leveraged to improve MCO performance and make program decisions.



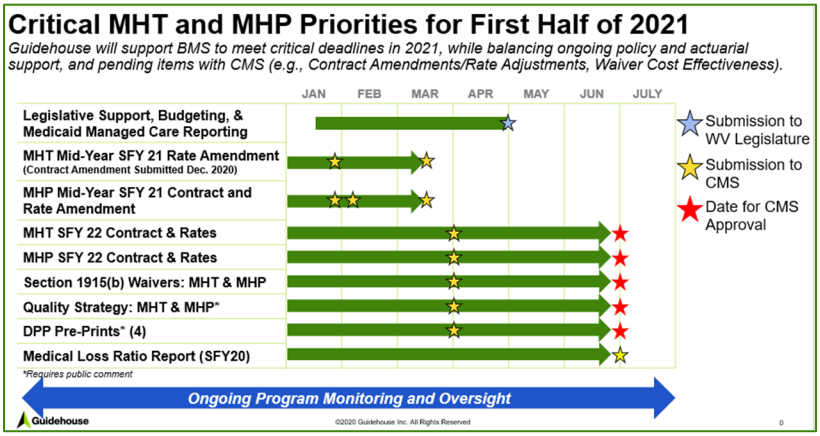
- **Promoting a Culture focused on Quality:** To accompany the 1915(b) waiver renewals to CMS, Guidehouse and BMS engaged in high-level quality discussions that:
  - Reframed the State's existing quality goals and objectives to establish actionable and aspirational goals for the State to pursue.
  - Streamline the MHT and MHP quality strategies into one comprehensive managed care quality strategy that encompasses all of the State's managed care programs (i.e., MHT, MHP and WVCHIP).
  - Address CMS comments provided on the pervious iteration of the Quality Strategy.

  The refreshed Quality Strategy was well-received by DHHR leadership and is currently under review by the public. Guidehouse is also working with BMS to establish continuous quality improvement mechanisms through the State's Directed Payment Program. Guidehouse recommended quality performance targets for participating State Directed Payment providers, as well as, assisted BMS in its communications with stakeholders (e.g., providers and associations) to further cultivate a culture across the State focused on quality improvement.

- **Enhancing Social Determinants of Health Design:** Throughout Quality Strategy and MHT and MHP contract activities, Guidehouse has strengthened the State's approach to social determinants of health (SDOH) by encouraging and incorporating SDOH into the governing documents (i.e., Quality Strategy, managed care MCO contracts, etc.) of the

managed care programs. Guidehouse has further provided access to our in-house SDOH subject matter experts to elevate the SDOH conversation at BMS's convenience.

- **Establishing Disciplined Program Management Tools and Timelines to Meet BMS Goals and CMS Expectations:** Guidehouse provided program management tools, timelines and trackers to monitor deliverable progress, establish expectations for Guidehouse and BMS, and motivate all parties to meet the expectations set by CMS for program document submission.



- **Addressing Ad Hoc Policy Issues and Provide Decision-Making Support:** As a trusted advisor, BMS has requested Guidehouse's assistance on a range of ad hoc issues include braided foster care residential rates, CMS Managed Care 2020 Rule impact summaries and recommendations, high-cost drugs, integrating the and legislative research requests regarding competitive procurement requirements.

Key Compliance-Oriented Tasks Facing BMS in 2021

Section 1115 Substance Use Disorder (SUD) Waiver Extension: BMS will need to submit an extension request for its current Section 1115 waiver. Planning must begin almost immediately to allow for appropriate program design discussion and public notice.

The current waiver not only authorizes non-Medicaid state plan behavioral health services, but also includes authority for mandatory managed care enrollment of members in the Children for Serious Emotional Disorders Waiver. BMS may also decide to include authority for mandatory managed care enrollment for additional Section 1915(c) waivers within this extension request.

***Next Generation MHT Program Design and Contracting*:** To drive increasing value from its MHT program, BMS will need to strategically plan for expanding the impact of MHT to transform health care in the State. Incorporating clinically impactful objectives such as behavioral health integration, alternative payment models, rural health access, and inclusion of the Drug Free Moms and Babies Project will be top of mind to meet the goals and objectives in the Managed Care Quality Strategy. The Department of Health and Human Resources may also consider including WVCHIP populations within a combined MCO contract with Medicaid to leverage purchasing power.

Managed Long-Term Services and Supports (MLTSS): BMS is also planning for the inclusion of Section 1915(c) waiver populations into its MHT and/or MHP programs. BMS requires a vendor with a deep understanding of not only this population, but also best practices to move effectively through this process.

MHP Refinements: Since the MHP program has been operating for less than a year, and in a COVID-19 environment, BMS will need to review performance and outcomes under the first year and identify program design changes. For example, review of EPSDT access, court-ordered treatments, and plans of care in place within required timeframes will be key issues to address.

Combined West Virginia Familiarity with National Insights and Best Practices

In **Figure 3** 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 RFQ requirement to have at least five years of experience in providing Medicaid managed care in Medicaid managed care contract and policy development and/or oversight as the prime contractor across numerous states. This table summarizes our experience providing managed care services represented in this RFQ; however, it is not an exhaustive list. Additional references are available upon request.

Appendix A includes additional qualifications from our work with states and CMS that are not included in the figure below.

Figure 3. Guidehouse's Experience in Medicaid Managed Care Program Administration

	Medicaid Managed Care Experience										
State *Years of Service*	**WV** *'18-pres.*	**AL** *'13-pres.*	**AZ** *'93-pres.*	**GA** *'07 - pres.*	**IL** *'92-pres.*	**IA** *'15-'16*	**KS** *'94-'96; '14-'19*	**MS** *'10-'17*	**PA** *'01-'13*	**TN** *'04-pres.*	**TX** *'96-98; '05-'09 '14-'15 '19-pres.*
Project Identifying Numbers	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Managed Care Contracting and Compliance											
Compliance with Federal Regulations	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Managed Care Contracts	✓	✓	✓	✓	✓	✓		✓	✓		✓
Managed Care Procurements		✓	✓	✓		✓	✓	✓	✓	✓	✓
Readiness Reviews	✓	✓		✓		✓		✓	✓	✓	✓
Managed Care Operations and Oversight											
Managed Care Monitoring	✓	✓		✓	✓	✓	✓	✓	✓		✓
Network Adequacy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dashboard / Scorecard Development	✓	✓		✓	✓	✓	✓	✓	✓		✓
Data Analysis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Annual Reports	✓						✓	✓	✓	✓	
Program Integrity	✓	✓	✓					✓	✓		✓
Quality Management	✓	✓		✓		✓	✓	✓	✓		

	Medicaid Managed Care Experience										
State *Years of Service*	**WV** *'18-pres.*	**AL** *'13-pres.*	**AZ** *'93-pres.*	**GA** *'07 - pres.*	**IL** *'92-pres.*	**IA** *'15-'16*	**KS** *'94-'96; '14-'19*	**MS** *'10-'17*	**PA** *'01-'13*	**TN** *'04-pres.*	**TX** *'96-98; '05-'09 '14-'15 '19-pres.*
Project Identifying Numbers	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
EPSDT	√	√		√			√	√	√		
Legislative Support	√	√	√	√		√	√	√	√	√	
Managed Care Waivers											
Managed Care Waivers and Program Design	√	√	√	√	√		√			√	√
Quality Strategy	√	√		√			√	√	√		
Section 1115 for SUD	√	√					√				
1915(c) Waivers	√	√		√	√	√	√		√		
Special Populations and Models											
Foster Care Children	√			√		√	√	√	√		√
Long-Term Services and Supports	√	√	√		√	√	√	√	√	√	
Behavioral Health	√	√	√	√	√	√	√	√	√	√	√
Alternative Payment Models	√	√	√	√	√		√	√	√	√	
Social Determinants of Health	√	√	√	√			√	√	√	√	√
Rural Health		√		√			√	√	√	√	
New Delivery or Payment Methodologies		√	√	√	√		√		√	√	

A narrative project summary for each Guidehouse project listed in **Figure 3** above can be found on the pages listed below:

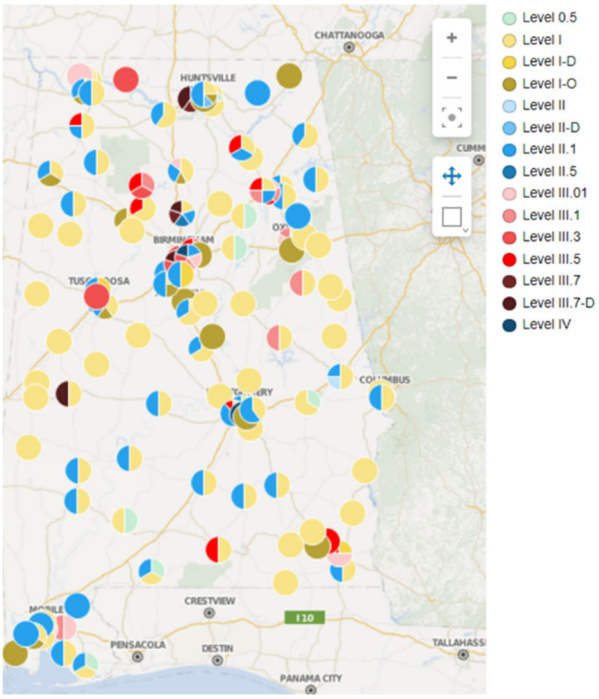
Guidehouse's Clients

Client Name / Description
1. West Virginia Department of Health & Human Resources | Bureau for Medical Services | February 2018- Present
Key Impacts: ✓ ***Strengthen regulatory compliance*** ✓ ***Secure Federal approval for MHT and MHP programs*** ✓ ***Promote a culture focused on quality*** ✓ ***Enhance and streamlined MCO monitoring and oversight*** ✓ ***Enhance program design for social determinants of health and care management*** ✓ ***Establish disciplined program management tools and timelines*** ✓ ***Address ad hoc policy issues and provide decision-making tools and support***
As described above, Guidehouse supports BMS in all aspects of Medicaid managed care program administration. Below we describe our experience related to managed care contracting, program oversight, and managed care waivers. Guidehouse staff works with State staff to prepare Medicaid managed care contracts and amendments, ensuring that contract language complied with federal regulations and State law. Our staff also participate in discussions with CMS regional staff, incorporating their comments as needed. We assisted the State in bringing the MCO contract into full compliance with significant changes in federal laws and regulations coming out of the ACA and the Medicaid and CHIP Managed Care Regulations finalized in 2016. Our staff conducted multiple desk and on-site readiness reviews, created implementation tools, and scoring guides. We monitored and evaluated managed care expansions, including behavioral health and SSI populations. We also helped integrate the Substance Abuse Waiver, Foster Care, and Institutions for Mental Disease services under the managed care model. Our team also supports BMS' robust program monitoring and oversight processes to promote compliance and improvement in health outcomes for MHT and MHP programs. Guidehouse develops a quarterly dashboard and identifies questions and follow-up with MCOs to home in on specific areas for improvement. We also offer summaries and insights to inform legislative discussions. Finally, we prepare the 1915(b) waivers that authorize the MHT and MHP programs. In 2021, Guidehouse took the lead in drafting all relevant and required materials, including application language, data analysis, coordination with other contractors, and preparation of the Quality Strategy.
2. Alabama Medicaid Agency and Alabama Department of Mental Health | 2013 – Present
Key Impacts: ✓ ***Designed a new Medicaid managed care program to promote care coordination and adequate access to services*** ✓ ***Successfully secured CMS approval for transition to Medicaid managed care and a DSRIP-like program*** ✓ ***Developed 1115 waiver to expand access to substance use disorder services*** ✓ ***Effectively plan, design, and implement managed care long-term services and supports program (Integrated Care Network)***
Guidehouse worked with the state of Alabama Medicaid Agency (AMA) to implement a new care delivery model that will improve beneficiary outcomes and address fragmentation in Alabama's Medicaid program. Under this new delivery system, risk-bearing, provider-based regional care organizations (RCOs) will be paid on a capitated basis to provide the full scope of Medicaid benefits, including primary, acute, behavioral, maternal, pharmacy and post-acute services.

Section 1115 SUD Demonstration

Guidehouse worked with Alabama's Department of Mental Health (ADMH) on developing a 1115 Waiver to expand access of services to Alabamians suffering from Substance Use Disorder (SUD). As part of this support, we:

- Analyzed two years of SUD claims data in conjunction with county census data to determine prevalence of SUD rates by county for potential SUD 1115 Waiver submission.
- Established Per Member Per Year (PMPY) spend on SUD residential and non-residential spend by county to determine regional prevalence rates.
- Through assisting ADMH with their State Opioid Response (SOR) Grants, reviewed Opioid Use Disorder (OUD) rates across the State including identifying underserved regional localities.
- Wrote concept paper for 1115 Waiver.
- Created a survey for SUD treatment facilities to determine Federal Poverty Level (FPL) of new recipients
- Created online heatmap of service providers by American Society of Addiction Medicine (ASAM) levels, as illustrated in the example graphic.



Waiver Demonstrations

Guidehouse completed a CMS Section 1115 Demonstration Waiver process related to Medicaid transformation for public notice and public comment. As part of the waiver demonstration process we assisted AMA with:

- Managing the public waiver comment process, which necessitated a full understanding of and compliance with the state public notice process in the Code of Federal Regulations,
- Drafting the public notices, logistics for the public hearings,
- Tracking and compiling the public comments received, and
- Summarizing and addressing the public comments in Section VIII of the waiver and participating in meetings with stakeholders

We also compiled a report on the Federal requirements and considerations for the State and a guide for the waiver public comment period.

Medicaid Managed Care Waiver

We worked with AMA for the development and submission of a Section 1115 Demonstration Proposal. **We drafted the Demonstration Proposal and managed the public comment process (**including drafting the public notices, logistics for the public hearings, tracking and compiling the public comments received, summarizing and addressing the public comments in the Demonstration Proposal and participating in meetings with stakeholders). **We also supported AMA in discussions and negotiations with CMS,** including responding to CMS' questions on the Demonstration Proposal.

Medicaid Managed Care Contract Development

We developed a contract with AMA to be executed between AMA and its RCOs, which will govern the requirements of the RCO program. **Guidehouse led the contract development process, including compiling state and federal requirements for Medicaid managed care programs**, reviewing best

Client Name / Description

practices from other state Medicaid programs, serving as the first author for contract sections and facilitating meetings with AMA staff to incorporate feedback and desired program components. Guidehouse also provided training to AMA staff regarding the contract development process and managed care requirements.

Quality Measures and Incentive Payments

Guidehouse supported AMA's process to develop a standard set of quality measures by which AMA will monitor the RCOs for a component of its value-based purchasing program. We provided subject matter expertise and identified and shared best practices with a multi-stakeholder Quality Assurance Committee, the committee responsible for selecting the quality measures. A subset of the selected quality measures will be tied to incentive payments for which RCOs are eligible. We also worked with AMA to develop a methodology for distribution of the incentive payments, based on satisfactory reporting and achievement of outcome and quality targets.

Communications Plan

Guidehouse developed a Communications Plan to guide internal and external communications related to the RCO program and includes developing educational and training materials to prepare for the organizational transformation. The comprehensive Communications Plan identifies the relevant stakeholders and major barriers and concerns by stakeholder group and lays out a plan for using a mix of communications methods such as legislative briefings, public forms, internal and external newsletters, email inboxes and social media to effectively reach a variety of audiences. The Communications Plan is organized by major milestones in the RCO implementation and includes key messages and proposed activities associated with each milestone to facilitate a broad and transparent communication approach.

Health Homes

AMA currently operates a Health Home program approved by CMS through Section 2703 of the Affordable Care Act. **Guidehouse worked with AMA to integrate its Health Home program into the broader RCO program**. To do so, we assisted in developing and refining AMA's procurement Health Home procurement materials, including a Health Home RFP. We also identified the components of AMA's Health Home program that must be addressed in AMA's contracts with RCOs, as RCOs will have responsibility for providing Health Home services to their eligible members. One important element of this process is structuring the program so that AMA will continue to receive enhanced federal funding for Health Home services delivered in a managed care environment.

Care Integration

We worked with AMA in developing an approach to physical health and behavioral health care coordination. In Alabama, multiple state agencies are involved in the delivery of care coordination and case management services to Medicaid beneficiaries. To support a multi-stakeholder approach to developing care coordination and case management requirements for the RCO program, Guidehouse facilitated meetings between AMA and its sister agencies including Department of Mental Health, Department of Public Health and Department of Human Resources. These meetings helped to identify program requirements for RCOs regarding participation on care teams, screening and assessment processes, transition approaches and data sharing options. We also worked with stakeholders to identify improvements to the delivery system, while avoiding the duplication of services across agencies and RCOs.

Supporting Organizational Change

Guidehouse had worked closely with AMA on a multi-phase project to assess and determine what organizational changes will be required, the impact of these changes on existing staffing levels, roles,

Client Name / Description
and responsibilities and how changes should be implemented. During the first phase of the project, Guidehouse conducted interviews with personnel from 19 departments within seven different divisions across AMA, including division deputies and department leaders. The interviews focused on understanding current processes, roles, responsibilities and assessing the ability of AMA's current organizational structure and operating capacity to successfully operate the RCO program. Guidehouse supplemented the interviews with a detailed review of internal documents, including reports, employee job descriptions, manuals, and organizational charts, to gain a more in-depth understanding of the department or AMA's functions and roles. We also conducted research about other states that have successfully implemented managed care programs. The interviews focused on how each state structures its managed care program, as well as challenges and lessons learned from these states in monitoring managed care organizations. We continued to work to assist AMA with implementing the required organizational changes during the second phase of the project. Key activities include: • Conducting a work allocation study to better understand the impact the RCO program will have on current staffing functions and workload, including the percentage of a staff member's time that will devoted to RCO program functions versus FFS functions. The analysis will also assist in identifying areas that will see a decrease in workload and that may be able to assist with new functions to support the RCO program. • Working with AMA to identify internal and external candidates to fill key positions • Updating existing position descriptions for staff assigned new functions and creating new position descriptions for areas that require an increase in staffing • Developing and deploying training modules regarding the RCO program and Medicaid managed care concepts • Assisting AMA with developing and executing a plan to communicate the agency-wide organizational changes • Developing and documenting new process and procedures that AMA will require to manage and provider oversight of the RCO program *Delivery System Reform Incentive Payments (DSRIP)* A key component of the delivery transformation initiative is creating a payment system that incentivizes RCOs, hospitals and other providers through CMS approved funding pools. Those pools are funded through CMS approval of Designated State Health Programs (DSHP) already in existence at the State level that are leveraged to draw new Federal Matching Funds for two primary funding pools: • Transition Pools • Delivery System Reform Incentive Payments (DSRIP) Guidehouse, with AMA, developed and established the Alabama DSRIP program and managed the operational and programmatic tasks that are required to appropriately administer the DSRIP program in Alabama.
3. Arizona Health Care Cost Containment System | 1993 – 2018
Key Impacts: ✓ ***Robust Medicaid managed care contract specifications and strategy for integrated physical and behavioral health service delivery platform*** ✓ ***Enhanced social determinants of health reporting requirements for MCOs and contracted providers*** ✓ ***Supported organizational transformation of Medicaid agency***
Medicaid Managed Care Over the last two decades Guidehouse has worked numerous agencies within the State of Arizona including AHCCCS, the Arizona Department of Economic Security (ADES), the Division of Disability

Client Name / Description

(DDD), the Arizona Attorney General, and the Department of Health Services (DHS) on a variety of projects. Recently, our teams have supported various AHCCCS initiatives including:

- Provided project management and workgroup support to AHCCCS during the development of program and contract requirements and procurement documents for the AHCCCS Complete Care (ACC) RFP which integrated physical and behavioral health services for most Medicaid beneficiaries across Arizona.
- Provided Substance Abuse and Mental Health Block Grant (SABG/MHBG) technical assistance focused on reporting requirements and addressing social determinants of health. All requirements applied to Medicaid managed care organizations and their provider networks.
- Served as project manager to support the transition of the Department of Behavioral Health Services (DBHS) into AHCCCS, which involved leading and facilitating the operational and personnel integration of the two agencies to support a seamless transition.
- Assisted in the implementation of the State's Medicaid mental health managed care program, a component of AHCCCS' programs. We developed standards in the areas of provider network, case management, client assessment, service provision, quality assurance, and utilization review and reporting requirements.

HCBS Provider Reimbursement Rate Rebase and Ongoing Support

Guidehouse has supported the rebasing of Arizona's Home- and Community-Based Services (HCBS) and Early Intervention Program rates to improve competitiveness and defensibility in the market while accounting for changes in minimum wage legislation. Through our work we were able to align rates with provider costs and utilization, assess any fiscal impact and other potential effects of proposed rate changes, maintain strong provider communication to minimize pushback and improve transparency and provide robust and defensible methodology for use in future rate rebases. To achieve these objectives, we completed the following:

- *Provider Focus Groups*: Conducted focus group with providers in various areas of the state to identify key areas and services in need of rate adjustments. This process included providers in the urban and rural areas including tribal lands where service delivery can be more challenging and costly
- *Provider Survey:* Created and administered a survey of staffing, cost, wage, and productivity data for more than 100 providers to create a baseline for rebased rates
- *Rebase Analysis:* Leveraged the provider survey, along with Bureau of Labor Statistics data and client feedback to build up rates for all services, and analyzed the fiscal impact of proposed rate changes

Upon completion of this work, our final deliverable was to create detailed rate book with updated rates for all services, geographic areas, and acuity tiers, as well as a full explanation of assumptions and methodologies, with a focus on services impacted by minimum wage changes.

HCBS Rate Adequacy Studies

In accordance with A.R.S.§ 36-2959, Guidehouse has assessed the adequacy of provider reimbursement rates for agencies in the State of Arizona. For the last two years, our team has assessed the HCBS provider reimbursement rates for DDD to identify potential programmatic and individual rate level concerns. Our assessment included the following analyses of five years of claims / encounters data:

- Utilization Analysis
- Users Analysis
- Payment Analysis
- Provider Analysis

Client Name / Description
These assessments also included an assessment of the impact of Propositions 206 and 414, voter initiatives that increased Arizona's statewide and Flagstaff municipal minimum wages, on provider rates and the overall HCBS workforce. In addition, we reviewed unassigned / outstanding authorization data to determine specific services where needs have been identified by no providers are available or willing to deliver the service. The combination of these findings informed our determination of provider reimbursement rate adequacy. In addition to the HCBS Rate Adequacy Study, Guidehouse also concluded an assessment of the adequacy of AHCCCS Fee-For- Service behavioral health provider reimbursement rates in 2019. With Guidehouse's assistance in dually analyzing clients with behavioral health needs demand for services, as well as providers' capability to deliver those services, AHCCCS can better serve their mission to provide comprehensive, quality healthcare to those in need. To determine the adequacy of the above services, Guidehouse analyzed the following data sources: • Three years (2015 - 2017) of behavioral health outpatient and inpatient claims and encounter data provided by AHCCCS • Provider self-reported rate information gathered from a Guidehouse created survey • AHCCCS Survey of Managed Care Plans • Bureau of Labor Statistics occupational statistics for behavioral health occupations (May 2017)
4. Georgia Department of Community Health | 2007 – Present
Key Impacts: ✓ ***Identified strategic options for Medicaid managed care program transformation*** ✓ ***Successfully procured Medicaid MCOs for various types of programs: TANF, SSI, and Foster Care Children*** ✓ ***Implemented value-based purchasing program targeted towards Medicaid managed care program for foster care children***
DCH retained Guidehouse in August 2011 to **analyze and implement strategic options for managing the financing and care of the State's Medicaid and PeachCare for Kids™** programs which cover nearly 1.7 million members. We continue to work with the State on this important initiative to transform the Medicaid program and to support improved outcomes and quality of care for members. We began our efforts to transform the Medicaid program through an assessment of re-design options for the State. **We used a robust, structured, objective, and analytic approach to evaluating what is often a politically-charged environment that includes stakeholders and politicians with competing priorities.** Guidehouse initially conducted the following tasks to support development of a Comprehensive Design Strategy Report. Our activities included the following: • Assessed the model and structure of Georgia's current Medicaid and PeachCare for Kids™ programs; this includes Medicaid funded services including developmental disabilities and behavioral health • Conducted a national environmental scan of Medicaid and Children's Health Insurance Programs and of best practices in commercial health plans relating to delivery and financing of services • Provided considerations and recommendations for moving ABD populations into managed care • Determined how reform would require reengineering and restructuring of Medicaid program with a focus on the delivery system • Identified waiver possibilities, issues regarding obtaining waivers and prepared for and participated in meetings with the Medicaid Agency and a CMS Medicaid State Technical Assistance Team (MSTAT) • Participated in a number of meetings with State actuaries when considering budgeting and financing options

Client Name / Description

- Conducted focus groups across the State with and an online survey of providers, consumers, advocacy groups and vendors, as well as three task forces that provided ongoing input to the program design

Guidehouse performed the following activities:

- Providing trainings to staff responsible for conduct of monitoring and oversight for the Georgia Families and Georgia Families 360 programs
- Supporting the development of key program design features for Medicaid program modernization, through activities such as procurement materials to contract with a Credentialing Verification Organization to conduct credentialing for the FFS delivery system and all contracted CMOs
- Supporting re-procurements, including interviewing staff and conducting national research, identifying program enhancements, and developing re-procurement materials for the following contracts:
  - Georgia Families (including Georgia Families 360)
  - Medical Review and Compliance Vendor
  - Pharmacy Benefit Manager
  - Pharmacy Rebate Vendor
- Supporting workgroups charged with identifying key program design components and issues to consider for the proposed integrated delivery systems and program design
- Assisting with strategic planning and development of program design components
- Assisting in planning for and implementation of an expansion of the State's risk-based Medicaid managed care program, Georgia Families, to children in foster care and adoption assistance and select children in juvenile justice; helping the State to build infrastructure, processes and tools to support implementation of the new program (e.g., Readiness Review tools, use case workflows, transition work plans, etc.)
- Supporting the development of key program design features and procurement materials for a new Medical Coordination Program for members who are aged, blind, and disabled
- Participating in and advising on negotiations with CMS about innovative program design features such as opportunities to request alternative funding options
- Preparing documents to obtain federal authority for the program changes the State is implementing

With this project, Guidehouse has demonstrated proficiency in design, procurement, operation, evaluation, and improvement of risk-based and other Medicaid managed care programs.

Guidehouse also recently **helped Georgia design a Value Based Purchasing (VBP) model** to implement as part of its expansion of Georgia Families to children in foster care, adoption assistance and juvenile justice. Our VBP approach has been endorsed by providers and managed care organizations alike. This effort will increase opportunities for the State to align all quality improvement efforts across stakeholders. This VBP model goes beyond Pay for Performance – a very clear and transparent goal-setting process is conducted, including mining of data to identify gaps and areas where a focus is needed. Based on the goal or the aim for a given year, the VBP model requires a process to conduct monthly measurement of progress. Guidehouse has advised Georgia through a process that is anticipated to make the State a national leader in Medicaid performance improvement and quality improvement.

Client Name / Description
5. Illinois Department of Healthcare and Family Services | 1992 – Present
Key Impacts: ✓ ***Developed enhanced program monitoring and reporting structure*** ✓ ***Implemented expansion Medicaid managed care that included long-term services and supports, behavioral health, and other special populations*** ✓ ***Developed internal agency capacity for Medicaid managed care program administration***
For more than 20 years, Guidehouse has worked on competitively bid contracts and assisted the State of Illinois with implementation of expanded Medicaid managed care programs and development of managed care monitoring processes and tools. In particular, we have: • Assisted with improvements to Medicaid managed care program administration, including consultation on organizational structure and optimal staffing alignment and job descriptions and desirable core skills for position vacancies, evaluation of MCO contract reporting requirements, including inventory, review, standardization and enhancement of current reports and development of standard operating procedures for analyzing those reports upon receipt. • Assessed organizational structure and operational activities of the Medicaid agency's managed care compliance and monitoring business unit, including a comprehensive, qualitative review of program documentation, structured interviews with key management and program staff stakeholders, and benchmarking other states' operational structures supporting managed care program monitoring and oversight activities. • Provided an assessment and recommendations report and conducted strategic planning sessions with leadership, managers, and program staff to identify priority areas and plan for operational improvements and consultation and technical assistance. Focused on building resources and capacity, streamlining and documenting business processes to promote concerted monitoring and oversight of MCOs, and preparing for integration of new coordinated care initiatives. • Provided options for refining the Bureau of Managed Care (BMC) organizational structure to align contract monitoring activities with subject matter expertise, such as quality, utilization, member grievances and appeals, care coordination and waiver services. • 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. • Provided program staff training on Medicaid managed care, data analysis, report reviews and MCO monitoring to support ongoing performance improvement efforts. • Provided technical and planning assistance related to encounter data collection and validation activities, including development of handbooks, reports, and project guides. • Worked with BMC staff to develop executive summaries and dashboard reports that can be used to communicated Medicaid managed care performance to Agency leadership, sister agencies and other stakeholders. • Participated in meetings with BMC, CMS, and the Medicare-Medicaid Alignment Initiative (MMAI) MCOs to better understand how BMC can leverage MMAI MCO data to support program monitoring activities. • Assisted the State with preparations for the implementation of expanded Medicaid managed care programs • Assisted with review of MCO contracts for the Integrated Care Program (ICP), MMAI and Family Health Plan (FHP)/ACA Medicaid Expansion and providing recommendations to strengthen contract language and align requirements across programs, where applicable.

Client Name / Description
6. Iowa Department of Human Services | 2015 – 2016
Key Impacts: ✓ ***Conducted readiness reviews for enrollment of Medicaid members into MCOs*** ✓ ***Developed external reporting regarding MCO preparedness*** ✓ ***Prepared legislative reports*** ✓ ***Developed state Medicaid agency staff capacity***
In January 2015, Iowa Governor Terry Branstad announced plans to move the majority of members served through Iowa's existing Medicaid fee-for-service delivery system to a comprehensive risk-based managed care program, IA Health Link. The Iowa Department of Human Services (DHS) initially contracted with four Managed Care Organizations (MCOs) for this program and **engaged Guidehouse to conduct readiness reviews and to provide ongoing technical assistance in monitoring and oversight of the MCOs.** Readiness reviews are a critical task lending to the overall success of a managed care program or any contract. One of the primary objectives of Guidehouse's initial work was to verify that the MCOs were ready to provide services for the covered population in accordance with the State's contract and state and federal laws. Guidehouse performed six key tasks as part of this project: • Developed readiness review process and governance • Developed the readiness review tool and shared it with MCOs • Conducted desk audits • Conducted site visits • Developed a report of our findings that identified areas of concerns and recommended mitigation strategies to address those concerns DHS also requested that **Guidehouse provide technical assistance for the ongoing monitoring and proactive management** of the MCOs after program implementation. We are strategizing with DHS to establish a thorough and detailed monitoring and oversight process. Guidehouse has assisted with activities such as the creation of an MCO Reporting Manual, reporting requirements and report templates to collect information in program areas such as: 1. Operations: Claims processing, call center, grievances, and appeals, etc. 2. Finance: Third party liability, medical loss ratio, etc. 3. Quality and Access: Care coordination, clinical outcomes, utilization We also provided training to DHS staff responsible for monitoring and oversight of the MCOs, including foundational trainings on Medicaid and Managed Care and more advanced trainings on Data Analysis and Performance Management.
7. Kansas Department of Health & Environment | 1994-1996, 2014 – 2019
Key Impacts: ✓ ***Led the relationship with CMS to provide necessary information and develop activities to complete State's Corrective Action Plan for Medicaid managed care*** ✓ ***Designed and helped negotiate subsequent five-year renewal of "next generation" Medicaid managed care program to include value-based purchasing, ensure program financial sustainability, and promote integration of physical health, behavioral health, and social services*** ✓ ***Provided interim staffing for Acting Deputy Secretary of Kansas Department of Health and Environment, interim CFO, interim Commissioner-level support for behavioral health and long-term services and supports, and other analytics and operational support***

Client Name / Description

Guidehouse performed an organizational assessment of the KanCare Medicaid managed care program. KDHE hired Guidehouse to analyze the organizational structure and resources needed to effectively administer its programs within a managed care delivery model.

Guidehouse's assessment focused on identifying opportunities for organizational and operational improvements across KDHE and its sister Agency, Kansas Department of Aging and Disability Services (KDADS) as it related Medicaid functions. Guidehouse examined the Medicaid programs and waivers for staffing alignment, policy, and procedural documentation, training protocols, monitoring and oversight practices, staff evaluations, communication practices, internal documentation efforts, and information technology systems across KDHE and KDADS.

Implementation of Organizational Assessment Recommendations

The Kansas Department of Health and Environment (KDHE) retained Guidehouse in August 2015 to perform an organizational assessment of the KanCare Medicaid managed care program. KDADS contracted with Guidehouse to implement key recommendations focusing on the following areas:

- Policy development and alignment
- Process improvement for working with key stakeholders and contractors, such as Medicaid Managed Care Organizations (MCOs), community developmental disability organizations, Community Mental Health Centers (CMHCs), and aging and disability resource centers
- Contractor monitoring and oversight
- Internal and cross-agency data analytics

KanCare Corrective Action Support

In 2017, **Guidehouse began supporting the development of the State's responses to two Corrective Action Plans (CAPs) issued by the Centers for Medicare and Medicaid Services (CMS)** to improve the monitoring and oversight of the State's Medicaid Managed Care program (KanCare). Guidehouse assisted in the development the State's CAP responses, which were subsequently approved for implementation by CMS. After approval, Guidehouse then facilitated bi-weekly discussions with CMS to keep all parties aware of the status of the implementation of more than 150 related CAP tasks. Guidehouse also supported the State to design, implement, and sustain the changes as a result of the CAPs. One of the CAPs is in the final stages of completion, while the other is still ongoing. The State is on track to complete all CAP tasks within the timeframes required by CMS.

Guidehouse reviewed and provided suggestions to improve the KanCare Quality Strategy, such as:

- Development of quality goals and objectives
- Cross-agency collaboration approaches to achieve quality goals and objections
- Quality metrics
- Implementation of the quality framework within HCBS programs

In coordination with HCBS advocates and stakeholders, **Guidehouse facilitated the development of a core set of quality measures that KDADS intends to report out on publicly.** Specifically, Guidehouse worked with stakeholders to identify desired measures, review the availability of the identified measures or similar ones, and help prioritize measures for public reporting. For example, we developed LTSS provider-specific network adequacy requirements and pay for performance measures that KDADS used to hold its Medicaid MCOs accountable.

Substance Use Disorder (SUD) Waiver Approval and Evaluation Design

In 2018 and 2019, **Guidehouse drafted the State's SUD Implementation Plan, which was approved by CMS in August 2019.** Guidehouse provided complete support to Kansas for supporting development, including:

- Reviewing the current Medicaid State Plan and MCO contracts

Client Name / Description

- Developing recommendations for a proposed "future state" and "summary of actions needed"
- Facilitating discussions with CMS and between sister agencies (e.g., Medicaid agency and KDADs)
- Preparing an operational project plan to implement the SUD Implementation Plan upon approval by CMS
- Estimating the difficulty level to meet CMS' required milestones to prepare the State with discussions with CMS
- Recommending a stakeholder communication plan and preparing supporting communication materials
- Facilitating and coordinating the agency's Monitoring Protocols and Evaluation Plan Design to meet CMS requirements
- Quality improvement framework and processes

Interim Staffing Support

In Spring 2018, **Guidehouse began providing interim staffing support at the Commissioner-level to provide strategic expertise on LTSS, behavioral health, data analytic, and other operational issues at KDADS.** In this capacity, Guidehouse has represented and guided KDADS through issues such as:

- LTSS stakeholder engagement
- CMS Section 1915(c) waiver renewals
- Provider network adequacy and monitoring for behavioral health services
- Quality improvement framework and processes
- KanCare MCO monitoring and oversight
- Realignment of LTSS Commission and Behavioral Health Commissions to improve efficiency and performance
- Coordination with Medicaid agency
- Development of State policies and procedures for reporting and investigating adverse incidents
- State legislature testimony
- KanCare pay for performance program

Electronic Medical Record

KDADS contracted with Guidehouse to complete a **comprehensive review of existing billing and Electronic Medical Record (EMR) systems** in place at the four Kansas state hospitals

Across all four hospitals, Guidehouse identified core functionality gaps that prevent optimized productivity and revenue realization, such as:

- Denial management and follow-up
- Underpayments
- Claims processing
- Reporting and interoperability
- Clinical care and care management
- Efficiency, operational integrity, quality, patient safety, patient experience, staff experience

The EMR Assessment findings support the need for KDADS and state hospitals to pursue strategic modernization of EMR system functionality, which will require procurement of a new EMR system.

KDADS issued a Request for Information from potential vendors. Based on the range of responses, KDADS is in the process of securing budget through the legislative process to procure and implement a new EMR system.

Client Name / Description

Provider Network Standards for Behavioral Health and Long-Term Services

As part of our interim staffing support, **Guidehouse helped KDADS design and develop updated provider network for behavioral health and LTSS.** These standards were developed based on national state Medicaid and commercial best practices and relevant Federal guidance.

After design of the network standards, Guidehouse helped prepare KDADS to hold three public stakeholder sessions and solicit feedback from contracted MCOs and other consumer advocacy organizations. Based on this feedback, **Guidehouse supported KDADS to refine its proposed network standards and finalize them for MCO compliance and reporting**. As part of this finalization, we worked with KDADS' Electronic Visit Verification (EVV) vendor to develop reporting to determine initial compliance with LTSS-related provider network standards and establish ongoing reporting to support KDADS and the Medicaid agency.

Actuarial and Analytics

Guidehouse developed and certified managed care rates involving comprehensive covered services for the following programs: TANF, CHIP, ABD non-dual eligible, former faster care children, medically needy/spenddown, Medicare-Medicaid dual eligible, 1915(c) HCBS waiver, and LTSS. We also assisted the State with Risk adjustment design and implementation, **DRG weight and rate development**, and Medicaid expansion enrollment and **budget analysis**.

Since 2015, Guidehouse has supported the Kansas Department of Health and Environment to enhance its Medicaid managed care program, KanCare. As part of this work we have assisted KDHE **with two 1115 waiver renewals** – a one-year renewal and a five-year renewal. KDHE pursued two different waiver renewals because it wanted to use the time during the one-year renewal period to plan and prepare for the changes it requested for the five-year waiver renewal. All of the 1115 waiver negotiation activities that Guidehouse has supported have occurred during the current Trump administration.

