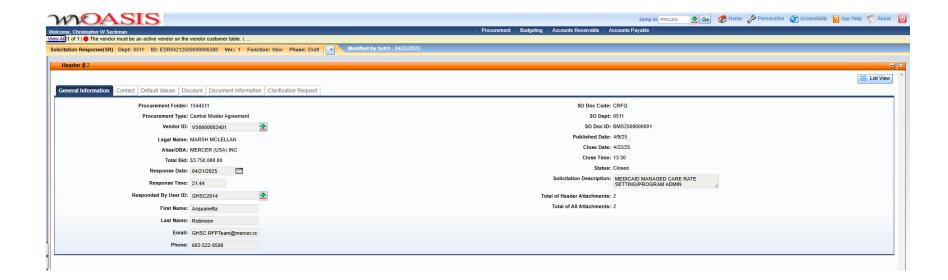


2019 Washington Street, East Charleston, WV 25305 Telephone: 304-558-2306 General Fax: 304-558-6026

Bid Fax: 304-558-3970

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.





### State of West Virginia Solicitation Response

Proc Folder: 1544511

Solicitation Description: MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN

Proc Type: Central Master Agreement

 Solicitation Closes
 Solicitation Response
 Version

 2025-04-22 13:30
 SR 0511 ESR04212500000006380
 1

**VENDOR** 

VS0000002401 MARSH MCLELLAN

Solicitation Number: CRFQ 0511 BMS2500000001

**Total Bid:** 3750000 **Response Date:** 2025-04-21 **Response Time:** 21:44:55

Comments:

### FOR INFORMATION CONTACT THE BUYER

Crystal G Hustead (304) 558-2402 crystal.g.hustead@wv.gov

Vendor Signature X

ture X FEIN# DATE

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

 Date Printed:
 Apr 23, 2025
 Page: 1
 FORM ID: WV-PRC-SR-001 2020/05

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
1	Lead Actuary Services				0.00

Comm Code	Manufacturer	Specification	Model #	
93151507				

**Commodity Line Comments:** \$0 Per Hour X 5,000 Hours Annually = \$0

**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				0.00

Comm Code	Manufacturer	Specification	Model #	
93151507				

Commodity Line Comments: \$0 Per Hour X 20,000 Hours Annually

**Extended Description:** 

**Staff Actuary Services** 

\$\_\_\_\_Per Hour X 20,000 Hours Annually

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	<b>Ln Total Or Contract Amount</b>
3	Technical Support Staff (non-actuary)				1350000.00

Comm Code	Manufacturer	Specification	Model #	
93151507				

Commodity Line Comments: \$270 Per Hour X 5,000 Hours Annually = \$1,350,000

**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				0.00

Comm Code	Manufacturer	Specification	Model #	
93151507				

Commodity Line Comments: \$0 Per Hour X 5,000 Hours Annually = \$0

**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				

Date Printed: Apr 23, 2025 Page: 2 FORM ID: WV-PRC-SR-001 2020/05

### **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				0.00

Comm Code	Manufacturer	Specification	Model #	
93151507				

**Commodity Line Comments:** \$0 Per Hour X 5,000 Hours Annually = \$0

### **Extended Description:**

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	<b>Ln Total Or Contract Amount</b>
7	Actuarial Services Ad Hoc Services				0.00

Comm Code	Manufacturer	Specification	Model #	
93151507				

Commodity Line Comments: \$0 Per Hour X 5,000 Hours Annually = \$0

### **Extended Description:**

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
8	Financial Services				1200000.00

Comm Code	Manufacturer	Specification	Model #	
93151507				

### **Commodity Line Comments:**

### **Extended Description:**

Financial Services Annual Cost All-Inclusive Fixed Annual Amount (Inclusive of 12 Months)

 Date Printed:
 Apr 23, 2025
 Page: 3
 FORM ID: WV-PRC-SR-001 2020/05



## Medicaid Managed Care Rate Setting/Program Admin

Solicitation No. CRFQ 0511 BMS2500000001

State of West Virginia
Department of Human Services
Bureau for Medical Services

April 22, 2025

Price Quote

## **Contents**

1. Pricing Page	
I. I HURIU I auc	

## Section 1 Pricing Page

Mercer Health & Benefits LLC (Mercer) is pleased to present our Price Quote in response to Centralized Request for Quote 0511 BMS250000001: Medicaid Managed Care Rate Setting/Program Admin to the State of West Virginia Department of Human Services, Bureau for Medical Services on the following page. Mercer followed the instructions included in Exhibit A: Instructions for Pricing to complete the Pricing Page (as included in Addendum No. 2).



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: 1544511

Doc Description: MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN

Reason for Modification:

Addendum No. 2

Proc Type:

Central Master Agreement

 Date Issued
 Solicitation Closes
 Solicitation No
 Version

 2025-04-09
 2025-04-22
 13:30
 CRFQ
 0511
 BMS25000000001
 3

### **BID RECEIVING LOCATION**

BID CLERK

DEPARTMENT OF ADMINISTRATION

PURCHASING DIVISION

2019 WASHINGTON ST E

CHARLESTON

WV 25305

บร

### **VENDOR**

Vendor Customer Code: VS0000002401

Vendor Name: Mercer Health & Benefits LLC

Address: 2325

Street: East Camelback Road, Suite 600

City: Phoenix

State : AZ

**Country: United States of America** 

Zip: 85016

Principal Contact : William Aaron

Vendor Contact Phone: +1 502 271 0435 Extension: N/A

### FOR INFORMATION CONTACT THE BUYER

Crystal G Hustead (304) 558-2402

crystal.g.hustead@wv.gov

Vendor

Signature X (FEIN#: 34-2015463

DATE: April 21, 2025

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

Date Printed: Apr 9, 2025

Page: 1

FORM ID: WV-PRC-CRFQ-002 2020/05

### ADDITIONAL INFORMATION

Addendum No. 2 issued to provide the following -

- 1. Provide responses to vendor questions. See attachment.
- 2. The bid opening remains ion 04/22/2025 at 1:30 pm EST.

No other changes.