1115 Waiver One-Year Renewal

We first supported KDHE with completing an 1115 waiver application to request a one-year renewal of Kansas' current 1115 waiver. We gathered supporting documentation and materials from KDHE staff (e.g., external quality review organization reports, 1115 waiver quarterly and annual reports, budget neutrality summaries) and used this information to serve as the lead writer for the 1115 waiver renewal application. We participated in weekly calls with CMS, developed public notice materials, and provided comments on presentations used for the public hearings.

As part of the one-year renewal request, KDHE requested minimal changes to the current waiver. However, to approve the renewal of Kansas' safety net care pools (which are approved as part of the 1115 waiver), CMS required that KDHE prepare a Safety Net Care Pool report. This report reviewed the cost of uncompensated care in Kansas and the financing involved with the current safety net care pools. Guidehouse completed this report on behalf of KDHE. CMS approved the one-year waiver renewal in October 2017.

1115 Waiver Five-Year Renewal

Following the approval of Kansas' one-year 1115 waiver renewal, KDHE wanted to make more significant changes to its waiver program. **Guidehouse assisted the State with drafting a Concept Paper that outlined the major changes that KDHE was interested in pursuing** as part of the five-year waiver renewal. Together with KDHE staff, we shared the Concept Paper with CMS representatives to receive initial feedback and understand if CMS had any concerns regarding Concept Paper topics. KDHE's five-year 1115 waiver renewal application covers topics such as:

- Increased use of value-based purchasing contracts with MCOs

Client Name / Description
• State directed payments to support quality improvement among providers • Increased focus on social determinants of health through expanding service coordination, including assisting members with accessing affordable housing; food security; and employment and increasing employment and independent living supports for members with behavioral health needs • IMD exclusion waiver • Increased use of data and analytics to achieve transformation goals **The Guidehouse team drafted the 1115 waiver renewal application,** serving as the primary writer. Many of the elements included in this renewal application required Guidehouse to draw upon our deep knowledge of federal regulations to determine what was and was not permissible for KDHE to request. In addition, we provided guidance to KDHE leadership on the potential impact of initiatives requested in the 1115 waiver renewal application, such as work requirements and an IMD exclusion waiver. Guidehouse developed a schedule to review the draft waiver with KDHE leadership and incorporate their comments and suggested modifications. Guidehouse also supported the public comment process, including drafting public notices, preparing public hearing meeting materials, preparing stakeholder engagement materials, and responding to written public comments. We also prepared KDHE leadership and State legislators with talking points about the significant changes in the 1115 renewal application and how those changes will support KDHE's objectives. Because these talking points were used with a broad audience, we focused on key messages and wrote them in an easy-to-understand manner. As part of KDHE's 1115 waiver renewal, **we provided guidance and expertise regarding state directed payments as described in 42 CFR 438.6(c).** We conducted visioning sessions with KDHE leadership regarding the objectives for state directed payments and the types of providers that should be eligible to receive these payments. Our team also participated in a call with CMS regarding state directed payment programs to receive the most up-to-date guidance. Guidehouse is currently supporting KDHE in discussions and negotiations with CMS, including responding to CMS' questions on the 1115 waiver renewal application. CMS approved Kansas's one-year waiver renewal in October 2017 and the five-year waiver renewal in December 2018.
8. State of Mississippi Division of Medicaid | 2010 – 2017
Key Impacts: ✓ ***Successfully implemented and operated integrated Medicaid managed care program*** ✓ ***Created robust compliance and quality improvement framework for Medicaid managed care, including completion of readiness reviews, monthly quality improvement meetings with MCOs and other partners, and encounter data validation*** ✓ ***Developed internal state agency capacity to operate and oversee Medicaid managed care program***
For seven years, Guidehouse provided technical assistance to the State of Mississippi Division of Medicaid. Guidehouse's original contract was to serve as Implementation Manager for implementation of a voluntary **coordinated care program, MississippiCAN, for high-risk Medicaid consumers.** As part of this contract, we: • Assisted with strategic planning for implementation of contracts with two Coordinated Care Organizations (CCOs) administering the program services. • Assisted the State with conducting readiness reviews of the CCOs, including development of a readiness review tool, training staff, and participating in readiness reviews. • Provided training and support to the Division for data analysis and ongoing monitoring of the CCOs. • Supported preparations for and participated in meetings with the CCOs and the State's fiscal agent.

Client Name / Description
• Made recommendations for planning for the expansion of MississippiCAN to new populations and behavioral health services. In addition, we supported the Division in an expanded role with activities such as the following: • Participated in ongoing strategic planning to identify opportunities to improve upon the current MississippiCAN program, prepare for program expansion activities, and streamline and improve managed care contract monitoring oversight operations and business processes. • Conducted ongoing monitoring of the CCOs. • **Developed tools such as reporting templates and standard operating procedures** and are analyzing reports submitted by the CCOs to identify successes and areas for improvement. • Assisted with re-procurement of the CCOs by conducting national research of other programs to identify opportunities for the Division to consider, participating in strategic planning sessions and incorporating new and more stringent requirements into the Request for Proposals Scope of Work. • Assisted the Division with conducting contract readiness reviews and follow-up to review findings, including strategic planning and preparation for future readiness and compliance monitoring activities. • **Developed, standardized, and maintained a multiyear analytic database containing over five years of eligibility, fee-for-service claims, and CCO encounter data** representing approximately 750,000 annual covered lives. This analytic environment supported a variety of ad hoc and regular reporting activities, including: eligibility and enrollment trending analysis; encounter data validation; core service utilization trending (primary care visits, emergency department visits, hospital admissions and re-admissions, potentially avoidable admissions, etc.); topical focus studies (EPSDT, diabetes and other chronic and disease management conditions, medication prescribing patterns and use – including children and psychotropic and ADHD medications, and perinatal care and birth outcomes, etc.); quality and outcomes measurement; cost analysis and rate modeling; and development of standard reporting, including annual program reports and dashboards for executive, program management, and external stakeholders. • Conducted an operational assessment and developing a one-year strategic plan for the Bureau of Program Integrity fraud, waste, and abuse operations as they relate to the CCOs and the MississippiCAN program. For this assessment, we researched national best practices at the State and Federal level, reviewed the Bureau's operations and related policies and State regulations through program and policy documentation review and focused Division staff interviews, and conducted a gap analysis to identify best practices and opportunities for improvement relative to established industry standards. Guidehouse also provided ongoing support to the Division with a variety of quality management activities, including: • Development of the State's MississippiCAN Quality Strategy for submission to the Centers for Medicare and Medicaid Services (CMS), which CMS approved without required modifications. • Preparation of the Division's Quality Leadership and Quality Task Force meetings. • Preparation of the scope of work requirements for the procurement of an External Quality Review Organization.

Client Name / Description
9. State of Pennsylvania Department of Public Welfare | 2001 – 2013
Key Impacts: ✓ ***Assisted with health and human services agency transition*** ✓ ***Effectively designed, implemented, and operated Medicaid managed care program*** ✓ ***Designed electronic health record and information technology initiatives*** ✓ ***Planned Medicaid long-term services and supports procurement, contracting, and implementation approaches***
For 12 years, Guidehouse provided assistance to the Commonwealth of Pennsylvania in all facets of the implementation and operation of HealthChoices, the mandatory Medicaid managed care program. As part of this engagement, we assisted with the following: • Worked with Office of Medical Assistance Programs (OMAP) to develop a strategy to implement a HealthChoices Value-Based Purchasing framework. • Assisted in identifying program goals and developed a process to communicate MCO performance and conducted a gap analysis to assess how the program was performing against goals at the state-, regional-, MCO- and facility-level. • Supported policy processes and program development by developing waivers, analyzing proposed changes, developing public issue papers, and holding public meetings and surveys. • Assisted in developing RFPs and contracts for the procurement of MCOs and other managed care contractors to provide services to Medicaid recipients. • Assisted in creating monitoring protocols and systems and trained staff. • Assisted in restructuring the Contract Team Monitoring process to streamline MCO monitoring. • Assisted with Readiness Reviews of MCOs by developing databases, conducting desk reviews, and participating in on-site reviews. • Helped to develop RFPs and contracts for enrollment broker services and administration of the Primary Care Case Manager (PCCM) program and Early and Periodic Screening, Diagnosis and Treatment services. • Assisted development and maintenance monitoring, trained staff and operational provide support. • Helped to develop Consumer Guides and HealthChoices Trending Reports using Health Plan Employer Data and Information Sets, Consumer Assessment of Health Plans, and specific Pennsylvania performance measures to profile the performance of MCOs. • Assisted in developing report layouts, comparing results against national benchmarks, circulating performance measures, and validating these calculations, writing the report, and translating into Spanish. • Assisted in developing monitoring tools and tracking systems and continue to assist the Division of Quality Monitoring with staff development and training and a variety of ongoing Quality Management/Utilization Management reporting and data analysis initiatives. • Assisted developing public reports like the HealthChoices Annual Report. • Assisted the Bureau of Managed Care Operations with strategic planning and training sessions for staff. • Provided ongoing contract management support, such as subcontracting as needed, preparing budget and status reports, and maintaining contract management records and reports. In addition, Guidehouse assisted with the design of Pennsylvania's Performance-based Contracting Program, which measures and rewards MCOs for high-quality performance. As part of this work, we: • Developed a methodology determining whether a health plan qualifies for a performance payment, and if so, the amount of that performance payment. • Developed a model estimating the potential performance payments to health plans based on a variable set of assumptions regarding health plan performance.

Client Name / Description

- Assisted in the initial stages of determining potential cost-savings as a result of implementing the Performance-Based Contracting program.
- Modified the initial Performance-Based Contracting model to allow calculation of actual performance payments to health plans based on their performance metrics.
- Conducted surveys to help refine the Performance-Based Contracting program.
- Conducted a three-year evaluation of the MCO Performance-Based Contracting program to assess effectiveness in improving and maintaining high performance among the Medicaid managed care plans. We compared health plan rates in the baseline year (pre-program implementation) to rates after implementation and national benchmarks.

As a result of this work, Pennsylvania entered into and concluded contract negotiations with each of the HealthChoices MCOs to implement the Performance-Based Contracting program.

Guidehouse provided assistance to the Commonwealth of Pennsylvania in all facets of the implementation and operation of HealthChoices, the mandatory Medicaid managed care program, and assisted with other Medicaid and public welfare reforms.

As part of this engagement, we assisted with:

Health and Human Services Transformation

We assisted the Office of Medical Assistance Programs (OMAP) and Governor's Office of Health Care Reform (GOHCR) in analyzing the financial impact of the Health Information Exchange (HIE) on projected savings for multiple payers including Medical Assistance, Medicare, and commercial insurers. We collected and analyzed data to project savings from the implementation of an HIE. We consulted payers and stakeholders regarding methodology and study findings and identified existing data and gaps to shape the methodology. We developed a flexible model for GOHCR's continued use as variables changed (e.g., EHR adoption rates, HIE take-up rates, demographics, and utilization rates). The results and analysis were a critical piece of GOHCR's operational plan and were used to demonstrate ROI for Pennsylvania's HIE and to identify sources of revenue, help to price services and create a plan for sustainability.

Guidehouse assisted GOHCR to develop a strategic plan with action steps and timeframes for increasing the accessibility, affordability, and quality of healthcare coverage. We reviewed and analyzed data, conducted literature reviews and summarized results, interviewed other states and evaluated policy options for improving access, reducing costs, and improving quality. We researched regulations, certificates of need, providers, and cost. We prepared briefs and presentations, drafted the report for HRSA, drafted the strategic plan tying the various initiatives together and helped encourage buy-in from stakeholders.

We also:

- Facilitated focus groups with uninsured individuals and small businesses to understand why employers do or do not provide insurance, what might encourage them to do so, why employees do or do not participate in the employer's plan and how these behaviors vary by individual.
- Described the Federal Health Insurance Flexibility and Accountability (HIFA) Medicaid Waiver program and made recommendations for covering the state-only insurance program, AdultBasic, under a HIFA waiver. We also modeled costs of options on eligibility, benefits, cost-sharing, and reinsurance.

As a result, former Governor Rendell proposed Cover All Pennsylvanians, an insurance program for small businesses, submitted to the State Legislature in March 2007. Our work was integrated with the former Prescription for Pennsylvania program, aimed to lower costs by reducing hospital-acquired infections and uncompensated care costs, reducing avoidable hospitalizations and promote transparency for consumers and payers on cost and quality.

Client Name / Description

HealthChoices Medicaid Managed Care

Guidehouse worked with OMAP to develop a strategy to implement a HealthChoices Value-Based Purchasing framework. We assisted in identifying program goals and developed a process to communicate MCO performance and conducted a gap analysis to assess how the program was performing against goals at the state-, regional-, MCO- and facility-level. We supported policy processes and program development by developing waivers, analyzing proposed changes, developing public issue papers, and holding public meetings and surveys. We assisted in developing RFPs and contracts for the procurement of MCOs and other managed care contractors to provide services to Medicaid recipients.

Guidehouse also assisted in creating monitoring protocols and systems and trained staff. We assisted in restructuring the Contract Team Monitoring process to streamline MCO monitoring. We also assisted with Readiness Reviews of MCOs by developing databases, conducting desk reviews, and participating in on-site reviews.

Guidehouse helped to develop RFPs and contracts for enrollment broker services and administration of the PCCM program and Early and Periodic Screening, Diagnosis and Treatment services. We assisted development and maintenance monitoring, trained staff and operational provide support.

We helped to develop Consumer Guides and HealthChoices Trending Reports using Health Plan Employer Data and Information Sets, Consumer Assessment of Health Plans, and specific Pennsylvania performance measures to profile the performance of MCOs. We assisted in developing report layouts, comparing results against national benchmarks, circulating performance measures, and validating these calculations, writing the report, and translating into Spanish. We assisted with the design of Pennsylvania's Performance-based Contracting Program, which measures and rewards MCOs for high-quality performance.

We:

- Developed a methodology determining whether a health plan qualifies for a performance payment, and if so, the amount of that performance payment.
- Developed a model estimating the potential performance payments to health plans based on a variable set of assumptions regarding health plan performance.
- Assisted in the initial stages of determining potential cost-savings as a result of implementing the Performance-Based Contracting program.
- Modified the initial Performance-Based Contracting model to allow calculation of actual performance payments to health plans based on their performance metrics.
- Conducted surveys to help refine the Performance-Based Contracting program.
- Conducted a three-year evaluation of the MCO Performance-Based Contracting program to assess effectiveness in improving and maintaining high performance among the Medicaid managed care plans. We compared health plan rates in the baseline year (pre-program implementation) to rates after implementation and national benchmarks.

As a result, Pennsylvania entered into and concluded contract negotiations with each of the HealthChoices MCOs to implement the Performance-Based Contracting program.

We assisted in developing monitoring tools and tracking systems and continue to assist the Division of Quality Monitoring with staff development and training and a variety of ongoing Quality Management/Utilization Management reporting and data analysis initiatives.

We worked with the Division of Quality and Special Needs Coordination and Access on: developing monitoring to assess performance of the health plans' Special Needs Units; developing internal activity reporting, external MCO reporting and staff development, cultural competency initiatives, contract monitoring and special initiatives such as monitoring plan compliance with the Americans with Disabilities Act requirements related to provider access; and procuring and implementing a contractor for specialized accessibility assistance services.

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We assisted developing public reports like the HealthChoices Annual Report. We also assisted the Bureau of Managed Care Operations with strategic planning and training sessions for staff. We provided ongoing contract management support, such as subcontracting as needed, preparing budget and status reports, and maintaining contract management records and reports. *ACCESS Plus Medicaid Primary Care Case Management (PCCM)* We supported several aspects of the initial program planning and design phase, including developing waivers, analyzing proposed program changes, and assisting with public meetings, research, and state surveys. We assisted with the development of the RFP for the procurement of the ACCESS Plus vendor and developed scoring tools to assess proposals. We assisted to develop and maintain monitoring protocols and train staff. We assisted with Readiness Reviews of the selected ACCESS Plus vendor by performing tasks such as reviewing information systems, conducting desk reviews, and participating in on-site reviews. We assisted with the development and ongoing monitoring of a Financial Performance Measures program (i.e., P4P) that aligned with the HealthChoices P4P program, including the development of estimate models to determine potential payouts based on methodology options. *Medicaid Electronic Health Record (HER) Incentive Program and other HIT Initiatives* We helped implement the Medicaid HER Incentive Program by assisting in the design and administration of a pilot program using enhanced 90/10 match to promote HIE among providers who care for Medicaid recipients with behavioral health and LTSS needs. It enabled the exchange of continuity of care documents among behavioral health and LTC providers. We: • Developed program requirements such as evaluation metrics for community technical experts. We identified experts to provide assistance to behavioral health and LTC providers wishing to participate in HIE and developed contracting mechanisms. • Developed a white paper and other materials both for providers wishing to participate in HIE and for state and federal governments and other providers who wished to develop a similar pilot. We identified model practices and challenges to share with local, state, and federal partners. Finally, we developed a poster presentation describing the pilot for the Medicaid Enterprise System Conference. • We developed a request (through an update to the Implementation Advanced Planning Document, or IAPD) to CMS for 90/10 funds under the Medicaid HER Incentive Program for building a public health gateway and capacity for statewide HIE. We convened relevant staff to determine the scope of the request and requirements associated with the public health gateway and the Commonwealth's HIE. We drafted the IAPD request and developed budget tables and workbooks. We assisted in negotiations with CMS on the scope and what CMS would fund. *Long-Term Care* We helped the Department of Public Welfare (DPW), Bureau of Home- and Community-Based Services (HCBS) to review several Medicaid HCBS waiver programs. We assisted to clarify and evaluate the current reimbursement system for each Medicaid HCBS waiver program. We assisted in analyzing and developing new reimbursement methodologies. We facilitated and participated in stakeholder workgroup meetings. We trained staff on developing a Quality Management Strategy. We worked to understand state-specific responsibilities and developed Operational Guidelines to improve internal operations and recommend strategies. We drafted the Strategy component and developed Quality Indicators for submission of two HCBS waivers. We developed internal infrastructure for the proposed Strategy and

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training presentations for waiver providers. We developed templates and reports to analyze activities and allow for automated monitoring of the waiver assurances. We helped to create a Quality Council and Quality Management Efficiency Teams. We reviewed the service planning process and recommended solutions for automating the approvals. Our staff researched activities of other states and prepared a white paper for developing individualized budgets and automated service approvals. *Affordable Care Act (ACA) Health Insurance Exchange (Marketplace)* We assisted in assessing selected existing information technology infrastructure that could be used to implement an Insurance Marketplace as required by provisions of the ACA. Guidehouse worked closely with GOHCR, the Insurance Department and DPW. On this project, • Our consultants compared the draft Marketplace capabilities statement to Federal requirements, guidance from national organizations and other states' approaches. • We conducted stakeholder interviews with key departments and agencies. We also interviewed high-frequency external users of the current COMPASS system to see if key functional components could be adapted to meet Marketplace requirements. • We reviewed systems documentation, analyzed potential gaps between current systems and anticipated business requirements and identified capabilities of other states' and commercial payers' Marketplaces. We determined the relative level of effort and resources required to modify current systems to meet Marketplace business functions and identified areas where the Commonwealth may want to consider purchasing "off-the-shelf" components or functionalities from third-party vendors. We presented our initial findings and delivered a final report in January 2011 as part of an overall healthcare reform report submitted to the incoming Corbett administration.
10. State of Tennessee Division of TennCare | July 2004 – Present
Key Impacts: ✓ ***Analyzing strategic options for Medicaid managed care programs, including current evaluation of design for first-in-nation Block Grant*** ✓ ***Legislative support for major program initiatives*** ✓ ***Developed Telehealth initiatives and assisted in implementation*** ✓ ***Assisted in development of I/DD program***
Analyzing strategic options for Medicaid managed care programs, including current evaluation of design for first-in-nation Block Grant Guidehouse's assistance includes the following efforts in relation to the waiver as part of the evaluation design: 1) Evaluating process for obtaining an independent entity to conduct the evaluation: Description of qualifications the entity must possess, how TN will ensure no conflict of interest and that the Evaluator will conduct a fair and impartial evaluation / prepare an objective Evaluation Report; 2) Evaluating Budget for implementing the evaluation: Total estimated cost, breakdown of estimated staff, administrative, and other costs (e.g., development of all survey and measurement instruments, data collection, data cleaning, report generation); and 3) Evaluating the timeline for conducting evaluation activities, related milestones (e.g., deliverables, procuring an outside contractor, etc.), and 4) Ensuring compliance with CMS requirements Other assistance includes: • Helping TennCare digest all waiver approval requirements, develop plan for monitoring adherence • Advise on policies and strategies impacting different populations • Assist the State in meeting other STCs. For example: Implementation Plan: Within 90 days of approval, TN must submit an Implementation Plan to cover key policies being tested and strategic approach to implementing these policies, including timelines and milestones

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• Shared Savings Quality Measures Protocol: No later than 60 calendar days after the demonstration approval, TN must submit a protocol that includes:
  ○ At least 10 quality metrics from the Medicaid Adult, Child, and Maternity Core Sets (at least 3 applicable to each population impacted by the demonstration) to be monitored for performance measurement in order to access shared savings
  ○ A mathematical representation by which to document how shared savings are earned and spent
  ○ Reporting on Shared Savings Quality Measures:
  ○ Quarterly/annual monitoring reports
 	
Developed Telehealth initiatives and assisted in implementation, including:
• Logistical support for stakeholder events, fielding questions from online and written in-person questions), agendas, etc., focusing on the major topics of Chronic conditions, Rural health, Transparency, and Innovation
• Assistance with development of implementation plan including providing analyses and comparisons of policies previously pursued by comparable states
 	
Assisted in development of I/DD program
Our Guidehouse team was instrumental in assisting the State in developing, framing, and implementing TennCare's ECF CHOICES I/DD program in managed care. This included assistance with identifying and evaluating the most suitable MCO for the program for procurement, reviewing and setting administrative framework and financial readiness, and implementing the program as a startup component of managed care

11. State of Texas Health and Human Services Commission | 1996-1998, 2005-2009; 2014-2015; 2019-Present
Key Impacts: ✓ ***Transitioning current DSRIP initiatives to managed care directed payment programs*** ✓ ***Supporting stakeholder and provider engagement efforts related to directed payment transition*** ✓ ***Effective management and reporting to CMS for DSRIP*** ✓ ***Robust program monitoring and oversight of managed care network adequacy***
Directed Payment and DSRIP Reporting Guidehouse assists the state with two directed payment programs. The first targets inpatient and outpatient hospitals as well as academic physicians and is financed primarily by provider taxes. The second program targets physicians employed by acute care hospitals and is also financed by provider taxes. Guidehouse assists the state in soup-to-nuts preprint support: from percentage of Medicare modeling; to average commercial rate data collection, scrubbing, and analysis; to integrating the quality strategy into the program; to full preprint writing and support of CMS questions. We also incorporate the programs into the state's managed care contracts and rate certifications. We assist the state in a comprehensive review and projection of the acute care tax receipts which support the programs' financing including development of future years' payment pool levels with FMAP analysis. We also calculate the quarterly distributions of both programs including development of all exhibits. Guidehouse is currently assisting the Texas Health and Human Services Commission in migrating their legacy Delivery System Reform Incentive Payment (DSRIP) program to managed care directed payments. We are reviewing multiple types of providers including local health departments, outpatient clinics, physicians, rural health clinics, and community mental health centers, and providing both policy support and detailed financial analysis. Policy support ranged from a national scan of other states' preprints; providing a detailed list of considerations for all allowable directed payment methodologies for distributing funding including for value-based payments; assisting in determining which

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methodologies were optimal to operationalize. Financial analysis ranged from percentage of Medicare and average commercial rate analysis to determine maximum payment amounts under the program, to determining maximum amount of payments under a cost report framework for rural health clinics and community mental health centers. Several iterations of the analysis were performed to continually incorporate stakeholder feedback from senior leadership and providers. *Office of Inspector General* Guidehouse conducted two projects for the Texas HHSC Office of the Inspector General (OIG). The first project was a high-level review of the OIG's oversight of HHSC and the second was an in-depth assessment of the initial findings. Guidehouse performed an in-depth analysis of OIG to include an organizational assessment of its current functions and structure to determine the best organizational structure and improve critical processes; incorporate best practices into the structure, processes, and systems; assess current technology capabilities and current and future needs; and recommend options to increase the efficiency and effectiveness of OIG activities that will realize the HHSC-OIG mission and the vision; and assist in the implementation of recommendations from previous internal reviews. A key focus of the assessment is the oversight and management of Medicaid managed care. *Network Composition Compliance Assessment* Our consultants provided technical assistance to the Texas Health and Human Services Commission (The Commission) to evaluate Provider Network Composition Compliance for all of its Medicaid and Children's Health Insurance Program (CHIP) Managed Care Organization (MCO) contracts. The assessment included an evaluation of the Accuracy of Provider Directory information, a Geo-Access Assessment of the provider network files and an evaluation of the MCO's strategies for monitoring provider network compliance. In the evaluation of the Accuracy of Provider Directory data, we sampled each MCO's network, stratifying by program and service delivery area. Our consultants compared the sampled records to the hard copy provider directories and submitted provider contracts and Department of Insurance applications (or other approved submissions). Results were logged in a customized database that automated comparative analysis for each evaluation. We also conducted telephone surveys to evaluate Primary Care Physician (PCP) Open Panel status and Specialists appointment scheduling times. To evaluate Network Composition Compliance, we conducted a Geo-Access assessment using MCO network files. We then incorporated MCO self-reported data to supplement our findings due to underlying issues the MCO's experienced in producing the network files. Finally, we completed desk reviews and telephone interviews to evaluate the MCOs' efforts to monitor the composition of their networks and provider availability. The Commission used our reports to evaluate ongoing monitoring efforts and to report to the Texas Legislature and other stakeholders regarding the network composition of Medicaid and CHIP MCOs. *Systems Readiness Review of Managed Care Organization Selected to Provide Comprehensive Health Care for Children in Foster Care* We provided assistance to the State of Texas Health and Human Services Commission to assess the systems readiness of Superior Health Plan Network (Superior), the Managed Care Organization (MCO) selected to provide comprehensive health care for foster care children in the State of Texas as of April 1, 2008. Our consultants conducted a multi-phased readiness review, beginning with a desk review of Superior's policies and procedures for the new systems, which was then supplemented with an on-site review of their claims and data processing systems approximately three months prior to the effective date of the foster care managed care program. In addition to standard managed care readiness review activities, our consultants needed to ensure that specific initiatives included within the managed care program for foster care children could be supported by Superior's system. For example, our readiness

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review included a focus on Superior's ability to accept the State's Daily Notification File, which was created for this new program so foster children can immediately get services from providers upon entry into the program without any lag in provider notification regarding the child's eligibility. Another key feature of our readiness review work included an assessment of Superior's ability to support Health Passport, the first state electronic health record. Health Passport was designed to allow providers and foster parents to view foster children's available health records online. Based on our onsite readiness review activities, we identified areas for further development and review during the final three months before the system went live. Our work included comprehensive preliminary and final reports with recommendations to the State regarding Superior's readiness to implement this program. The report assessed Superior's readiness to accept and download various interface files from the State's administrative services contractor, enrollment broker, Department of Family and Protective Services, drug vendor and providers to populate the Health Passport. During the completion of the readiness review, our consultants developed a comprehensive systems readiness review tool by reviewing contract documents and Superior's proposal. We developed tracking mechanisms for documents received from the State and Superior. During the desk review, we reviewed Superior's Joint Interface, Disaster Recovery, Business Continuity, Risk Management, and Systems Quality Assurance plans to assess their compliance with the contract and their ability to carry out the functions required. As part of the on-site review, we designed test data scenarios to determine whether the Health Passport and claims and data processing systems were functioning correctly and would process correct claims and eligibility data and reject incorrect or missing data. Our review included real-time demonstrations of Superior's ability to accept this test data and process it through their systems.

Compliance with RFQ Requirements

Guidehouse affirms that it is qualified and well-prepared to execute all mandatory contract services requirements and deliverables. We will meet or exceed all mandatory requirements listed in **Section 4 of the RFQ as detailed in Appendix B**.

Actuarial Services Qualifications

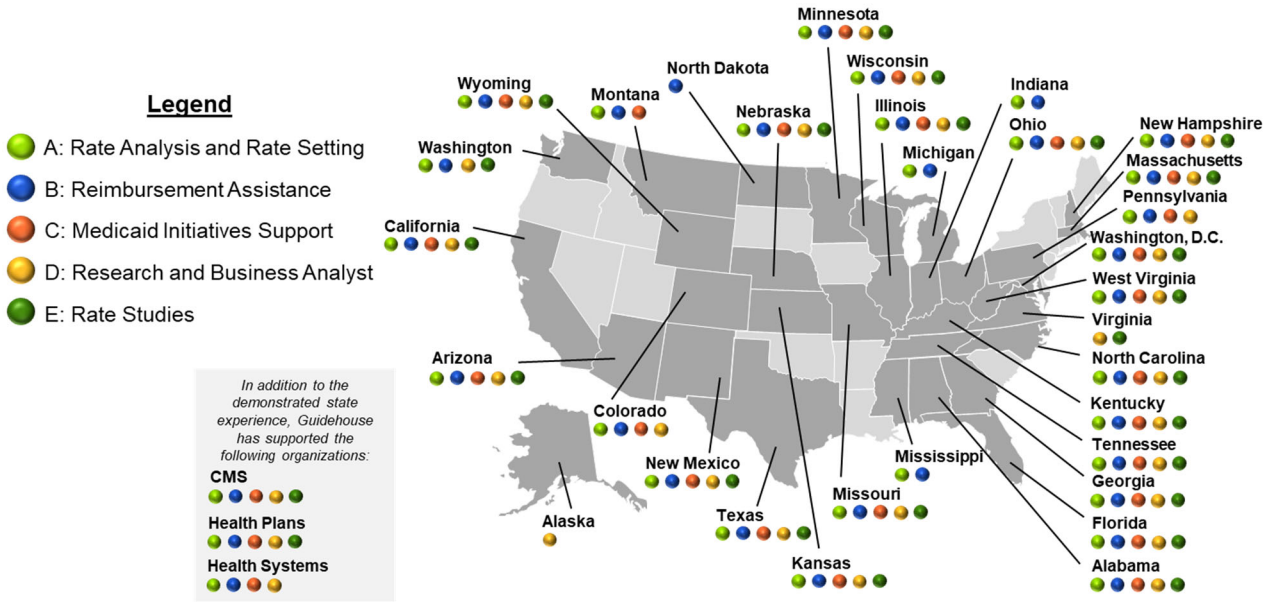
Guidehouse has worked in almost every Medicaid program in the country, serving as an innovative catalyst and providing technical support to state Medicaid agencies and administrations – executing and transforming their actuarial practices, reimbursement strategy, and managed care program design. Our team of actuaries has numerous years of experience developing capitation rates for many states with differing and unique needs.

We are the largest payment systems consulting team in the industry and we not only serve state Medicaid agencies, but we also are at the forefront of payment systems design for major providers, state employee accounts, and workers compensation. We also have extensive hands-on knowledge and expertise in hospital payment system design, development, and operations and the important role of hospitals and other providers in the success of achieving efficiency, quality, and financial objectives.

Figure 4 below depicts our robust experience across the country, serving states, federal agencies, and health systems in rate analysis and rate setting work and other reimbursement and Medicaid initiatives. We are excited about the opportunity to continue working with West Virginia to advance value and efficiency principles in its Medicaid managed care programs.

When other states have asked for West Virginia's BMS feedback on our actuarial consulting, those states have been told that our Guidehouse team of actuaries is the best that DHHR and BMS has ever worked with. Our other state clients would readily provide similar feedback in reference to our work for them. We are grateful for the trust that has been built and our actuarial work with BMS.

Figure 4. Overview of Guidehouse Experience



We have developed and implemented managed care rate methodologies for the following types of managed care programs and populations:

- Temporary Assistance for Needy Families (TANF)
- Children's Health Insurance Plan

- Supplemental Security Income (SSI) Dual Eligibles and Non-Dual Eligibles
- Foster Care and Adoption Assistance
- Medically Needy and Spend-Down
- Nursing Home members
- 1915c waivers (e.g., Autism waiver, I/DD waiver, Traumatic Brain Injury waiver, Serious Emotional Disturbance waiver, Frail Elderly waiver, Physically Disabled waiver)
- Non-Emergency Medical Transportation

We anticipate the need for future rate methodologies to consider social risk factors and to consider more value-added and in lieu of services offered by Medicaid managed care organizations to better address whole-person needs. Our actuarial and policy team is experienced in design of social determinants of health programs and are well positioned to design rate setting methodologies that consider the evolution of Medicaid managed care.

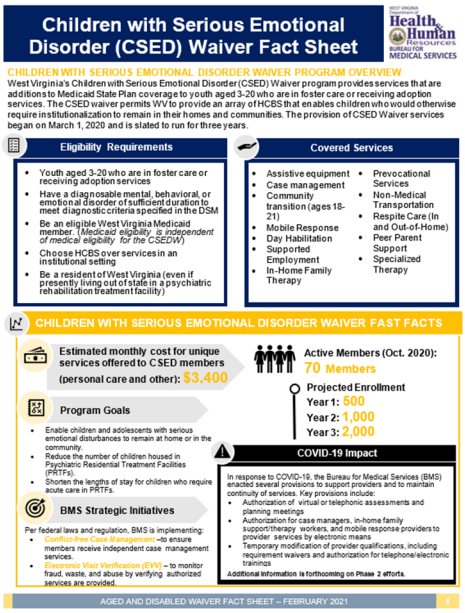
Our Work with West Virginia to Provide Actuarial Services

Since 2018, our Guidehouse team has worked with the West Virginia Bureau for Medical Services (BMS) to oversee, manage, and enhance the State's Mountain Health Trust and Mountain Health Promise managed care programs, **initially focusing on actuarial services and currently for all services**. Throughout our tenure collaborating with BMS, Guidehouse has served as a trusted advisor and extension of BMS, helping it achieve its mission and managed care program goals. Guidehouse is supporting BMS to make an impact on and stride towards the following:

- **Successfully Launch and Monitor the Mountain Health Promise Program:** Leveraging West Virginia data and prior experience from other states and the MHP population groups, Guidehouse established actuarially sound managed care rates. Establishing a new program or transitioning new populations into manage care is an exciting and challenging opportunity for States. BMS hired Guidehouse to lead the state through this transition, relying on Guidehouse's multi-faceted actuarial expertise to launch the program on-time and with CMS approval. Including several rate revisions as additional data became available. Included saving State roughly $5m (over 4 months) by developing and supporting 10% rate reduction for SFY20 foster care rates due to declining population acuity.
- **Design and Deliver Innovative Approaches to Achieve Higher Value:** Throughout the current contract tenure, our Guidehouse actuarial team has designed, analyzed, or strengthened new and existing payment programs such as:
    - State Directed Payment Programs which leverages provider taxes and Federal match funding to distribute payments to hospitals and physicians in exchange for providing for Medicaid and specialty services and improving on select quality metrics.
    - High-Cost Drug Program which needed financial modeling and qualitative analysis including approaches being utilized by other states and full carve-out option.
- **Navigate Sudden Shifts in the Policy and Program Landscape Due to COVID-19:** In the early months of our work the BMS, the COVID-19 Public Health Emergency (PHE) changed the policy and financial landscape across the United States. With uncertain outlook and new challenges, Guidehouse led, with BMS leadership, eFMAP budget

modeling of enrollment changes due to unemployment and reverification suspension and including various COVID-related program changes. Work was utilized for key NAMD survey used to support FMAP lobbying efforts on behalf of states. Guidehouse further supported the State by developing utilization projections, rate adjustments, and financial support for SPA and 1115 Waiver submissions related to the COVID-19 PHE.

- **Establish a Strong Foundation for MCO Programmatic and Policy Innovation:** Guidehouse provides ongoing financial and actuarial support to inform BMS programmatic and policy decisions and enable the State to make fiscally responsible decisions regarding future plans for BMS and its programs. Since 2019, Guidehouse has Finalized SFY21 rates and SFY20 midyear rates including rate certifications, amendments and support of CMS negotiations. Guidehouse also assisted the State in revising its strategy for midyear rates payment (to be based on entire year enrollment instead of final six months; will save State money in times of increasing enrollment). Rates work also led to the development of a new program change tracking tool to be used by State for FFS and managed care.
- **Support Legislative Process and Priorities:** Throughout the State's legislative sessions, Guidehouse has provided actuarial support to inform policy-making and establish actuarially sound budgets. For example, for the 2021 legislation session, Guidehouse created nine (9) program fact sheets/issue briefings to support BMS leadership. BMS leadership used the fact sheets to support their conversations with Legislators and to respond to questions raised during the Legislative session. Guidehouse prepared the following materials:
  - SFY 2021 Budget Fact Sheet
  - Medicaid Fact Sheet
  - COVID-19 Issue Briefing
  - BMS Agency Fact Sheet
  - Specific Program Fact Sheets (e.g., Adult Dental, 1915(c) waiver services, etc.)



Children with Serious Emotional Disorder (CSED) Waiver Fact Sheet

CHILDREN WITH SERIOUS EMOTIONAL DISORDER WAIVER PROGRAM OVERVIEW

West Virginia's Children with Serious Emotional Disorder (CSED) Waiver program provides services that are additions to Medicaid State Plan coverage to youth aged 3-20 who are in foster care or receiving adoption services. The CSED waiver permits WV to provide an array of HCBS that enables children who would otherwise require institutionalization to remain in their homes and communities. The provision of CSED Waiver services began on March 1, 2020 and is slated to run for three years.

Eligibility Requirements

- Youth aged 3-20 who are in foster care or receiving adoption services
- Have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the DSM
- Be an eligible West Virginia Medicaid member. (*Medicaid eligibility is independent of medical eligibility for the CSEDW*)
- Choose HCBS over services in an institutional setting
- Be a resident of West Virginia (even if presently living out of state in a psychiatric rehabilitation treatment facility)

Covered Services

- Assistive equipment
- Case management
- Community transition (ages 18-21)
- Mobile Response
- Day Habilitation
- Supported Employment
- In-Home Family Therapy
- Prevocational Services
- Non-Medical Transportation
- Respite Care (In and Out-of-Home)
- Peer Parent Support
- Specialized Therapy

CHILDREN WITH SERIOUS EMOTIONAL DISORDER WAIVER FAST FACTS

Estimated monthly cost for unique services offered to CSED members (personal care and other): $3,400

Active Members (Oct. 2020): 70 Members

Projected Enrollment
Year 1: 500
Year 2: 1,000
Year 3: 2,000

Program Goals

- Enable children and adolescents with serious emotional disturbances to remain at home or in the community.
- Reduce the number of children housed in Psychiatric Residential Treatment Facilities (PRTFs).
- Shorten the lengths of stay for children who require acute care in PRTFs.

COVID-19 Impact

In response to COVID-19, the Bureau for Medical Services (BMS) enacted several provisions to support providers and to maintain continuity of services. Key provisions include:

- Authorization of virtual or telephonic assessments and planning meetings
- Authorization for case managers, in-home family support/therapy workers, and mobile response providers to provider services by electronic means
- Temporary modification of provider qualifications, including requirement waivers and authorization for telephone/electronic trainings

Additional information is forthcoming on Phase 2 efforts.

BMS Strategic Initiatives

Per federal laws and regulation, BMS is implementing:

- Conflict-free Case Management – to ensure members receive independent case management services.
- Electronic Visit Verification (EVV) – to monitor fraud, waste, and abuse by verifying authorized services are provided.

AGED AND DISABLED WAIVER FACT SHEET – FEBRUARY 2021

Combined West Virginia Familiarity with National Insights and Best Practices

In addition to our work with state Medicaid agencies, Guidehouse is also the prime contractor and performs actuarial bid desk reviews on behalf of the CMS Office of the Actuary. These bids represent a broad spectrum of MA-PDP product offerings (e.g., PFFS, Regional PPO, SNP, etc.). Guidehouse performs a high-level review of the pricing assumptions contained in each bid form in light of (i) the bid form instructions, (ii) supplemental data and review guidelines provided by CMS, (iii) appropriate Actuarial Standards of Practice (ASOPs), and (iv) professional judgment. Guidehouse works with the health plans and their actuaries along with CMS to resolve any potential issues. The results of our bid desk reviews are documented within Health Plan Management System (HPMS). Guidehouse has performed this work under previous contracts since CY 2006.

In **Figure 5** below, we provide a summary of our experience in selected states across the key focus areas associated with RFQ. As illustrated in this table, we meet and exceed the RFQ requirement to have at least 10 years of experience in the development of capitation rates for Medicaid managed care organizations (MCOs).

This table summarizes our experience providing managed care services represented in this RFQ; however, it is not an exhaustive list. Additional references are available upon request.

Appendix A includes additional qualifications from our work with states and CMS that are not included in the figure below.

Figure 5. Guidehouse's Experience in Medicaid Actuarial Services by State

State *Years of Service*	WV 2018-pres.	GA *2007-pres.*	KS *2014-2019*	KY *2015-2018*	TN *2004-pres.*	TX *2019-pres.*	WY *1992-2008*
Project Identifying Numbers	1	2	3	4	5	6	7
Capitation Rate Setting	✓	✓	✓	✓	✓		
Support for Rate Setting Meetings	✓	✓	✓	✓	✓		✓
Encounter Data Analysis	✓	✓	✓	✓	✓		
Directed Payment Programs	✓	✓	✓		✓	✓	
Data Modeling	✓	✓	✓	✓	✓	✓	✓
Financial Data Management	✓	✓	✓	✓	✓	✓	✓
Alternative Payment Models		✓	✓	✓	✓	✓	
Budget Neutrality	✓	✓	✓		✓	✓	
Cost Effectiveness	✓	✓	✓		✓		✓
Trend Analysis	✓	✓	✓	✓	✓	✓	✓
Statistical Analysis	✓	✓	✓	✓	✓	✓	✓
Risk Adjustment	✓	✓	✓	✓	✓		✓
CMS Negotiations	✓	✓	✓	✓	✓		
Pharmacy Savings	✓	✓	✓	✓	✓		
Legislative Inquiries	✓	✓	✓	✓	✓		✓

Following, we have listed the **areas of expertise and projects** that prove our ability to perform the Scope of Work requirements. A narrative project summary for each Guidehouse project listed in **Figure 5** above can be found on the pages listed below:

Guidehouse's Clients

Client Name / Description
1. West Virginia Department of Health & Human Resources | Bureau for Medical Services | 2018-Present
Key Impacts: ✓ ***MHT and MHP State Fiscal Year Rate Setting and Certification*** ✓ ***MHT Revenue Neutral Risk Adjustment*** ✓ ***MHT, MHP, and other extensive Actuarial Support*** ✓ ***MHT and MHP Analytics of Actuarial Data*** ✓ ***COVID-19 and Related Impacts Actuarial Support*** ✓ ***Budget and Cost Neutrality Support*** ✓ ***Actuarial Services for Nursing Facilities, Psychiatric Residential Treatment Facilities and Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID)*** ✓ ***Pharmacy Carve-out Savings Analysis, as a highly visible and robust actuarial analysis of the financial impact carving out pharmacy had on BMS' Medicaid programs*** ✓ ***Actuarial support for FFS Program IBNR Reserves*** ✓ ***Directed Payment Program Actuarial and Financial Impact Analysis***

Guidehouse and our staff has worked with the State of West Virginia for the past years providing actuarial services including the development of MCO capitation rates, amending prior year capitation rates, directed payments approach, CMS pre-prints for 42 CFR 438.6 (c), budget neutrality and cost effectiveness, MLR compliance, HIPF validation, policy support, pharmacy savings analysis, annual IBNR valuation of FFS part of Medicaid program, revenue code pricing, fiscal impact analysis of 1115 SUD waiver, and presentations to state staff and the MCOs. Populations covered under the MCO capitation rates include TANF, Pregnant Women, Children with Special Health Care Needs (CSHCN), SSI (Disabled), and ACA Expansion members. Recent populations for potential inclusion include foster care children.
Our extensive tenured actuarial expertise and experience with West Virginia DHHR and BMS includes all current contractual components related to actuarial services plus support of CHIP and FFS financial analysis where requested by BMS. Further detailed examples of our extensive and highly valued actuarial service to the State's programs include:
• MHT and MHP State Fiscal Year Rate Setting, where the process includes: 1) Data Intake and Validation, 2) Actuarial Modeling 3) Rate Presentation and Documentation and 4) Certification of capitation rates to CMS
• MHT Revenue Neutral Risk Adjustment, including: 1) Developing and refining risk adjustment methodology scenarios for the different populations; then studying, testing and communicating scenario results to BMS for decisions, where actuarial models to assess and re-assess the following:
  ○ When and how previously determined approaches will be applied and implemented
  ○ Base data criteria
  ○ Usage of national versus state specific weights
  ○ The application of prospective or concurrent factors
  ○ Addressing risk adjustment for new managed care enrollment
  ○ Enrollment churn and movement between MCOs
• MHT, MHP, and other extensive Actuarial Support, wherein addition to capitation rate development, there are other actuarial items that rely on rates and underlying data and models. Guidehouse has (and continues to) provide actuarial support for these items although the items do not all require submission to CMS nor the MCOs or actuarial certification. Our actuaries assist BMS as requested with these items. Based on our experience in working with BMS in the past, these items include the following high-level tasks: Responding to BMS requests that address external inquiries from the legislature or even advocacy groups and

Client Name / Description

provider associations. Additional coordination for items such as the MCO contracts or the Annual Report to the State to ensure all is in sync with the rate certifications. Furthermore, cost effectiveness assessments and any other analysis tied to the rate development. A list of our experience in supporting BMS includes:

- Mid or Partial Year Program Changes
- MLR Actuarial Validation and CMS Submission, Risk Corridor
- Directed Payment Program (DPP) and other Hospital Based Physician Reimbursement Calculations
- Fiscal Impact Analyses and Legislative Response Support
- Actuarial Coordination with Managed Care Contract
- IBNR for FFS Programs
- Medicaid Fee Schedule Analysis and Development
- Actuarial Input for Annual Report
- Pharmacy Carve-out Analysis
- 1915(b) Cost Effectiveness Support as Needed
- 1115 SUD Budget Neutrality

- MHT and MHP Analytics of Actuarial Data
  - One benefit to BMS has experienced with our Guidehouse team is leveraging actuarial data analytics and problem-solving techniques to become more informed users of the trend results. Analytics leveraging underlying claims and enrollment data to provide actuarial representation of various data items have and continue to be produced to help mitigate some interdepartmental requests related to actuarial services with the State's own internal analytic departments.
  - Since the data is already being received monthly due to actuarial project needs, it is most efficiently being leveraged to verify MCO reporting and provides BMS a deeper dive into potential issues and red flags, as well as MCO performance.
- Medicaid and other Ad Hoc actuarial services, including COVID-19 actuarial support, wherein our Guidehouse team provides additional actuarial support to assist the Medicaid program in light of the COVID-19 pandemic. As part of these ad hoc needs, Guidehouse actuaries provide the following services:
  - Actuarial analysis of waiver programs
  - Data Reporting
  - Special capitation rate provisions and risk mitigation strategies for MCOs
  - Budget support and forecasting (overflow from 'MHT Other Actuarial' task)
  - Provider and MCO solvency analysis
  - Hospital and nursing home financing
  - Eligibility and enrollment pattern modeling
  - FMAP analysis
- Budget and Cost Neutrality Support, and other Ad Hoc Actuarial Services including Hospital Inpatient Services and cost-based calculations and Hospital Outpatient Services
- Actuarial Services for Nursing Facilities, Psychiatric Residential Treatment Facilities and Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID)
- Pharmacy Carve-out Savings Analysis, as a highly visible and robust actuarial analysis of the financial impact carving out pharmacy had on BMS' Medicaid programs
- Actuarial support for FFS Program IBNR Reserves
- Directed Payment Program actuarial and financial impact analysis

Client Name / Description
BMS has previously received under our current contract all supporting documentation and evidence of each of these actuarial services provided by our Guidehouse actuarial team. If BMS would like us to re-provide any evidential documentation, we will be happy to reproduce all necessary documents to BMS upon request.
2. Georgia Department of Community Health | 2007 – Present
Key Impacts: ✓ ***Developed capitation rates for Medicaid managed care programs that have achieved* a projected revenue for FY20 of $4B+ with 1.3M+ members** ✓ **Ensure compliance with CMS regulations and guidance**

DCH retained Guidehouse in August 2011 to analyze and implement strategic options for managing the financing and care of the State's Medicaid and PeachCare for KidsTM programs which cover nearly 1.7 million members. We continue to work with the State on this important initiative to transform the Medicaid program and to support improved outcomes and quality of care for members.
We began our efforts to transform the Medicaid program through an assessment of re-design options for the State. We used a robust, structured, objective and analytic approach to evaluating what is often a politically-charged environment that includes stakeholders and politicians with competing priorities. Guidehouse initially conducted the following tasks to support development of a Comprehensive Design Strategy Report. Our activities included the following:
• Assessed the model and structure of Georgia's current Medicaid and PeachCare for KidsTM programs; this includes Medicaid funded services including developmental disabilities and behavioral health
• Conducted a national environmental scan of Medicaid and Children's Health Insurance Programs and of best practices in commercial health plans relating to delivery and financing of services
• Provided considerations and recommendations for moving ABD populations into managed care
• Determined how reform would require reengineering and restructuring of Medicaid program with a focus on the delivery system
• Identified waiver possibilities, issues regarding obtaining waivers and prepared for and participated in meetings with the Medicaid Agency and a CMS Medicaid State Technical Assistance Team (MSTAT)
• Participated in a number of meetings with State actuaries when considering budgeting and financing options
• Conducted focus groups across the State with and an online survey of providers, consumers, advocacy groups and vendors, as well as three task forces that provided ongoing input to the program design
Guidehouse is currently performing the following activities:
• Providing trainings to staff responsible for conduct of monitoring and oversight for the Georgia Families and Georgia Families 360 programs
• Supporting the development of key program design features for Medicaid program modernization, through activities such as procurement materials to contract with a Credentialing Verification Organization to conduct credentialing for the FFS delivery system and all contracted CMOs
• Supporting re-procurements, including interviewing staff and conducting national research, identifying program enhancements and developing re-procurement materials for the following contracts:
  ○ Georgia Families (including Georgia Families 360)
  ○ Medical Review and Compliance Vendor

Client Name / Description
○ Pharmacy Benefit Manager ○ Pharmacy Rebate Vendor • Supporting workgroups charged with identifying key program design components and issues to consider for the proposed integrated delivery systems and program design • Assisting with strategic planning and development of program design components • Assisting in planning for and implementation of an expansion of the State's risk-based Medicaid managed care program, Georgia Families, to children in foster care and adoption assistance and select children in juvenile justice; helping the State to build infrastructure, processes and tools to support implementation of the new program (e.g., Readiness Review tools, use case workflows, transition work plans, etc.) • Supporting the development of key program design features and procurement materials for a new Medical Coordination Program for members who are aged, blind and disabled • Participating in and advising on negotiations with CMS about innovative program design features such as opportunities to request alternative funding options • Preparing documents to obtain federal authority for the program changes the State is implementing With this project, Guidehouse has demonstrated proficiency in design, procurement, operation, evaluation and improvement of risk-based and other Medicaid managed care programs. Guidehouse also recently **helped Georgia design a Value Based Purchasing (VBP) model** to implement as part of its expansion of Georgia Families to children in foster care, adoption assistance and juvenile justice. Our VBP approach has been endorsed by providers and managed care organizations alike. This effort will increase opportunities for the State to align all quality improvement efforts across stakeholders. This VBP model goes beyond Pay for Performance – a very clear and transparent goal-setting process is conducted, including mining of data to identify gaps and areas where a focus is needed. Based on the goal or the aim for a given year, the VBP model requires a process to conduct monthly measurement of progress. Guidehouse has advised Georgia through a process that is anticipated to make the State a national leader in Medicaid performance improvement and quality improvement.
3. Kansas Department of Health & Environment | 2014 – 2019 (Previous work: 1994-1996)
Key Impacts: ✓ ***Developed capitation rates for Medicaid managed care programs that included a number of different populations, including 1915(c) long-term services and supports waiver populations***
Guidehouse developed and certified managed care rates involving comprehensive covered services for the following programs: TANF, CHIP, ABD non-dual eligible, former faster care children, medically needy/spenddown, Medicare-Medicaid dual eligible, 1915(c) HCBS waiver, and LTSS. We also assisted the State with Risk adjustment design and implementation, DRG weight and rate development, and Medicaid expansion enrollment and budget analysis.
4. Kentucky Department for Medicaid Services (DMS) | 2014 – 2017
Key Impacts: ✓ ***Developed capitation rates for Medicaid managed care programs*** ✓ ***Corrected prior actuarial capitation rate issues identified*** ✓ ***Prepared rate setting analyses for 1915(c) waivers***
Guidehouse has developed and certified managed care rates involving comprehensive covered services for the following programs: TANF, CHIP, ABD non-dual eligible, Former foster care children, NEMT, Medicare-Medicaid dual eligible, and Mental and Behavioral health services.

Client Name / Description
Guidehouse also provided risk adjustment analysis for all populations, including implementation of risk adjustment for the ACA expansion population. Additionally, Guidehouse assisted the Commonwealth in determining budget neutrality in preparation for their 1115 waiver. **Guidehouse helped the Commonwealth redesign all of their 1915(b) and (c) waivers**. We successfully developed and certified past years' NEMT rate ranges (SFY14 and SFY15) that were previously deemed non-compliant by CMS due to non-submission; and re-developed and re-certified both SFY15 traditional/non-expansion and CY14-SFY15 ACA expansion rate ranges developed and certified past years' NEMT rate ranges (SFY14 and SFY15) that were previously deemed non-compliant by CMS due to non-submission.
5. Tennessee Division of Health Care Finance and Admin. (TennCare) | 2004 – Present
Key Impacts: ✓ ***Developed rates for TennCare's managed care programs, CY20 projected $7.2B*** ✓ ***Developed reverification adjustment methodology that has survived intense and prolonged scrutiny of MCOs, CMS, and other actuarial firms*** ✓ ***Developed I/DD program capitation rates*** ✓ ***Developed Expansion and Block Grant Analyses***
Guidehouse performed all work related to MCO managed care rates for TennCare, including the creation of a databook, certifications, reviews with CMS, and necessary documentation. We provided actuarial, data and financial services currently provided by three MCOs along with reconciliations for PCP enhancement and HIPF reimbursement, Directed Payments, annual Medicaid budget and Comptroller reports, visual analytics with in-depth claim and membership movement analysis, dashboard development, and policy/program design support. Populations included TANF, disabled, dual-eligible, and LTSS. TN also required input on reforming hospital reimbursement, detailed analysis of state budget needs for Medicaid, development of an annual comptroller report, evaluation of programs, and ad hoc actuarial, financial,1115 and policy support. Guidehouse assists the State with all aspects of Medicaid managed care capitation rate setting. We have assisted with the following tasks: developing actuarially sound capitation rates, creating databooks, assisting with certifications, reviewing with the Centers for Medicare and Medicaid Services (CMS) and stakeholders, and assisting with all related documentation. Guidehouse's team provided actuarial services for rate-setting related to three MCOs. Our work also included reconciliations for primary care physician enhancement and health insurance provider fee reimbursement, annual Medicaid budget and comptroller reports, visual analytics with in-depth claim and membership movement analysis, dashboard development, Medical Loss Ratio (MLR) analysis and monitoring of results, and policy / program design support. For Tennessee MCOs, we developed actuarially sound risk-adjusted capitation rates for Temporary Assistance for Needy Families (TANF), disabled, dual-eligible, and Long-term Support Services (LTSS) populations. TennCare, the State of Tennessee's managed Medicaid agency, required input on reforming hospital reimbursement, detailed analysis of State budget needs for Medicaid, evaluation of programs, and ad hoc actuarial, program integrity, legislative, and policy support. Guidehouse's team also developed, implemented, and monitored the risk payment methodology for the MCOs. The engagement focused on the following four objectives: • Develop managed care capitation rates for TennCare's programs, including acute care and LTSS • Ensure financial viability of Medicaid programs • Efficiently and proactively track, analyze, and manage risks to TennCare's program • Assist with additional budgetary review and program needs an on ongoing basis Guidehouse assisted with the following actions: • Rate Setting: Regularly process and validate claims and enrollment data, develop actuarial models and assumptions, present rates, provide documentation, and provide ongoing rate support between the State, MCOs, and CMS

Client Name / Description
• Financial and Budgetary Projections: Develop annual budget projections for the State as well as provide an annual report that compiles cost projections for both managed care and fee-for-service programs • Other Actuarial Support: Risk adjustment in various forms, directed payment analysis and calculations, Medicare repricing, HIF Reconciliation, fiscal impact analyses and legislative response support, incurred but not reported valuation, quarterly review of MCO MLR submissions • Social Determinants of Health Support (SDOH): Provide presentations to leadership team on available financing mechanisms to support possible future SDOH endeavors
6. Texas HHSC | 1996-1998, 2005-2009, 2014-2015, 2019 – Present
Key Impacts: ✓ ***Transitioning current DSRIP initiatives to managed care directed payment programs*** ✓ ***Supporting stakeholder and provider engagement efforts related to directed payment transition*** ✓ ***Effective management and reporting to CMS for DSRIP***
Directed Payment Guidehouse assists the state with two directed payment programs. The first targets inpatient and outpatient hospitals as well as academic physicians and is financed primarily by provider taxes. The second program targets physicians employed by acute care hospitals and is also financed by provider taxes. Guidehouse assists the state in soup-to-nuts preprint support: from percentage of Medicare modeling; to average commercial rate data collection, scrubbing, and analysis; to integrating the quality strategy into the program; to full preprint writing and support of CMS questions. We also incorporate the programs into the state's managed care contracts and rate certifications. We assist the state in a comprehensive review and projection of the acute care tax receipts which support the programs' financing including development of future years' payment pool levels with FMAP analysis. We also calculate the quarterly distributions of both programs including development of all exhibits. *DSRIP Reporting* Guidehouse is currently assisting the Texas Health and Human Services Commission in migrating their legacy Delivery System Reform Incentive Payment (DSRIP) program to managed care directed payments. We are reviewing multiple types of providers including local health departments, outpatient clinics, physicians, rural health clinics, and community mental health centers, and providing both policy support and detailed financial analysis. Policy support ranged from a national scan of other states' preprints; providing a detailed list of considerations for all allowable directed payment methodologies for distributing funding including for value-based payments; assisting in determining which methodologies were optimal to operationalize. Financial analysis ranged from percentage of Medicare and average commercial rate analysis to determine maximum payment amounts under the program, to determining maximum amount of payments under a cost report framework for rural health clinics and community mental health centers. Several iterations of the analysis were performed to continually incorporate stakeholder feedback from senior leadership and providers.
7. Wyoming Department of Health | 1992 – Present
Key Impacts: ✓ ***Developed sound rate setting methodology for select facilities*** ✓ ***Developed Wyoming's first PACE payment rates*** ✓ ***Transitioned ambulatory surgery center reimbursement methodology to a prospective methodology***
Guidehouse assisted Wyoming with modeling potential reimbursement approaches including APR-DRGs for hospitals, bundled payments, and prospective payments for ambulatory surgery centers (ASCs). Highlights of our work with Wyoming in the last five years includes:

Client Name / Description
• Managing Medicaid rate analysis and rate setting practices to establish reimbursement methodologies, including general research, policy analysis, analysis of State and Federal rules and regulations, and administrative support New payment policies developed, include rates for hospitals physicians, ASCs, community mental health centers (CMHCs), rural health clinics (RHCs), federally qualified health centers (FQHCs), and psychiatric residential treatment facilities (PRTFs). As part of the methodology support, Guidehouse assists the State to coordinate, facilitate, and present to provider groups and the State Legislature on various payment and reform activities. • Developed Wyoming's first PACE, led the analysis to develop the per member per month rates, and prepared the State Plan materials to explain the methodology. • Assessed the dual-eligible population, compared performance to national trends, and identified options for transforming the care delivery mechanism. • Transitioned Wyoming's current ASC reimbursement methodology to a prospective payment methodology. This includes quarterly and/or annual analyses of the outpatient prospective payment system, inpatient hospital level of care reimbursement system, hospital intergovernmental transfer payment program and private hospital tax program, hospital disproportionate share hospital (DSH) payment program, physician RBRVS reimbursement system, FQHC and RHC rates, and PRTF rates. Guidehouse also analyzed health home, ACO options, and alternative delivery systems that emphasized integrated care, preparation of the Wyoming Medicaid Reimbursement Benchmarking Study, which provides the Division with a strategic overview of Medicaid programs and expenditures; development of numerous written reports and communications on behalf of the Division, including reports to the legislature, Office of the Governor, Healthcare Commission, Department of Education, and several other sectors of the State government; and development of numerous waiver programs, state plan amendments, and other policies that require working with and negotiating with CMS.

Compliance with RFQ Requirements

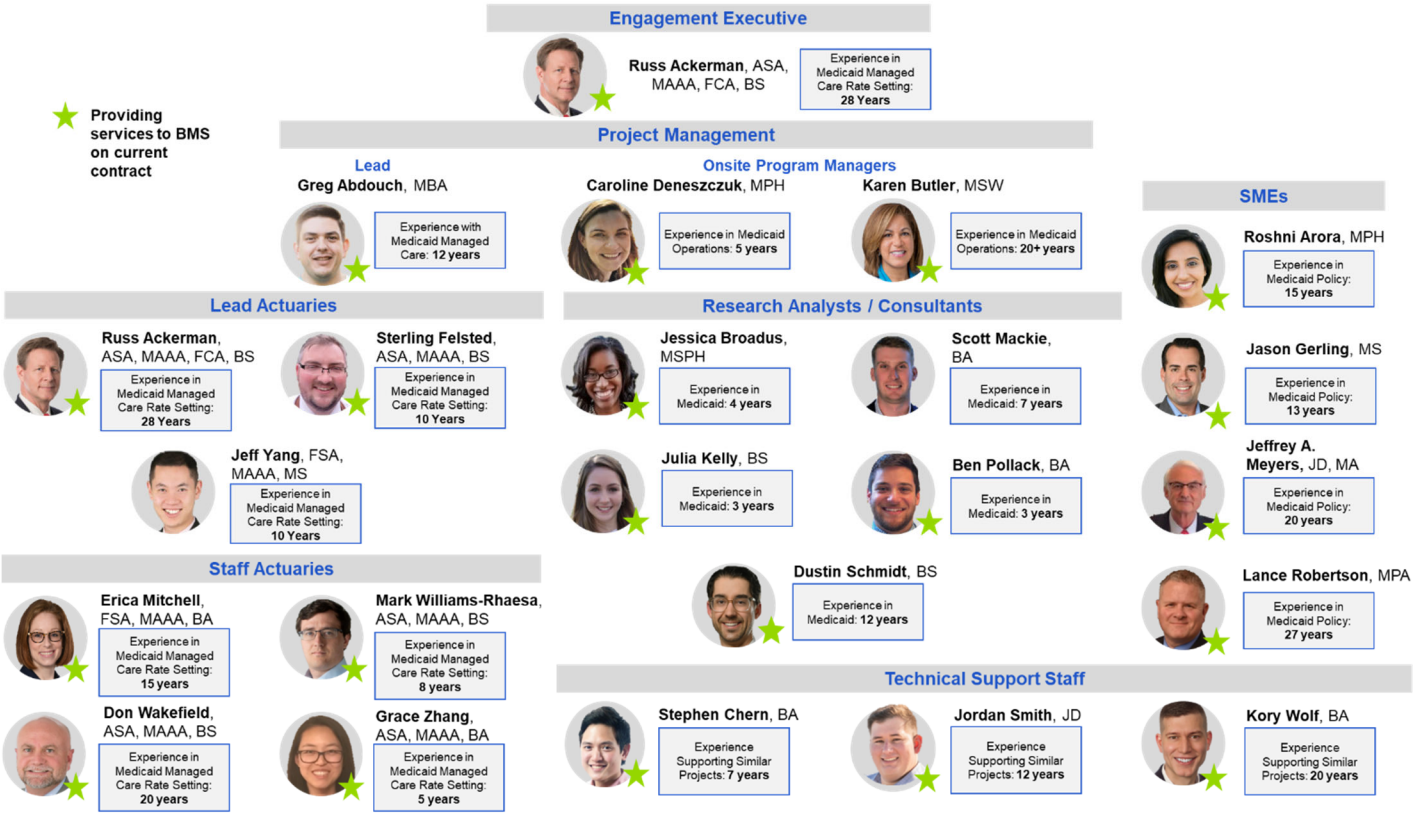
Guidehouse affirms that it is qualified and well-prepared to execute all mandatory contract services requirements and deliverables. We will meet or exceed all mandatory requirements listed in **Section 4 of the RFQ as detailed in Appendix B**.

Section 3 Engagement Team

Guidehouse's actuarial team has extensive experience developing actuarially sound capitation rates and actuarial models using a broad variety of data sources for various types of Medicaid managed care programs in more than 20 states. Guidehouse's actuarial team has developed Medicaid capitation rates for managed care programs over the last 10 years. We have a combined 35 years of experience signing capitation rates across five states including Tennessee, Georgia, Kansas, Kentucky, and West Virginia.

The actuarial team is embedded within Guidehouse's broad State Medicaid practice. Our State Medicaid practice works with and alongside our extensive 1,000-person Healthcare practice, which gives our experts extensive access to broader resources to benefit West Virginia via a comprehensive understanding of all provider and payer influences on Medicaid programs throughout the nation. This gives us both broad and deep expertise across every single Medicaid program due to projects covering health policy support, CMS-64 financial analyses, Medicaid fee schedule rate setting, Medicaid provider transformation assessment, operational implementation, and program integrity.

Figure 6. Guidehouse Project Team Structure



The needs outlined in this RFQ align with Guidehouse actuarial and Medicaid managed care expertise, as shown in the following skills matrix.

Figure 7. Staff Skills Matrix

Topic	WV Experience	Medicaid Mgd Care Ops	Medicaid Mgd Care Waivers	Monitoring & Oversight	MLTSS	Behavioral Health	Social Determinants of Health	CMS Negotiations	Pharmacy	Capitation Ratesetting / Support	Encounter Data Analysis	Directed Payment Programs	Data Modeling	Financial Data Mgmt	Alternative Payment Models	Budget Neutrality	Cost Effectiveness	Trend & Statistical Analysis
Project Management Lead																		
Greg Abdouch	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓			✓			
On-Site Program Manager																		
Karen Butler	✓	✓	✓	✓	✓	✓	✓	✓	✓						✓			
Caroline Deneszczuk	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓			✓			
Research Analysts / Consultant																		
Jessica Broadus	✓	✓	✓	✓	✓	✓	✓		✓						✓			✓
Julia Kelly	✓	✓	✓	✓	✓	✓						✓						✓
Scott Mackie		✓	✓	✓	✓	✓	✓	✓	✓	✓					✓			✓
Ben Pollack	✓	✓	✓	✓	✓	✓						✓						✓
Dustin Schmidt	✓	✓	✓	✓	✓	✓	✓	✓	✓						✓			✓
Medicaid Policy Subject Matter Expert																		
Roshni Arora	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
Jason Gerling	✓	✓	✓	✓	✓	✓	✓	✓	✓						✓	✓	✓	✓
Jeff Meyers		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓			✓	✓	✓	✓
Lance Robertson		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓			✓	✓	✓	✓
Lead Actuary																		
Russ Ackerman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sterling Felsted	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jeff Yang	✓		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Staff Actuary																		
Erica Mitchell	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Don Wakefield	✓		✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mark Williams-Rhaesa	✓		✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Grace Zhang	✓		✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Technical Support Staff																		
Stephen Chern	✓	✓	✓							✓	✓	✓	✓	✓	✓	✓		✓
Jordan Smith	✓	✓		✓						✓	✓	✓	✓	✓	✓	✓		✓
Kory Wolf	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓			✓

Guidehouse's committed resources are healthcare professionals with numerous years of hands-on managerial and subject matter experience. We expect that the following professionals will lead Guidehouse's efforts in respective functional areas:

Project Executive

Russ Ackerman, ASA, MAAA, FCA (28 years)

Russ is Guidehouse's Chief Actuary, with responsibility for all actuarial and associated analytics for the firm. He has 28 years of experience in consulting, health plan, and Managed Care Organization (MCO) environments; and is responsible for assisting states with Medicaid managed care program development, capitation, and rate setting efforts. Throughout his consulting career, he has both consulted governments and agencies on their overall strategies, actuarial requirements, financial management practices, financial and eligibility data, analytics, and modeling. His work includes leading and performing work for all aspects of Managed Care and Fee for Service Medicaid programs. For those programs, he consults on both legacy Medicaid strategies and strategizes with state and agency forward looking innovations. In his past, Russ also worked for a large Midwestern health plan in corporate finance leadership and chief actuary role with oversight over all government sponsored, commercial, and retail lines of business, including Medicaid, Medicare, Individual, Large and Small Group, and Provider ACO business.

Some states Russ has led actuarial consulting services for West Virginia, Arizona, Georgia, Idaho, Kansas, Kentucky, Massachusetts, Mississippi, North Carolina, Ohio, Tennessee, and Texas. Projects he has led for these states and their agencies include Medicaid rate setting strategies, risk adjustment implementations, Long Term Services and Supports (LTSS), Home and Community Based Services (HCBS), Intellectual or Developmental Disabilities (IDD), and other specific population strategies. This work includes related financial data modeling, analysis, pricing activities, and decision facilitation for 1115 waivers, 1915b, c, and b / c combo waivers, state innovation model (SIM) strategies, and development and implementation of both Accountable Care Organizations (ACOs) and Patient Centered medical Homes (PCMHs) to serve Medicaid and other higher risk populations.

Projects he has led have been the bases for various states' governors' and legislative stakeholders' decisions for Medicaid strategy, rural health initiatives, pharmacy financing approaches, and general healthcare reform. He is an active Member of the American Academy of Actuaries (MAAA) and its Medicaid and Medicare Committees, an Associate of the Society of Actuaries (ASA) and its Health Section Medicaid Subcommittee. He is also a Fellow in the Conference of Consulting Actuaries (FCA). He participates and contributes regularly to industry associations and conferences.

Russ is currently directing and leading all aspects of Guidehouse support to BMS. Under this leadership, the Guidehouse team has delivered multiple CMS-compliant MHT and MHP capitation rate certifications, analytics, analyses of COVID-19 impacts, Section 1915(b) cost effectiveness support, Section 1115 waiver budget neutrality support, pharmacy carve-out savings analyses, and additional ad hoc support to BMS leadership.

Project Management Lead (1)

Gregory Abdouch, MBA (12 years)

Greg focuses on managed care, long-term supports and services, behavioral health, and providing project management oversight of engagements for clients who are making large-scale transitions in their Medicaid programs. Greg has more than 12 years of experience in Medicaid managed care and the supervision and management of program transformation teams within both state agencies and Medicaid managed care plans. He received his Bachelor of Science in Business Administration from the University of Arizona and his Master of Business Administration from Washington University in Saint Louis with a focus on healthcare management and finance. He is finishing his Project Management Professional (PMP) Certification with estimated completion in April 2021.

In our current support to BMS, Greg serves as the Project Management Lead. In this role, he has managed Guidehouse's delivery of services and deliverables within the timeframes required by BMS. Greg is readily available to BMS leadership to answer questions and provide immediate guidance on pressing policy issues.

Previously, Greg has also provided project management support to solve complex issues for CMS, Arizona, Kentucky, Illinois, Mississippi, and others. His experience also includes having managed the implementation of a long-term services and supports benefit for a Medicaid health plan.

Onsite Program Managers (2)

Caroline Deneszczuk, MPH (5 years)

Caroline specializes in health policy research, stakeholder engagement and communications, project management, operational assessments, and compliance. Caroline has significant experience working with government entities and legislative groups to conduct research and support health reform initiatives. Her areas of focus are health insurance coverage and access, healthcare demonstrations and waiver policy, dual eligible individuals, end-of-life care, home- and community-based settings, program operations, and evaluation. 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.

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.

In our current support to BMS, Caroline serves as the Policy Lead. She has led preparation of the 1915(b) waiver renewal applications for the MHT and MHP programs, revisions of the Quality Strategy, policy and quality aspects of BMS' directed payment programs, and the analysis of key regulations and guidance from CMS. Caroline lives in Chicago, Illinois but will be available on-site to assist BMS with day-to-day MCO operations oversight, addressing MCO and other inquiries, and attending operations meetings.

Karen Butler, MSW (20 years)

Karen is a Master's level Social Worker with more than 20 years of experience in government agency management, including Medicaid program administration, Child Welfare program administration and Child Support program functions. She has led organizational change management and development, quality improvement, legislative advocacy, and community collaboration and resource development activities for several public human service agencies in Maryland, Washington, DC and North Carolina.

As a former Department of Social Services Director for more than ten years, she has an excellent track record managing public health programs and enhancing collaboration among health and human service stakeholders to optimize the equitable access and delivery of Medicaid services.

Karen has served as a subject matter expert in care coordination of Medicaid managed care services, communications, and stakeholder engagement. She has participated in high-level assessments and planning for state-level Medicaid managed care program redesigns and has integrated change management principles with stakeholders, using the opportunity to design and implement service and practice changes.

In our current support to BMS, Karen serves as the Compliance Lead. She is leading the review and updates to the MHT and MHP MCO contracts, as well as the content expert related to social determinants of health and care coordination. Karen combines her regulatory and compliance expertise with first-hand knowledge of program operations to provide maximum value to BMS. Karen lives outside of Washington, DC but will be available on-site to assist BMS with day-to-day MCO operations oversight, addressing MCO and other inquiries, and attending operations meetings.

Research Analysts / Consultants (5)

Jessica Broadus, MSPH (4 years)

Jessica received her a Master of Science in Public Health and Bachelor of Science in Public health from the University of North Carolina at Chapel Hill. She brings more than four years of experience in healthcare consulting, with a focus on state government and public health clients. Her background includes experience with assessing and optimizing Medicaid program performance, conducting research on healthcare industry and policy trends, and developing operational improvement or strategic development plans.

On Guidehouse's current project with BMS, Jessica is supporting the Program Oversight and Monitoring Team. Jessica tracks receipt of MCO reports, communicates directly with MHT and MHP MCOs to clarify submitted report data, and oversees the development of the MHT and MHP reporting dashboards. She also leads development of key findings and issues to raise with BMS regarding MCO performance based on her review of operational reports.

Julia Kelly (3 years)

Julia has experience supporting state governments, state Medicaid programs, and community healthcare providers through research, data analysis, grant management, communications and other program oversight initiatives. Her professional experience includes assisting with West Virginia's Medicaid managed care program operations by analyzing provider network adequacy,

editing quality strategy, creating communication aides, reviewing health plan marketing materials, and compiling other research and reports.

She has also supported Tennessee's Medicaid agency (TennCare) in compiling and drafting legislative research, planning an 1115 waiver evaluation design, and developing stakeholder engagement materials. For South Dakota, she was involved in planning, constructing, and implementing a major state healthcare grant management program to distribute COVID-19 relief funding. Her role included developing state communications initiatives, including managing an applicant assistance email account, creating weekly client deliverables, writing FAQs, planning communications events for providers, and assisting with call center planning and maintenance. She also helped generate daily reports for the healthcare team using Salesforce application and email inbox data.

Julia has had more than three years of health policy experience, particularly surrounding Medicaid operations, behavioral health, and substance use disorders. Prior to Guidehouse, Julia was a research assistant at the Duke-Margolis Health Policy Center. She analyzed trends in Medicaid data for dental opioid prescriptions in North Carolina. She used the results to craft policy recommendations to NC DHHS and propose a collaborative letter campaign aimed at educating opioid prescribers about high-risk prescribing practices. Additionally, she assisted with research for a healthcare cost drivers collaborative investigation, in which Duke-Margolis worked with the Health Care Cost Institute to analyze and model trends in costs for North Carolina residents by payer and health condition.

On Guidehouse's current project with BMS, Julia is already serving as a Research Analyst / Consultant for BMS. She contributes to Policy, and Program Oversight and Monitoring tasks related to the Quality Strategy, Provider Network Assessment, HB417 legislative reporting, and additional ad hoc policy research.

Scott Mackie (7 years)

Scott has seven years of experience in state Medicaid agency operations and supporting large program implementations. Scott 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).