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Lead Actuary Services		5,000	\$0	\$0
1					

Comm Code	Manufacturer	Specification	Model #	
93151507				

### **Extended Description:**

Lead Actuary Services

### \$\_0 Per Hour X 5,000 Hours Annually

INVOICE TO		SHIP TO
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICA SERVICES	L	BUREAU FOR MEDICAL SERVICES
350 CAPITOL ST, RM 2	51	350 CAPITOL ST, RM 251
CHARLESTON	WV	CHARLESTON WV
us		US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Staff Actuary Services		20,000	\$0	\$0

Comm Code	Manufacturer	Specification	Model #	
93151507				

### **Extended Description:**

Staff Actuary Services

\$\_0 Per Hour X 20,000 Hours Annually

Date Printed: Apr 9, 2025 Page: 2 FORM ID: WV-PRC-CRFQ-002 2020/05

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	Technical Support Staff (non-actuary)		5,000	\$270	\$1,350,000

Comm Code	Manufacturer	Specification	Model #	
93151507				

### **Extended Description:**

Technical Support Staff (non-actuary)

### \$270 Per Hour X 5,000 Hours Annually

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICA SERVICES	L	BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 2	51	350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON WV	
us		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	Clerical Support Staff		5,000	\$0	\$0

Comm Code	Manufacturer	Specification	Model #	
93151507				

### **Extended Description:**

Clerical Support Staff

\$\_0 Per Hour X 5,000 Hours Annually

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	<b>Total Price</b>
5	Managed Care Program Oversight Services		1	\$1,200,000	\$1,200,000

Comm Code	Manufacturer	Specification	Model #	
93151507				

### **Extended Description:**

Managed Care Program Oversight Services Annual Cost

All-Inclusive Fixed Annual Amount (Inclusive of 12 Months)

INVOICE TO		SHIP TO		
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES		
BUREAU FOR MEDICA SERVICES	L	BUREAU FOR MEDICAL SERVICES		
350 CAPITOL ST, RM 2	51	350 CAPITOL ST, RM 251		
CHARLESTON	WV	CHARLESTON	WV	
us		US		

Line	Comm Ln Desc	Qty	8	Unit Issue	Unit Price	Total Price
6	Managed Care Oversight Ad Hoc Services			5,000	\$0	\$0

Comm Code	Manufacturer	Specification	Model #	
93151507				
93151507				

### **Extended Description:**

Managed Care Oversight Ad Hoc Services

\$\_0 per hour X 5,000 hours Annually

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HI RESOURCES	UMAN
BUREAU FOR MEDICAL SERVICES		BUREAU FOR M SERVICES	MEDICAL
350 CAPITOL ST, RM 251		350 CAPITOL ST	T, RM 251
CHARLESTON	WV	CHARLESTON	WV
us		US	

Line	Comm Ln Desc Qty  Actuarial Services Ad Hoc Services	Unit Issue	<b>Unit Price</b>	Total Price	
7	Actuarial Services Ad Hoc Services		5,000	\$0	\$0

Comm Code	Manufacturer	Specification	Model #	
93151507				

### **Extended Description:**

Actuarial Services Ad Hoc Services

### \$\_0 per hour X 5,000 hours Annually

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	<b>Total Price</b>
8	Financial Services		1	\$1,200,000	\$1,200,000

Comm Code	Manufacturer	Specification	Model #	
93151507				

### **Extended Description:**

Financial Services Annual Cost

All-Inclusive Fixed Annual Amount (Inclusive of 12 Months)

### SCHEDULE OF EVENTS

<u>Line</u>	Event	<b>Event Date</b>
1	VENDOR QUESTION DEADLINE	2025-03-19

 Date Printed:
 Apr 9, 2025
 Page: 5
 FORM ID: WV-PRC-CRFQ-002 2020/05

### Medicaid Managed Care Rate Setting/Program Admin CRFQ 0511 BMS2500000001

	Document Phase	Document Description	Page 6
BMS2500000001		MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN	

### ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions



Mercer Health & Benefits LLC 2325 East Camelback Road, Suite 600 Phoenix, AZ 85016 www.mercer-government.mercer.com

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# Medicaid Managed Care Rate Setting/Program Admin

Solicitation No. CRFQ 0511 BMS2500000001

State of West Virginia
Department of Human Services
Bureau for Medical Services

April 22, 2025

**Technical Quote** 

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## Section 1 Transmittal Letter

April 21, 2025

Ms. Crystal Hustead West Virginia Purchasing Division 2019 Washington Street, East Charleston, WV 25305

Dear Ms. Hustead and Members of the Evaluation Committee:

I am pleased to submit our technical quote in response to the Request for Quotation (RFQ) for Medicaid Managed Care Rate Setting and Program Administration, Solicitation No. CRFQ 0511 BMS2500000001. Mercer Health & Benefits LLC (Mercer) is committed to providing high-quality services that meet the needs of the State of West Virginia and its Medicaid beneficiaries.

Attached, you will find our comprehensive proposal, which outlines our qualifications, experience, and approach to fulfilling the requirements of the RFQ. We are confident that our extensive background in Medicaid managed care, coupled with our dedicated team of professionals, positions us as a strong partner for the Bureau for Medical Services (BMS), or herein referred to as "Agency".

### Mercer meets and/or exceeds all mandatory qualifications:

- Mercer is an Actuary of Record in 11 states, Puerto Rico, and the District of Columbia, with more than 10 years of experience in at least five states.
- Mercer offers comprehensive policy, operations, and managed care oversight services, backed by over **five years** of experience across at least **five states**.
- Lead Actuaries, including but not limited to, Stewart Campbell, ASA, MAAA, and Colby Schaffer, ASA, MAAA, each possess over 10 years of Medicaid and Children's Health Insurance Program (CHIP) Managed Care experience, with proven records in capitation rate development and negotiations with the Centers for Medicare & Medicaid Services (CMS) and hold certifications as Fellows of the Society of Actuaries (FSA) and/or Members of the American Academy of Actuaries (MAAA).
- Staff Actuaries, including but not limited to, Dave Dombrowski, ASA, MAAA, and
  Garland Chan, FSA, MAAA, each have a minimum of five years of experience in
  healthcare pricing and Medicaid and CHIP, with expertise in developing actuarially sound
  rates for various Medicaid and CHIP populations, and are certified as Associates of the
  Society of Actuaries (ASA) and/or MAAA.
- Executive Program Director William Aaron, MBA, has significant leadership experience, including former roles as Chief Financial Officer and Chief Operating Officer in state Medicaid programs, with over 25 years of experience in Medicaid policy, strategy, and operations.