Ben Pollack (3 years)

Benjamin has three years of experience in many aspects of the development, operation, and oversight of Medicaid programs, working with both state governments (e.g., Illinois) and the Centers for Medicare & Medicaid Services (CMS). His most recent areas of focus have included redesigning rate methodologies for developmental disability services across midwestern community residential facilities and leading a training series on oversight of Home- and Community-Based Services (HCBS) through technological solutions, quality monitoring, and interagency collaboration.

On Guidehouse's current project with BMS, Ben is already serving as a Research Analyst / Consultant for BMS. He supports the Policy Team and helped to prepare the 1915(b) waiver renewal applications for the MHT and MHP programs, revisions of the Quality Strategy, and policy and quality aspects of BMS' directed payment programs.

Dustin Schmidt (12 years)

Dustin has more than 12 years of consulting experience, providing technical and strategic expertise to the government healthcare industry. Dustin is a practice leader in conducting operational and performance improvement assessments for state Medicaid agencies and long-term services and supports (LTSS) agencies to improve efficiencies, reduce costs, enhance staff alignment, and improve quality of care. He has also led multiple states in designing and implementing strategies to improve their oversight functions of MCO entities and has provided training to state staff on how to effectively monitor managed care programs.

On Guidehouse's current project with BMS, Dustin serves as Lead for the Program Oversight and Monitoring Team. Dustin oversees all aspects of our monitoring strategy for the MHT and MHP programs – including report templates, MCO clarifications and questions, enhancements to operational reports, analysis, and review of MCO performance, and development of ad hoc reporting to BMS or other external entities. He also provided ad hoc support to BMS leadership by created nine (9) program fact sheets/issue briefings to support BMS leadership through the State's legislative session. BMS leadership used the fact sheets to support their conversations with Legislators and to respond to questions raised during the Legislative session.

Medicaid Policy Subject Matter Experts (4)

Roshni Shah Arora, MPH (15 years)

Roshni has more than 15 years of experience in the healthcare industry working with government-sponsored programs, including Medicaid, Medicare, CHIP, and uninsured programs. Roshni has led engagements specializing in healthcare service delivery system activities, including Medicaid managed care initiatives for over 10 state Medicaid agencies.

These delivery system engagements include assisting states and payers with all phases of a program lifecycle: design, implementation, monitoring, operations, organizational readiness, as well as care management, network adequacy, and federal and regulatory compliance.

On Guidehouse's current project with BMS, Roshni is currently directly and leading all aspects of managed care program administration on behalf of the West Virginia Department of Health and Human Services, Bureau for Medical Services. Since she began in this role, Roshni directed and led key priorities for BMS, including: (1) completion of an managed care organization (MCO) compliance review, (2) updates of Mountain Health Trust and Mountain Health Promise MCO contracts, (3) refresh of Managed Care Quality Strategy (including Medicaid and CHIP), (4) payment and renewal of current directed payment programs (state-directed payments), and (5) implementation of more robust MCO monitoring and oversight processes.

She also served as the Project Management Lead for the services within this RFQ under her previous employer from 2009 to 2012, providing direct counsel and deliverables to BMS and directly to the Commissioner.

Jason Gerling, MS (13 years)

As a Master's level Gerontologist and leader of long-term and services and supports consulting for Guidehouse, Jason has more than 13 years of professional experience building successful long-term services and supports and community based case management / population health models that enhance collaboration between public services sectors including health, human

services, and affordable housing. His work is keenly focused on engagements that advance initiatives for vulnerable populations including Older Americans, persons with disabilities, persons with mental illness, low-income households and individuals facing health inequity. He leads complex, multi-workstream engagements in multiple states and for other high-profile organizations like Fannie Mae.

Jason is experienced in facilitating partnerships and engaging external partners both in program management, technical assistance, and training roles. He is also experienced in qualitative research, stakeholder engagement and strategic communications. Jason's work is committed to improving upon current systems to better serve vulnerable populations across socioeconomic groups, by developing cost-efficient and creative ways to serve them and their circles of support.

On Guidehouse's current project with BMS, Jason is already serving in this role, providing subject matter expertise on key BMS priorities such as the Quality Strategy, effective Medicaid managed care operations, social determinants of health, and care coordination.

Jeff Meyers, JD, MA (20 years)

Jeff supports and manages the strategic challenges of healthcare environments for state, provider, and payer clients. He has deep experience in state government, federal regulatory practice, and healthcare, having served most recently as Commissioner of the New Hampshire Department of Health and Human Services, overseeing all Medicaid, Behavioral Health, Public Health, Human Services, Child Welfare and Long-Term Care divisions. Jeff has worked extensively with the Centers for Medicare and Medicaid Services on a range of complex Medicaid programs, including the New Adult Group expansion, the Disproportionate Share Hospital (DSH) Program, and Supplemental and Directed Payments. He also was deeply involved in rate setting for the State's Medicaid Managed Care program, behavioral health rates, and nursing home and other long-term care rates.

On Guidehouse's current project with BMS, Jeff has contributed as a subject matter expert on deliverables related to impacts of the Biden administration and legislative analysis (e.g., Medicaid Buy-In Programs).

Lance Robertson, MPA (27 years)

Lance has extensive experience working with programs and services that support the nation's most vulnerable and marginalized populations. His unmatched experience in the development and execution of large public sector agencies, both at the state and federal level, brings a unique point of view to any engagement. Lance also has the practical experience of creating partnerships and successful collaborations across disparate agencies and partners, increasing the potential for impactful solutions with lasting effects.

On Guidehouse's current project with BMS, Lance has contributed as a subject matter expert on deliverables related to social determinants of health and care coordination.

Lead Actuary (3)

Russ Ackerman, FCA, ASA, MAAA (28 years)

Russ, also listed as our Engagement Executive, and his detailed experience, can be found on previous pages.

Sterling Felsted, ASA, MAAA (10 years)

Sterling is a credentialed actuary with 10 years of actuarial consulting experience, mostly focused on Medicaid work. He drives many of the projects and actuarial models for Medicaid program development, rate setting, risk adjustment and other financial analyses. Sterling's experience includes pricing and budget projections, IBNR reporting, rate setting (including MLTSS and HCBS), Health care reform impact modeling, Medicare pricing, fee schedule development, discount analysis, and additional ad hoc model building for Medicaid programs, state health plans, and other employer-based health plans. For AHCCCS, he will be a subject matter resource leveraged for his deep working experience with MLTSS populations.

He is the lead technical actuary for Tennessee Medicaid where he oversees the capitation rate development process, budgeting, and reporting needs for the State, as well as coordinating day to day ad hoc work. Sterling has contributed to developing models and reporting to Tennessee Medicaid, Kentucky Medicaid, West Virginia Medicaid, and the State Health Plans for Tennessee and Kentucky.

On Guidehouse's current project with BMS, Sterling is supporting the development of Medicaid managed care capitation rates for the MHT and MHP programs. Early in the engagement of the contract with BMS, Sterling was critical for setting up several of the ancillary models that support State risk adjustment and the accounting of directed payment distributions. He still routinely presents at weekly BMS Leadership meetings to present financial and actuarial analyses that inform the MCO capitation rate setting process and other projects due to his working knowledge of the program. Sterling leverages his experience supporting Tennessee and other states to inform and guide financial-related policy recommendations the Guidehouse team offers.

Jeff Yang, ASA, MAAA (10 years)

Jeff is a credentialed actuary who specializes in Medicaid managed care capitation rate development. His 10 years of experience across the state side and health plan side help bring a unique perspective to rate negotiations between insurers and state agencies.

Jeff serves as the lead actuary for Georgia's Medicaid managed care capitation rates. He is responsible for the quality of client deliverables and facilitates conversations with State contacts. He is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

Staff Actuaries (4)

Erica Mitchell, FSA, MAAA (15 years)

Erica is a Fellow of the Society of Actuaries and has more than 15 years of experience in healthcare and actuarial consulting. She has worked across numerous healthcare lines of business including Medicaid, Commercial, Individual, and Medicare; all roles have had a deep focus on pricing. Her array of experience allows her to look at actuarial problems in a unique way, such as when she recently provided Tennessee, Georgia, and Arizona with a deep dive into methods of financing state Social Determinants of Health goals within the Medicaid framework.

In the Medicaid space, she is the lead actuary for West Virginia Medicaid, and oversees ad hoc consulting services for two other States. Her work includes rate setting, cost effectiveness, budget neutrality, ad hoc modeling, and directed payment support for both financial modeling

and preprint strategy. She has also presented on high cost drug risk mitigation methods for MCOs and States in Medicaid.

On Guidehouse's current project with BMS, Erica leads the development of key actuarial deliverables and analyses, including but not limited to the 1915(b) waiver cost effectiveness modeling, directed payment program financial modeling, and legislative and budget-related analysis and projections. She was critical to the launch of the MHP program and worked actively with MCO financial and actuarial staff to finalize the MCO capitation rates. Erica also performs quality control and validation procedures on the MHT and MHP capitation rates.

Don Wakefield, ASA, MAAA (20 years)

Don's responsibilities have included leadership of rate setting, financial forecasting, data warehouse management, reporting tool development, trend development, and model development efforts for many types of medical plans. Don actively develops capitation rates for successful submission to Centers for Medicare and Medicaid Services (CMS) and engages with multiple states on actuarial modeling and program review.

Don is an expert who comes with more than 20 years' experience developing healthcare related actuarial solutions in both the private and public sectors, over 5 of which have been in the Medicaid managed care arena. Don has been a project manager for Medicaid rate setting projects, including work on NEMT, risk adjustment, and risk reconciliation projects.

On Guidehouse's current project with BMS, Don is already serving as a staff actuary working on multiple ad hoc projects ranging from pricing of adult dental benefit options to determining the financial impact of administering COVID-19 tests during the early stages of the Public Health Emergency. Don has also prepared IBNR analyses of the West Virginia Medicaid FFS population.

Mark Williams Rhaesa, ASA, MAAA (8 years)

Mark is part of the healthcare strategy business unit at Guidehouse with nine years of actuarial experience focused on pricing, reporting development and optimization, and trend analysis. His actuarial experience focuses on pricing, reserving, and data analytic techniques for both the private employers and Medicaid clients using tools such as Excel, Access, and SQL. In the Medicaid space, Mark has assisted the rate setting for last 2 years with both new and existing managed care programs. He has experience in areas such as cost effectiveness, budget neutrality, and other waiver elements.

On Guidehouse's current project with BMS, Mark is currently one of the lead actuaries of Guidehouse assisting BMS with MHT and MHP capitation rate certifications. He also works on various other modeling projects such as budget projections, COVID-19 impacts, and pricing out new services such as adult dental.

Grace Zhang, ASA, MAAA (5 years)

Grace is a credentialed actuary specializing in Medicaid rate-setting and rate reviewing. She has over five years of health care actuarial experience. Her knowledge achieved by working on the health plan side helps bring a different perspective to rate setting process, as well as rate negotiation with the health plans. Grace has achieved her ASA credential in 2020.

Grace serves as a key contributor for actuarial requests from Georgia's Department of Community Health. She also supports Texas's Medicaid directed payment program, and West Virginia and Tennessee's Medicaid programs.

Technical Support Staff (3 – Non Actuary)

Stephen Chern (7 years)

Stephen is responsible for providing output, data insights, and limitations to actuaries in capitation rate setting of Managed Care Organizations (MCOs). He also assists healthcare payers, providers, or state Medicaid agencies with developing innovative reimbursement systems and pay-for-performance models to achieve payment transformation. He focuses on using analytics to manage risk, improve care quality, and align payment incentives.

On Guidehouse's current project with BMS, Stephen primarily supports Directed Payment Programs (DPP) and preprint submission process as required by CMS. With his knowledge in various database programming, he manages SQL and SAS-based payment model to simulate Medicaid and Medicare costs and payments and application of Average Commercial Rates (ACR). He also analyzes data for actuarial use in MHT and MHP's capitation rate setting and risk adjustment process.

Jordan Smith, JD (12 years)

Jordan lives in Charleston, WV, and received his Juris Doctorate from West Virginia University College of Law in 2016. He came to Guidehouse in 2020 after several years of public-interest legal work within West Virginia. Possessing experience in administrative law, government policy analysis, and the implementation of innovative, people-centered projects, Jordan's J.D. skillset and background offer unique insight into the way people and policy interact. At Guidehouse, Jordan works in the Healthcare Strategy segment where his research, analysis, and forward-thinking solutions help ensure the quality and integrity of state Medicaid programs.

On Guidehouse's current project with West Virginia, Jordan contributes to our Compliance and Policy teams. He plays a critical role in reviewing all member informational and marketing materials submitted by MCOs for approval, supporting the MHT and MHP contract updates, and contributing to ad hoc policy research requests. Jordan resides in Kenna, West Virginia, which is a short 25-minute drive to Charleston and is available to provide on-site support to BMS.

Kory Wolf (20 years)

Kory is with the Value Transformation team bringing more than 20 years of healthcare experience. He brings extensive background in data analytics; data management, SQL experience, IT business analysis; member, provider, and claim payment system configuration; and health plan daily operations. He is at the forefront of all client data submissions between actuarial and technical consulting firms, such as Myers and Stauffer and DXC, to ensure seamless transitions into Guidehouse (and formerly Aon) data systems and infrastructures. He has worked extensively with the Medicaid membership and claim data from Tennessee, Georgia, Kansas, Kentucky, and West Virginia; the membership and claim data of BCBS' PPO/POS; and HMO products in nearly all 50 states and the national commercial and Medicare claim data from Humana.

He is responsible for leading the data team in all data validation and visualization work. As team data manager, he performs client bulk data transfers, data loading, SQL coding, processing,

and output preparation. He prepares risk-adjustment models using licensable software, such as CDPS+Rx and John Hopkins ACG, from client datasets for actuarial use in capitation rate setting of managed care organizations (MCO) participating in state Medicaid programs to calculate risk-adjusted capitation rates that are budget-neutral to the state. He performs DRG client repricing exercises using 3M's core grouping software for DRG assignment, APC assignment, and Medicare inpatient / outpatient fee schedule pricing.

He works with Guidehouse's IT to maintain system readiness, compliance, and functionality. He is the key contact for clients in responding to detail data questions, issues, and resolution, along with handling any advanced analytic projects. Prior to his current role, he spent many years working with actuarial data at Milliman and other consulting firms.

On Guidehouse's current project with BMS, Kory currently serves as Guidehouse's data manager and lead SQL programmer, tasked with the intake of MCO encounters, FFS claims and eligibility files supplied from BMS' data vendor. He leads a team of data analysts and programmers responsible for reviewing, preparing, and summarizing the information for the actuarial suite of services performed for BMS.

Detailed professional resumes can be found in **Appendix C**.

Appendix A Additional State Qualifications Matrix

	AL	AK	AZ	CA	CO	DC	FL	GA	IL	IN	KS	KY	MA	MI	MN	MO	WY
Rate Analysis, Rate Setting, and Reimbursement																	
Price / cost analysis	✓		✓	✓			✓	✓	✓		✓	✓			✓	✓	✓
Analysis of Other states	✓		✓		✓	✓	✓		✓		✓	✓			✓	✓	✓
Rate updating	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓			✓	✓	✓
Rate Setting / Other Rate Support	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DSH	✓													✓	✓		✓
FQHC	✓																✓
PRTF, RTCs	✓																✓
I/P HOSP	✓		✓	✓			✓	✓	✓		✓	✓			✓		✓
IGT/QRA	✓				✓		✓										✓
OPPS	✓						✓		✓								✓
RBRVS	✓		✓								✓		✓			✓	✓
RHC	✓																✓
UPL	✓		✓	✓	✓	✓	✓	✓	✓		✓		✓		✓	✓	✓
Care Mgmt	✓											✓	✓				✓
HEDIS	✓			✓						✓		✓	✓		✓		✓
ICD-10	✓		✓	✓			✓						✓		✓		✓
ABI, DD waivers			✓						✓			✓					✓
Actuarial Support			✓	✓									✓		✓		
General Research	✓		✓	✓		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Policy Development	✓		✓		✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Analysis of state / federal rules	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓
Medicaid Initiatives Support																	
Reimbursement initiatives	✓		✓		✓	✓	✓	✓	✓			✓			✓	✓	✓
Hearing and litigation	✓						✓		✓								
Plan for Reimbursement							✓	✓	✓		✓	✓					✓
Annual Report																	✓
Research and problem solving	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Research and Business Analysis																	
Gathering information	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Statistics	✓		✓	✓		✓	✓	✓	✓		✓	✓			✓	✓	✓
Analysis of expenditures	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Medicaid claims analysis	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Analysis of payment systems	✓	✓	✓			✓	✓	✓	✓		✓				✓	✓	✓
COGNOS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓
Rate Studies																	
Cost of services	✓		✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Analyzing cost information	✓		✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Developing conceptual models	✓		✓			✓	✓	✓	✓		✓	✓			✓	✓	✓
Rate recommendations	✓		✓	✓		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
CMHSA												✓					
Behavioral Health	✓					✓			✓				✓			✓	✓

	WV	MS	MT	NE	NC	ND	NH	NM	OH	PA	TN	TX	VA	WA	WI	WY	CMS	Health Plan	Health Sys.
Rate Analysis, Rate Setting, and Reimbursement																			
Price / cost analysis	✓			✓	✓		✓	✓			✓				✓	✓	✓	✓	✓
Analysis of Other states			✓		✓		✓		✓		✓					✓	✓		✓
Rate updating	✓				✓		✓	✓	✓		✓				✓	✓	✓	✓	
Rate Setting / Other Support	✓			✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
DSH		✓		✓	✓										✓	✓			
FQHC										✓						✓			
PRTF, RTCs																✓			
I/P HOSP	✓			✓	✓			✓			✓			✓	✓	✓		✓	✓
IGT/QRA					✓							✓			✓				
OPPS	✓			✓							✓				✓	✓		✓	
RBRVS	✓					✓					✓					✓			
RHC								✓			✓					✓			
UPL	✓			✓	✓			✓						✓	✓				
Care Mgmt							✓									✓			
HEDIS								✓		✓						✓		✓	✓
ICD-10				✓				✓							✓	✓			
ABI, DD waivers							✓									✓	✓		
Actuarial Support	✓				✓			✓			✓								
General Research	✓		✓	✓	✓		✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
Policy Development			✓	✓	✓		✓		✓	✓	✓	✓			✓	✓	✓	✓	✓
Analysis of state / federal rules	✓			✓	✓		✓		✓	✓	✓	✓			✓	✓	✓	✓	✓
Medicaid Initiatives Support																			
Reimbursement initiatives	✓			✓			✓		✓	✓	✓	✓			✓	✓	✓	✓	✓
Hearing and litigation										✓	✓							✓	✓
Plan for Reimbursement	✓			✓	✓				✓	✓	✓				✓	✓	✓	✓	✓
Annual Report										✓						✓	✓	✓	✓
Research and problem solving	✓		✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Research and Business Analysis																			
Gathering information	✓			✓	✓		✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
Statistics	✓			✓	✓		✓	✓	✓	✓	✓	✓			✓	✓	✓		
Analysis of expenditures				✓	✓		✓	✓	✓		✓	✓			✓	✓	✓	✓	✓
Medicaid claims analysis	✓			✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	
Analysis of payment systems	✓			✓	✓								✓		✓	✓		✓	
COGNOS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A
Rate Studies																			
Cost of services	✓				✓		✓	✓	✓		✓				✓	✓	✓	✓	
Analyzing cost information	✓				✓		✓	✓	✓		✓	✓		✓	✓	✓	✓		
Developing conceptual models	✓						✓	✓	✓	✓	✓					✓			
Rate recommendations	✓			✓	✓		✓	✓	✓		✓				✓	✓	✓	✓	
CMHSA																			
Behavioral Health							✓									✓			

Appendix B Confirmation that Contract Services Must Meet or Exceed the Mandatory Requirements

Guidehouse affirms that it is qualified and well-prepared to execute all mandatory contract services requirements and deliverables. We will meet or exceed all mandatory requirements listed in section 4 of the RFQ. The following figure confirms that Guidehouse will meet all mandatory requirements.

Requirement	Guidehouse Confirmation that We Meet or Exceed all Mandatory Requirements	
	Yes	No
4.1 Mandatory Contract Services Requirements and Deliverables: Contract Services must meet or exceed the mandatory requirements listed below.	✓	
4.1.1 Managed Care Program Administration		
4.1.1.1 The State Medicaid Managed Care Program, both Mountain Health Trust and Mountain Health Promise, currently operate under a 1915(b) waiver. Requests for services related to waiver analyses outside of the Managed Care waivers shall be accounted for under ad hoc services. Services provided under the ad hoc section will be done at an hourly rate and will require execution of an approved SOW and delivery order before work can commence.	✓	
4.1.1.2 The vendor shall provide oversight with current and new programs developed and operating under existing managed care waivers, new waivers, or waiver renewals.	✓	
4.1.1.3 The vendor shall assist with drafting 1915(b) waiver applications and associated quality strategies.	✓	
4.1.1.4 The vendor shall develop correspondence, such as waiver applications, letters to federal entities, etc. related to waivers or other managed care program needs.	✓	
4.1.1.5 The vendor shall conduct analyses of waiver programs and develop recommendations for improving effectiveness and efficiency of waiver programs.	✓	
4.1.1.6 The vendor shall assist the Bureau with activities related to its 1115 waiver for Substance Use Disorder, including but not limited to, federal reporting requirements and other analyses, as needed, which will be administered under the managed care organizations.	✓	
4.1.1.7 The vendor shall provide policy impact analyses and support to the Bureau, including, but not limited to, reviewing and analyzing policy options, developing documents for review, programmatic impact assessments, conducting federal regulatory review, developing presentations, and assisting with implementation of strategies (i.e. preparation of work plans, facilitation of meetings, monitoring, and evaluation).	✓	
4.1.1.8 The vendor must agree to revise all analyses based on future releases or revisions of information at the state or federal level within an agreed upon timeframe between the vendor and Bureau.	✓	
4.1.1.9 The vendor shall monitor federal regulations and requirements for potential changes and provide analyses on program impact on an ongoing basis.	✓	
4.1.1.10 The vendor must develop and submit an Operations Plan within the first thirty (30) calendar days of contract award that addresses compliance with program requirements and services.	✓	
4.1.1.11 The vendor shall develop and maintain the MCO contracts associated with both Mountain Health Trust and Mountain Health Promise.	✓	

Requirement	Guidehouse Confirmation that We Meet or Exceed all Mandatory Requirements	
	Yes	No
4.1.1.12 The vendor shall conduct annual network adequacy assessments, with approach to completing approved by the Bureau, for both MHT and MHP, in a mutually agreed upon schedule.	√	
4.1.1.13 The vendor shall analyze and monitor Managed Care contract performance, as described in greater detail in 4.1.15.1.	√	
4.1.1.14 The vendor shall develop an annual report on MCO performance and compliance with contractual obligations within ninety (90) calendar days of the end of the reporting period. The end of the reporting period is the end of the state fiscal year annually. The annual report shall also address program enrollment, services available, cost savings resulting from the program, performance on key quality indicators, Medical Loss Ratio (MLR) overview, improvement strategies implemented, program goals, and other information as requested by the Bureau.	√	
4.1.1.15 The vendor shall conduct program readiness documentation and desk reviews, as needed, for an undetermined number of managed care entities, dependent upon entry into the WV Medicaid program. Reviews shall also be provided on an on-going basis for existing MCOs, as deemed necessary by the Bureau to ensure continued programmatic compliance.	√	
4.1.1.16 The vendor shall perform analyses and ongoing monitoring of MCO provider networks, conduct quarterly analyses of the MCOs' networks against program requirements.	√	
4.1.1.17 The vendor shall develop MCO-specific reports and maps showing providers, clinics, and hospitals by specialty and location. Information shall be submitted within 10 calendar days of request, unless otherwise noted.	√	
4.1.1.18 The vendor shall work with the bureau to develop a comprehensive reporting calendar for the MHT and MHP programs that complies with federal, state, and bureau-specific reporting requirements as defined by the managed care contracts.	√	
4.1.1.19 The vendor must identify and comply with all federal and state Medicaid laws, regulations, and policies, as outlined by the Centers for Medicare and Medicaid Services and the Bureau for Medical Services.	√	
4.1.1.20 The vendor shall analyze Early Periodic Screening, Diagnosis and Treatment (EPSDT) service provisions and prepare federal and state reports on methods to improve efficiency, effectiveness, coordination and quality of those services in West Virginia as needed, in an agreed upon format and submission standard between the vendor and the Bureau.	√	
4.1.1.21 The vendor must provide ad-hoc reports upon request on information including, but not limited to, comparisons of the Managed Care program with the fee-for-service program to improve the efficiency, effectiveness, and quality of the Managed Care program within the timelines established for each project as outlined by the Department. These ad-hoc reports will be based on an approved SOW and Delivery Order.	√	
4.1.1.22 The vendor must provide an analysis tool with access for ten (10) state users for use in identifying medical service utilization patterns by category of service and medical and administrative cost profiles for all Managed Care cohorts, major lines of business, and individual Managed Care recipients to improve quality of care and outreach.	√	

Requirement	Guidehouse Confirmation that We Meet or Exceed all Mandatory Requirements	
	Yes	No
4.1.1.23 The vendor must provide all data, program and regulatory analyses required to respond to, but not limited to, Legislative, Federal, State, Budgetary, Provider or Advocacy requests in a timeframe that is mutually agreed upon by vendor and state.	✓	
4.1.1.24 The vendor must develop a strategy for MCO contracting, including options for performance targets, use of incentives and/or penalties, modifications to program requirements, implementation and oversight of a Managed Care medical loss ratio (MLR), and others as requested.	✓	
4.1.1.25 The vendor shall develop a comprehensive quality assessment and performance improvement strategy, that complies with federal regulations, Quality Improvement Systems for Managed Care (QISMC), CMS standards, other quality review programs, and input from enrollees, advocates, Managed Care organizations, and other stakeholders to identify options and recommendations for monitoring and evaluating the quality and appropriateness of care and services to enrollees.	✓	
4.1.1.26 The vendor shall meet with the State's Managed Care entities, provider groups and other parties as determined necessary by the Bureau at locations to be determined dependent upon availability of space at no additional cost to state.	✓	
4.1.1.27 The vendor shall assist in developing options for program expansion and assist in implementation of program expansion, including preparation of documents outlining options for program expansions, including cost savings, policy considerations, risks, issues, agency and bureau coordination requirements, and legal constraints, etc.	✓	
4.1.1.28 The vendor shall assist with the development of reports for WV House Bill 4217.	✓	
4.1.1.29 The vendor shall be responsible for collection of all required reports of the MCOs, reviewing reporting for any errors or omissions, generating reports for the Bureau based on the data reported, and maintaining a tracking log of the submission to be used in monitoring MCO contract compliance. Required reports and due dates of the MCOs are included in Exhibit C.	✓	
4.1.1.30 The vendor shall provide an electronic tool that serves as a program compliance dashboard that will allow the Bureau to track, at a minimum, but to be refined by the Bureau: • All deliverables submitted by the MCOs as outlined under the Managed Care contract • MCO policies and procedure documents • Contract and amendment language and version history • MCO quality metrics and report card • Network adequacy documents and readiness review materials • Grievances and Appeals • Vendor shall provide classroom-led training to staff on utilizing the project management system and maintain a training manual for reference. • Platform must be hosted by the vendor and allow access for up to ten (10) users at any time. Settings must be configurable to meet state needs. The current state operating system is Windows 10. For teleconference capabilities, the State currently uses Skype for Business. The State will then switch over to Google Workplace at a point in the coming months for teleconferencing. There is no firm date on the switch to Google Workplace.	✓	
4.1.2 Actuarial Services		
4.1.2.1 The vendor shall complete the development, setting, certification, and/or review of rates for the State's Managed Care programs. Capitation rates for Managed Care	✓	

Requirement	Guidehouse Confirmation that We Meet or Exceed all Mandatory Requirements	
	Yes	No
shall be developed based on readily available State data and set by cohorts, including, but not limited to, age, gender, eligibility category, geographic location, and population risk factors.		
4.1.2.2 Vendor shall develop high, mid, and low capitation rate ranges for review.	√	
4.1.2.3 Vendor must develop Managed Care rates at the individual MCO level, if the Bureau chooses to develop MCO-specific rates based on risk stratification.	√	
4.1.2.4 Vendor shall participate and provide support in rate setting discussions and meetings as needed, and provide supporting documentation, including but not limited to, presentations, rate workbooks, spreadsheet files, and rate memos, as requested by Bureau staff for meetings.	√	
4.1.2.5 Vendor shall work collaboratively with Department staff to improve the accuracy and efficiency of the existing data sources and new data sources used for rate development, and the methodologies used in the rate setting process. Collaboration shall include attending meetings, conference calls, and other requests that the Bureau deems necessary. It is the expectation of the Bureau that the vendor shall provide new and innovative ideas around the rate setting process and efficiencies of such. The Vendor shall facilitate direct communication channels between Actuary and the Department. The frequency shall be on an as requested basis. The location of the meetings will be mutually agreed upon, either in-person or virtually.	√	
4.1.2.6 Vendor shall provide the Bureau with reports and calculations in the formats specified by the Bureau, including all formulae, databases, data sets, and other documents as requested on an as needed basis in an agreed-upon	√	
4.1.2.7 The vendor shall assist the Department in identifying where rate uniformity can occur to ensure payments are made consistently across all bureaus by conducting a rate uniformity workgroup and analysis of all rates currently administered in a schedule to be coordinated between the vendor and Department. The analysis shall identify inconsistencies and recommendations to the Department for improving its rate setting process and helping align areas that are not in uniformity.	√	
4.1.2.8 Vendor shall update the capitation rates based on data, pricing trends, changes resulting from federal and/or state requirements, program changes and certify such amendments, at a minimum of one time per fiscal year.	√	
4.1.2.9 The vendor shall develop and successfully implement a plan to transition all data, methodologies, documentation, and ongoing projects to the next succeeding vendor, at least thirty (30) calendar days in advance of the contract end date.	√	
4.1.2.10 The vendor shall coordinate with the State's fiscal agent to ensure accurate encounter, claims, and eligibility data is used for rate setting. Vendor shall review encounter data for completeness and/or inconsistencies as part of rate setting process and provide a summary report of any inconsistencies to the Bureau for review on an ad hoc basis in a format agreed upon between the vendor and Bureau.	√	
4.1.2.11 Vendor shall work with fiscal agent to ensure completeness of all reports used for state and federal reporting, as requested by the Bureau.	√	
4.1.2.12 The vendor must gather, process, validate and analyze Managed Care encounter and claims data, including carved out services and provide technical assistance to the Managed Care organizations on data issues.	√	
4.1.2.13 The vendor shall assist in development of methodologies for calculating Directed Payment Program amounts or other supplemental payments, and the associated preprints and quality strategies for such programs.	√	

Requirement	Guidehouse Confirmation that We Meet or Exceed all Mandatory Requirements	
	Yes	No
4.1.2.14 The vendor must perform actuarial analysis and valuation of the costs or savings established by implementing programmatic changes, including, but not limited to, the transitioning of populations from FFS to managed care or alternate coverage options.	√	
4.1.2.15 The vendor must agree to provide a detailed billing report with each invoice for actuarial services, which details the hours billed per staffing position, per staff member.	√	
4.1.3 Ad Hoc Services		
4.1.3.1 The contractor must provide the Bureau and/or Department with additional consultation and actuarial services and complete other work as requested.	√	
4.1.3.2 The vendor shall provide a Statement of Work, including but not limited to, the number of project hours, resources to be used, and cost affiliated with each ad hoc request for review by the Bureau/Department.	√	
4.1.3.3 The vendor shall provide a fixed hourly rate for programmatic services and a fixed hourly rate for actuarial services.	√	
4.1.3.4 The vendor shall analyze the accuracy of payments and reimbursements related to changes under the Affordable Care Act (ACA) or other federal or state health care and/or payment provision rules, regulations, laws, or codes.	√	
4.1.3.5 The vendor shall provide assistance in development of payment methodologies for other programs, including, but not limited to, long-term care, nursing home, and Home and Community Based Services waivers.	√	
4.1.3.6 The vendor shall assist with programmatic activities needed within other divisions of the Bureau for Medical Services outside of the Managed Care Unit.	√	
4.1.3.7 The vendor shall assist finance with all facets of the provider rate development and implementation process.	√	
4.1.3.8 The vendor shall conduct research and recommend approaches in key areas of chronic care/disease management, pharmacy, eligibility and coverage, quality improvement, rural health, and other as requested.	√	
4.1.3.9 The vendor shall provide assistance in overseeing continued implementation of the State's Serious Emotional Disorder (SED) 1915(c) waiver, which falls under the Mountain Health Promise program.	√	
4.1.4 Service Level Agreement		
4.1.4.1 The vendor shall agree to be bound to all service level agreements as defined within Attachment 3: Exhibit B Service Level Agreements.	√	
4.1.5 All Services		
4.1.5.1 The vendor agrees that the Department has the right to review and approve hiring of key staff and to request replacement staff if it is felt that qualifications and/or needs are not being adequately met.	√	

Appendix C Staff Resumes

Full resumes for our proposed project team, listed below, are on the following pages:

Key Staff

- Project Management Lead
  - Greg Abdouch, MBA
- On-site Program Manager
  - Caroline Deneszczuk, MPH
  - Karen S. Butler, MSW
- Research Analysts / Consultants
  - Jessica Broadus, MSPH
  - Julia Kelly
  - Scott Mackie
  - Benjamin J. Pollack
  - Dustin T. Schmidt
- Medicaid Policy Subject Matter Experts
  - Roshni Arora, MPH
  - Jason S. Gerling, MS
  - Jeff Meyers, JD
  - Lance Robertson
- Lead Actuaries
  - Russell H. Ackerman, ASA, MAAA, FCA
  - Sterling Felsted, ASA, MAAA
  - Jeff Yang, FSA, MAAA
- Staff Actuaries
  - Erica Mitchell, FSA, MAAA
  - Mark Williams-Rhaesa, ASA, MAAA
  - Don Wakefield, ASA, MAAA
  - Grace Zhang, ASA, MAAA

Non-Key Staff

- Technical Support Staff
  - Stephen Chern
  - Jordan Smith, JD
  - Kory Wolf

WV BMS2100000002
Project Management Lead

Greg Abdouch, MBA
Associate Director

gregory.abdouch@guidehouse.com
Chicago, Illinois
Direct: 602.528.8101

Professional Summary

Requirement: minimum of a Bachelor's Degree, with five (5) years' experience with Medicaid managed care

Greg focuses on managed care, long-term supports and services, behavioral health, and providing project management oversight of engagements for clients who are making large-scale transitions in their Medicaid programs. Greg has more than 12 years of experience in Medicaid managed care and the supervision and management of program transformation teams within both state agencies and Medicaid managed care plans. He received his Bachelor of Science in Business Administration from the University of Arizona and his Master of Business Administration from Washington University in Saint Louis with a focus on healthcare management and finance. He is finishing his Project Management Professional (PMP) Certification with estimated completion in April 2021.

In our current support to BMS, Greg serves as the Project Management Lead. In this role, he has managed Guidehouse's delivery of services and deliverables within the timeframes required by BMS. Greg is readily available to BMS leadership to answer questions and provide immediate guidance on pressing policy issues.

Areas of Expertise

- Project Management experience including large scale implementation and merger integration
- Extensive Medicaid Managed Care health plan operations experience including claims payment, medical management, and provider network management
- Medicaid Managed Care Oversight and Monitoring
- Managing and implementing Long-Term Supports and Services programs
- Stakeholder engagement
- Home and Community Based Services Rate Setting

Professional Experience

Medicaid Managed Care

- Currently serving as Project Manager for the West Virginia Department of Health and Human Resources (DHHR) Bureau for Medical Services (BMS) for all Mountain Health Trust (MHT) and Mountain Health Promise (MHP) program oversight and policy related work including MCO Contract updates, 1915(b) waiver renewals, directed payment programs, MCO reporting, and numerous other objectives.
- Assisted the Arizona Health Care Cost Containment System (AHCCCS) organization (Arizona Medicaid) with contract and policy compliance related to the Medicaid Managed Care Final Rule changes around Network Adequacy, External Quality Review Organizations and Member Information.

Greg Abdouch, MBA
Associate Director

- Facilitated workgroup meetings for the AHCCCS related to program design and procurement support for the AHCCCS Complete Care Request for Proposal. Developing work plan, agenda, and objectives to achieve predetermined goals for procurement.
- Served as an Executive Immersion Program Manager/Associate for a managed care organization (MCO) in the areas of health plan operations, internal audit, and product management and innovation. Assisted with the development of proposals for new managed care markets including technical writing and analysis. Provided procurement assistance in securing provider contracts and conducted stakeholder engagement for the communication of new health plan business lines and changes to processes. Managed Health Benefits Ratio initiatives such as emergency room diversion and network improvement resulting in $1,500,000 savings. Conducted operational audits of health plans for compliance and identification of risks. Managed implementation and operations of Medicaid member incentive program across 12 health plans.
- Assisted Georgia's Department of Community Health as it planned for and implemented redesign options for its Medicaid and Children's Health Insurance Programs. Evaluated and prepared summaries of stakeholder feedback for consideration in development of state programs.

Medicaid Performance Management

- Supported the Illinois Bureau of Managed Care with monitoring of the Institutional Care Program's managed care plans. Developed tools for the State to use in assessing health plan performance. Reviewed reports submitted by plans and providing actionable feedback to State for plan improvement.
- Developed Fraud, Waste, and Abuse Plan for large health plan's Texas STAR+PLUS business unit. Ensured all Federal and State requirements were met and aligned with internal C-HS policies and procedures.
- Supported the Mississippi Division of Medicaid with review and analysis of operational managed care plan report submissions for a voluntary coordinated care program, MississippiCAN, for high-risk beneficiaries. Drafted requirements for the Division's managed care contract for the Children's Health Insurance Program (CHIP).

Behavioral Health

- Acted as project manager for AHCCCS Substance Abuse and Mental Health Block Grant (SABG / MHBG) Technical Assistance focused on social determinants of health (SDOH) and provider monitoring and reporting. Led interviews with subject matter experts to identify best practices related to SDOH data collection. Developed recommendations for areas of improvement related to SDOH data to be implemented by AHCCCS which included utilizing standardized claims codes and expanded provider education.
- Led assessment of the adequacy and appropriateness of inpatient and outpatient behavioral health provider reimbursement rates for Arizona Health Care Cost Containment System (AHCCCS). Managed utilization analyses, distribution and analysis of provider survey and comparison of rate methodologies used by neighboring states.
- Served as project manager to support the transition of Arizona's Division of Behavioral Health Services (DBHS) into the Arizona Health Care Cost Containment System

Greg Abdouch, MBA
Associate Director

(AHCCCS) organization (Arizona Medicaid). Led and facilitated the operational and personnel integration of the two agencies to support a seamless Administrative Simplification transition. Managed and facilitated several departmental work groups that include representatives from divisions managing policy, contracts, communications and legal. Fostered inter-agency collaboration and managed the overall structure and timeline of the integration. Reviewed and updated integrated Behavioral Health and Medicaid policies and procedures to maintain compliance with a previous settlement agreement.