- Project Management Lead Ashley Wieser, BA, has extensive experience in managing complex Medicaid projects, including her current role providing project management support for the Commonwealth of Pennsylvania's Department of Human Services. With 10 years of public health experience and a proven record in overseeing project deliverables, managing budgets, and facilitating stakeholder engagement, she demonstrates the necessary skills and expertise to fulfill contractual obligations within required timeframes.
- Financial Project Lead Joe Schaller, B.S., in accounting, is a Finance Project Lead at Mercer Health & Benefits LLC, bringing over 25 years of experience in health plan finance and operations. He holds a bachelor's degree in accounting and finance and has more than three years of direct experience in financial management within Medicaid programs.
- Medicaid Policy Subject Matter Expert, 0.5 Full-Time Equivalent (FTE), and Research Analyst/Consultant, 0.5 FTE, Nicole Kaufman, JD, LL.M., brings over 14 years of experience in Medicaid and CHIP policy research and development, including direct involvement in CMS federal regulatory compliance, reporting, managed care contract approvals, and compliance oversight, supported by relevant degrees and certifications in her field.
- Technical Support Staff including, but not limited to, Dennis Yano, B.S., Elijah Chesko, MBA., and Sandy Amorado, MPH., are highly qualified to serve as Technical Support Staff, each bringing unique expertise and experience that align with the service requirements outlined in the RFQ.
- All team members are **licensed** and in **good standing** with their respective professional organizations, ensuring compliance with industry standards and regulations.
- Our team members are committed to attending all required on-site meetings and have staff located within driving distance of Charleston, West Virginia who can readily attend on-site meetings on short notice. Our team is fully prepared to ensure we meet all meeting requirements efficiently.

We appreciate the opportunity to participate in this solicitation and look forward to the possibility of working together to enhance the quality of care for West Virginia's Medicaid population. Should you have any questions or require further information, please do not hesitate to contact me.

Thank you for your consideration.

Sincerely,

William Aaron, MBA

**Principal** 

## Section 2 Designated Contact Information Form

Mercer provides the completed Designated Contact Information form on the following page.

**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.

(Printed Name and Title) William Aaron, Principal

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

(Phone Number) / (Fax Number) +1 502 271 0435

(email address) william.aaron@mercer.com

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through wvOASIS, I certify that: I have reviewed this Solicitation/Contract 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/Contract 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 this bid or offer was made without prior understanding, agreement, or connection with any entity submitting a bid or offer for the same material, supplies, equipment or services; that this bid or offer is in all respects fair and without collusion or fraud; that this Contract is accepted or entered into without any prior understanding, agreement, or connection to any other entity that could be considered a violation of law; 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.

By signing below, I further certify that I understand this Contract is subject to the provisions of West Virginia Code § 5A-3-62, which automatically voids certain contract clauses that violate State law; and that pursuant to W. Va. Code 5A-3-63, the entity entering into this contract is prohibited from engaging in a boycott against Israel.

Mercer Health & Benefits LLC

(Company)

(Signature of Authorized Representative)

William Aaron, Principal

April 21, 2025

(Printed Name and Title of Authorized Representative) (Date)

+1 502 271 0435

(Phone Number) (Fax Number)

william.aaron@mercer.com

(Email Address)

Revised 8/24/2023

## Section 3 **Executive Summary**

Mercer Health & Benefits LLC (Mercer) is uniquely positioned to serve as the ideal partner for the State of West Virginia's (State's or West Virginia's) Medicaid Managed Care Rate Setting and Program Administration, as outlined in Solicitation No. CRFQ 0511 BMS2500000001. With over 40 years of specialized experience in Medicaid and Children's Health Insurance Program (CHIP) managed care, Mercer has established itself as a leader in the field, providing comprehensive support to Medicaid agencies across more than 40 states and territories. Our extensive qualifications include a dedicated team of credentialed actuaries, policy experts, and program managers who bring a wealth of knowledge and proven methodologies to support the effective administration of Medicaid programs.

Our commitment to collaboration and responsiveness is at the core of our approach. We prioritize open communication and active engagement with the Agency and all stakeholders, ensuring their needs and concerns are addressed promptly. Our comprehensive program administration plan emphasizes transparency and stakeholder involvement, fostering a collaborative environment that enhances the quality of care for West Virginia's Medicaid beneficiaries.

Mercer's extensive experience in developing actuarially sound capitation rates, coupled with our proven record in Medicaid and CHIP program development and oversight, positions us as the qualified vendor for this contract. Our actuarial partner, Incline Actuarial Group (Incline), has been a trusted advisor to Medicaid consulting firms (including Mercer), national associations (such as the National Association of Medicaid Directors [NAMD]), and risk-bearing provider organizations that support the underserved. Incline's leadership brings a unique balance of experience from both state and health plan perspectives, enabling Incline to be an effective communicator among different stakeholders. Incline adds ample resources for the BMS and is a registered small business with the State of West Virginia. The team has dedicated actuarial leadership from those who have firsthand experience working at a Medicaid agency, as well as several actuaries who have extensive experience working with West Virginia Medicaid.

All together, we are dedicated to delivering high-quality services that not only meet but exceed the expectations of the Agency, ensuring the Medicaid program operates efficiently and effectively for the populations served.

Mercer is committed to being a responsive and collaborative partner, leveraging our deep expertise and experience to enhance the quality of care for West Virginia's Medicaid population. We look forward to the opportunity to work together to achieve the Agency's goals and improve health outcomes for all beneficiaries.

### **Section 4**

## **Qualifications (Section 3)**

3. Qualifications: Vendor, or Vendor's staff if requirements are inherently limited to individuals rather than corporate entities, shall have the following minimum qualifications: (Documentation demonstrating qualifications should be submitted with bid, but must be submitted within three (3) business days of request).

Mercer meets and/or exceeds all qualifications. For a detailed overview of our staff qualifications please refer to **section 3.2** of this document.

Figure 1: Mercer Meets All Staffing Qualifications



Mercer Meets
All
Staffing
Qualifications

### Project Management Lead (1 Full-Time Equivalent)

The position is required to have a minimum of a bachelor's degree, with five (5) years' experience with Medicaid or Medicaid and CHIP managed care.