- Supported the Louisiana Office of Behavioral Health (OBH) by developing a risk assessment that reviewed the adequacy and structure of monitoring and oversight of the State's managed care entity responsible for the administration of behavioral health services. Made procedural and operational recommendations based on findings of interviews with OBH staff and desk review of policies, procedures, and monitoring documentation.

Long-Term Care

- Supporting the Arizona Department of Economic Security Division of Developmental Disabilities (DDD) with the Home and Community Based Services (HCBS) and Arizona Early Intervention Program (AzEIP) rate rebases. Leading stakeholder engagement initiatives including multiple site visits numerous provider focus groups across the state to solicit feedback on the development of the rate models for various services.
- Led MLTSS Workgroup at Virginia Premier Health Plan focused on the identification and implementation of cost saving and process improvement initiatives including nursing facility member management, personal care authorization reviews, capitation payment reconciliation, and case management vendor oversight.
- Assisted the Commonwealth of Kentucky's Cabinet for Health and Family Services, Department for Medicaid Services (DMS) with an organizational assessment of its HCBS waiver operations to increase program efficiencies, analyze staff skillsets and alignment, improve organizational structure and offer overall HCBS program oversight.
- Assisted the State of Alabama Medicaid in the development of the Integrated Care Networks program focused on delivering acute and long-term care services to individuals who meet nursing facility level of care. Leading contract development process to ensure compliance with Federal and State regulations. Supporting Stakeholder Engagement initiatives to ensure feedback is thoroughly considered and documented.
- Supported the implementation of the long-term care program operations at a managed care organization contracted with the Florida Agency for Health Care Administration to serve Medicaid, long-term care, and other government program members. Led and participated in work groups tasked with development of key operational processes, such as claims and medical management. Acted as primary liaison between the health plan and a subcontractor responsible for electronic visit verification of home care visits throughout the implementation.
- Served as Director of Long-Term Supports and Services and oversaw a regional team of more than 130 supervisors, case managers and support staff. Responsible for managing health plan finances and budget in excess of $300 million and 10,000 members.

Greg Abdouch, MBA
Associate Director

Represented health plan in meetings with stakeholders representing providers, consumers, advocates, and state agencies for the development and implementation of managed care coverage for long-term care and support services across Florida. Oversaw configuration, claims, contracting, and provider data management to develop and accurately and promptly compensate the provider network for delivery of care to members.

Work History

- Director of Long-Term Care and Supports Services, Centene Corporation (2013 – 2014)
- Executive Immersion Program Associate/Manager, Centene Corporation (2010 – 2013)
- MBA Intern, Centene Corporation (2009 – 2010)
- Finance Intern, Citi Smith Barney (2008)
- Personal Banker, JPMorgan Chase (2006 – 2008)

Education

- Master of Business Administration, Finance and Healthcare Management, Washington University in St. Louis, Olin School of Business
- Bachelor of Science, Business Administration, University of Arizona

WV BMS2100000002
Onsite Program Manager

Caroline Deneszczuk, MPH

Managing Consultant

caroline.deneszczuk@guidehouse.com
Chicago, IL
Direct: 202.973.3277

Professional Summary

Requirement: minimum of a bachelor's degree, with three (3) years' experience in Medicaid operations, either with a State Agency, Federal Agency, or rendering services under contract to a State Agency

With more than five years of experience supporting Medicaid operations for government agencies at Guidehouse, Caroline specializes in health policy research, stakeholder engagement and communications, project management, operational assessments, and compliance. Caroline has significant experience working with government entities and legislative groups to conduct research and support health reform initiatives. Her areas of focus are health insurance coverage and access, healthcare demonstrations and waiver policy, dual eligible individuals, end-of-life care, home- and community-based settings, program operations, and evaluation. Prior to working at Guidehouse, she served in positions in Washington, D.C. that have afforded her a deep understanding of Federal health regulations and reform in the United States.

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.

In our current support to BMS, Caroline serves as the Policy Lead. She has led preparation of the 1915(b) waiver renewal applications for the MHT and MHP programs, revisions of the Quality Strategy, policy and quality aspects of BMS' directed payment programs, and the analysis of key regulations and guidance from CMS. Caroline lives in Chicago, Illinois but will be available on-site to assist BMS with day-to-day MCO operations oversight, addressing MCO and other inquiries, and attending operations meetings.

Areas of Expertise

- Healthcare program redesign including decision-making models and options analysis, waiver applications or Standard Terms and Conditions (STCs) and Centers for Medicare and Medicaid Services (CMS) negotiations, conducting readiness reviews, and site visits to assess health plan readiness to serve Medicaid members, and development of standard operating procedures (SOPs) and manuals for future monitoring and operations.
- Expertise in healthcare policy on a Federal, state and local level including Medicaid reforms, managed care, eligibility and benefits for dual-eligible and uninsured populations, and long-term care.
- Expertise in stakeholder engagement through developing, scheduling, and conducting stakeholder interviews, focus groups, and surveys, operationalizing and facilitating public comment periods, formation of advisory panels, workgroups and task forces, and

Caroline Deneszczuk, MPH
Managing Consultant

ongoing communications with the public and key stakeholders through frequently asked questions (FAQs), brochures, and public announcements.

- Analysis of healthcare policy issues and development of reports, issue briefs, and other deliverables.
- Facilitation and training of elected officials, healthcare executives, and other stakeholders on state and Federal policy-related issues and the healthcare delivery system.

Professional Experience

Medicaid Managed Care

- Led drafting of the Alabama Medicaid Agency (AMA) and West Virginia's Bureau for Medical Services (BMS) Managed Care Quality Strategies and, in Alabama, established a framework for collecting and analyzing quality data to reflect managed care organization and state performance.
- Assisted West Virginia's Bureau for Medical Services (BMS) to renew the 1915(b) waiver applications for the Mountain Health Trust and Mountain Health Promise programs.
- Assisted the Alabama Medicaid Agency with its planned transition to managed LTSS delivery system (expected implementation October 2018). 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.
- Managed teams in conduct of 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 provided 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.

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 subs 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.

Guidehouse

WV BMS2100000002
Onsite Program Manager

Caroline Deneszczuk, MPH
Managing Consultant

Medicaid Reform

- Played a leading role in Tennessee's Health Care Modernization Task Force by leading a team of researchers into how to expand access and improve healthcare quality for Tennesseans. Caroline researched innovative health report ideas, presented possible solutions to Task Force members and developed research and discussion materials for Task Force and Sub-Committee meetings.
- 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 through conduct of 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.
- 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.

Performance Management and Reporting

- In collaboration with subject matter experts within Guidehouse 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 CAHPS survey during each year of the monitoring and evaluation effort.
- Led hospital reporting process in Tennessee to monitor and measure the impact of the Rural Hospital Transformation Program, a program of 14 rural hospitals required to report implementation progress to the State on a quarterly basis.

Rural Health Care

- Led day-to-day activities of the Tennessee Rural Hospital Transformation Program including but not limited to, leading a team of data analysts to develop hospital profiles, conducting facility assessments, and developing individualized transformation plans for each participating hospital including initiatives and opportunities for community partnerships and financial improvements.

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WV BMS2100000002
Onsite Program Manager

Caroline Deneszczuk, MPH
Managing Consultant

Long-term Care

- Led 1915(c) waiver redesign efforts for Kentucky's Cabinet for Health and Family Services (the Cabinet). Facilitate waiver redesign activities including policy research of 1915(c) waiver consolidation, 1915(c) waiver amendments, State Plan Amendments (SPAs), 1115 waivers and managed care. Facilitate assessments of state administrative code and operational processes related to redesign. Develop SOPs, manuals and regulations to support post-implementation operations.
- 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.

Other Relevant Experience

- Assisted Guidehouse'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. Provided weekly training to coding and billing staff at UTMB and produced policy and procedure documents for long-term software management.
- Developed and conducted training of survey staff on how to approach, conduct and record responses from Medicaid enrollees regarding their experiences in the healthcare system. Analyzed and interpreted the data collected by survey staff to develop healthcare reforms for the District of Columbia's State Healthcare Innovation Plan.
- 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.

Work History

- NORC at the University of Chicago (2013 – 2015)
- Office of Congressman Jim McDermott (2012– 2013)
- American Association for Retired Persons (2011 – 2012)

Education

- Master of Public Health, Health Policy, The George Washington University
- Bachelor of Science, Psychology, The Ohio State University

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WV BMS2100000002
Onsite Program Manager

Caroline Deneszczuk, MPH
Managing Consultant

Thought Leadership

- 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.

WV BMS2100000002
Onsite Program Manager

Karen S. Butler, MSW
Associate Director

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Washington, DC
Direct: 202.481.7343

Professional Summary

Requirement: minimum of a bachelor's degree, with three (3) years' experience in Medicaid operations, either with a State Agency, Federal Agency, or rendering services under contract to a State Agency

Karen is a Masters-level Social Worker with more than 20 years of experience in government agency management, including Medicaid program administration, Child Welfare program administration and Child Support program functions. She has led organizational change management and development, quality improvement, legislative advocacy, and community collaboration and resource development activities for several public human service agencies in Maryland, Washington, DC and North Carolina.

As a former Department of Social Services Director for more than 10 years, she has an excellent track record managing public health programs and enhancing collaboration among health and human service stakeholders to optimize the equitable access and delivery of Medicaid services.

Karen has served as a subject matter expert in care coordination of Medicaid managed care services, communications and stakeholder engagement. She has participated in high-level assessments and planning for state-level Medicaid managed care program redesigns and has integrated change management principles with stakeholders, using the opportunity to design and implement service and practice changes.

In our current support to BMS, Karen serves as the Compliance Lead. She is leading the review and updates to the MHT and MHP MCO contracts, as well as the content expert related to social determinants of health and care coordination. Karen combines her regulatory and compliance expertise with first-hand knowledge of program operations to provide maximum value to BMS. Karen lives outside of Washington, DC but will be available on-site to assist BMS with day-to-day MCO operations oversight, addressing MCO and other inquiries, and attending operations meetings.

Areas of Expertise

- Management of Child Welfare services, adult protective services, child support services and public assistance programs including TANF and Medicaid.
- Administrator of Medicaid programs for Maryland Department of Human Services, including the design and optimization of service delivery plans for Medicaid (general population and foster care) and long-term care benefits.
- Case management and care coordination services including integrated care management models for public welfare programs for all populations. Designed coaching and training programs for case managers.
- Multi-system collaboration and stakeholder engagement to address barriers to stability, equity in access to services and disproportionately represented populations.

Karen S. Butler, MSW
Associate Director

- Organizational assessments, implementing process improvements and realignments and managing the effects of the implemented change.
- Management of large budgets and maximizing federal, state and local funding sources.
- Development of outcome measures for performance-based management and the planning and evaluating of programs.
- Management of agency operations including direct service delivery, systems improvement, quality assurance, finance, operations, information systems, data analysis, policy development, risk management, and personnel.

Professional Experience

Medicaid Policy and Program Experience

- Communications workstream leader for Kentucky's Medicaid waiver redesign project; draft responses to public comments, manage stakeholder input and interaction and facilitate stakeholder work groups. Managed communication and relationship building with state staff, program participants, stakeholders and advocates.
- Subject Matter Expert in the area of state Child Welfare Programs, Medicaid managed care programs and managing challenges to outreach to underserved child and adult populations.
- Subject matter expert on social determinants of health and equity for Tennessee's modernization project for their statewide delivery of Medicaid services.
- Subject matter expert for local government operations and co-facilitator of the race equity framework for the city of Columbus (OH) Celebrate One initiative to improve infant mortality and maternal and child health.
- Identify high-value, high-impact enhancements, improvements, and innovations needed to improve program quality, accountability, etc.
- Assess the needs and gaps of existing clients and participated in requirements development.

Social Service Administration

- Implemented several process and practice changes by convening stakeholders, assessing needs, developing a process and implementation plan, evaluating the change and managing the effects of change on staff and stakeholders. Initiated ongoing evaluations of changes to measure improvement.
- Subject matter expert on human service program policy and practice, including child welfare, public eligibility programs, serving at-risk and disparate populations and housing initiatives.
- Managed all administrative functions of the department including, but not limited to finance, human resources, child welfare, adult services, economic public benefits, child support, quality improvement, legislative advocacy, quality assurance, community collaboration, and resource development.

Karen S. Butler, MSW
Associate Director

- Managed multi-million dollar budgets and oversaw program changes and personnel and budgetary issues, including budget formulation and monitoring.
- Exhibited leadership and direction for program development, including establishing standards and priorities and monitoring and evaluating the quality of the services delivered to ensure compliance with short- and long-term goals.
- Developed and implemented outcome-based measures, ensuring performance that is in compliance with policy and procedures and adheres to best practice guidelines.

Government Relations

- Served as liaison to trade association members and legislators; kept abreast of government affairs and relayed any pertinent information to members of the trade association.
- Educated legislators on related issues and prepared testimony for legislative committees.

Work History

- Director, Howard County Department of Social Services (2012 – 2019)
- Director, Charles County Department of Social Services (2010 – 2012)
- Deputy Director, Mecklenburg County DSS (2006 – 2009)
- Planning and Policy Supervisor, DC Child & Family Services (2000 – 2006)

Education

- Master of Science, Social Work, Howard University
- Masters Certification, Strategic Organizational Leadership, Villanova University
- Bachelor of Arts, Journalism, University of Maryland

WV BMS2100000002
Research Analyst / Consultant

Jessica Broadus, MSPH

Managing Consultant

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Direct: 404.602.5028

Professional Summary

Requirement: minimum of a bachelor's degree, with three (3) years' experience in Medicaid operations, either with a State Agency, Federal Agency, or rendering services under contract to a State Agency

Jessica received her a Master of Science in Public Health and Bachelor of Science in Public health from the University of North Carolina at Chapel Hill. She brings more than four years of experience in healthcare consulting, with a focus on state government and public health clients. Her background includes experience with assessing and optimizing Medicaid program performance, conducting research on healthcare industry and policy trends, and developing operational improvement or strategic development plans.

On Guidehouse's current project with BMS, Jessica is supporting the Program Oversight and Monitoring Team. Jessica tracks receipt of MCO reports, communicates directly with MHT and MHP MCOs to clarify submitted report data, and oversees the development of the MHT and MHP reporting dashboards. She also leads development of key findings and issues to raise with BMS regarding MCO performance based on her review of operational reports.

Areas of Expertise

- Research and analysis of healthcare policy issues
- Development of deliverables, including strategic roadmaps, reports, training materials, and other deliverables
- Organizational and operational performance assessments

Professional Experience

Medicaid

- Assisted the Kentucky Department of Medicaid Services (DMS) in its process to standardize and strengthen operations for Participant Directed Services. Assisted in developing minimum operating standards for Financial Management Agencies and redesigning supporting policy and regulations. Led development, implementation, and training for a consumer-facing Participant Directed Services employer responsibilities assessment tool.
- Assisted Washington State Department of Social and Health Services (DSHS) in evaluating Medicaid long-term care payment methodology and rates for sufficiency in providing access to quality care across Assisted Living, Nursing Facility, Adult Family Homes, and Supported Living settings. Supported DHS in developing assessment analytics, including care quality, payment-to-cost, and demand projection analyses.
- Assisting the Rhode Island Executive Office of Health and Human Services (EOHHS) develop a strategic roadmap for implementing a Person-Centered Options Counseling

Jessica Broadus, MSPH
Managing Consultant

network to support consumers entering into or inquiring about the State's system of publicly and privately financed long-term services and supports.

- Supporting the West Virginia Bureau for Medical Services (BMS) with managed care program administration and oversight activities, including oversight of managed care reporting and compliance with contractual, state, and federal requirements.

Affordable Housing

- Assisted in developing a health and wellness strategy report for Fannie Mae's Sustainable Communities Initiative. Conducted industry research on the intersections between housing and healthcare to identify cross-sector opportunity with healthcare players and inform health and wellness strategy development.

Payer Operations

- Assisted in conducting a comprehensive operational performance assessment within a provider-sponsored health plan to identify operational improvement opportunities and position the organization for success in its growth strategy. Conducted more than seven stakeholder interviews across three functional areas to assess operational strengths and opportunities. Developed recommendations to align network development operations and optimize clinical care management programs across the enterprise.

Work History

- Health Policy Intern, Government Accountability Office (GAO) (2017)
- Graduate Research Assistant, Gillings School of Global Public Health (2016 – 2018)
- Healthcare Analyst, Huron Consulting Group (2013 – 2016)

Education

- Master of Science in Public Health, Health Policy and Management, University of North Carolina at Chapel Hill, Gillings School of Global Public Health
- Bachelor of Science in Public Health, Health Policy and Management, University of North Carolina at Chapel Hill Gillings School of Global Public Health

WV BMS2100000002
Research Analyst / Consultant

Julia Kelly
Consultant

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Washington, DC
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Professional Summary

Requirement: minimum of a bachelor's degree, with three (3) years' experience in Medicaid operations, either with a State Agency, Federal Agency, or rendering services under contract to a State Agency

Julia has experience supporting state governments, state Medicaid programs, and community healthcare providers through research, data analysis, grant management, communications, and other program oversight initiatives. Her professional experience includes:

- Assisting with West Virginia's Medicaid managed care program operations by analyzing provider network adequacy, editing quality strategy, creating communication aides, reviewing health plan marketing materials, and compiling other research and reports.
- Working to support Tennessee's Medicaid agency (TennCare) in compiling and drafting legislative research, planning an 1115 waiver evaluation design, and developing stakeholder engagement materials.
- Planning, constructing, and implementing a major state healthcare grant management program to distribute COVID-19 relief funding in South Dakota. Her role included developing state communications initiatives, including managing an applicant assistance email account, creating weekly client deliverables, writing FAQs, planning communications events for providers, and assisting with call center planning and maintenance. She also helped generate daily reports for the healthcare team using Salesforce application and email inbox data.

Julia has had over three years of health policy experience, particularly surrounding Medicaid operations, behavioral health, and substance use disorders. Prior to Guidehouse, Julia was a research assistant at the Duke-Margolis Health Policy Center. She analyzed trends in Medicaid data for dental opioid prescriptions in North Carolina. She used the results to craft policy recommendations to NC DHHS and propose a collaborative letter campaign aimed at educating opioid prescribers about high-risk prescribing practices. Additionally, she assisted with research for a healthcare cost drivers collaborative investigation, in which Duke-Margolis worked with the Health Care Cost Institute to analyze and model trends in costs for North Carolina residents by payer and health condition.

As a student at UNC at Chapel Hill, Julia co-created "Tar Heel Navigators," an acute peer-based support program that helps students reintegrate into academic life and campus after a mental health-related hospitalization. With grant funding from the Parent's Council, she also co-created a transportation program, "Well Ride," which provides UNC students with free transportation to off-campus counseling and psychological services. The program removed logistical barriers to care and assisted almost 100 students who attended regular off-campus appointments.

On Guidehouse's current project with BMS, Julia is already serving as a Research Analyst / Consultant for BMS. She contributes to Policy, and Program Oversight and

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Research Analyst / Consultant

Julia Kelly
Consultant

Monitoring tasks related to the Quality Strategy, Provider Network Assessment, HB417 legislative reporting, and additional ad hoc policy research.

Areas of Expertise

- Development of presentations for research teams and executive audiences
- Analysis and graphical representation of trends in Medicaid claims data
- Policy research and writing on medication-assisted treatment, syringe exchange programs, and other opioid crisis policy responses

Professional Experience

Duke Margolis Center for Health Policy

- Conducted background research on clinical guidelines for opioid prescribing to draft policy recommendations for the NC Department of Health and Human Services
- Used Excel to analyze trends in NC Medicaid opioid prescription data and draft JADA article submission
- Presented opioid prescription trend findings to Duke-Margolis Durham and DC offices

Targetcare, Inc.

- Created a database of health education resources for nurse practitioners to use during behavioral counseling sessions
- Organized health survey data to identify individuals in need of counseling and medical intervention
- Oversaw the administration of three clinical health assessments at SteelFab, Inc. to ensure organization of triage data

Hands on Peru Public Health Center, Huanchaquito, Peru

- Took vital signs and taught health education classes to reduce high rates of chronic illness in Huanchaquito
- Gathered survey data from residents to improve clinic outreach and community sanitation

Work History

- Research Assistant, Duke-Margolis Center for Health Policy (2019 – 2020)
- Undergraduate Learning Assistant, UNC Department of Economics (2017 – 2019)
- Summer Intern, TargetCare (2017 – 2018)

Education

- Bachelor of Science in Public Health, Health Policy and Management with a Minor in Philosophy, Politics, and Economics, University of North Carolina at Chapel Hill

Guidehouse

WV BMS2100000002
Research Analyst / Consultant

Scott Mackie
Managing Consutlant

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Chicago, Illinois
Direct: 312.583.3714

Professional Summary

Requirement: minimum of a bachelor's degree, with three (3) years' experience in Medicaid operations, either with a State Agency, Federal Agency, or rendering services under contract to a State Agency

Scott has seven years of experience in state Medicaid agency operations 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

Medicaid Performance Management

- Served as the day-to-day project manager for an organizational assessment of the Missouri Medicaid program to assess the current Missouri Medicaid organizational model and provide recommendations for the future to optimize the Missouri Medicaid operations. Managed client relations and directed workplan activities which included staff interviews, staff surveys, and working sessions to understand the current operations of the Medicaid program. Collaborated with key client department leads to identify areas of opportunity and develop future state operating models. Serving as project manager, managed the project budget, along with the utilization of sub-contractors.
- Serving as a workstream lead, conducted an organizational assessment of the Kentucky Cabinet for Health and Family Services, focusing on the improvement of internal and external processes related to the delivery of home and community-based services. Interviewed staff across the Cabinet to identify operational deficiencies and areas of opportunity. Collaborated with Cabinet leadership to identify workflows appropriate for redesign, to enhance internal operations, partnership with providers, and customer service to provider and participants. Analyzed current workflows and provided solutions to improve the effectiveness of the Cabinet. Facilitated a series of statewide focus

Scott Mackie
Managing Consutlant

groups to learn the current landscape of Kentucky's HCBS waiver programs and to understand how participants and providers perceive the delivery of services under the waivers.

- Conducted an organizational assessment of the South Dakota Medicaid program with an emphasis on the care management, prior authorizations, and program integrity processes. Evaluated the existing business environment for conducting monitoring, oversight and operational activities within these areas. Made recommendations to align with industry standards and identified opportunities to leverage external models to enhance Medicaid operations.
- Conducted an 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.
- Assisted 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.
- 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 Guidehouse 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

Scott Mackie
Managing Consutlant

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.
- 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.

Education

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

WV BMS2100000002
Research Analyst / Consultant

Benjamin J. Pollack

Senior Consultant

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Chicago, Illinois
Direct: 312.583.6873

Professional Summary

Requirement: minimum of a bachelor's degree, with three (3) years' experience in Medicaid operations, either with a State Agency, Federal Agency, or rendering services under contract to a State Agency

Benjamin has three years of experience in many aspects of the development, operation, and oversight of Medicaid programs, working with both state governments and the Centers for Medicare & Medicaid Services (CMS). His most recent areas of focus have included redesigning rate methodologies for developmental disability services across midwestern community residential facilities and leading a training series on oversight of Home- and Community-Based Services (HCBS) through technological solutions, quality monitoring, and interagency collaboration.

On Guidehouse's current project with BMS, Ben is already serving as a Research Analyst / Consultant for BMS. He supports the Policy Team and helped to prepare the 1915(b) waiver renewal applications for the MHT and MHP programs, revisions of the Quality Strategy, and policy and quality aspects of BMS' directed payment programs.

Areas of Expertise

- Electronic Visit Verification (EVV)
- Program design and oversight of Medicaid 1115, 1915(b), and 1915(c) waivers
- Quality monitoring and oversight of HCBS
- Analysis and implementation of federal policies which impact Medicaid services and state Medicaid administration
- Development and analysis of Medicaid payment rates and rate-setting methodologies

Professional Experience

Medicaid Quality and Program Integrity

- Managing the policy and compliance review of states' submissions of Advanced Planning Documents (APDs) including Planning APDs, Implementation APDs, and other proposals for enhanced funding for the development and operation of EVV systems.
- Planning, developing, and executing six collaborative discussion sessions covering topics associated with a new federal mandate, electronic visit verification for certain HCBS. These sessions include stakeholders from federal and state governments as well as individuals receiving services, caregivers, advocates, providers, and insurers.
- Delivering training materials relating to quality monitoring and oversight in home- and community-based programs including through billing validation, financial accountability, records maintenance and retention, oversight of service delivery and participant health and welfare, and the application of technological solutions to enhance these monitoring activities.

Benjamin J. Pollack
Senior Consultant

- Conducting reviews of key areas relating to fiscal integrity and cost neutrality in states' home- and community-based 1915(c) waiver application reviews, which include services delivered to individuals with intellectual and developmental disabilities. Determining whether applicant states' rate-setting methodologies were economical and sufficient to enlist qualified providers in the waiver program.

Medicaid Payment Transformation

- Assessing rate methodologies for residential services across midwestern community residential facilities on behalf of a state division of developmental disabilities. Conducted a comprehensive review of historical costs via provider-reported information and cost reports in order to recommend a revised rate methodology to expand access to developmental disability services in the state.
- Designing a national survey to assess how State Medicaid Agencies evaluate Medicaid fee-for-service reimbursement rates for sufficiency and to promote access to an adequate provider network.

Work History

- Research Fellow, Children's Hospital of Philadelphia (2017 – 2018)
- Research Fellow, Affordable Care Act Implementation Research Network at the Nelson A. Rockefeller Institute of Government (2015 – 2017)

Education

- Bachelor of Arts, Sociology and Economics, University of Pennsylvania

Thought Leadership

- "What's Next for Healthcare in the Biden Administration: Positioning the Industry for Success." Guidehouse Center for Health Insights, January 2021. https://guidehouse.com/insights/healthcare/2021/blog/whats-next-in-biden-administration
- "State-Based Trends in Leveraging Telehealth Post-COVID-19." Guidehouse Center for Health Insights, May 2020. https://guidehouse.com/insights/healthcare/2020/covid-19/state-based-trends-in-telehealth-post-covid19
- "Leveraging Electronic Visit Verification (EVV) to Enhance Quality Monitoring and Oversight in 1915(c) Waiver Programs." Centers for Medicare & Medicaid Services (CMS) Home & Community Based Services (HCBS) Training Series, February 2020. https://www.medicaid.gov/medicaid/downloads/evv-enhance-quality.pdf
- Carol S. Weissert, Benjamin Pollack, Richard P. Nathan, Intergovernmental Negotiation in Medicaid: Arkansas and the Premium Assistance Waiver, *Publius: The Journal of Federalism*, Volume 47, Issue 3, Summer 2017, Pages 445–466, https://doi.org/10.1093/publius/pjx034

WV BMS2100000002
Research Analyst / Consultant

Dustin T. Schmidt

Associate Director

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Atlanta, Georgia
Direct: 480.323.0565

Professional Summary

Requirement: minimum of a bachelor's degree, with three (3) years' experience in Medicaid operations, either with a State Agency, Federal Agency, or rendering services under contract to a State Agency

Dustin has more than 12 years of consulting experience, providing technical and strategic expertise to the government healthcare industry. Dustin is a practice leader in conducting operational and performance improvement assessments for state Medicaid agencies and long-term services and supports (LTSS) agencies to improve efficiencies, reduce costs, enhance staff alignment, and improve quality of care. He has also led multiple states in designing and implementing strategies to improve their oversight functions of MCO entities and has provided training to state staff on how to effectively monitor managed care programs.

On Guidehouse's current project with BMS, Dustin serves as Lead for the Program Oversight and Monitoring Team. Dustin oversees all aspects of our monitoring strategy for the MHT and MHP programs – including report templates, MCO clarifications and questions, enhancements to operational reports, analysis, and review of MCO performance, and development of ad hoc reporting to BMS or other external entities. He also provided ad hoc support to BMS leadership by created nine (9) program fact sheets/issue briefings to support BMS leadership through the State's legislative session. BMS leadership used the fact sheets to support their conversations with Legislators and to respond to questions raised during the Legislative session.

Areas of Expertise

- Designs compliance strategies and advanced monitoring approaches for states to effectively drive value and optimize MCO performance.
- Supports state Medicaid and LTSS agencies with program operations and pilot program implementation.
- Conducts operational assessments and related implementation activities for state health agencies to improve efficiency, reduce costs, and improve performance.

Professional Experience

Medicaid Performance Management

- Assisted a state Medicaid agency on a multi-phase project re-design its staffing structure and operations to successfully oversee several managed care entities. Developed over forty standard operating procedures across the entire agency, developed a staffing structure and related position descriptions, developed dashboards to oversee performance and to identify risks, developed seventeen programmatic and financial reporting templates to assess MCO performance, provided training to state staff and health plan employees, and assisted the State's IT team design a web-based system to

Dustin T. Schmidt
Associate Director

support monitoring. Staff training included topics such as Medicaid Foundations, Managed Care Concepts, and a Monitoring series to cover specific content related to day-to-day oversight responsibilities.

- Served as the project manager for an engagement with Mississippi's State Legislature to conduct a performance assessment of Mississippi Medicaid's managed care program and its hospital access payment program. Successfully developed a report, within a tight legislative timeframe, that identified 29 findings and provided 31 recommendations for operational improvement.
- Served as a subject matter expert for an engagement with Kansas Medicaid to conduct an operational assessment across multiple state agencies that administer Medicaid long-term care, behavioral health, and physical health services. Interviewed more than 50 department leaders and program area managers to identify areas of deficiency, duplication, and/or uncoordinated processes as part of day-to-day operations. Successfully provided a report that identified over seventy-five opportunities for improvement.
- Led Alabama Medicaid, a 500+ employee organization, through a reorganization as it moved from a fee-for-service to a managed care delivery system. Developed a strategy and approach to conducting agency-wide training. Quantified the number of new staff needed, developed new position classifications and salary ranges using private industry and other state data. New positions and salary ranges were ultimately approved by Alabama's State Personnel department.
- Assisted a state healthcare agency to create a new division to streamline its provider licensure, certification, and monitoring functions across five existing state agencies. Eliminated duplicate activities by successfully streamlining the provider certification process.

Long-Term Services and Supports (LTSS)

- Currently supporting a State health and human services agency to implement person centered options counseling (PCOC) to assist consumers who are entering into or inquiring about the State's system of publicly and privately financed LTSS. While this project is ongoing, specific activities to date includes: 1) Assessing current funding opportunities to support financial sustainability of the PCOC program 2) conducted stakeholder engagement with over 20 different key informant groups 3) developed operational materials to support PCOC delivery.
- Supported a state agency to improve its HCBS quality assurance program, which monitored and oversaw quality across five different 1915(c) waivers. Worked with Medicaid staff, three sister agencies, and the Area Agencies on Aging to identify gaps in existing quality assurance activities and to support performance improvement.
- Supported a state Medicaid agency improve its home and community-based services (HCBS) quality assurance program by developing operational dashboards, audit tools, standard operating procedures, and performance measures to evaluate performance.
- Supported a State LTSS agency to improve its LTSS service delivery model. Interviewed state staff and 12 different key informant groups including direct service providers, case managers, and different advocacy groups. Developed a summary of key interview

Dustin T. Schmidt
Associate Director

findings and recommendations. Performed several analyses to validate stakeholder findings including: 1) Analyzed Medicaid eligibility determination timeframes 2) compared HCBS rates to neighboring states 3) compared case management service activities to neighboring states and 4) analyzed capacity for nursing facilities and home and community-based services.

- Led an operational assessment for South Dakota's LTSS program to improve performance and to assess Aging and Disability Resource Connection (ADRC) and adult protective services (APS) staff capacity and performance. Developed a data driven approach to calculate the number of staff needed to support the State's ADRC call center and an adult protective services (APS) division. Created interactive training materials (e.g., case scenarios, role playing, etc.) to support the State's new ADRC call center. Analyzed funding across state-funded LTSS programs to identify opportunities for improvements.
- Supported a state Medicaid agency streamline its LTSS processes and activities across three different state government agencies. Specific activities include: 1) Assessing staff alignment and capacity across three state agencies and 2) Standardizing the state's approach to critical incident reporting, provider licensure and certification, and corrective action plans (CAPs).
- Led a twenty-member Quality Assurance Committee identify quality measures for a $1 billion Medicaid long-term care program. Presented to the Committee on Federal and state requirements, best practices, and benchmark data to assist the Committee in its selection of thirty-five quality measures.
- Conducted eleven different stakeholder engagement sessions and developed a web-based survey to identify opportunities to improve a States LTSS delivery system.

Work History

- Consultant – Associate Director, Guidehouse (formally Navigant) (2008 - Present)
- Accounting Intern, Arizona State University (2006 – 2007)
- Accounting Intern, Freeport-McMoRan Copper and Gold Inc. (2006)

Recent Presentations and Publications

- "It's Time for States to Reshape Medicaid" Article on Guidehouse's website (Jan. 2021)
- "Core Elements of a Critical Incident Management System" Webinar for ADvancing States (Feb. 2020)
- "Essentials of Critical Incident Management" Webinar for ADvancing States (Nov. 2019)
- "Innovation Track: A Comprehensive Critical Incident Management System – A Proposed Best Practice" HCBS Conference (Aug. 2019)
- "How State Medicaid Agencies Can Prepare for Administration Changes" (Dec. 2018)

Education

- Bachelor of Science, Finance, W.P. Carey School of Business, Arizona State University

WV BMS2100000002
Medicaid Policy Subject Matter Expert

Roshni Shah Arora, MPH
Director

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Professional Summary

Requirement: Medicaid Policy Subject Matter Expert shall be leveraged for consultation services on federal Medicaid regulation and policy and serve as a SME under both the program oversight and actuarial services sections. Position is required to have a minimum of Bachelor's Degree, with ten (10) years' experience in Medicaid policy research and development, either with a State Agency, Federal Agency, or rendering services under contract to either Agency type

Roshni has more than 15 years of experience in the healthcare industry working with government-sponsored programs, including Medicaid, Medicare, CHIP, and uninsured programs. Roshni has led engagements specializing in healthcare service delivery system activities, including Medicaid managed care initiatives.

These delivery system engagements include assisting states and payers with all phases of a program lifecycle: design, implementation, monitoring, operations, organizational readiness, as well as care management, network adequacy, and federal and regulatory compliance.

Roshni is currently directing and leading all aspects of managed care program administration on behalf of West Virginia Department of Health and Human Resources, Bureau for Medical Services. Since she began in this role, Roshni directed and led key priorities for BMS, including: (1) completion of an managed care organization (MCO) compliance review, (2) updates of Mountain Health Trust and Mountain Health Promise MCO contracts, (3) refresh of Managed Care Quality Strategy (including Medicaid and CHIP), (4) payment and renewal of current directed payment programs (state-directed payments), and (5) implementation of more robust MCO monitoring and oversight processes.

Areas of Expertise

- Directs Medicaid managed care projects focused on strategic planning, design, implementation, operation, quality improvement, stakeholder engagement, and evaluation of healthcare delivery systems and healthcare reform options.
- Conducts procurement and contracting activities on behalf of states for contractors such as managed care organizations, enrollment brokers, and external quality review organizations.
- Supports clients with building processes and strategies for monitoring program performance and driving quality improvement and developing tools to facilitate program monitoring and operations.
- Leads engagements to demonstrate compliance with relevant federal and state regulations for state Medicaid agencies and health plans. Significant experience working directly with CMS on behalf of states to clarify policy expectations and secure approval for new waiver authorities.

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- Leads efforts to expand access to behavioral health services, including substance use disorders, and social determinants of health.

Professional Experience

Medicaid Managed Care

- Leads initiatives to design, implement, and operate Medicaid managed care programs in states such as Alabama, Kansas, Illinois, Mississippi, Pennsylvania, and West Virginia (2009-2012; 2020-2021). Work has involved:
  - Evaluating program design considerations through research, analysis, and stakeholder engagement.
  - Designing and operationalizing inclusion of Medicaid managed care for long-term services and supports (LTSS) (e.g., monitoring and oversight, MCO contracting, stakeholder engagement).
  - Applying policy expertise to financial and actuarial aspects of program design (e.g., state-directed payments, MCO capitation rate setting, value-based care)
  - Developing reporting templates, dashboards, and other reports to collect and disseminate performance data (quality, operational, and financial) to internal and external stakeholders.
  - Leading quality improvement and performance monitoring, including development and update of the federally-required Quality Strategy and establishing performance through metrics such as Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®), and other state-generated measures.
  - Assessing and reviewing organizational structures, processes, and policies and procedures to promote effective program monitoring and continuous performance improvement.
  - Conducting data analysis to identify performance opportunities and successes and evaluate program effectiveness.
  - Facilitated stakeholder workgroups consisting of agency staff, providers, and health plan executives, and consumers to identify health plan and program performance measures.
  - Conducted reviews of state agency and health plan to assess readiness prior to program go-live.
  - Developed and provided feedback on procurement materials, including Medicaid managed care organization contracts, Requests for Proposals, responses to bidder questions, and proposal scoring tools.
  - Trained agency staff on subject matter, such as Medicaid and managed care, and skills, such as data analysis and program monitoring.
- Supporting Texas Health and Human Services to secure authority for new state-directed payment programs operating within Medicaid managed care and targeted towards local

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health departments, public health districts, rural health clinics, and behavioral health facilities.

- Managed the development and CMS approval Kansas' Section 1115 waiver demonstration application, which included preparation of application materials, coordination of public comment and stakeholder feedback responses, and participation in CMS discussions and negotiations. This work resulted in CMS approval to enable Kansas Medicaid program operations from 2019 – 2023, and implementation of improvement initiatives (e.g., new funding allowances for substance use disorder services).
- Provided interim staffing support at the Commissioner-level to the Kansas Department for Aging & Disability Services to provide strategic expertise on LTSS, behavioral health, data analytic, and other operational issues. In this capacity, Roshni represented and guided KDADS through issues such as:
  - LTSS stakeholder engagement
  - CMS Section 1915(c) waiver renewals
  - Provider network adequacy and monitoring
  - Quality improvement framework and processes
  - KanCare MCO monitoring and oversight
  - Realignment of LTSS Commission to improve efficiency and performance
  - Coordination with Medicaid agency
  - Development of State policies and procedures for reporting and investigating adverse incidents
  - State legislature testimony
  - KanCare pay for performance program
  - Strategic planning objectives that were presented to legislative committees (Available at: http://www.kslegislature.org/li/b2019_20/committees/ctte_jt_robert_g_bob_bethell_joint_committee_1/documents/testimony/20190827_05.pdf)
- Prepared the Kansas' SUD Implementation Plan for the Section 1115 waiver demonstration application, which included:
  - Reviewing the current Medicaid State Plan and managed care organization (MCO) contracts
  - Developing recommendations for a proposed "future state" and "summary of actions needed"
  - Facilitating discussions with CMS and between sister agencies (e.g., Medicaid agency and aging and disability services agency)
  - Preparing an operational project plan to implement the SUD Implementation Plan upon approval by CMS

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Director

  - Estimating the difficulty level to meet CMS' required milestones to prepare the State with discussions with CMS
  - Recommending a stakeholder communication plan and preparing supporting communication materials

- Supported strategic planning for senior leadership from the Florida Agency for Health Care Administration's Division of Medicaid to prioritize activities in 2017-2020. Led interviews with senior leaders to understand their role, activities and approach for oversight, monitoring, and performance management, and ongoing challenges. Facilitated strategic planning session using a decision-making framework to prioritize agency activities and establish goals for 2017-2020 to achieve short- and long-term program goals.
- Managed daily project operations for a technical assistance contract with West Virginia's Bureau for Medical Services, which included serving as the primary point of contact with the client, contracted MCOs, CMS, and other vendors. Supported the State with expansion of managed care to include SSI beneficiaries and new services (e.g., behavioral health, dental, and pharmacy services). Prepared the 1915(b), quality strategy, and other supporting documentation to obtain federal authority for program changes. Provided strategic support for implementation activities such as phased-expansion schedule, stakeholder communications, and supported readiness reviews.
- Provided assistance to the Georgia Department of Community Health to develop and implement a value-based purchasing model for select Georgia Medicaid managed care programs. Designed a collaborative process with vendors, identified key priority areas, developed an incentive payment model, and prepared performance measurement specifications.
- Provided recommendations for combining New York's Medicaid managed care contract for the special needs plan (SNP) program for Medicaid-eligible individuals with HIV/AIDS into the mainstream Medicaid managed care program contract. As a result, the State adopted a single managed care contract for these programs, facilitating contract oversight and vendor monitoring.
- Assisted multiple Medicaid MCOs in responding to state Requests for Proposals to participate in mandatory Medicaid managed care programs. Reviewed health plan policies and procedures, interviewed health plan staff and executives and drafted responses to RFP questions.

Federal Initiatives

- Led an engagement for a large national health plan (Part C, Part D, Medicare-Medicaid) to overhaul existing policy infrastructure to develop a comprehensive set of policies addressing Medicare and Medicare-Medicaid products. Tasks included policy life cycle management design, development of a policy template, policy research and development, and procedure review. The policy research and development component incorporated a review of all relevant regulatory frameworks, including federal and state regulations, federal and state guidance, and contracts with government purchasers. At the conclusion of the project, led the review and update of over 400 policies.

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- Through a multi-year contract with the Agency for Healthcare Research and Quality (AHRQ), coordinated and provided onsite and individualized technical assistance to 17 states for selected areas of interest related to Medicaid care management.
    - Facilitated peer-to-peer learning across the states through in-person meetings and web conferences on topics such as program design, procurement, measurement, evaluation, communications, and continuous quality improvement. Developed resources such as issue briefs and a technical assistance website for states.
    - Designed and coordinated a day-long session at the National Academy for State Health Policy conference to disseminate lessons learned about Medicaid care management.
    - Developed a toolkit, “Designing and Implementing Medicaid Disease and Care Management Programs: A User’s Guide.”
- Developed network adequacy criteria used by CMS for evaluating Medicare Advantage applications. Established criteria requirements and exceptions, documented detailed business requirements for automating review and evaluation of application data, and drafted communication materials.
- Supported CMS in the development of the Medicaid and CHIP Program System (MACPro) by designing standardized templates for the 1937 Benchmark State Plan Amendment to facilitate consistent state reporting and streamline review, resulting in a more streamlined, efficient, and transparent process and data for state partners and researchers.
- Assisted in the development of a Medicaid managed care oversight guide to facilitate CMS review of Medicaid managed care programs. Managed a scan of existing Medicaid managed care contractual requirements and identifying best practices.

Healthcare Reform

- Lead support to the Tennessee Governor’s Office and Department of Finance & Administration to complete a Listening Tour and convene a Healthcare Modernization Task Force. Leading stakeholder engagement, policy analysis, and strategy implementation efforts to develop healthcare policy and program options to address the most pressing challenges facing the State.
- Provided recommendations to AHCCCS to improve its data collection and use of Social Determinants of Health (SDoH) ICD-10 codes. Support included a completion of a national survey and review of SDoH best practices, an inventory of federal compliance requirements for Mental Health and Substance Abuse Block Grant reporting, and development and execution of a training for providers and contracted health plans.
- Assisted the District of Columbia to engage public and private sector stakeholders in developing the District’s proposal for innovative payment and service delivery models. Tasks include data collection and research, stakeholder engagement, meeting facilitation, development of policy recommendations, financial modeling, and communications activities. Developing the District’s State Health System Innovation Plan (SHIP) that the District will submit to CMS.

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- Conducted a study for the Association of Community-Affiliated Health Plans (ACAP) to identify the benefits and challenges associated with leveraging Medicaid safety net health plans for health reform.

Medicaid Performance Management

- Led the analysis of the impact of Medicaid expansion on Montana's economy and access to care, given that legislation authorizing Montana's Medicaid expansion program was set to expire in June 2019. Roshni presented its findings to stakeholders in Montana and members of the media in March 2019: https://www.navigant.com/insights/healthcare/2019/hospital-funded-study-medicaid-expansion.
- Performed a review of national best practices for collecting information on social determinants of health and Mental Health Block Grant / Substance Abuse Block Grant reporting requirements and identified opportunities for improvement for the Arizona Health Care Cost Containment System.
- Performed an assessment of Mississippi's Medicaid managed care program to improve operational and program performance. The assessment focused on the areas such as monitoring and oversight, data analytics, enrollment, quality management, and care management.
- Assessed program integrity functions to identify improvements in Alabama, Mississippi, Texas, and West Virginia. Project work has involved:
    - Assessing organizational structure and processes to improve critical processes, especially in the context of increased managed care enrollment.
    - Building agency program integrity capacity through the development of policies and procedures and staff trainings.
    - Developing strategic work plans to prioritize agency activities.
    - Developing reporting templates to collect contractor data for program integrity activities.
- Provided consultation on organizational structure and development to the Illinois Bureau of Managed Care to identify operational and structural efficiencies. Facilitated strategic planning to determine priorities to enhance the Bureau's oversight of current and new programs. Proposed recommendations for organizational realignment to increase functional efficiency.
- Conducted an analysis for Arizona to identify potential cost savings that would minimize adverse impacts on the health status of Arizona Health Care Cost Containment System (AHCCCS) beneficiaries. For each proposed area, identified and estimated the projected cost savings and identified advantages and the potential for adverse effects on the target population, exacerbation of related chronic conditions, cost shifting to other covered services, and delayed access to care.
- Provided technical assistance to West Virginia on overall quality improvement, program monitoring, and oversight. Reviewed all MCO deliverables and prepared a quality

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dashboard to highlight key issues. Coordinated with the State's EQRO to identify interventions to improve performance.

- Led the collection and analysis of information of Medicaid primary care case management (PCCM) programs, including beneficiary access, cost-sharing, and associated disease management and care management components, for New York to use in considering a future PCCM program as an alternative to full-risk managed care in rural areas. Evaluated beneficiary access to primary care and specialist providers in New York's Medicaid managed care program through conduct of focus groups.
- Assessed the performance of Connecticut's HUSKY Program, a capitated Medicaid managed care to compare the policy alternatives of retaining HUSKY versus adopting a "managed fee-for-service" model of coverage for the Connecticut Association of Health Plans.
- Developed an independent assessment of New Mexico's managed care program, Salud!, and behavioral health managed care programs, assessing access, quality, and cost-effectiveness.

Other Relevant Experience

- Assisted a life sciences company with developing an enhanced methodology and forecast model for estimating Medicaid drug rebates. Researched factors that impact Medicaid rebate submissions, such as state Medicaid enrollment, impact of ACA Medicaid expansion, managed care penetration, and 340B changes.

Work History

- Consultant, The Lewin Group (2006 – 2012)

Certifications, Memberships, and Awards

- Navigant Most Outstanding Leadership Collaboration, 2015-2016
- Client Focus Award, OptumInsight Consulting

Education

- Master of Public Health, Health Policy and Management, Columbia University
- Bachelor of Arts, Health and Societies and Political Science, University of Pennsylvania

Thought Leadership

- "It's Time for States to Reshape Medicaid," (lead co-author), Guidehouse. Available at: https://guidehouse.com/insights/healthcare/2021/blog/states-reshape-medicaid.
- "Tennessee Healthcare Modernization Listening Tour Findings and Considerations," prepared in partnership with Tennessee State Government. Available at: https://www.tn.gov/content/dam/tn/finance/documents/Findings.pdf
- "Hospital Funded Study: Medicaid Expansion has Huge Economic, Health Impact in Montana," (lead co-author), Navigant Consulting, Inc. Available at:

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https://guidehouse.com/insights/healthcare/2019/hospital-funded-study-medicaid-expansion

- "Evolving Medicaid Managed Care Regulations: What do These Changes Mean for You?," (multiple co-authors), Guidehouse, November 2018. Available at: https://guidehouse.com/insights/healthcare/2018/evolving-medicaid-managed-care-regulations.
- "Upcoming Medicaid Managed Care Regulations — How Do You Stack Up?," (multiple co-authors), Navigant Consulting, Inc., May 2018. Available at: https://guidehouse.com/insights/healthcare/2018/upcoming-medicaid-managed-care.
- "Provider Network Adequacy Changes in Medicaid Managed Care Final Rule Leave States with Much to Address," (multiple co-authors), Navigant Consulting, Inc., July 2016. Available at: https://guidehouse.com/-/media/www/site/insights/healthcare/2016/hc_networkadequacy_tl_0616.pdf.
- "Coordination Between Medicaid Health Plans and Marketplace QHPs," (multiple co-authors), Navigant Consulting, Inc., April 2014.

WV BMS2100000002
Medicaid Policy Subject Matter Expert

Jason S. Gerling, MS
Director

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Professional Summary

Requirement: Medicaid Policy Subject Matter Expert shall be leveraged for consultation services on federal Medicaid regulation and policy and serve as a SME under both the program oversight and actuarial services sections. Position is required to have a minimum of Bachelor's Degree, with ten (10) years' experience in Medicaid policy research and development, either with a State Agency, Federal Agency, or rendering services under contract to either Agency type

A Master's level Gerontologist and leader of long-term and services and supports consulting for Guidehouse, Jason has more than 13 years of professional experience building successful long-term services and supports and community based case management / population health models that enhance collaboration between public services sectors including health, human services, and affordable housing. His work is keenly focused on engagements that advance initiatives for vulnerable populations including Older Americans, persons with disabilities, persons with mental illness, low-income households and individuals facing health inequity. He leads complex, multi-workstream engagements in multiple states and for other high-profile organizations like Fannie Mae.

Jason is experienced in facilitating partnerships and engaging external partners both in program management, technical assistance, and training roles. He is also experienced in qualitative research, stakeholder engagement and strategic communications. Jason's work is committed to improving upon current systems to better serve vulnerable populations across socioeconomic groups, by developing cost-efficient and creative ways to serve them and their circles of support.

On Guidehouse's current project with BMS, Jason is already serving in this role providing subject matter expertise on key BMS priorities such as the Quality Strategy, effective Medicaid managed care operations, social determinants of health, and care coordination.

Areas of Expertise

- Develops and optimizes long-term services and supports programs for older, disabled and special needs populations, with emphasis on home-and community-based delivery models.
- Designs and optimizes Medicaid 1915(c) waiver and Older American's funded models, including policy development, operational assessment, monitoring design, and inter-agency consolidations.
- Designs and delivers case management, care coordination services and population health models including person-centered service planning, options counseling, information and referral development, crisis intervention and integrated care management models across disability types (including behavioral health), including development and provision of professional coaching and training.

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Director

- Implements and is a proficient facilitator of comprehensive stakeholder engagement with consumers, service providers, consumer advocates and other members of the public as well as legislative and executive stakeholders.
- Leads formation of inter-agency partnerships and community collaboratives aimed at integrating home and community-based services, behavioral health and affordable housing services with shared goals and objectives, braided funding approaches and streamlined day-to-day operations.

Professional Experience

Federal

- Advised as subject matter expert a national strategic planning efforts for market area health service optimization of Community Living Centers for the U.S. Veteran's Health Administration.
- Designed and managed implementation of the Community Living Program in Oneida County, New York, an early pilot implementation of participant-directed service delivery using Older American's Act funding from the U. S. Administration on Aging.
- Spearheaded and managed New York's first operational Veterans-Directed Home and Community Based service program – establishing a revenue generating relationship between an area agency on aging and the Syracuse VA Medical Center to extend person-centered planning and participant-directed services to the Veteran population.

State Medicaid

- Assisted West Virginia in drafting its initial COVID-19 pandemic-related 1115 emergency waiver and additionally advised the 2021 update of the state's Quality Management strategy for the Medicaid enterprise.
- Led Kentucky's multi-year assessment and redesign of statewide 1915(c) waivers. The assessment phase included extensive stakeholder engagement and analysis, operational assessment and a comprehensive policy review of federal waiver applications and associated state regulations. Re-design efforts include a top-to-bottom revision of all waiver applications and state regulations along with: redesign centralized quality management across three state departments, case management redesign, overhaul of the state's participant directed service approach, a rate methodology study resulting in rate development for all waiver-funded HCBS and modernizing functional assessment platforms.
- Supported Alabama with transition of its Medicaid funded LTSS services to a provider-sponsored, managed delivery system, playing a significant role in design and execution of a comprehensive public stakeholder strategy including facilitation of dozens of public meetings, design and analysis of a public survey, and development of external reports and correspondence. Additionally, provided subject matter expertise on home-and community-based case management design and led inter-agency sessions between the Medicaid agency and sister 1915(c) designated operating agencies.
- Developed Kansas' Integrated Person Centered Service Planning policy on behalf of the Kansas Department of Aging and Disability Services. Additionally, supported the

Jason S. Gerling, MS
Director

department in developing MLTSS monitoring and oversight approaches including establishing HCBS network adequacy standards and tracking tools.

- Participated in the re-design of Florida's nursing home reimbursement system to a prospective payment model for the State of Florida, helping to develop and execute a stakeholder engagement strategy, and providing clinical and operational expertise in the development of the state's first quality incentive program tied to skilled nursing reimbursement.

Aging and Disability Network Initiatives

- Leading and advising an evaluation of validity of the Minnesota Department of Human Services' Structured Decision Making© tool used to govern statewide intake of Adult Protective Services. Responsible to lead staff in project management, data analytics, actuarial analysis, qualitative research and stakeholder engagement while serving the project as a protective services and clinical subject matter expert.
- Led a Minnesota Department of Human Services commissioned study of quality management and metrics in adult day services in older adult-targeted programs, including developing and leading multiple layers of qualitative stakeholder analysis, completing internal and external policy analysis and facilitating a study committee leading to targeted recommendations on the design and potential quality framework for adult day services.
- Completed a study of Wyoming's statewide system for prevention and response to abuse, neglect and exploitation (ANE) of vulnerable adults, assisting Wyoming Medicaid by designing and facilitating a series of interviews with key agencies and professionals, culminating in the delivery of a recommendations report identifying mechanisms to enhance prevention and intervention of ANE, and enhance inter-departmental communication so that the state could meet critical incident reporting to the Centers for Medicare and Medicaid Services.

Behavioral Health

- Performed initial assessments of statewide community mental health centers for the Tennessee's Bureau of TennCare, assisting with curriculum development for their primary care transformation project intended to deliver multimodal practice training and coaching services to CMHCs as they shifted to an integrated Health Home model.
- Convened and facilitated a multi-disciplinary coalition of housing and mental health providers to establish local pathways for collaboration, in partnership with Emory Healthcare's Fuqua Center for Late Life Depression and LeadingAge Georgia.
- Appointed to Board of Georgia's Institute on Aging, past coalition member for Atlanta Area Coalition on Aging & Mental Health, Advisory Board member Emory Fuqua Center for Late Life Depression, active member Piedmont Care Transitions Work Group, active member Fulton Crisis Collaborative.

Social Determinants of Health / Affordable Housing

- Currently advising Fannie Mae's Sustainable Communities Initiative team to test a national advisory services business line. Project tasks include strategic advisory support,

Jason S. Gerling, MS
Director

professional coaching and strategic communications support along with subject matter expertise on healthcare investment in affordable housing.

- Co-led sector strategy development of a health and wellness strategy for Fannie Mae's Sustainable Communities Initiative, acting as a subject matter expertise to Fannie Mae on healthcare policy and operations, economic mobility-oriented work with large employers, supportive housing models and cross-sector opportunity with healthcare payors and providers. Additionally, led the team's design and piloting of place-based interventions in the Charlotte, NC market.
- Designed and implemented a housing services delivery model offering housing stabilization case management and service network referral to elderly and disabled adults residing within the Atlanta Housing Authority's Housing Choice Voucher program portfolio. The program reported 89% housing stabilization rates amongst households served in FY14 reporting. Additionally, grew the agency's network of non-contract service provider network significantly, nearly tripling the number of aligned agencies and programs with cross referring relationships to the Authority's Human Development Services.
- Designed and implemented a training and development curriculum for the Atlanta Housing Authority's portfolio of public housing high-rises for the elderly and disabled, delivering training and technical assistance to more than a dozen resident service coordinators over a year, covering nearly 2,000 tenants.
- Provided subject matter expertise to the Atlanta Housing Authority in the design of procurement requirements for Resident Service program implementation prior to release of a multi-year public procurement for property management and development organizations.

Commercial Payor

- Provided technical writing support, technical subject matter review and acted as a strategic advisor to Centene Corporation as it developed multiple procurement responses. Advisory focus areas included: population health, care management, member services, social determinants of health, community engagement, homelessness, long-term services and supports delivery and network development, et al.
- Provided technical writing support, technical subject matter review and acted as a strategic advisor to Blue Cross Blue Shield of North Dakota to respond to a Managed Medicaid procurement and currently providing strategic advisory services in the areas of care management, population health, medical management and behavioral health model design.

Other Relevant Experience

- Served as Director of Sales at two Sunrise Senior Living properties – Webb Gin and Johns Creek, maintaining and increasing census by 10% through effective internal sales, including through an executive leadership transition. Conducted external business development – developing and sustaining positive community relationships within the aging services network.

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- Managed admissions for a Hospice provider, including educating patients and families about Hospice, completing insurance verifications, leading multidisciplinary care team meetings, and monitoring documentation compliance in clinical documentation.
- Delivered person centered planning and options counseling training to clinical staff, providing representation at statewide conferences in New York, and in multimedia training projects designed by Boston College's National Center for Participant Directed Services.
- Delivered Medicaid and Older American's Act funded case management services, information, and referral to a case load of 150 individuals with high success rate in development of community based long-term care plans – including floating assistance for coworkers and other geographic teams.
- Served as interim Director of an AARP-model volunteer bill payer program, and its organizational representative payee agreement with the Social Security Administration.
- Developed policies and procedures for a non-profit organizational Representative Payee Program, designing and delivering compliance training to program staff and volunteers.

Work History

- Program Manager, Aging Well Services, Atlanta Housing Authority (2013 – 2016)
- Director of Sales, Sunrise Senior Living (2011 – 2013)
- Admissions Coordinator, Odyssey Hospice (2010 – 2011)
- Program Coordinator, Oneida County Office for the Aging and Continuing Care (2010 – 2011)
- Case Management Consultant, Family Services for the Mohawk Valley, Bill Payer Program (2008 – 2009)
- Case Manager, Oneida County Office for the Aging and Continuing Care (2007 – 2009)

Certifications, Memberships, and Awards

- Barbara A. Romano Memorial Award for Excellence in Gerontology, 2007
- Past Member, Sigma Phi Omega National Gerontological Honor Society

Education

- Master of Science, Gerontology, Management of Aging Services Track, University of Massachusetts
- Bachelor of Arts, Psychology (*Magna Cum Laude*), Specialist in Aging Certification, Canisius College

Thought Leadership

- "'Win-Win' Payer Strategies for Predicting Risk and Supporting Health Equity." Guidehouse Consulting. February 2021. Available online: 'Win-Win' Payer Strategies for Predicting Risk and Supporting Health Equity | Guidehouse

Jason S. Gerling, MS
Director

- "Balancing Person-Centeredness and Utilization Management." - National Home and Community Based Service National Conference. December 2020.
- "Pop-Up Communities: How to Disrupt Housing in Aging and Disability Communities." - National Home and Community Based Service National Conference. December 2020.
- "Delivering Telehealth to Home and Community Based Services." Guidehouse Consulting. June 2020. Available Online: https://guidehouse.com/insights/healthcare/2020/covid-19/delivering-telehealth-to-home-and-community
- "State Budget Challenges Due to the COVID-19 Pandemic." Guidehouse Consulting. April 2020. Available Online: https://guidehouse.com/insights/healthcare/2020/covid-19/state-budget-challenges-due-to-covid19
- "Considering Partnership Opportunities in Health / HCBS and Affordable Housing" National Home and Community Based Service National Conference. August 2019.
- "Modernizing Congregate Settings for a Person-Centered World" National Home and Community Based Service National Conference. August 2019.
- "1915(c) Home and Community Based Services Waiver Redesign Assessment: Final Report" Prepared for the Commonwealth of Kentucky Cabinet for Health and Family Services. October 2018. Available Online: https://chfs.ky.gov/agencies/dms/dca/Documents/kyhcbsassessmentfinalreport.pdf
- "Stakeholder Engagement: Lessons Learned from the Field" – National Home and Community Based Service National Conference. August 2018.
- "Integrating Housing and Behavioral Health Supports: Taking a Pilot to Scale" – National Association of Area Agencies on Aging Annual Conference. August 2017.
- Gerling, Jason and Walton, Betsy. "State Considerations for Provision of Support Services to Affordable Housing Tenants." (White paper). October 2016.
- "Leveraging Aging and Social Services to Stabilize Tenancy in Affordable Housing" – National Home and Community Based Services Conference. August 2016.
- "The Crossroads of Housing and Healthcare" – National Aging in Place Council Annual Meeting. December 2015.
- "Ethics of Responding to Self-Neglect: Opening the Conversation" – Atlanta Area Coalition on Aging and Mental Health: 2015 Building Workforce Competency Conference. September 2015.

WV BMS2100000002
Medicaid Policy Subject Matter Expert

Jeffrey A. Meyers, JD, MA
Director

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Professional Summary

Requirement: Medicaid Policy Subject Matter Expert shall be leveraged for consultation services on federal Medicaid regulation and policy and serve as a SME under both the program oversight and actuarial services sections. Position is required to have a minimum of Bachelor's Degree, with ten (10) years' experience in Medicaid policy research and development, either with a State Agency, Federal Agency, or rendering services under contract to either Agency type

Jeff supports Guidehouse's Healthcare Strategy group and manages the strategic challenges of healthcare environments for state, provider, and payer clients. He has deep experience in state government, federal regulatory practice, and healthcare, having served most recently as Commissioner of the New Hampshire Department of Health and Human Services, overseeing all Medicaid, Behavioral Health, Public Health, Human Services, Child Welfare and Long-Term Care divisions. Jeff has worked extensively with the Centers for Medicare and Medicaid Services on a range of complex Medicaid programs, including the New Adult Group expansion, the Disproportionate Share Hospital (DSH) Program, and Supplemental and Directed Payments. He also was deeply involved in rate setting for the State's Medicaid Managed Care program, behavioral health rates, and nursing home and other long-term care rates.

On Guidehouse's current project with BMS, Jeff has contributed as a subject matter expert on deliverables related to impacts of the Biden administration, legislative analysis (e.g., Medicaid Buy-In Programs), and the Quality Strategy.

Areas of Expertise

- Organizational Leadership
- Budget and Financial Management
- Client Communication
- Public Speaking
- Legal Analysis and Advocacy
- Complex Contract Negotiation
- Federal Regulatory Practice
- Strategic Planning
- Policy Development

Jeffrey A. Meyers, JD, MA
Director

Professional Experience

Commissioner for Department of Health and Human Services

- Served four years as commissioner with a focus on addressing the pressing challenges of the Opioid Crisis, enhancing mental health and substance misuse provider capacity, expanding Medicaid coverage to the uninsured, re-building the Child Welfare system, and developing alternative payment and delivery systems to achieve long-term stability for critical safety-net programs and services. Working with both Governor Maggie Hassan and Governor Christopher T. Sununu, led a reorganization of the department to achieve integration of programs and funding streams, established new divisions of Behavioral Health, Housing and Economic Stability, Long Term Supports and Services, and Performance Evaluation and Innovation, and put into place new senior leadership that will carry the Department into the future.

Director for Intergovernmental Affairs for the Department of Health and Human Services

- Member of the Department's senior management and policy teams, worked to plan, design, and implement department strategies, programs, and services. Among the major initiatives overseen were the development and implementation of New Hampshire's Medicaid Expansion Program (NH Health Protection Program) and the negotiation of a $150 million federal Medicaid Delivery System Reform Incentive Program Waiver. Worked with state executive branch, legislative, and federal officials, as well as stakeholders, on a wide variety of program and budget issues affecting the department. Appeared regularly on behalf of the Department before the New Hampshire General Court and other organizations.

Director of Government Relations for Granite Healthcare Network (GHN)

- Established an initial advocacy program for five New Hampshire hospitals to engage and educate state officials and other centers of influence on GHN's mission to transform the delivery of healthcare and on the impact of specific healthcare policies on patients, providers, and communities.

Chief Legal Counsel to Governor John H. Lynch

- Provided counsel to New Hampshire's longest serving governor on legal, legislative, and policy issues. Worked with executive branch department heads, the leadership and members of the legislature, the executive council, and the judiciary in implementing the governor's legislative and public policy priorities. Represented New Hampshire's interests before federal government agencies on wide range of issues affecting the state.

Legal Counsel to the New Hampshire State Senate

- Provided ongoing advice to the senate leadership, individual senate members, and to senate committees on a broad range of legal, legislative, and ethics issues.

Additional Professional Experience

- Worked on Capitol Hill for both members of the House of Representatives and US Senate.
- Founding member of Kissinger Associates in New York City.

Jeffrey A. Meyers, JD, MA
Director

Work History

- Commissioner, New Hampshire Department of Health and Human Services (2016 – 2019)
- Director, Intergovernmental Affairs, New Hampshire Department of Health and Human Services (2013 – 2015)
- Director of Government Relations, Granite Healthcare Network (2013)
- Chief Legal Counsel, Office of the Governor (2009 – 2013)
- Legal Counsel, New Hampshire State Senate (2006 – 2009)
- Partner, Nelson, Kinder and Mosseau, P.C. (2003 – 2009)
- Associate and Secretary of the Corporation, Kissinger Associates, Inc. (1982 – 1983)

Certifications, Memberships, and Awards

Bar Admissions / Memberships

- Supreme Court (New Hampshire, Maine, and Vermont)
- U.S. District Court (New Hampshire, Maine, and Vermont)
- U.S. Court of Appeals for the District of Columbia

Professional Associations

- Director, New Hampshire Charitable Foundation (2020 – Present)
- Past Chairman of the Board, New England States Consortium Systems Organization (2019)
- American Health Lawyers Association
- National Association of State Health Policy
- New Hampshire Bar Association
- Member, Ethics Committee, New Hampshire Bar Association (2001 – 2007)

Education

- Juris Doctor, Georgetown University Law Center
- Master of Arts, Candidate, Johns Hopkins University, School of Advanced International Studies
- Bachelor of Arts, Political Science, George Washington University

Guidehouse

WV BMS2100000002
Medicaid Policy Subject Matter Expert

Lance Robertson
Director

lrobertson@guidehouse.com
Oklahoma City, Oklahoma
Direct: 405.208.2570

Professional Summary

Requirement: Medicaid Policy Subject Matter Expert shall be leveraged for consultation services on federal Medicaid regulation and policy and serve as a SME under both the program oversight and actuarial services sections. Position is required to have a minimum of Bachelor's Degree, with ten (10) years' experience in Medicaid policy research and development, either with a State Agency, Federal Agency, or rendering services under contract to either Agency type

Lance has more than 20 years of extensive experience working with programs and services that support the nation's most vulnerable and marginalized populations. His unmatched experience in the development and execution of large public sector agencies, both at the state and federal level, brings a unique point of view to any engagement. Lance also has the practical experience of creating partnerships and successful collaborations across disparate agencies and partners, increasing the potential for impactful solutions with lasting effects.

On Guidehouse's current project with BMS, Lance has contributed as a subject matter expert on deliverables related to social determinants of health and care coordination.

Areas of Expertise

- Home- and Community-Based Services and Long-Term Care with a focus on aging / disability
- Medicaid, Older Americans Act, and safety net services
- Value-Based and Accountable Care Solutions
- Service program development and execution
- Inter-agency collaboration

Professional Experience

US Assistant Secretary for Aging at Health and Human Services Administration on Community Living (2017 – 2021)

- Delivered executive leadership to a national team across 36 major aging services programs and a $4 billion budget
- COVID-19 Response Executive Leadership Team member
- Secretarial designee for global health affairs and abuse prevention
- National Chairman for multiple councils and boards related to healthcare, aging, and disability
- Worked at leadership level with all CMS components including CMCS (Medicaid).
- Held monthly meetings with CMCS Administrator and divisional leadership (ex: DEHPG)
- Regular meetings with peer group to include CMS Administrator

Lance Robertson
Director

- ACL team actively engaged with CMS on policy issues (ex: HCBS Settings Rule), waiver renewals, quality measures, 1115 waiver reviews, health and wellness, etc.
- Jointly funded the NCAPPS resource center
- Collaborated on various programs like No Wrong Door, AT Reuse, MFP (to include tribal), Medicaid Buy-In, data improvement projects (ex: ID/DD)
- Championed predictive analytics work
- Worked on Medicaid administrative claiming
- ACL led multiple agency-wide collaboratives and CMS was a strong partner including: Adult Maltreatment Prevention, Elder Justice, Disability Collaborative, RAISE Family Caregiver Council.
- Assisted CMCS with recent ToolKit for Rebalancing LTSS expenditures.
- Championed SDoH in linking provider network with health plans.
- Final ACL authority on clearing CMS documents during agency review process

State Director, Oklahoma Aging Services (2007 – 2017)

- Directed 15 major programs and a $325 million dollar budget
- Ran agency with administrative oversight for Oklahoma's 1915c waiver
- Worked closely with State Medicaid Agency (OHCA) on key issues including possible expansion, conversion to Managed Care, etc.
- As NASUAD President, participated in quarterly meetings (on site) with CMCS leadership
- Implemented EVV system for waiver
- Worked with appropriators on annual support for Medicaid waiver as well as other service adjustments pre-approval by CMS
- Explored BIP opportunity and offered analysis for state consideration

Director, Oklahoma State University (1994 – 2005)

- Served as Executive Director for PartnerShips for Aging
- Co-founded the Gerontology Institute

Work History

- U.S. Assistant Secretary for Aging at Health and Human Services Administration on Community Living (ACL) (2017 – 2021)
- State Director, Aging Services, Oklahoma Department of Human Services (2007 – 2017)
- Director, Oklahoma State University (1994 – 2005)

Lance Robertson

Director

Certifications, Memberships, and Awards

- Past President, National Association of States United for Aging and Disabilities (NASUAD, now ADvancing States)
- Distinguished Alumni Award, University of Central Oklahoma
- National Salute to Leaders Award
- Aging Professional of the Year

Education

- Master of Public Administration, University of Central Oklahoma
- Bachelor of Science, Business, Oklahoma State University

WV BMS2100000002
Lead Actuary

Russell H. Ackerman, ASA, MAAA, FCA

Partner and Chief Actuary

russ.ackerman@guidehouse.com
Phoenix, Arizona
Direct: 480.318.9390

Professional Summary

Requirement: minimum of ten (10) years' experience with Medicaid Managed Care rate setting, and shall be either a Fellow of the Society of Actuaries (FSA) and/or Member of the American Academy of Actuaries (MAAA)

Russ is Guidehouse's Chief Actuary, with responsibility for all actuarial and associated analytics for the firm. He has 28 years of experience in Consulting, Health Plan, and Managed Care Organization (MCO) environments; and is responsible for assisting states with Medicaid managed care program development, capitation, and rate setting efforts. Throughout his consulting career, he has both consulted governments and agencies on their overall strategies, actuarial requirements, financial management practices, financial and eligibility data, analytics, and modeling. His work includes leading and performing work for all aspects of Managed Care and Fee for Service Medicaid programs. For those programs, he consults on both legacy Medicaid strategies and strategizes with state and agency forward looking innovations. In his past, Russ also worked for a large Midwestern health plan in corporate finance leadership and chief actuary role with oversight over all government sponsored, commercial, and retail lines of business, including Medicaid, Medicare, Individual, Large and Small Group, and Provider ACO business.

Some states Russ has led consulting services for Arizona, Georgia, Idaho, Kansas, Kentucky, Massachusetts, Mississippi, North Carolina, Ohio, Tennessee, Texas, and West Virginia. Projects he has led for these states and their agencies include Medicaid rate setting strategies, risk adjustment implementations, Long Term Services and Supports (LTSS), Home and Community Based Services (HCBS), Intellectual or Developmental Disabilities (IDD), and other specific population strategies. This work includes related financial data modeling, analysis, pricing activities, 1115 budget neutrality, and decision facilitation for 1115 waivers, 1915b, c, and b / c combo waivers, state innovation model (SIM) strategies, and development and implementation of both Accountable Care Organizations (ACOs) and Patient Centered medical Homes (PCMHs) to serve Medicaid and other higher risk populations.

Projects he has led have been the bases for various states' governors' and legislative stakeholders' decisions for Medicaid strategy, rural health initiatives, pharmacy financing approaches, and general healthcare reform. He is an active Member of the American Academy of Actuaries (MAAA) and its Medicaid and Medicare Committees, an Associate of the Society of Actuaries (ASA) and its Health Section Medicaid Subcommittee. He is also a Fellow in the Conference of Consulting Actuaries (FCA). He participates and contributes regularly to industry associations and conferences.

Russ is currently directing and leading all aspects of Guidehouse support to BMS. Under this leadership, the Guidehouse team has delivered multiple CMS-compliant MHT and MHP capitation rate certifications, analytics, analyses of COVID-19 impacts, Section 1915(b) cost effectiveness support, Section 1115 waiver budget neutrality support, pharmacy carve-out savings analyses, and additional ad hoc support to BMS leadership.

Guidehouse

WV BMS2100000002
Lead Actuary

Russell H. Ackerman, ASA, MAAA, FCA

Partner and Chief Actuary

Areas of Expertise

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

Professional Experience

- Leads all actuarial activities for Guidehouse Healthcare.
- Strategy and actuarial leader for multiple state Medicaid programs.
- Medicaid managed care, state agency, legislative and other stakeholder facilitation.
- Oversight of all actuarial rate-setting and analytics for Medicaid clients and providers.
- Medicaid waiver and demonstration program strategies.
- Corporate finance and chief actuary for a large midwestern health plan.
- Corporate improvements affecting all actuarial, reserving, capitalization, pricing, underwriting, financial reporting, and operations across all health insurance lines of business.
- Experience in executive, management, actuarial, pricing, reserving, underwriting, and financial consulting.
- Consulting large corporations on benefit design, pricing, underwriting activities, and healthcare funding mechanisms.

Work History

- Senior Vice President and Medicaid National Practice Leader, Aon (2014 – 2018)
- Principal and Client Leader, Mercer (2012 – 2014)
- Financial Department Leader and Chief Actuary, Medica (2005 – 2012)
- Consultant, Deloitte (2003 – 2005)
- Assistant Vice President and Actuarial / Underwriting Consultant, Aon (2001 – 2003)
- Corporate Lead for National and Major Accounts, PacifiCare Health Systems (1995 – 2000)
- Consultant, Watson Wyatt (1992 – 1995)

Certifications, Memberships, and Awards

- Fellow of the Consulting Conference of Actuaries (FCA)

Russell H. Ackerman, ASA, MAAA, FCA

Partner and Chief Actuary

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

Education

- Bachelor of Science, Statistics, Brigham Young University

WV BMS2100000002
Lead Actuary

Sterling Felsted, ASA, MAAA

Associate Director

sterling.felsted@guidehouse.com
Atlanta, Georgia
Direct: 312.805.0169

Professional Summary

Requirement: minimum of ten (10) years' experience with Medicaid Managed Care rate setting, and shall be either a Fellow of the Society of Actuaries (FSA) and/or Member of the American Academy of Actuaries (MAAA)

Sterling has more than 10 years of Medicaid Managed Care rate setting experience, with further consulting experience in healthcare in general. This experience, though focused on Medicaid Managed Care, also includes consulting and analysis work for commercial and state health programs. In his current role he provides project management and client interfacing for the firm's Medicaid clients. He orchestrates the development of the annual capitated rates as well as providing oversight on all ad hoc requests as well.

On Guidehouse's current project with BMS, Sterling is supporting the development of Medicaid managed care capitation rates for the MHT and MHP programs. Sterling has been critical for setting up several of the ancillary models that support State risk adjustment and the accounting of directed payment distributions. He routinely presents at weekly BMS Leadership meetings for financial and actuarial analyses that inform the MCO capitation rate setting process and other projects due to his working knowledge of the program. Sterling leverages his experience supporting Tennessee and other states to inform and guide financial-related policy recommendations the Guidehouse team offers for 1115 waivers, and all other aspects of our broad Medicaid actuarial suite of services.