### Executive Program Director (1 Full-Time Equivalent)

This position is required to have a minimum of a bachelor's degree, with three (3) years' experience in Medicaid or Medicaid and CHIP managed care operations, either with a State Agency, Federal Agency, or rendering services under contract to a State Agency.

### ✓ Program Administration Lead (1 Full-Time Equivalent)

This position is required to have a minimum of a bachelor's degree, with three (3) years' experience in Medicaid or Medicaid and CHIP managed care operations, either with a State Agency, Federal Agency, or rendering services under contract to a State Agency.

### ✓ Finance Project Lead (1 Full-Time Equivalent)

This position is required to have a minimum of a bachelor's degree in finance, accounting, business administration, or related field with three (3) years' experience in financial management in Medicaid or Medicaid and CHIP programs, regulations, relmbursement processes, financial analysis, budgeting, and forecasting.

### ✓ Research Analyst/Consultant (.50 Full-Time Equivalent)

The position is required to have a minimum of a Bachelor's Degree, with two (2) years' experience working with Medicaid or Medicaid and CHIP, either with a State Agency, Federal Agency, or rendering services under contract to a State Agency. Staff for Contract development and maintenance, corrective action plans will have a Juris Doctor (JD).

### ✓ Medicaid Policy Subject Matter Expert (0.5 Full-Time Equivalent)

The position is required to have a minimum of a Bachelor's Degree, with ten (10) years' experience in Medicaid or Medicaid and CHIP policy research and development, either with a State Agency, Federal Agency, or rendering services under contract to either Agency type.

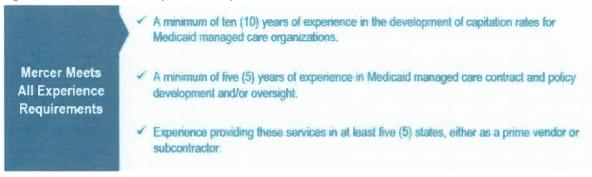
### ✓ Lead Actuary (1 Full-Time Equivalent)

This position is required to have a minimum of ten (10) years' experience with Medicaid or Medicaid and CHIP 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.

### Staff Actuary (2 Full-Time Equivalent)

This position is required to have a minimum of five (5) years' experience with Medicaid or Medicaid and CHIP 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.

Figure 2: Mercer Meets All Experience Requirements



3.1. The Vendor(s) must have a minimum of ten (10) years of experience in the development of capitation rates for Medicaid managed care organizations and a minimum of five (5) years' experience in Medicaid managed care contract and policy development and/or oversight. The vendor is required to have experience providing both services in at least five (5) states, either as a prime vendor or subcontractor.

## 10 Years of Experience in Capitation Rate Development in Five States

Mercer exceeds all qualifications and service requirements for the actuarial, financial, and program oversight scopes.

With over 40 years of specialized experience in the development of capitation rates for Medicaid managed care organizations (MCOs), Mercer has established itself as a leader in this domain. Our actuarial team has been engaged in the formulation of actuarially sound capitation rates since 1985, effectively serving diverse populations across a multitude of states. Currently, we hold 13 actuary of record (AOR) contracts for 11 states, the District of Columbia, and Puerto Rico, underscoring our extensive expertise and commitment to delivering high-quality actuarial services in this critical area.

Mercer has delivered Medicaid managed care program administration and actuarial services across more than 40 states and territories, serving as a prime vendor in numerous instances. Our extensive engagements include significant projects in states such as California and New Jersey, where we have successfully implemented and managed Medicaid managed care initiatives. This breadth of experience across multiple jurisdictions highlights our capability to adapt to varying regulatory environments and effectively manage complex Medicaid programs.

Mercer has supported many of our Medicaid and CHIP clients for multiple decades, as shown in the table below for our current AOR contracts. These long-tenured relationships exemplify our approach of building trust and partnership with clients through consistent delivery of high-quality work.

Table 1: Number of Years Mercer has Developed and Certified Capitation Rates

Medicaid Program	Number of Years Mercer has Developed and Certified Capitation Rates
California	20 years
Delaware	17 years
<b>District of Columbia</b>	25 years
Massachusetts	33 years
Missouri	32 years
Nevada	6 years
New Jersey	31 years
New Mexico	27 years
North Carolina	24 years
Oregon	3 years
Pennsylvania	30 years
Puerto Rico	3 years
Virginia	7 years

Mercer possesses the requisite experience in capitation rate development, Medicaid managed care contract, and policy development, and has successfully provided these services across multiple states. Our extensive background and proven record position us as a highly qualified vendor, fully capable of fulfilling the requirements outlined in the solicitation, including but not limited to:

- Rate Development and Certification: Section 4.1.2
- Managed Care Program Oversight: Sections 4.1.1 and 4.1.1.1
- Preparation of Waiver Applications: Section 4.1.1.4
- Policy Impact Analyses: Sections 4.1.1.8 and 4.1.1.19
- Annual Reporting: Section 4.1.1.15
- Training and Support: Section 4.1.1.30
- Compliance with Federal and State Regulations: Sections 4.1.1.19 and 4.1.1.20
- Data Management and Reporting Tools: Section 4.1.1.30
- Stakeholder Engagement: Section 4.1.1.26
- Risk Assessment and Management: Section 4.1.1.31
- Program Integrity: Section 4.1.1.31

Transition Planning: Section 4.1.2.9

Budget Forecasting: Section 4.1.3.1

Our wealth of specialized experience directly demonstrates our ability to provide similar services for West Virginia. Mercer's proposed team offers a broad mixture of this experience across their specialty disciplines along with BMS-specific knowledge, as detailed in the tables below.

Table 2: Mercer Experience

State	Medicaid/ CHIP Capitation Rate Development	Fee-For- Service (FFS) Rate Review and Setting	Directed Payment Development	Waiver and Federal Policy Support	Financial and Data Analytics	Alternative Payment Models (APMs)/ Value-Based Purchasing (VBP)	Risk Adjustment	Budget Projections
California	<b>√</b>	<b>√</b>	<b>√</b>	✓	✓	✓	✓	✓
Delaware	$\checkmark$	✓	✓	✓	✓	✓	✓	✓
District of Columbia	✓			✓	✓	✓	<b>√</b>	✓
Massachusetts	✓			✓	✓	✓	✓	✓
Missouri	✓	<b>√</b>	✓	✓	✓	✓	✓	✓
Nevada	✓		✓		✓	✓	✓	✓
New Jersey	✓	✓	✓	✓	✓	✓	✓	✓
New Mexico	✓	✓	✓	✓	<b>√</b>	✓	✓	✓
North Carolina	✓	✓	✓	✓	✓	✓	$\checkmark$	<b>✓</b>
Oregon	✓			✓	✓			
Pennsylvania	✓	✓	✓	✓	✓	✓	✓	✓
Puerto Rico	✓		✓	✓	✓			
Virginia	✓	✓	✓	✓	✓	✓	✓	✓

Table 3 below identifies the populations, programs, and services that Mercer currently develops and certifies actuarially sound Medicaid and CHIP managed care rates for, as well as our experienced performing related services that West Virginia seeks to procure through this RFQ.

Table 3: Mercer's AOR Experience

Mercer's AOR Experience	CA	DE	DC	MA	MO	NV	NJ	NM	NC	OR	PA	VA	PR
Managed Care Rate Setting													
Temporary Assistance for Needy Families	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Supplemental Security Income	✓	✓	✓	✓		✓	✓	✓	✓	$\checkmark$	✓	✓	$\checkmark$
Expansion Adults	✓	✓	✓	✓	✓	✓	✓	✓	✓	$\checkmark$	$\checkmark$	✓	$\checkmark$
Dual Eligibles	✓	✓	✓	✓			$\checkmark$	✓	✓	✓	✓	✓	$\checkmark$
Nursing Home Level of Care/Home and Community-Based Services/Long-Term Services and Supports (excluding Program of All-Inclusive Care for the Elderly [PACE])	✓	✓		<b>√</b>			✓	✓			✓	✓	
Specialized and/or Integrated Behavioral Health		✓		✓	✓			$\checkmark$	✓	✓	✓	✓	
Standalone CHIP					✓						$\checkmark$	✓	
Standalone Dental	<b>√</b>					✓							
Standalone Non-Emergency Medical Transportation					✓						✓	✓	
PACE Amounts that Would have Otherwise been Paid/Rates	✓	✓	✓	✓	<b>√</b>		<b>√</b>	✓	<b>√</b>		✓	<b>√</b>	
Managed Care Efficiency Analyses/Adjustments		✓		✓	✓		✓	✓	✓	✓	$\checkmark$	$\checkmark$	<b>√</b>
Technical Assistance with Centers for Medicare & Medicaid Services (CMS)	✓	<b>√</b>	<b>√</b>	✓	<b>√</b>	✓	<b>√</b>	✓	✓	✓	<b>√</b>	✓	<b>✓</b>
Technical Assistance with MCOs	<b>✓</b>	<b>√</b>	<b>✓</b>	<b>✓</b>	✓	✓	✓	<b>√</b>	<b>√</b>	<b>√</b>	✓	<b>√</b>	✓

Mercer's AOR Experience	CA	DE	DC	MA	MO	NV	NJ	NM	NC	OR	PA	VA	PR
Risk Adjustment and Special Payment Provisions				To the			171."					<b>K.</b> 4	
Acute Care Risk Adjustment	<b>√</b>	<b>√</b>	✓	<b>√</b>	<b>√</b>	<b>√</b>	<b>✓</b>	<b>✓</b>	<b>✓</b>	<b>✓</b>	<b>√</b>	✓	✓
Managed Long-Term Services and Supports Risk Adjustment				<b>√</b>			<b>√</b>				✓		
State Directed Payments Rate Setting Adjustments	✓	✓	✓	✓	✓	<b>✓</b>	✓	✓	✓	✓	✓	✓	✓
State Directed Payment Benchmark Calculations	✓	✓		✓	✓			✓		$\checkmark$	✓	$\checkmark$	✓
State Directed Payment Reconciliations		✓	✓	✓	✓			✓			✓	$\checkmark$	✓
Risk Corridor/Risk Pool/Medical Loss Ratio (MLR) Reconciliation		✓	✓	✓	<b>√</b>	<b>✓</b>	✓	✓	✓		✓	✓	<b>✓</b>
Actuarial/Financial Technical Assistance							1		LEAN,				
Budget Forecasting	✓		✓		✓		✓		✓	✓	✓	✓	✓
Enrollment Projections	✓			✓	✓	✓			✓	<b>✓</b>	✓		✓
Legislative Support/Legislative Testimony								S	$\checkmark$		S		S
MCO Financial Monitoring		✓	✓		✓		✓	✓	$\checkmark$		✓		✓
Program Integrity (PI) Support		✓											$\checkmark$
Encounter Data Audits	✓	✓	✓		✓						$\checkmark$		
1115 Budget Neutrality Calculations		✓			<b>✓</b>			✓	✓		$\checkmark$		
1915(b) Cost Effectiveness					✓				✓		✓	$\checkmark$	
1915(c) Cost Neutrality									✓		✓		
In Lieu of Services	✓	<b>√</b>	✓		<b>✓</b>	<b>√</b>			✓	✓	✓		✓
VBP		<b>√</b>	✓	✓				<b>√</b>			✓	✓	✓

### Five Years of Experience in Medicaid Managed Care Contract and Policy Development in Five States

### Mercer exceeds all qualifications.

Mercer exceeds the minimum of five years of comprehensive experience in the development and oversight of Medicaid managed care contracts and policies in five states. We have successfully guided numerous states through the complexities of regulatory frameworks, facilitating the creation of robust managed care contracts while ensuring compliance with both federal and state regulations. Our strategic approach has enabled us to navigate the intricacies of Medicaid policy development effectively.

Across the country, we support a wide range of Medicaid and CHIP operations and policy consulting services, policy and waiver technical support, financial reporting and monitoring, APMs and VBP design and implementation, PI, MCO procurement support, legislative support, and budget projections. The following map illustrates services similar to those requested in this RFQ that we provide to a sample of our clients.