Professional Experience

- Determining and maintaining the timeline for annual rate-setting efforts
- Development of actuarial models
- Development of actuarial assumptions and estimates
- Providing guidance to junior staff
- Signing certifications and other actuarial statements of opinion as well as providing ongoing support with CMS
- Risk adjustment of capitation rates
- Provide guidance to large corporations and Medicaid programs on how to best comply with ACA and other regulations / guidance
- Repricing medical costs for comparison against Medicare benchmarks
- Communication of financial deliverable results to clients
- Financial projections for health plans for a number of large clients, including state health plans
- Validation and processing of large claims data in SQL, Access, Excel, and R

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Lead Actuary

Sterling Felsted, ASA, MAAA

Associate Director

- The collection, maintenance, and analysis of plan data for several large multinational corporations
- Analysis of plan performance and the estimation of future plan costs for global health and benefit programs, including life, accident, disability, medical, DB, DC, and hybrid plans
- Tracking, documenting, and justifying cost savings to clients

Work History

- Consulting Actuary (various roles): Aon, Navigant, and Guidehouse (2010 – present)
- Global Benefits Analyst: Aon (2009 – 2010)

Certifications, Memberships, and Awards

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

Education

- Bachelor of Science, Mathematics, Brigham Young University

Guidehouse

WV BMS2100000002
Lead Actuary

Jeff Yang, FSA, MAAA
Associate Director

jeff.yang@guidehouse.com
Los Angeles, California
Direct: 213.545.7698

Professional Summary

Requirement: minimum of ten (10) years' experience with Medicaid Managed Care rate setting, and shall be either a Fellow of the Society of Actuaries (FSA) and/or Member of the American Academy of Actuaries (MAAA)

Jeff is a credentialed actuary who specializes in Medicaid managed care capitation rate development. With 10 years of experience by the contract effective date for this project, his work in Medicaid managed care rate setting for states and health plans will help bring a unique perspective to rate negotiations between insurers and state agencies.

Jeff serves as the lead actuary for Georgia's Medicaid managed care capitation rates. He is responsible for the quality of client deliverables and facilitates conversations with State contacts. He has also helped develop capitation rates for Kansas and Tennessee. Jeff also provides subject matter expertise to other actuaries on our BMS actuarial team for rate setting and ad hoc capitation projects.

Jeff is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries, and is involved in industry thought development.

Areas of Expertise

- Medicaid capitation rate-setting – Claims reconciliation, trend development, service / population carve-in / out analysis, fee schedule pricing, DRG re-pricing, efficiency adjustments, administrative cost development, in-lieu of services, and rate certification
- Regulatory – Medicaid managed care final rule, ASOP #49, and CMS Medicaid rate-setting guidance
- Risk mitigation strategy – Risk adjustment, risk corridor, kick payments, and withhold arrangements
- Encounter data – Data querying, risk score development, and encounter data quality
- Pharmacy – Contracting, Hep C kick, Rx managed care carve-out, spread pricing, and emerging drugs
- Finance – Revenue projections, MLR remittance calculations, MLR monitoring, and NAIC reports

Professional Experience

Actuarial Rate Setting

- Certifying actuary for the Georgia Families, Planning for Healthy Babies Medicaid, and Georgia Families 360 capitation rates programs which total annual premium flows of more than $4B. Experience on these projects include data querying, detailed health plan MLR review, analysis, modeling, rate-setting assumption development, project management, compliance with federal regulations, rate certification, and leading the presentation of results to the State, health plan CEOs, CFOs, and senior actuaries.

Jeff Yang, FSA, MAAA
Associate Director

- Developed and certified capitation rates for Georgia Families 360°, Georgia's Foster Care and Adoptive Assistance program. Helped with rate assumption development when the program shifted from fee-for-service to managed care in initial years.
- Experienced with Kansas and Kentucky Medicaid capitation rate development, including base data querying, MCO reporting review, program change and trend analysis, administrative cost development, and packaging deliverables. Populations include TANF/CHIP, MLTSS, ABD, Duals, and Expansion.
- Served as the primary actuarial liaison to health plan leadership for Medi-Cal rate analysis in a prior role at a carrier. Familiar with the intricacies of the Rate Development Template (RDT) and the Medi-Cal capitation rate setting process. Populations include TANF/CHIP, MLTSS, ABD, Duals, Expansion, and Duals Demonstration.

Pharmacy Carve-out

- Led and certified Georgia's pharmacy carve-out actuarial study. Factors in the analysis included unit cost re-pricing, trends, rebates, utilization shifts, PBM administrative fees, risk margin and premium tax, and HIF.

COVID-19 Risk Mitigation

- Led the design and implementation of a retrospective rate adjustment and risk corridor strategy in Georgia managed care in response to the COVID-19 national emergency, which will result in hundreds of thousands of dollars in remittance payments due from the plans to the State.

Trend Analysis

- Extensive education, experience, and background in applying statistical techniques and regression modeling to historic experience to develop unit cost and utilization trends.
- Cognizant of up-to-date industry trend studies and benchmarks, which are used to supplement trend development in the capitation rates.
- Experienced in assessing the appropriateness and reasonableness of plan-submitted trend assumptions to the state.

Risk Adjustment

- Played a central role in creating a risk adjustment process for the Georgia Medicaid managed care program. Formulated, oversaw, and/or reviewed every step of the process from beginning to end, including data querying, regression / CDPS implementation, weight development, financial / actuarial modeling, and presentation of results to the client. Developed creative and transparent solutions to unique problems that addressed both the client's concerns and the health plans' concerns while maintaining a respectful and positive atmosphere among all parties.
- On the carrier side, worked closely with the Medi-Cal encounter data team to maximize risk scores for the plan. Contributions include educating the team on the mechanics of the Medicaid Rx, including weight development, regression modeling, individual NDC/J-code impact, member scoring, and revenue impact.

Jeff Yang, FSA, MAAA
Associate Director

Non-benefit Cost Analysis

- Experience comparing relative cost of MCOs to develop managed care savings assumptions at the category of service level. Other managed care savings experience includes MAC pricing, inpatient preventable admissions, and Part B/D savings.
- Development of administrative costs and risk margin assumptions based on CMO reported financials.
- Helped construct the withhold payment for Georgia's Foster Care program, which factors in reasonably achievable VBP metrics, provider risk sharing, and the finance and budgeting of applying a withhold to capitation rates.

MLR Analysis

- Engaged in review of plan submitted financial statements, MLR calculations, NAIC statements, and MLR regulation to ensure that capitation rates are set at appropriate levels.

Data Analysis

- Developed and certified IBNR for Georgia's FFS Medicaid population. Served as the primary point of contact for the client and the affiliated auditor.
- Familiarity with DRG pricing, including application of DRG weights, hospital base weights and outlier thresholds.
- Created numerous claims and unit cost re-pricing analysis.
- Fluent with data querying languages and with VBA.

Actuarial Rate Setting Guide Compliance

- Recently reviewed legislation includes the final rule mini-reg (November 2018), the 2019 – 2020 Rate Development Guide (March 2019), the CMS spread pricing bulletin (May 2019), and the CMS COVID-19 guidance (ongoing). Involvement includes interpretation of legislation, internal presentations, and brainstorming questions for CMS.

Regulatory Compliance

- Evaluated the fiscal impact of the American Health Care Act, the Better Care for Reconciliation Act, and the Graham-Cassidy Bill to Georgia's budget.

Supplemental Payments

- Assisted in the development of the directed payments program for teaching hospitals in Georgia managed care. Work includes pre-print submissions, payment structure development, tie-in with the rates, fee schedule calculations, rate cell allocation calculations and incorporate into rate certifications.
- On the plan side, subject matter expert on Medi-Cal's directed payment including the PDHP, EPP, and QIP directed payments programs. Worked closely with providers and the State to ensure accurate reporting of encounter utilization as it relates to CFR 438.6(c)(2)(i)(A) and CFR 438.6(c)(2)(i)(B). Familiar with the development of directed payment structures that are tied to utilization of services, equal expenditures, and/or quality strategy.

Jeff Yang, FSA, MAAA
Associate Director

Statistical Analysis

- Able to complete independent or parallel analysis from beginning to end by using SQL for data querying and Excel for modeling.
- Developed numerous models throughout his career and has created exhibits for at least every component of Georgia's rate development process.
- Strong attention to detail and ability to construct reliable analysis in a logical fashion.

Federal Waivers

- Completed a thorough analysis assessing the fiscal budgetary impact of Georgia Pathways, Georgia's limited expansion 1115 demonstration waiver. Considerations include the impact of work requirements, FPL mandates, category of aid requirements, and other rate-setting related techniques.

Payment Models

- Utilized CMS 64 hospital reports to develop DRG weights, hospital base rates, CCRs, and other related factors for Kansas's hospital DRG schedule.
- Constructed event-based kick payments for maternity, NICU, or Hepatitis C related costs.
- Developed plans-specific risk corridor mechanisms and remittance payments for specific CMOs in Kansas.

Budget and Forecasting

- Worked with health plan finance to projected costs, revenue, and membership on a semi-annual basis. Factors include trend development, member mix shifts, rating assumptions, and MLR remittance calculations.

CMS Negotiations

- Multiple years of Georgia capitation rate development, including submitting rate certifications, going through the approval process with CMS, and Q&A from CMS.

MCO Contract Design

- Assisted the State in drafting contract language on directed payments, risk corridors, and capitation rate payments.

Quality Measures

- Helped develop the Georgia Families 360° withhold with tie-in to MCO and provider quality measures.
- Worked with the State to develop quality measures for the Georgia directed payments program.
- Currently exploring options to incorporate Social Determinant of Health and other quality measures into Georgia rate development. This may be done through managed care savings factors or withholds / incentives.

Guidehouse

WV BMS2100000002
Lead Actuary

Jeff Yang, FSA, MAAA

Associate Director

Technical Skills

- Microsoft Office (Advanced) – Excel (including VBA), PowerPoint, Word
- Data Querying (Intermediate) – MSSQL, Teradata, SAS
- Programming (Intermediate) – Python, JavaScript, C++, Java, C#
- Mathematical Packages (Beginner) – R, S-Plus, MATLAB, LateX, Maple

Certifications, Memberships, and Awards

- Member of the Academy of Actuaries (2014 – Present)
- Associate of the Society of Actuaries (2014 – Present)
- Fellow of the Society of Actuaries (August 2020 – Present)

Education

- Master of Engineering in Financial Engineering, Cornell University
- Bachelor of Science in Applied Mathematics and Economics, The College of William and Mary

Publications

- Automating Bivariate Transformations, IJoC, Winter 2012, Vol. 24, No. 1.

WV BMS2100000002
Staff Actuary

Erica Mitchell, FSA, MAAA

Director

erica.mitchell@guidehouse.com
Atlanta, Georgia
Direct: 404.602.3471

Professional Summary

Requirement: minimum of five (5) years' experience with Medicaid managed care rate setting or other insurance pricing, and shall be either a Fellow of the Society of Actuaries (FSA) and/or Member of the American Academy of Actuaries (MAAA)

Erica is a Fellow of the Society of Actuaries and has more than 15 years of experience in healthcare and actuarial consulting. She has worked across numerous healthcare lines of business including Medicaid, Commercial, Individual, and Medicare; all roles have had a deep focus on pricing. Her array of experience allows her to look at actuarial problems in a unique way, such as when she recently provided Tennessee, Georgia, and Arizona with a deep dive into methods of financing state Social Determinants of Health goals within the Medicaid framework.

In the Medicaid space, she is the lead actuary for West Virginia Medicaid, and oversees ad hoc consulting services for two other States. Her work includes rate setting, cost effectiveness, budget neutrality, ad hoc modeling, and directed payment support for both financial modeling and preprint strategy. She has also presented on high cost drug risk mitigation methods for MCOs and States in Medicaid.

On Guidehouse's current project with BMS, Erica leads the development of key actuarial deliverables and analyses, including but not limited to the 1915(b) waiver cost effectiveness modeling, directed payment program financial modeling, and legislative and budget-related analysis and projections. She was critical to the launch of the MHP program and worked actively with MCO financial and actuarial staff to finalize the MCO capitation rates. Erica also performs quality control and validation procedures on the MHT and MHP capitation rates.

Professional Experience

Ratesetting

- Led retrospective and prospective ratesetting for West Virginia from 2019-2020.
- Co-lead actuary in developing West Virginia rates for a new managed care program for foster care children including cost effectiveness submission and support on CMS questions. As part of that work, she was integral in a risk adjustment analysis used to reflect the changing acuity of the population as enrollment increased within the capitation rates, saving the state approximately $5 million in four-month initial launch of program. Subsequently defended this downward adjustment to the incoming MCO using in-depth durational analyses.
- As part of annual rate setting process and legislative support, analyzed financial impacts of various Medicaid program changes ranging from fee schedule changes to delayed implementation of new DRG payment methodologies for a select number of facilities. Additional analyses include:
    - Trend drivers
    - Mix shift analysis

Erica Mitchell, FSA, MAAA
Director

  - High cost drug risk pool modeling
  - Addition of Substance Use Disorder (SUD) benefits
  - COVID modeling including impact of stay-at-home orders on member utilization.
- Leading state in exploring high cost drug risk mitigation techniques under the managed care framework including driving stakeholder engagement conversations across BMS teams, financial analysis to support decision-making, and policy discussions.

Financial Modeling / Ad Hoc Analysis

- Supported state ad hoc analyses on Medicaid expenditures for legislative actions including increasing the state minimum smoking age to 21, expanding telehealth access for managed care Medicaid members, and expansion of school-based services including revisions to medical necessity criteria.
- Supported West Virginia with eFMAP budget modeling including enrollment projections due to unemployment and reverification suspension and including various COVID-related program changes. Work was utilized for key NAMD survey used to support FMAP lobbying efforts on behalf of states.
- As part of annual IBNR work on behalf of one State's fee-for-service Medicaid program, noted excessive trends for a particular service category, leading to attorney general investigations into several providers' billing practices.
- Developed and supported 2019 cost effectiveness submission for West Virginia for 1915(b) and 1915(c) waivers (new and existing programs), including both the numeric components of the submission as well the accompanying narrative. Reviewed CMS-64 data provided by the state and made adjustments to the base period data used in the 2019 submission for data anomalies related to directed payments and State-to-MCO risk corridor payouts, garnering CMS approval.
- Supported West Virginia financial analysis in CMS approval of new HMO premium tax including compliance review with 42 CFR 433.68(e)(2)(ii). Led to tax revisions and presentation of multiple options to state to meet financing objectives while maintaining regulatory guideline compliance, including negotiations with the tax commissioner.
- Presented WV's risk corridor strategy to NAMD CFOs on national call during COVID pandemic at the request of WV's Deputy Commissioner, Finance and Administration.
- Researched requirements for a State's 1332 waiver including understanding of the commercial market, Medicaid, and Medicare interactions. Analysis included considerations for possible impact to ACA marketplace rates due to changes in proportion of exchange members eligible for cost-sharing reductions and premium subsidies if waiver were approved.

Social Determinants of Health (SDOH)

- As Guidehouse's SDOH Financing lead, Erica has led strategic discussions with state Medicaid programs on methodologies for incorporation of state SDOH objectives into payment models. States include Tennessee, Georgia, and Arizona, and discussions covered payment models ranging from value-based payment methodologies; to integrating withholds into capitation rates while maintaining actuarial soundness; to

Erica Mitchell, FSA, MAAA
Director

updating risk adjustment methodologies; to changing in-lieu-of service offerings. She has also participated in National Alliance to impact the SDOH (NASDOH) meetings to develop recommendations to CMS and the Office of the Actuary on clarifications needed in the Medicaid SDOH arena around medical loss ratio formulas and allowable expenditures in capitation rate development.

- Participated in discussions with leading risk adjustment researchers from California and Massachusetts including methodologies to integrate SDOH into future risk adjustment and quality benchmarks. Communicated these conversations to non-technical state audiences to address appropriateness for their Medicaid programs in future years.

Supplemental Payments

- Led the analysis of West Virginia's SB 546, a new Medicaid Managed Care Directed Payment program to support the State's recruitment and retention of physicians employed by acute care hospitals. Analysis included a review of resulting Medicaid payment rates after fee schedule changes as a percentage of Medicare reimbursement and average commercial rates, and discussion of state quality strategy integration into payment methodology. Work included stakeholder vetting and communication, preprint development and support, and minimum fee schedule analysis. New preprint was launched in near-record time (2 weeks).
- As part of ongoing review and support of West Virginia's Directed Payment Program (DPP) under 43 CFR 438.6, participated in stakeholder discussions on quality models and withholds, and the possible future changes of DPP as CMS guidance evolves. Supported state in annual DPP renewal including implementation of new annual strategy to maximize state funding based on tax receipt projections and analysis of resulting Medicaid payments as a percentage of Medicare and average commercial rates. Drafted responses to CMS questions and supported state in calls with CMS.
- Developed recommended autism provider reimbursement rates for Mississippi's Medicaid program to balance program costs and provider participation using state payment rate market scan. Supported minimum fee schedule preprint for rate revisions.

Work History

- Actuarial Consultant, Horizon Actuarial Services (2017 – 2018)
- Actuarial Director, Aetna (2016 – 2017)
- Vice President, Aon (2013 – 2016)
- Actuarial Consultant, Coventry Health Care, an Aetna Company (2009 – 2011)

Certifications, Memberships, and Awards

- Fellow of the Society of Actuaries (FSA)
- Member of the American Academy of Actuaries (MAAA)
- Highlighted as Guidehouse Women in Science, 2021 (1 of 7 across the firm)
- 2020 Q2 Healthcare Heartbeat Award "Build the Guidehouse Brand"

Guidehouse

WV BMS2100000002
Staff Actuary

Erica Mitchell, FSA, MAAA

Director

Education

- Bachelor of Arts, Economics and Mathematics, Emory University

WV BMS2100000002
Staff Actuary

Don Wakefield, ASA, MAAA

Associate Director

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Atlanta, Georgia
Direct: 404.602.5034

Professional Summary

Requirement: minimum of five (5) years' experience with Medicaid managed care rate setting or other insurance pricing, and shall be either a Fellow of the Society of Actuaries (FSA) and/or Member of the American Academy of Actuaries (MAAA)

Don's responsibilities have included leadership of rate setting, financial forecasting, data warehouse management, reporting tool development, trend development, and model development efforts for many types of medical plans. Don actively develops capitation rates for successful submission to Centers for Medicare and Medicaid Services (CMS) and engages with multiple states on actuarial modeling and program review.

Don is an expert who comes with more than 20 years' experience developing healthcare related actuarial solutions in both the private and public sectors, over 5 of which have been in the Medicaid managed care arena. Don has been a project manager for Medicaid rate setting projects, including work on NEMT, risk adjustment, and risk reconciliation projects.

On Guidehouse's current project with BMS, Don is already serving as a staff actuary working on multiple ad hoc projects ranging from pricing of adult dental benefit options to determining the financial impact of administering COVID-19 tests during the early stages of the Public Health Emergency. Don has also prepared IBNR analyses of the West Virginia Medicaid FFS population.

Areas of Expertise

- Rates setting for both Medicaid managed care and commercial plans.
- Forecasting and monitoring of financial results for both Medicaid managed care and commercial plans.
- Managed data warehousing of enterprise-wide healthcare data (premium, claim, and membership).
- Developing management and reporting tools for use at all organizational levels (C-suite to front line employees).
- Analyzing and developing healthcare cost trends used in rate development.
- Participating in contract negotiations between payers and providers (facility and professional groups) and providing financial impact analysis and strategic insights.

Professional Experience

Medicaid Managed Care

- Served as project manager and client lead overseeing rate development process and ad hoc projects. Signing actuary for rate development. Peer reviewed all elements of project including risk adjustment. Activities have served both traditional (non-ACA) and emerging expansion (ACA) populations.

Don Wakefield, ASA, MAAA
Associate Director

- Developed cost analysis and proposals for benefit changes (traditional and expansion related) with focus on medical, prescription drug, behavioral health, transportation, and dental benefits.
- Acted as signing actuary on claim reserving efforts (IBNR); this includes review of IBNR model development and actuarial assumptions used.

Health Information Technology

- Elevated the significance of enterprise-wide experience monitoring and reporting, while championing and growing a burgeoning business intelligence system.
- Built a reporting system to measure performance of all aspects a multi-billion dollar enterprise (e.g., pension plans' funded status, claim processing efficiency, pricing and reserving accuracy). Reports were an integral part of board and senior management meetings.
- Led vendor search and implementation of healthcare business intelligence system. Subsequently assumed on-site responsibility for the business intelligence system.
- Created Excel-based financial models to assist regional provider contracting teams in analyzing profitability of facility and physician group contracts. Also developed and conducted training classes on using provider contracting models.

Health Insurance Studies

- Developed reports to identify aberrant provider billing patterns. Multiple cases were identified, and resolution pursued by provider contracting and legal.
- Developed cost analysis and proposals for benefit changes (traditional and expansion related) with focus on medical, prescription drug, behavioral health and dental plans.
- Analyzed the actuarial and financial impact of various national contracting initiatives.
- Set pricing, reserving, and forecasting for state regulated individual and Medicare supplement products.
- Developed a hospital readmission rate study to gauge the impact various new facility protocols had on readmissions.
- Regularly acted as signing actuary on claim reserving efforts (IBNR) for commercial plans; this includes review of IBNR model development and actuarial assumptions used.

Other Relevant Experience

- Led development of employee-benefit budget forecasting tool for federal organization, applying understanding of employee benefits and actuarial skills to project success.
- Led inter-departmental Six Sigma project to improve customer experience. Misrouted calls were decreased through employee training and changes to interactive phone menu system, leading to greater customer and employee satisfaction.
- Worked together with provider contracting, medical management, and volunteer-related medical plans to provide actuarial and analytical support.

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Staff Actuary

Don Wakefield, ASA, MAAA

Associate Director

- Educated staff not familiar with actuarial and analytical concepts about topics such as applying completion (IBNR) to claim data and demonstrating an “underwriting effect” within volunteer populations.
- Supported quick turnarounds in response to state hearings regarding appropriateness of premium rate proposals.
- Provided actuarial support (pricing, reserving, forecasting) to a fledgling state CHIP program.
- Provided statistical and analytical support for quality management initiatives in behavioral health space.
- Created quality metrics that quality management staff used, leading to greater system efficiencies and improved patient outcomes.
- Developed, distributed, and analyzed patient satisfaction surveys.

Work History

- Assistant Vice President, Aon (2015 – 2018)
- Actuary, Deseret Mutual Benefit Administrators (1999 – 2015)
- Senior Actuarial Analyst, PacifiCare Health Systems (1997 – 1999)
- Actuarial Analyst, Blue Cross Blue Shield of Massachusetts (1994 – 1997)
- Quality Management Analyst, Human Affairs International (1993)

Certifications, Memberships, and Awards

- Associate of the Society of Actuaries (ASA)
- Member of the American Academy of Actuaries (MAAA)
- Six Sigma Black Belt

Education

- Bachelor of Science, Brigham Young University

WV BMS2100000002
Staff Actuary

Mark Williams-Rhaesa, ASA, MAAA

Managing Consultant

mark.williams.rhaesa@guidehouse.com
Atlanta, Georgia
Direct: 404.575.4123

Professional Summary

Requirement: minimum of five (5) years' experience with Medicaid managed care rate setting or other insurance pricing, and shall be either a Fellow of the Society of Actuaries (FSA) and/or Member of the American Academy of Actuaries (MAAA)

Mark is part of the healthcare strategy business unit at Guidehouse with nine years of actuarial experience focused on rate setting, pricing, reporting development and optimization, and trend analysis. His actuarial experience focuses on pricing, reserving, and data analytic techniques for both the private employers and Medicaid clients using tools such as Excel, Access, and SQL. In the Medicaid space, Mark has assisted the rate setting with both new and existing managed care programs. He has experience in areas such as cost effectiveness, budget neutrality, and other waiver elements.

On Guidehouse's current project with BMS, Mark is currently one of our Guidehouse actuaries assisting BMS with MHT and MHP capitation rate certifications. He also works on various other modeling projects such as budget projections, COVID-19 impacts, and pricing out new services such as adult dental.

Areas of Expertise

- Rate Pricing and Reserve Setting
- Managed Care Medicaid Programs
- Model Development

Professional Experience

Capitation Rate Setting

- Assisted with capitation rate setting in West Virginia for various categories of aid including conversion of foster care from fee-for-service to managed care. Successfully supported large downward acuity adjustment for rollout of foster care program using durational analysis.
- Modeled program changes associated to new legislative changes and additional fee schedules for client's managed care program.

Fiscal Impacts

- Assisted multiple states with fiscal impact analysis on a multitude of topics including:
  - Addition of new coverage
  - Fee schedule changes
  - Directed payment strategy changes

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Staff Actuary

Mark Williams-Rhaesa, ASA, MAAA
Managing Consultant

Employer Benefits Consulting

- Designed cost-saving initiatives to hold client's self-insured healthcare spend to a 1% trend each year, over last eight years.
- Helped Commonwealth of Kentucky manage their multi-year budget for state employee benefits, while navigating unique legislative hurdles present in the public sector.
- Developed custom reporting solutions for clients to assist with their quarterly reporting needs and describe the cause for any changes over time.

Work History

- Actuarial Consultant, Aon (2012 – 2019)

Certifications, Memberships, and Awards

- Associate of the Society of Actuaries (ASA) (2018)
- Member of the American Academy of Actuaries (MAAA) (2019)

Education

- Bachelor of Science, Mathematics, University of Georgia

Guidehouse

WV BMS2100000002
Staff Actuary

(Grace) Xianjun Zhang, ASA, MAAA

Managing Consultant

gzhang@guidehouse.com
San Francisco, California
Direct: 415.399.2115

Professional Summary

Requirement: minimum of five (5) years' experience with Medicaid managed care rate setting or other insurance pricing, and shall be either a Fellow of the Society of Actuaries (FSA) and/or Member of the American Academy of Actuaries (MAAA)

Grace is a credentialed actuary specializing in Medicaid rate-setting and rate reviewing. She has over five years of Medicaid actuarial experience. Her rate setting and pricing knowledge on the health plan side rounds out Guidehouse's broad perspectives to the rate setting process, as well as rate negotiation with the health plans. Grace is an ASA with the Society of Actuaries and a Member of the American Academy of Actuaries.

Grace serves as a key contributor for actuarial requests from Georgia's Department of Community Health. She also supports Texas's Medicaid directed payment program; and has assisted with West Virginia's BMS and Tennessee's TennCare Medicaid programs.

Areas of Expertise

- Medicaid capitation rate setting and reviewing – claim and encounter reporting, reserve estimation, unit cost and utilization trend analysis and program change implementation
- Pharmacy Cost and Utilization Analysis – high cost drugs and physician administered drug study
- Actuarial / Data Reporting and Analytics – rate development template, data pulling, and analysis
- Risk Mitigation Strategy – risk adjustment, risk corridor, kick payments, and carve-out
- Provider Contracting – fee for service and capitation rate contract negotiating, capitation withhold reconciliation

Professional Experience

HealthNet / Centene Corp.

- Analyzed and evaluated the pricing model and key assumptions of Medi-Cal premium rates for all counties and categories of service
- Lead on fulfilling CA Adult Expansion Medical Loss Ratio (MLR) Rebate calculation template filing request
- Complete the State Fiscal Year 2020 – 2021 Rate Development Template (RDT) filing to the Department of Health Care Services (DHCS)
- Conduct business correspondence and provide technical data support for calendar year 2017 RDT audited by Mercer and DHCS
- Gave expertise in UCSD Medicaid Rx risk adjustment model and pharmacy cost trend monitoring

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Staff Actuary

(Grace) Xianjun Zhang, ASA, MAAA
Managing Consultant

- Performed as the subject-matter expert for the Denti-Cal program, transportation service benefit, and outpatient pharmacy benefit
- Lead developing run-rate report to monitor Medicaid dental benefit revenue, cost, and medical loss ratio trend and provide strategic suggestion on how to improve managed care efficiency
- Supported provider contracting and incentive payment analysis in Los Angeles county
- Functioned as the point of contact between actuarial team and corporate / health plan finance team
- Provided actuarial / data analytic support Centene's Nevada Medicaid health plan (SilverSummit), including discussion with the State government on risk adjustment methodology and potential risk corridor program implementation
- Participated in Opioid and Substance Use Abuse study to estimate cost and potential savings by implementing rehab programs
- Collaborated with colleagues to collect and evaluate risk mitigation strategies of high cost drugs in various states

Molina Healthcare Inc.

- Developed monthly Pharmacy Cost and Utilization report set to monitor and break down trends using multiple perspectives, such as seasonality, AWP, discount rate, and dispensing fee, in both T-SQL server and NZ-SQL server
- Generated quarterly experience report on corporate level, including 50 Lines of Business, and provide constructive dive-in analysis
- Provided report support to other departments, primarily pharmacy, on ad hoc requests
- Designed MAC pricing model for specialty drugs during bid with pharmacy provider Accredo, saving company more than $10 million projected in 2017
- Lead design and validation of seasonality predictive model in R on drug utilization for Medicare, Medicaid, and Marketplace
- Calculated prevalence rates based on diagnosis codes, historical claims, and membership data for pharmacy pipeline study
- Communicated with external agencies (Milliman, CVS) for internal data needs and provide feedback to improve their data quality

Work History

- Associate Actuary, HealthNet / Centene Corp. (2017 – 2020)
- Associate Actuarial Analyst, Molina Healthcare Inc. (2015 – 2017)

Certifications, Memberships, and Awards

- Associate of the Society of Actuaries (2020)
- Member of the American Academy of Actuaries (2021)

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Staff Actuary

(Grace) Xianjun Zhang, ASA, MAAA

Managing Consultant

Education

- Bachelor of Arts, Statistics / Applied Mathematics in Actuarial Science, University of California, Berkeley

Technical Skills

- Microsoft Office – Excel, Powerpoint, Word
- Data Querying – MySQL, Netezza SQL, SAS
- Predictive Modeling – R, Matlab

WV BMS2100000002
Technical Support Staff, Data Lead
(Non-Key Staff)

Stephen J. Chern

Managing Consultant

stephen.chern@guidehouse.com
Washington, DC
Direct: 202.481.7303

Professional Summary

Stephen is responsible for providing output, data insights, and limitations to actuaries in capitation rate setting of Managed Care Organizations (MCOs). He also assists healthcare payers, providers, or state Medicaid agencies with developing innovative reimbursement systems and pay-for-performance models to achieve payment transformation. He focuses on using analytics to manage risk, improve care quality, and align payment incentives.

On Guidehouse's current project with BMS, Stephen primarily supports Directed Payment Programs (DPP) and preprint submission process as required by CMS. With his knowledge in various database programming, he manages SQL and SAS-based payment model to simulate Medicaid and Medicare costs and payments and application of Average Commercial Rates (ACR). He also analyzes data for actuarial use in MHT and MHP's capitation rate setting and risk adjustment process.

Areas of Expertise

- Developing hospital prospective payment systems under an inpatient All-Patient Refined Diagnosis- Related Group (APR-DRG) System, Ambulatory Payment Classifications (APC) System, or outpatient Enhanced Ambulatory Patient Group (EAPG) System.
- Modeling with quality improvement software programs that identify hospitalizations, ED visits, and ancillary services that may be preventable and converted to savings. Including 3M™ Potentially Preventable Events (PPE) Groupings, 3M™ Potentially Preventable Readmissions (PPR) Grouping Software, or 3M™ Potentially Preventable Complications (PPC) Grouping Software.
- Calculating rate-setting of Average Commercial Rate (ACR) Fee Schedule(s) and supporting Upper Payment Limit (UPL) data analysis needed for payment processing and federal approval of Medicaid supplemental payments programs. Assisting state Medicaid agencies to meet the requirements of UPL demonstrations and complete reporting templates.
- Technical focus on 3M's Classification Methodology Analytics including 3M™ Core Grouping Software (CGS) and 3M™ Clinical Risk Grouping Software (CRG)
- Knowledge in various database programming skills, including SAS Certified Base Programmer for SAS 9. SQL Server Management Studio (SSMS), SQL Server Integration Services (SSIS); writing ad hoc SQL code to categorize and analyze data, create output reports, and perform complex data mining.

Professional Experience

Payment Transformation

- Assisted the Washington State Health Care Authority (HCA) with multiple UPL demonstration projects as required by CMS. The UPL demonstrations where for inpatient hospital, outpatient hospital, outpatient laboratory, clinic, physician, and "other" facilities.

Stephen J. Chern
Managing Consultant

Reviewed calculation of Medicaid costs and payments under Medicare compared to Medicaid payments to determine UPL gap for each provider class.

- Assisted Washington State HCA with assessing Medicaid inpatient psychiatric system capacity and rebasing per diem payment rates. Developed a dynamic payment simulation model to estimate payments under rebased based rates used as the basis for the final state legislative proposal.
- Assisted Washington State HCA with outpatient EAPG payment system updates, including grouper version and software setting changes. Created a SAS-based payment simulation model to calculate fiscal impacts and participated in multiple stakeholder meetings. Developed payment impact estimates monitoring post-implementation, including analysis to determine the fiscal impact of provider documentation and coding improvement.
- Assisted Washington State HCA with the design and implementation of hospital readmission policies using 3M's PPR software. Developed analysis of readmission chains in historical claims data, determined providers with "excess" readmissions (based on actual readmissions exceeding risk-adjusted "expected" readmissions), and finalized payment incentive models based on patient outcomes.
- Assisted University of Washington Medicine and other Washington Public Hospital Districts in cooperation with the Washington State Health Care Authority with the development and maintenance of a Professional Services Supplementation Payment (PSSP) Program through Washington Medicaid. Constructed a SAS-based physician UPL model required by CMS, validated provider commercial payment data, constructed master commercial fee schedules, and projected physician UPL payments using Medicaid claims data. Also assisted with analyses showing the projected payments from expanding the physician UPL program to managed care.
- Assisted a large children's hospital with the preparation and design of a pilot Medicaid physician UPL. Using a SAS-based model, developed an initial Medicaid Fee-For-Service (FFS) physician UPL demonstration using claims data. The initial demonstration provided with a fiscal impact estimate from the pilot physician UPL payment program and served as a basis for presenting the proposed pilot program to Medicaid for their consideration.
- Assisted University of Washington Medicine with analyses related to the Washington State HCA Medicaid Certified Public Expenditure (CPE) program. Created a SAS-based payment simulation model under the State's Medicaid FFS inpatient payment fee schedule, reconciled final CPE settlements, and estimated potential impacts of additional settlements for Medicaid FFS inpatient payments with affiliated University of Washington Medicine hospitals.
- Assisted Seattle Children's Hospital with analyses demonstrating the fiscal impact of the Washington State Medicaid inpatient APR-DRG and outpatient EAPG system. Simulated payments under both the new and legacy system and summarized the fiscal impact by service line, APR-DRG, and EAPG, EAPG type, and EAPG category. Contrasted base DRG / EAPG payments to outlier payments from new to legacy system and identifying DRGs / EAPGs with the highest projected losses for discussion purposes.

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WV BMS2100000002
Technical Support Staff, Data Lead
(Non-Key Staff)

Stephen J. Chern
Managing Consultant

- Assisted BlueCross BlueShield of Alabama (BCBSAL) with outpatient payment system development using EAPGs. Developed a SAS-based payment simulation model to determine fiscal impacts of new payment parameters. Assisted with monitoring payment impacts post-implementation, including analysis to determine the fiscal impact of provider documentation and coding improvement.
- Assisted a large western children's institution with APR-DRG inpatient payment methodology impact analyses. Developed a case rate reimbursement framework for Medicaid Managed Care and Commercial contracts which increased coherence with the APR-DRG case rate methodology. Assisted with the cost distribution analysis and APR-DRG service distribution analysis on inpatient claims data with reported APR-DRG assignments. Assisted review of preliminary findings and established a baseline set of service categories for client's case rate framework. Set specific set of rules used to assign claims to the baseline service categories and applied service line assignment to inpatient claims data. Calculated service line-level cost correlation and variance and recommended specific outlier policies that reduced risk to an acceptable level and determined the revenue neutral payment rate for each payer contracts.

Other Relevant Experience

- Assisted State of Wyoming to review its ICD-10 coding system for the corresponding ICD-9 codes in the Level of Care (LOC) hierarchy and update the inpatient and outpatient hospital billing reimbursement criteria for future ICD-10 implementation. Under a SAS-based model, integrated the General Equivalence Mappings from CMS, and identified the forward mappings and the reverse mapping, reviewed the ICD-10 code lists qualitatively and identified codes with equivalent translations to the current codes. Assisted recommendation of a list of codes to include in the updated LOC hierarchy for ICD-9 and ICD-10 codes lists that did not have direct, one-to-one mappings.
- Assisted a large healthcare payer to assess their copay differential agreement. Using historical data when the copay differential went into effect, calculated utilization trends beforehand, and identified the impact caused by the differential. Developed a benchmark total utilization by service lines and assessed referral rates based on the actual volume of the hospital's service lines.

Work History

- Portfolio Accountant, Thrive Communities Inc. (2012)

Certifications, Memberships, and Awards

- SAS Certified Base Programmer for SAS 9 (2016 – Present)

Education

- Bachelor of Arts, Business Administration, Finance, University of Washington

WV BMS2100000002
Technical Support Staff, Data Lead
(Non-Key Staff)

Jordan Smith, JD
Senior Consultant

jorsmith@guidehouse.com
Washington, DC
Direct: 681.214.7733

Professional Summary

Receiving his Juris Doctorate from West Virginia University College of Law in 2016, Jordan came to Guidehouse in 2020 after several years of public-interest legal work within West Virginia. Possessing experience in administrative law, government policy analysis, and the implementation of innovative, people-centered projects, Jordan's J.D. skillset and background offer unique insight into the way people and policy interact. At Guidehouse, Jordan works in the Healthcare Strategy segment where his research, analysis, and forward-thinking solutions help ensure the quality and integrity of state Medicaid programs.

On Guidehouse's current project with West Virginia, Jordan contributes to our Compliance and Policy teams. He plays a critical role in reviewing all member informational and marketing materials submitted by MCOs for approval, supporting the MHT and MHP contract updates, and contributing to ad hoc policy research requests. Jordan resides in Kenna, West Virginia, which is a short 25-minute drive to Charleston and is available to provide on-site support to BMS.