Figure 3: Mercer GHSC 2025 Experience Map — Active Contracts and Current AOR

### Mercer's Full Continuum of Medicaid and CHIP Expertise

Mercer offers a truly integrated service model, with the in-house expertise of our dedicated consultants from a variety of backgrounds — including credentialed actuaries, licensed pharmacists, Certified Public Accountants, licensed clinicians, former state Medicaid and CMS officials, and data experts. We will be your one-stop shop. With nearly 500 staff members dedicated to providing consulting to state government clients, Mercer is fully prepared to devote whatever resources are needed to West Virginia.

The following graphic demonstrates our organizational areas of expertise that align and expand upon the suite of services requested in this RFQ.

Figure 4: Areas of Expertise



Our team of over 20 policy experts has extensive experience from previous roles at CMS, state Medicaid agencies, state behavioral health authorities, and agencies focused on aging, developmental disabilities, and special needs. Many of our clients (including Arizona, California, Delaware, Kansas, Massachusetts, Nevada, New York, New Jersey, New Mexico, Pennsylvania, and Virginia) have Medicaid managed care. As a result, our policy experts have a broad range of experience with federal requirements regarding managed care, including the design, development, implementation, and monitoring of Medicaid managed care programs. Mercer will bring relevant experience from our work with states across the country to share best practices and lessons learned with West Virginia that are creative, realistic, and specific to the individual needs of BMS.

Our policy experts have the necessary expertise, experience, and capacity to assist West Virginia by:

- Applying policy expertise in day-to-day project operations: We apply what we learn through our relationships with other state Medicaid programs to the West Virginia program (as appropriate).
- Actively conducting environmental scans for emerging issues so we are ready to assist you upon the release of new rules, regulations, or guidance:
  - We regularly monitor the CMS regulatory agenda and regulations pending at the Office of Management and Budget, proposed and final rules, relevant federal legislation, Government Accountability Office and Office of the Inspector General Reports, and Health and Human Services Departmental Appeals Board decisions most relevant to Medicaid. We also analyze policy summaries, such as those developed by Brown & Peisch, and review public reports from sources such as the Medicaid and CHIP Payment and Access Commission.
  - We regularly participate in Center for Medicaid and CHIP Services and CMS Innovation calls and monitor sub-regulatory guidance, such as the Rate Development Guides, State Medicaid Director Letters, Information Bulletins, policy preprints, State Plan Amendments (SPAs), waivers, Advance Planning Documents and contract approvals, and financial deferrals/disallowances.

- Analyzing and evaluating Medicaid policy and legislative issues, as it relates to your program and goals: We produce written brief policy "flashes" on new rules, develop white papers, and hold customized client briefings.
- Providing strategic support during interactions and negotiations with CMS: Having worked at CMS directly, our experts have intimate knowledge of the terminology that can make the difference between an efficient CMS review and approval process and a long, drawn-out process.
- Assisting with reporting: We assist our state clients with budget neutrality and other waiver reporting.
- Offering administrative and operational support: We provide administrative and operational support, such as drafting of SPAs, preprints, and federal authority applications.
- Evaluating opportunities: We evaluate and assess the feasibility of program policies, procedures, social equity approaches, and/or improvement opportunities.

### **Mercer Subject Matter Experts**

We understand, based on our experience collaborating with various states and the outlined scope of services in this RFQ, that West Virginia seeks a firm capable of providing a genuinely multi-disciplinary team. At Mercer, we embody this model, showcasing a diverse array of subject matter experts (SMEs) who bring a wealth of knowledge and expertise to the table.

We have a wide variety of subject matter specialists across Medicaid pharmacy, clinical, policy, and claims/encounters systems on the team, including:

- One board-certified psychiatrist
- Two PhD clinical psychologists
- · Six independently licensed behavioral health clinicians
- Three social workers
- Thirteen registered nurses, including one Nurse Practitioner specializing in women's health
- One dental hygienist
- Eight licensed pharmacists
- Six claims/encounters and systems specialists

Our team covers the full continuum, from primary and acute care to long-term services and supports, including for those individuals with complex physical or behavioral health needs and/or intellectual/developmental disabilities. We are skilled in addressing the needs of all Medicaid populations and ages, from early intervention for young children to skilled nursing and Home and Community-Based Services for aging adults.

In addition to routinely supporting our actuarial teams with efficiency analyses, program change considerations/assumptions, and other clinical needs associated with financial aspects of administering Medicaid programs, this team of specialty consultants is available to our clients in a much larger role:

- Projects supporting clients with day-to-day or project-specific operations and/or with improving oversight/management of their contractors, such as:
  - Agency organization and staffing analysis
  - Procurement strategy, contracts, and support
  - Pharmacy management strategies
  - Policies, procedures, and manuals
  - Quality management strategy
  - Data mining, analytics, and visualization
  - Stakeholder engagement
  - Staff extension
- Projects supporting clients with readiness assessments and ongoing monitoring and evaluation of implemented programs to ensure both high quality and compliance, such as:
  - MCO readiness reviews.
  - Contractor performance reviews and audits
  - External quality reviews
  - Information systems capabilities assessments and claims reviews
  - Clinical program or waiver evaluations
  - Quality/performance measurement
  - Regulatory compliance/monitoring
  - Managed Care Program Accountability and Reporting
  - \_ PI
  - Parity compliance
  - Training

Together, our team of actuaries, financial consultants, analysts, and data experts, coupled with our robust team of policy and specialty consultants offers the capacity our clients need when it comes to technical assistance in the Medicaid space. Our approach is the SAFE one — it is about Strategy and programs, Authorities and regulations, Finance and budget, and Evaluation and management.

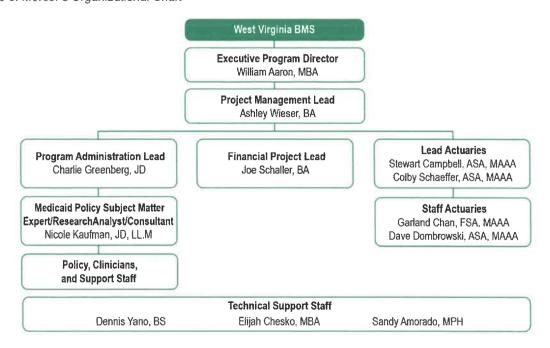
### "One Mercer" Execution

Our responses highlight the extensive Medicaid-specific expertise of our comprehensive in-house team. However, a high-performing team is not solely defined by individual expertise. Our organizational structure fosters synergy and cross-collaboration, enabling us to deliver holistic and integrated solutions for our Medicaid clients. We are committed to providing a seamless "One Mercer" experience, ensuring all areas of our expertise work together to meet our clients' needs effectively.