Professional Experience

Healthcare Strategy

- Provides thoroughly researched, analytical updates regarding federal and state laws, regulations, and emerging Medicaid issues.
- Provides detailed contract analysis, drafting, and pre/post-implementation support.
- Develops reports, presentations, and other specialized deliverables for external reporting, stakeholder meetings, and public-facing uses.
- Develops written and virtual presentation materials to support knowledge management among state agency clients.
- Creates targeted, model documents and processes to maximize efficiency and reduce administrative burden.
- Creates advanced exhibits and materials which allow clients to effectively communicate complex concepts to stakeholders, state legislators, and the public.
- Communicates effectively with all client staff, stakeholders, and contractors to advance projects and accomplish client goals.
- Delivers forward-thinking analysis, flexible problem solving, and innovative solutions for changing client needs.

Project Support Specialist, Lawyer in the School Program

- Provided legal support to program attorneys & Pro Bono volunteers.
- Facilitated legal clinics, conducted presentations, and served as liaison between attorneys and program participants.
- Managed short and long-term projects to accomplish program objectives.

WV BMS2100000002
Technical Support Staff, Data Lead
(Non-Key Staff)

Jordan Smith, JD
Senior Consultant

- Developed and implemented procedures for tracking program efficacy and client outcomes.
- Developed and implemented strategies / technologies to streamline processes and increase access to program services.
- Created data-driven presentations for firm management, state and federal grant funders, and other community stakeholders.
- Analyzed peer-reviewed research to determine future impacts of program assistance.

Law Graduate - Legal Aid

- Analyzed the policies of Social Security, Medicaid, and other governmental agencies.
- Compiled evidence and investigated factual assertions.
- Advocated client positions in administrative hearings.
- Provided research support and case strategy consultation to multiple attorneys.
- Prepared legal pleadings, motions, orders, client letters, and all manner of legal drafting.
- Organized evidence, assisted with discovery, and created exhibits for trial.
- Negotiated settlements with opposing counsel, pro se parties, insurance companies, and more.
- Utilized case management software to thoroughly document client files and case activity.

Education

- Juris Doctorate, West Virginia University College of Law
- Bachelor of Science, Psychology and Biblical Studies, Columbia International University

WV BMS2100000002
Technical Support Staff, Data Lead
(Non-Key Staff)

Kory Wolf
Director

kory.wolf@guidehouse.com
Coral Gables, Florida
Direct: 305.341.7891

Professional Summary

Kory is with the Value Transformation team bringing more than 20 years of healthcare experience. He brings extensive background in data analytics; data management, SQL experience, IT business analysis; member, provider, and claim payment system configuration; and health plan daily operations. He is at the forefront of all client data submissions between actuarial and technical consulting firms, such as Myers and Stauffer and DXC, to ensure seamless transitions into Guidehouse (and formerly Aon) data systems and infrastructures. He has worked extensively with the Medicaid membership and claim data from Tennessee, Georgia, Kansas, Kentucky, and West Virginia; the membership and claim data of BCBS' PPO/POS; and HMO products in nearly all 50 states and the national commercial and Medicare claim data from Humana.

He is responsible for leading the data team in all data validation and visualization work. As team data manager, he performs client bulk data transfers, data loading, SQL coding, processing, and output preparation. He prepares risk-adjustment models using licensable software, such as CDPS+Rx and John Hopkins ACG, from client datasets for actuarial use in capitation rate setting of managed care organizations (MCO) participating in state Medicaid programs to calculate risk-adjusted capitation rates that are budget-neutral to the state. He performs DRG client repricing exercises using 3M's core grouping software for DRG assignment, APC assignment, and Medicare inpatient / outpatient fee schedule pricing.

He works with Guidehouse's IT to maintain system readiness, compliance, and functionality. He is the key contact for clients in responding to detail data questions, issues, and resolution, along with handling any advanced analytic projects. Prior to his current role, he spent many years working with actuarial data at Milliman and other consulting firms.

On Guidehouse's current project with BMS, Kory currently serves as Guidehouse's data manager and lead SQL programmer, tasked with the intake of MCO encounters, FFS claims and eligibility files supplied from BMS' data vendor. He leads a team of data analysts and programmers responsible for reviewing, preparing, and summarizing the information for the actuarial suite of services performed for BMS.

Areas of Expertise

- Managing and guiding healthcare analytics staff with the responsibility of providing output, data insights, and limitations to actuarial staff. Using expansive knowledge of industry standard medical coding use for claims and encounter submissions and handling day-to-day interdepartmental operations of healthcare organizations.
- Writing ad hoc SQL code on client datasets to categorize and analyze data, create output reports, and perform complex data-mining.
- Maintaining client data warehouses in a SQL server environment and leading discussions on requirements for data transfer requirements, vendor software for projects, and security compliances.
- Risk adjusting client data sets using various licensed products.

Kory Wolf
Director

- Configuring and integrating claims, provider, membership, and medical management subsystems of payment software to process claims and meet business-required adjudication rates.
- Repricing client datasets using licensed tools as well as applying creating specific coding to work with items not covered under existing products.

Professional Experience

Medicaid Managed Care

- Performed receipt, quality control checks and on massive FFS, encounters, MCO claims, pharmacy claims, and membership datasets in numerous formats and layouts across multiple Medicaid programs for the States of Tennessee, Georgia, West Virginia, Kentucky, and Kansas.
- Summarized above-mentioned datasets into actuarial models according to client-specific requirements and measures for use in capitation rate setting.
- Prepared risk-adjustment models using licensable software, such as CDPS+Rx and John Hopkins ACG, from client datasets for actuarial use in capitation rate setting of MCOs participating in state Medicaid programs to calculate risk-adjusted capitation rates that are budget-neutral to the state.
- Performed Diagnosis-Related Group (DRG) client repricing exercises using 3M's core grouping software for DRG assignment, APC assignment, and Medicare inpatient / outpatient fee schedule pricing. Prepared and applied the core grouping software to numerous layouts of FFS, encounters, and claim data to apply categories of services to inpatient claims.
- Rebased DRG payments for KanCare with the actuarial team to maintain budget neutrality across hospital payors.

Other Relevant Experience

- Operated as lead technical analyst to health actuaries to develop and utilize actuarial models, analyze healthcare cost and utilization data, address data quality issues, and support data reconciliation for BCBS PPO/POS and HMO commercial products in nearly all 50 states.
- Worked as a project management team lead on organization's Clinical Care Management System (CCMS) corporate initiative implementation and acted as back-up to the clinical systems administrator.
- Performed business analyst work evaluating user / system requirements and configuration of claims payment, provider, and member systems.
- Skilled technical expertise in SQL Server Management Studio (SSMS), SQL Server Integration Services (SSIS), and SQL Server Analysis Services (SSAS); Medical informatics, data forensics, and health claims / member analysis.

Work History

- Associate Director, Guidehouse (2019-2020)

Guidehouse

WV BMS2100000002
Technical Support Staff, Data Lead
(Non-Key Staff)

Kory Wolf
Director

- Vice President, Aon (2013 – 2018)
- Actuarial Analyst, Approved Professional, Milliman (2004 – 2013)
- Data Analyst II/IT Business Analyst, Ochsner Health Plan (1998 – 2004)

Education

- Bachelor of Arts, University of New Orleans

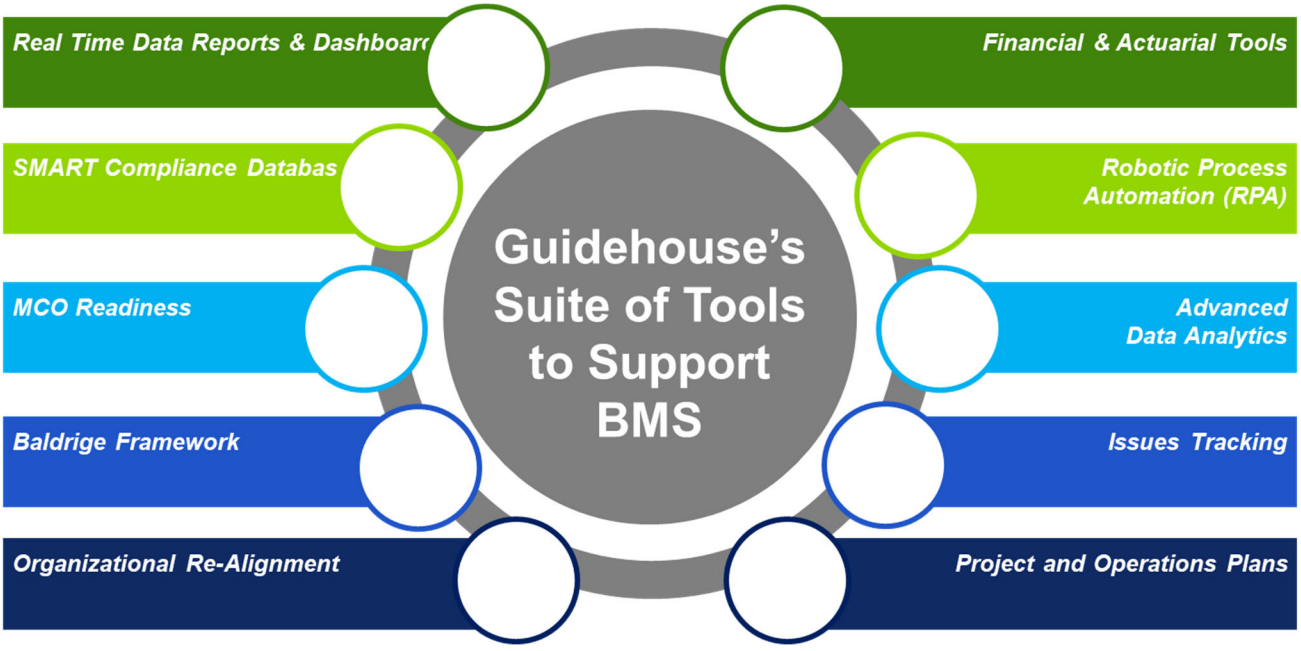
Appendix D Guidehouse's Tools to Support BMS

West Virginia Department of Health and Human Resources' Bureau for Medical Services (BMS) is looking to build on the prior successes of the MHT and MHP programs. This procurement will be critical for the Mountain Health Trust (MHT) and Mountain Health Promise (MHP) programs' future success – to build on historical successes and support BMS' aspirations for improvement. BMS has significant interest in addressing social determinants of health, health disparities and equity issues, and common chronic conditions that persist in the State due to cultural norms. In the next few years, we recommend that BMS place greater emphasis on:

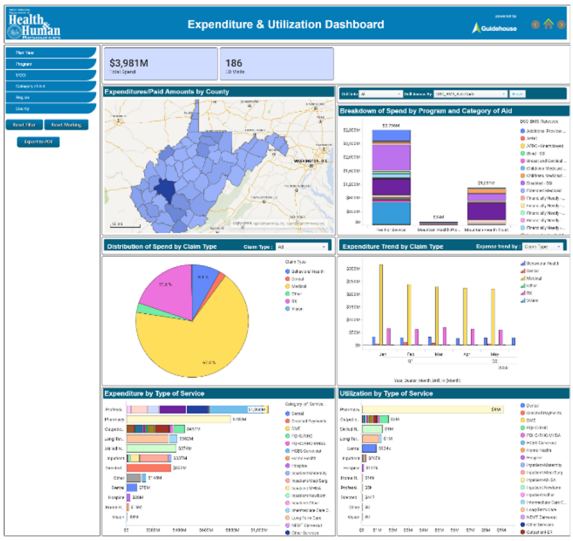
- Alternative payment models
- Value-added or in lieu of services to address clinical and social needs with technological infrastructure to assist members in navigating these complex networks of supports
- Social determinants of health, community investments, and health equity by further integrating with West Virginia's social programs (WIC and SNAP), better alignment of school-based programs, and increased adoption and reliance on telehealth

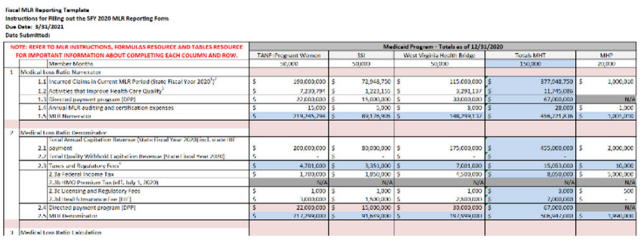
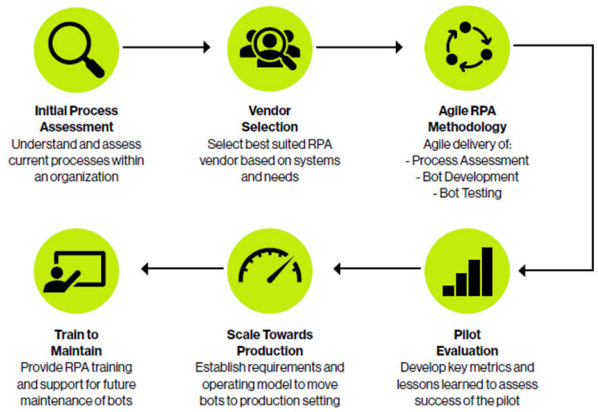
Further, changes in Federal policies and regulations continue to create opportunities for state health and human service program innovation. The potential for innovation is tempered by state budget realities and legislative intent, creating tension between providers, consumers, and BMS who manages Medicaid expenditures.

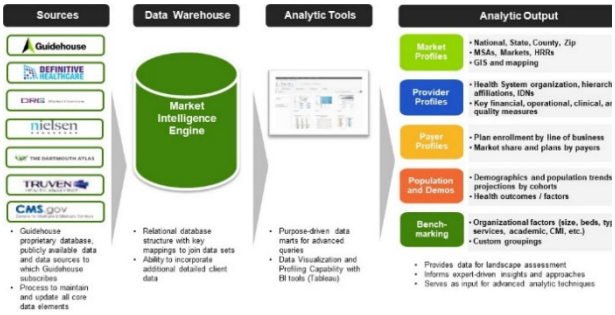
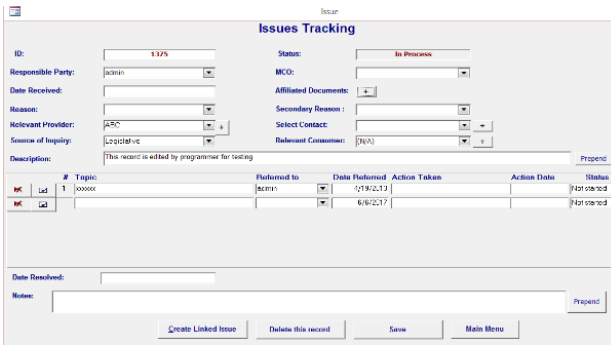
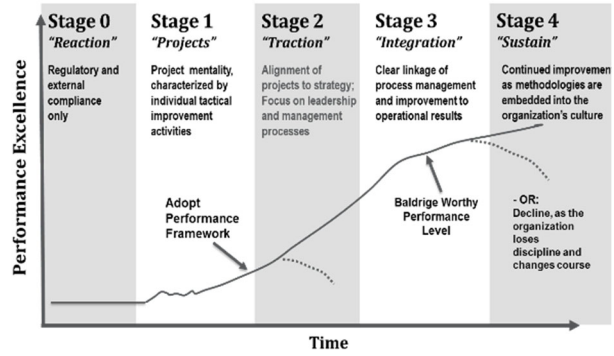
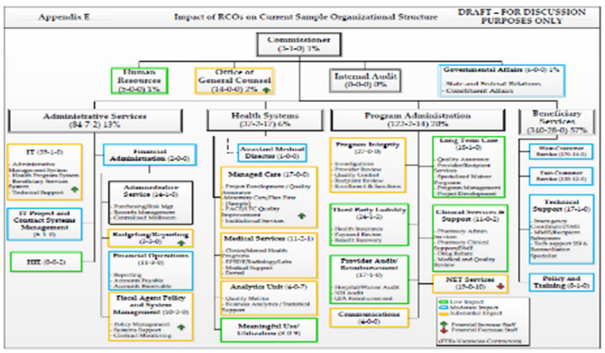
To further enhance our offerings to BMS, our next scope of work will include the delivery of proven tools, that have been refined and successfully implemented by our clients. Our tools will guide and support BMS' objectives and reinforce consistency and alignment. We will apply these same tools to our support for BMS, tailoring and enhancing the tools based on the BMS' priorities and needs.

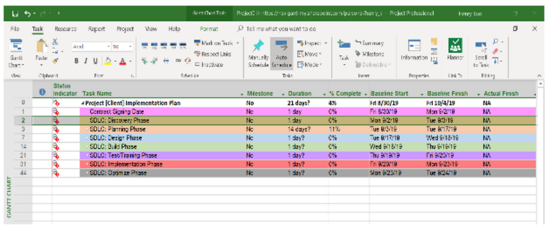


Guidehouse's Suite of Tools to Support BMS' Medicaid Managed Care Programs

Tool	Key Aspects of the Tool
	**Real-Time Data Reports and Dashboard:** Dashboards: We develop performance dashboards to highlight measures of importance for ongoing quality improvement with emphasis on trends and outliers that may serve as early warnings. Building on our current MHT and MHP Dashboard, Guidehouse will offer real-time access to claims, encounter, and performance data. In this new phase of our contract, BMS will have access and the ability to manipulate data through our interface. BMS can drill down to compare data on MHT, MHP, and FFS by county, region, or category of aid on a variety of metrics. We include this screen shot of this ***new dashboard we are already working on*** and will roll out very quickly after contract award.
	SMART System: Guidehouse will implement our proprietary compliance database and tool to automate compliance and oversight. We successfully implemented this system for Pennsylvania's HealthChoices Medicaid managed care program. The SMART system houses the review of over 300 performance standards design to support the delivery of quality care to Medicaid members. We also helped design a similar system implemented by Texas Medicaid, Medicaid Contract Administration Tracking System (MCATS). MCATS is an automated, web-based tool that supports vendor monitoring. IT houses contract requirements automates and tracks correspondence with the vendor, documents compliance, and utilizes a risk-based methodology for supporting and guiding monitoring efforts. *This system can be customized to meet the mandatory requirement 4.3.1.30.*

Tool	Key Aspects of the Tool
	**MCO Readiness:** Guidehouse's readiness review toolkit, such as review tools and summary dashboards, supports states to evaluate MCO readiness to provide services to Medicaid members. We successfully used this tool for the Compliance Review conducted in 2020 of MHT MCOs and are prepared to deploy this tool again, as appropriate.
	**Financial & Actuarial Tools:** Guidehouse uses a suite of financial and actuarial tools to help states to conduct financial and actuarial analysis. These tools are the platform for reviewing data used for capitation rate development, assessing medical loss ratios, preparing actuarial models, risk adjustment, calculation of costs for Medicaid Eligibility Group, and production of final capitation rates. We also use it to create reports such as we did for Tennessee - a quarterly review model that analyzes medical expenditures by MCO, region, and service category and provides the client with a dynamic tool to monitor the costs of its Medicaid program over time. The model utilizes statistical methodologies to pinpoint year over year or quarter over quarter outliers among MCOs, region, and service categories.
	**Robotics Process Automation (RPA):** We are working with multiple clients to automate compliance efforts. We can help BMS assess opportunities to automate its various data collection, reporting, and review processes. RPA has the ability to provide new efficiencies to BMS and is already being deployed by our other state clients effectively.

Tool	Key Aspects of the Tool
	**Advanced Data Analytics:** Guidehouse has a Central Analytics Team that develops data dashboards and has access to our Market Intelligence Engine and Data Repository, which contains Guidehouse's proprietary database, publicly available data, and data sources to which Guidehouse subscribes.
	**Issues Tracking:** We have an automated issue tracking and resolution tool creates a centralized location for all compliance support team members to enter and track issues pertaining to contract compliance or risk concerns. Robust reporting allows users to track issue resolution, common issue types and to utilize summary information as part of quality improvement.
	**Baldrige:** The Baldrige framework allows for quantitative comparisons of organizational culture, systems, processes, and structures with role model performance organizations, supplementing the qualitative expert observations of our senior consultants. This framework is invaluable for implementing changes through an organization.
	**Organizational Re-alignment:** Our first-hand experience offers not only understanding of the vision and the goals of such reorganization plans, but the work steps to execute. We have facilitated multiple inter-agency discussions, developed inter-agency agreements and numerous operating procedures that support, and provided training and software specifications that might automate certain workflows.

Tool	Key Aspects of the Tool
	**Project Plans and Operations Plans:** We track overall project milestones, deliverables, and dependencies. As BMS is already familiar, we use a standard template used by all workstreams allows for consistent reporting by major phases of work. On a weekly basis, Guidehouse will provide an updated operations plan to BMS to outline the status of all tasks, including any risks or anticipated delays.

Appendix E Required Forms

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

1. Designated Contact Certification
2. Addendum Acknowledgement Form
3. Ethics Disclosure Form
4. Purchasing Affidavit

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.

Russell H. Ackerman, Partner

(Name, Title)

Russell H. Ackerman, Partner

(Printed Name and Title)

150 N. Riverside Plaza, Suite 2100, Chicago, Illinois 60606

(Address)

480.318.9390 / 312.276.8658

(Phone Number) / (Fax Number)

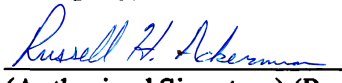
russ.ackerman@guidehouse.com

(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.

Guidehouse Inc.

(Company)

 Partner

(Authorized Signature) (Representative Name, Title)

Russell H. Ackerman, FCA, ASA, MAAA, Partner

(Printed Name and Title of Authorized Representative)

March 29, 2021

(Date)

480.318.9390 / 312.276.8658

(Phone Number) (Fax Number)

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS2100000002

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

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

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

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

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

Guidehouse Inc.
Company

Russell H. Ackerman
Authorized Signature

March 29, 2021
Date

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

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

(Required by *W. Va. Code* § 6D-1-2)

Name of Contracting Business Entity: Guidehouse Inc. **Address:** 150 N. Riverside Plaza, Suite 2100, Chicago, Illinois 60606

Name of Authorized Agent: Russell H. Ackerman, ACA, MAAA **Address:** Same as above

Contract Number: CRFQ 0511 BMS2100000002 **Contract Description:** Medicaid Managed Care Rate Setting / Program Admin

Governmental agency awarding contract: West Virginia Department of Health and Human Resources, Bureau for Medical Services (BMS)

☐ **Check here if this is a Supplemental Disclosure**

List the Names of Interested Parties to the contract which are known or reasonably anticipated by the contracting business entity for each category below *(attach additional pages if necessary)*:

1. **Subcontractors or other entities performing work or service under the Contract**
   ☒ Check here if none, otherwise list entity/individual names below.

2. **Any person or entity who owns 25% or more of contracting entity (not applicable to publicly traded entities)**
   ☐ Check here if none, otherwise list entity/individual names below.
   Guidehouse LLP

3. **Any person or entity that facilitated, or negotiated the terms of, the applicable contract (excluding legal services related to the negotiation or drafting of the applicable contract)**
   ☒ Check here if none, otherwise list entity/individual names below.

Signature: Russell H. Ackerman **Date Signed:** March 29, 2021

Notary Verification

State of Illinois, County of Cook:

I, Russell H. Ackerman, the authorized agent of the contracting business entity listed above, being duly sworn, acknowledge that the Disclosure herein is being made under oath and under the penalty of perjury.

Taken, sworn to and subscribed before me this 29th day of March, 2021.

Notary Public's Signature

OFFICIAL SEAL
SUSAN L MELIDOSIAN
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/10/24

To be completed by State Agency:

Date Received by State Agency: _____

Date submitted to Ethics Commission: _____

Governmental agency submitting Disclosure: _____

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

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

ALL 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: Guidehouse Inc.

Authorized Signature: Russell H. Ackerman Date: March 29, 2021

State of Illinois

County of Cook, to-wit:

Taken, subscribed, and sworn to before me this 29th day of March, 2021.

My Commission expires July 10, 2024.

AFFIX SEAL HERE

OFFICIAL SEAL
SUSAN L MELIDOSIAN
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/10/24

NOTARY PUBLIC Susan L Melidosian

Appendix F Exceptions and Reservation of Rights

Submission of this proposal is not an indication of Guidehouse Inc.'s ("Guidehouse") willingness to be bound by all of the terms presented in the State of West Virginia Department of Health and Human Services ("Department") Centralized Request for Quotes BMS2100000002 for Medicaid Actuarial Services and Managed Care Program Administration (the "CRFQ"). This proposal in response to the Department's CRFQ does not constitute a contract to perform services and cannot be used to award a unilateral agreement. Final acceptance of this engagement by Guidehouse is contingent upon successful completion of Guidehouse's acceptance procedures. Any engagement arising out of this proposal will be subject to negotiation of a mutually satisfactory vendor contract including modifications to certain CRFQ terms and conditions (including, without limitation, the CRFQ's General and Special Provisions and Business Associate Addendum).

With regard to the following subsections in the CRFQ **General and Special Provisions**:

- Section 8 (Insurance): Guidehouse will agree to the same insurance policy limits as the parties have agreed to in the current agreement with the Department.
- Section 13 (Pricing): Guidehouse cannot agree to the stated best price representation / most favored nations provision as part of its bid or in the awarded contract.
- Section 36 (Indemnification): Guidehouse has provided our required Limitation of Liability terms on the following pages as an alternative to this section.

Given history of successfully negotiating mutually agreeable terms with the Department, including our current project, we do not anticipate any difficulty in reaching a contractual agreement that will enable us to provide the professional services which you are requesting, while protecting the interests of both parties.

Pursuant to Guidehouse's risk management principles, Guidehouse requires the legal terms and conditions included in the following pages. In the event of award, Guidehouse will work in good faith to negotiate and finalize a definitive agreement with the Department.

For the purposes of the following Terms and Conditions, Guidehouse Inc. shall be referred to as "Guidehouse" and the State of West Virginia Department of Health and Human Services shall be referred to as "Company."

Access: Company agrees to provide Guidehouse with timely access to information, locations, and personnel reasonably necessary for the performance of the Services. The information provided by Company to Guidehouse shall be considered "as is" and Guidehouse will not validate or confirm the accuracy of the data and information provided. The work product produced by Guidehouse under this Agreement is to be used only in relation to the Services described herein and not for any other purpose without written approval from Guidehouse.

Third Party Work Product: It is further understood that Guidehouse may be reviewing work product prepared by parties other than Guidehouse on behalf of Company, and accordingly, Company agrees to hold harmless and indemnify Guidehouse for any and 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.

Preliminary Findings and Draft Reports: The preparation of Guidehouse work product is an evolving process during which Guidehouse analysis is focused and refined as research and document review proceeds and as information emerges. Preliminary conclusions, superseded drafts, notations, analyses, work lists, and irrelevant data are not a part of, and will not be recorded in, the final work product. Such documents may be appropriately discarded on a routine basis as work tasks are completed. Of course, circumstances may arise that require the retention of such drafts or other interim documents, including but not limited to subpoenas and court orders. Guidehouse understands that Company will provide it with any instructions regarding document retention or document production procedures that Company expects Guidehouse to follow.

Consulting Services Disclaimer: Guidehouse will not be auditing any financial statements or performing any attest procedures in the course of this engagement. Guidehouse's Services are not designed, nor should they be relied upon, to disclose internal weaknesses in internal controls, financial statement errors, irregularities, illegal acts, or disclosure deficiencies. Guidehouse is not a professional accounting firm and does not practice accounting.

Intellectual Property and Guidehouse Deliverables: Upon full payment of all amounts due Guidehouse in connection with this Agreement, all rights, title and interest in any information and items, including summaries, documents, reports and portions thereof it provides to Company (the "Guidehouse Deliverables") will become Company'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. Guidehouse 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 ("Guidehouse Property"). To the extent the Guidehouse Deliverables contain Guidehouse Property; Company 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 Guidehouse, in no event shall Guidehouse's name be mentioned nor shall Guidehouse 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 Company; and (c) Company's legal advisors and auditors. It is strictly prohibited for the Guidehouse 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.

Confidentiality: Guidehouse understands that all communications between Guidehouse and Company, either oral or written, as well as any materials or information developed or received by Guidehouse pursuant to this Agreement, are intended to be confidential. Accordingly, Guidehouse agrees, subject to applicable law or court order, not to disclose any such communications, or any of the information Guidehouse receives or develops in the course of Guidehouse's work for Company, to any person or entity apart from Company's office or such other persons or entities as Company may designate.

If access to any of the materials in Guidehouse's possession relating to this Agreement is sought by a third party, or Guidehouse is requested or compelled to testify as a fact witness in any legal proceeding related to Guidehouse's work for Company, by subpoena or otherwise, or Guidehouse is made a party to any litigation related to Guidehouse's work for Company, Guidehouse will promptly notify Company of such action, and either tender to Company Guidehouse's defense responding to such request and cooperate with Company concerning Guidehouse's response

thereto or retain counsel for Guidehouse's defense for which Company shall reimburse Guidehouse for all reasonable attorney's fees and costs of defense. In such event, Company will compensate Guidehouse at Guidehouse's standard billing rates for Guidehouse's professional fees and expenses, including reasonable attorneys' fees (internal and external), involved in responding to such action.

Conflicts of Interest: Guidehouse is not aware of circumstances that constitute a conflict of interest or that would otherwise impair Guidehouse's ability to provide objective assistance. Guidehouse's determination of conflicts is based primarily on the substance of its work and not the parties involved. Guidehouse is a large consulting company that is engaged by many companies and individuals. Guidehouse may have in the past represented, may currently represent, or may in the future represent other companies whose interests may have been, may currently be, or may become adverse to Company in litigation, transactions, or other matters (collectively "Other Companies"). Therefore, as a condition to Guidehouse's undertaking to provide the Services to the Company and absent any conflict in fact, Company agrees that Guidehouse may continue to represent, and in the future may represent Other Companies. Notwithstanding any other provisions herein, in exchange for Guidehouse agreeing to provide the Services under this Agreement, Company agrees and acknowledges that Guidehouse professionals who are not involved in providing the Services are not restricted in any way from providing eDiscovery services to Other Companies.

Limitation of Liability: Notwithstanding the terms of any other provision, the total liability of Guidehouse 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 Guidehouse in the preceding twelve (12) months. Neither Guidehouse nor Company shall in any event be liable for any indirect, consequential, or punitive damages, even if Company or Guidehouse 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 (1) year after the cause of action has accrued, except an action for non-payment may be brought within one (1) year following the date of the last payment due under this Agreement. Guidehouse shall not be liable for any loss or destruction of any valuable documents provided to Guidehouse. Company shall be responsible for insuring such documents against loss and destruction.

Standard of Care: In providing the Services, Guidehouse and its personnel shall exercise reasonable care, and Guidehouse, its interim personnel, officers, directors, agents, employees and outside consultants, if any, will not be liable to Company (or any parent, subsidiary or affiliate, director or officer thereof) for any loss, financial or otherwise, which may result to Company (or any parent, subsidiary, affiliate, director or officer thereof) as a result of the Services or the methods by which the Services were provided, unless such a loss is the direct result of an act of fraud. Guidehouse cannot guarantee or assure the achievement of any particular performance objective, nor can Guidehouse guarantee or assure any particular outcome for Company or any other person as a result of this Agreement or the performance of the Services.

Termination: Either party may terminate this Agreement without cause upon no less than thirty (30) days' written notice of termination to the other party; provided however that neither party may terminate this Agreement without cause where any portion of the compensation is based on performance or otherwise placed at risk. In the event of termination for any reason, Company will pay Guidehouse for all fees and expenses incurred, including without limitation all work in progress fees that may not yet have been invoiced, up and through the effective date of termination as well as reasonable engagement closing costs.

Resolution of Disputes: To promote rapid and economical resolution of any disputes which may arise, any and all disputes or claims related to or arising from this Agreement, except claims by Guidehouse for non-payment of amounts owed hereunder, shall be resolved by final, binding and confidential arbitration conducted in New York, NY by JAMS Inc. (formerly Judicial Arbitration and Mediation Services) ("JAMS") under the then-applicable JAMS rules, including its optional appellate procedure if the parties so elect. The parties hereby give up their right to have any such disputes or claims litigated in a court or by a jury. All issues related to interpretation of this Agreement or any issues arising out of this engagement shall be governed by the law of the State of New York without application of its conflict of laws principles.

Restriction on Use of Personnel: Company agrees that during the term of this Agreement (including any renewals and extensions thereof), and for a period of one year following its termination ("Restriction Period"), neither Company nor any affiliate, parent or subsidiary thereof will knowingly employ or engage as an independent contractor, consultant or otherwise, any person who, during the Restriction Period, is or was an employee or independent contractor of Guidehouse that provided Services under this Agreement.

Disposition of Documents: The preparation of the Guidehouse Deliverables and work product is an evolving process during which Guidehouse's analysis is focused and refined as its research and document review proceeds. Preliminary conclusions, superseded drafts, notations, analyses, work lists, and irrelevant data are not a part of, and will not be recorded in the Guidehouse Deliverables. Such documents may be discarded on a routine basis as tasks are completed.

At the conclusion of the Services, Company will have the following three options with respect to disposition of documents related to this Agreement. Company may (a) direct Guidehouse to return all such documents to Company, where practicable; (b) authorize Guidehouse to discard or destroy all documents; or (c) direct Guidehouse to store any or all such documents at the expense of Company. It is also Company's obligation to pay Guidehouse for storage costs in the event Guidehouse is bound to retain documents related to the Services by any third party, court order, operation of law, or other legally binding reason for retention. The terms and pricing for all storage will be the provided to Company at the beginning of any storage period. If Company does not request option (a), (b) or (c) within 60 days after the conclusion of the Services, Guidehouse may implement any one of these options at its sole discretion. Guidehouse may retain a copy of its reports and work papers.

Third Party Beneficiaries: This Agreement does not and is not intended to confer any rights or remedies upon any person or entity other than the parties.

Force Majeure: Guidehouse shall not be deemed in default of any provision of this Agreement or be liable for any delay, failure in performance, or interruption of the Services resulting directly or indirectly from acts of God, electronic virus attack or infiltration, civil or military authority action, civil disturbance, war, strike and other labor disputes, fires, floods, other catastrophes, and other forces beyond its reasonable control.

Use of Data: Notwithstanding any other term or provision in the Agreement, Guidehouse shall be permitted to use Company's data for purposes other than those set forth in this Agreement; provided however that any such data shall be rendered de-identified and not subject to the definition of PHI in accordance with the HIPAA Privacy Rule.

Entire Agreement: The cover letter, sections, and the Appendices attached hereto and incorporated herein by reference constitute the entire agreement between Guidehouse, on one side, and Company on the other side, regarding the terms of this Agreement. In the event Company requires Guidehouse to execute a purchase order or other Company documentation in order to receive payment for Services, the terms and conditions contained in such purchase order or documentation shall be null and void and shall not govern the terms of the Agreement. This Agreement is entered into without reliance on any promise or representation, written or oral, other than those expressly contained herein and supersedes any other such promises or representations. This Agreement can only be modified by a written agreement signed by duly authorized representatives of each party.

The terms of this Agreement, including the fees stated herein, shall remain valid and in effect for 90 days from the date of this Agreement.

Guidehouse

Proposal for:

Medicaid Actuarial Services and Managed Care Program Administration

CRFQ BMS2100000002

Presented to:

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

Cost Proposal

March 30, 2021

Presented by:

Russell H. Ackerman, FCA, ASA, MAAA
Partner
150 North Riverside Plaza, Suite 2100
Chicago, Illinois 60606
602.698.4366
russ.ackerman@guidehouse.com

guidehouse.com

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

State of West Virginia
Centralized Request for Quote
Service - Misc

Proc Folder: 797901			**Reason for Modification:**
Doc Description: MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN			ADDENDUM 3 TO PROVIDE ANSWERS TO VENDOR QUESTIONS
Proc Type: Central Master Agreement			
Date Issued	**Solicitation Closes**	**Solicitation No**	**Version**
2021-03-25	2021-03-30 13:30	CRFQ 0511 BMS2100000002	4

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Customer Code: VC0000037994
Vendor Name : Guidehouse Inc.
Address :
Street : 150 N. Riverside Plaza, Suite 2100
City : Chicago
State : Illinois **Country :** USA **Zip :** 60606
Principal Contact : Russell H. Ackerman, ASA, MAAA, FCA
Vendor Contact Phone: 480.318.9390 **Extension:**

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor Signature X Russell H. Ackerman **FEIN#** 36-409-4854 **DATE** March 30, 2021

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

Date Printed: Mar 25, 2021 **Page:** 1 FORM ID: WV-PRC-CRFQ-002 2020/05

ADDITIONAL INFORMATION
THE STATE OF WEST VIRGINIA PURCHASING DIVISION FOR THE AGENCY, WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES (WV DHHR), IS SOLICITING BIDS TO ESTABLISH AN OPEN-END CONTRACT FOR MEDICAID ACTUARIAL SERVICES AND MANAGED CARE PROGRAM ADMINISTRATION AND OVERSIGHT PER THE ATTACHED DOCUMENTS. ***QUESTIONS REGARDING THE SOLICITATION MUST BE SUBMITTED IN WRITING TO CRYSTAL.G.HUSTEAD@WV.GOV PRIOR TO THE QUESTION PERIOD DEADLINE CONTAINED IN THE INSTRUCTIONS TO VENDORS SUBMITTING BIDS***

INVOICE TO	SHIP TO
HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Lead Actuary Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Lead Actuary Services

$ **275** Per Hour X 5,000 Hours Annually

INVOICE TO	SHIP TO
HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Staff Actuary Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Staff Actuary Services

$ **190** Per Hour X 20,000 Hours Annually

INVOICE TO	SHIP TO
HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	Technical Support Staff (non-actuary)				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Technical Support Staff (non-actuary)

$**175** Per Hour X 5,000 Hours Annually

INVOICE TO	SHIP TO
HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	Clerical Support Staff				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Clerical Support Staff

$**1** Per Hour X 5,000 Hours Annually

INVOICE TO	SHIP TO
HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
5	Managed Care Program Oversight Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Managed Care Program Oversight Services Annual Cost

All-Inclusive Fixed Annual Amount (Inclusive of 12 Months) **$1,200,000**

INVOICE TO	SHIP TO
HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
6	Managed Care Oversight Ad Hoc Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Managed Care Oversight Ad Hoc Services

$**145** per hour X 5,000 hours Annually

INVOICE TO	SHIP TO
HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
7	Actuarial Services Ad Hoc Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Actuarial Services Ad Hoc Services

$**200** per hour X 5,000 hours Annually

SCHEDULE OF EVENTS

Line	Event	Event Date
1	VENDOR QUESTION DEADLINE	2021-03-05