To support concurrent service delivery across the variety of tasks included in this RFQ without creating bottlenecks or inefficiency, we have organized our proposed team into five major workstreams aligning with the scope of work included in the pro forma contract. Each workstream includes a clearly defined lead consultant or actuary and staff with the appropriate skill set to perform the corresponding tasks. Although the workstreams are independent, staff may shift across streams as needed based on project demands. The leadership team will work closely together to coordinate and exchange information. The Project Management Office will ensure consistency in execution as "One Mercer." It is not uncommon for large consulting firms to propose complex contract teams that create confusion and disarray for the client. This organized structure has proven nimble and effective while providing a small group of accountable consultants to eliminate any burden on West Virginia.

The following organizational chart illustrates our proposed team structure, designed to facilitate seamless service delivery across the various tasks outlined in this RFQ. Each workstream is led by a dedicated consultant or actuary, ensuring clarity and accountability while allowing for flexibility in resource allocation based on project demands. This structure exemplifies our commitment to operating as "One Mercer," promoting collaboration and efficiency throughout the project:

Figure 5: Mercer's Organizational Chart



This spirit of collaboration exists across our entire Mercer Government Human Services Consulting (GHSC) organization. Our Financial Analytics Consulting sector within our larger GHSC practice includes credentialed actuaries and students, financial experts, and data management professionals. Similarly, our Specialty Consulting sector includes Medicaid policy and operations experts, licensed pharmacists, and clinicians. Despite differences in expertise, these experts are organized and operate as collaborative teams instead of disparate silos, providing the full value of the firm to West Virginia.

3.2. Summarized below in Table 1 are the required key position staffing qualifications for each position that the Agency will utilize for both the actuarial services and program oversight components of the contract. The vendor shall not combine any key positions. In addition to these key positions, the vendor shall provide technical, financial, and clerical support staff with administrative duties that do not have the required minimum qualification, as need. Note – The number of actuarial staff needed will be driven by individual Statements of Work (SOW), with an annual estimation of hours outlined in the pricing page for cost estimation purposes.

### **Qualifications of Key Staff**

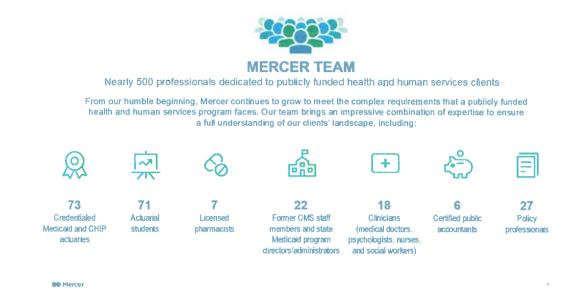
Mercer exceeds all qualifications.

Mercer Health & Benefits LLC (Mercer) confirms we not only meet but **exceed** all the minimum qualifications outlined in the RFQ. Our team possesses the necessary skills, experience, and credentials to meet and or exceed the contract requirements. We are prepared to provide documentation demonstrating our qualifications upon request and within the specified timeframe.

Mercer Government Human Services Consulting is a specialty consulting practice within Mercer, one of the largest healthcare and benefits consulting and brokerage services companies in the world. Since founding the first fully dedicated Medicaid actuarial consulting practice in 1985, we have served clients in more than 40 states and US territories, including Medicaid agencies, social services agencies, health departments, and mental health agencies, as well as federal healthcare agencies. This extensive experience has allowed us to continually expand our expertise and significantly enhance our impact in the field.

### The Mercer Team

Figure 6: Mercer Team



### Mercer Team Medicaid and CHIP Managed Care Expertise

✓ Mercer exceeds all qualifications.

Our team is dedicated to fulfilling all staffing requirements through our extensive expertise in Medicaid managed care. With a wealth of knowledge in contract and policy development, we have built a reputation for delivering high-quality support and innovative solutions. Our diverse team brings together professionals with specialized skills and experience, ensuring that we can address the unique challenges faced by each state. We are committed to fostering collaboration and leveraging our collective strengths to achieve successful outcomes in managed care initiatives.

### Mercer Team Medicaid and CHIP Actuarial Expertise — Actuaries

Mercer exceeds all qualifications.

To comply with the **RFQ requirement 4.1.6.5**, Mercer is demonstrating capacity with the following program certifications within the last two years.

Table 4: Program Certifications

Medicaid Program	Due Date to CMS	Mercer to State Submission	Timeframe	Reference
Oregon *91 days prior	10/3/2024	10/2/2024	CY 2025 Begins 1/1/2025	oregon.gov/oha/FO D/FODOHPRates/C Y25 OR CCO Rate Certification -

Medicaid Program	Due Date to CMS	Mercer to State Submission	Timeframe	Reference
				2024.10.02 with Appendices.pdf
				Oregon Health Authority: OHP Rate Development: Fiscal and Operations: State of Oregon
Pennsylvania *117 days prior	4/2/2025	3/5/2025	FY2026 Begins 7/1/2025	Appendix D
Puerto Rico *201 days prior	10/3/2024	6/13/2023	CY 2024 Begins 1/1/2024	Appendix D
Puerto Rico *211 days prior	10/3/2025	6/3/2024	CY 2025 Begins 1/1/2025	Appendix D

We have a West Virginia-dedicated team of at least two credentialed Lead Actuaries, exceeding the minimum of 10 years of experience in the development of capitation rates for Medicaid and CHIP MCOs.

### We are proud to highlight the following team members.



### Stewart Campbell, ASA, MAAA

As **Lead Actuary**, Stewart brings over 16 years of actuarial experience, including significant roles in capitation rate development and actuarial support for various state Medicaid programs, such as Connecticut, Massachusetts, New Mexico, and Pennsylvania. His experience as the Lead Actuary for the Arizona Health Care Cost Containment System (AHCCCS) further underscores his extensive background in Medicaid. Stewart is a Fellow of the Society of Actuaries

(FSA) and a Member of the American Academy of Actuaries (MAAA), fulfilling the credential requirement. In his recent role as Lead Actuary for New Mexico, he leads a team across various actuarial and policy consulting projects, managing timelines and ensuring deliverables are met as outlined in SOWs.

Stewart Campbell's extensive experience in Medicaid and CHIP actuarial services, strong professional credentials, and leadership in managing actuarial projects make him an excellent fit for the Lead Actuary position. His proven ability to develop and certify capitation rates, along with his experience in stakeholder communication and negotiation with CMS, demonstrates his capability to effectively oversee the responsibilities of this role.



### Colby Schaeffer, ASA, MAAA

As Lead Actuary, Colby brings 18 years of experience specializing in Medicaid capitation rate development, value-based payment methodologies, and health reform modeling. He is a proven project manager who has led on-site presentations across many states and developed more than two dozen rate certifications that have been successfully submitted to CMS. He has led comprehensive project teams supporting multi-billion-dollar programs for states. Colby has

deep experience working with West Virginia as an actuary representing BMS from 2012 to 2015 and again from 2017 to 2021. In his time supporting BMS, Colby developed the Hospital Directed Payments, which involved meeting the hospital association and working directly with CMS to navigate challenges amidst West Virginia Medicaid Expansion. He certified the first set of capitation rates for the Affordable Care Act (ACA) Expansion population, pharmacy carve-in (and carve-out), behavioral health carve-in, adult dental benefit add-on, and the foster care population (Mountain Health Promise). Colby also played a key role working with the State on the adoption of expanded benefit provisions under the 1115 Medicaid Substance Use Disorder waiver.

Although Colby has primarily worked in consulting, his experience also includes working for a major health insurance company, as well as having leadership roles with two different State Medicaid agencies where he was the Chief Actuary for Arizona's Medicaid agency and then, most recently, supporting Oklahoma Health Care Authority as Interim Chief Financial Officer. In addition to his work experience, Colby has actively volunteered with the Society of Actuaries (SOA) and the American Academy of Actuaries (AAA). Through volunteering, he has engaged in multiple Medicaid committees, supported actuarial thought leadership in Medicaid, and served as leader of the SOA's Medicaid public interest group for the last five years. Colby also led the national impact study and development of a publicly available working model on the Medicaid Unwinding for the SOA.

Incline Actuarial Group (Incline) has been a trusted advisor to Medicaid consulting firms (including Mercer), national associations (such as NAMD), and risk-bearing provider organizations that support the underserved. Incline's leadership brings a unique balance of experience from both State and health plan perspectives, enabling Incline to be an effective communicator among different stakeholders. Incline has ample resources for BMS and is a registered small business with West Virginia. The team has dedicated actuarial leadership from those who have firsthand experience working at a Medicaid agency, as well as several actuaries who have deep experience working with West Virginia Medicaid. As an added benefit, Colby lives within driving distance of Charleston, West Virginia and is available to attend meetings on short notice.

### Mercer Team Medicaid and CHIP Actuarial Expertise — Staff Actuaries

We have a dedicated team of at least two credentialed Staff Actuaries, exceeding the minimum of five years of experience in the development of capitation rates for Medicaid MCOs. We are proud to highlight the following team members.



### Dave Dombrowski, ASA, MAAA

As **staff actuary**, Dave has over 15 years of actuarial experience, specifically working on Medicaid programs across more than 20 states. His roles have included capitation rate development and pricing for various Medicaid services, clearly exceeding the five-year requirement. Dave is an Associate of the Society of Actuaries (ASA) and an MAAA, fulfilling the credential requirement. In his current role, he supports the development of actuarially sound capitation rates and

provides technical assistance, collaborating with the Lead Actuary to ensure deliverables are met as outlined in SOWs. His extensive experience, strong professional credentials, and proven ability to assist in rate-setting and program development make him an excellent fit for the Staff Actuary position.



### Garland Chan, FSA, MAAA

As **staff actuary**, Garland brings 16 years of career experience, including significant actuarial consulting services for state Medicaid clients, including extensive experience specifically in capitation rate development for Medicaid MCOs. His current work involves rate setting and value-based contracting analysis for Puerto Rico, aligning perfectly with the Medicaid experience requirement. Garland is an FSA and an MAAA, fulfilling the credential requirement. In his current

role, he supports rate setting and financial analysis for Medicaid programs, collaborating with other actuaries to ensure deliverables are met as outlined in SOWs. His extensive experience in Medicaid actuarial consulting, strong professional credentials, and current involvement in rate setting and value-based contracting make him an excellent fit for the Staff Actuary position.

Together, Dave and Garland enhance Mercer's ability to deliver effective Medicaid solutions, positioning them as invaluable assets to any Medicaid initiative.

### Key Staffing Qualifications for Actuarial Services and Program Oversight

Mercer exceeds all qualifications.

Mercer confirms that we will not only meet but exceed all staffing qualifications outlined in **Table 5** for the key positions required for actuarial services and program oversight. We will not combine any key positions and will provide the necessary technical, financial, and clerical support staff as needed. The number of actuarial staff will be determined based on individual SOWs, with annual hour estimations included in our pricing page.



### William Aaron, MBA

As Executive Program Director, William brings a wealth of experience. Having worked with an array of state Medicaid clients in a variety of ways, including designing and implementing a new assessment and corresponding supplemental payment programs, MCO procurement question design and facilitating consensus decision-making, identification of Medicaid cost-containment strategies, and helping lead the restructuring and operations of one of Mercer's largest state client groups.

Before joining Mercer, William worked for TennCare for more than a decade. He served as Chief Financial Officer and Chief Operating Officer, leading the program's financial, managed care, information technology, and member enrollment/eligibility functions. William was a primary architect of the TennCare III 1115 waiver, projected to provide significant additional federal funding to the state for the next decade. He has worked extensively with a wide range of stakeholders, including elected legislative and executive leaders, advocacy groups, and professional associations. His direct expertise in Medicaid financing, policy, strategy, and operations is available to help states facing various challenging problems.



### **Ashley Wieser, BA**

As the **Project Management Lead**, Ashley Wieser will oversee the fulfillment of all contractual deliverables, ensuring they are provided within the required timeframes. With 10 years of public health experience, Ashley specializes in managing complex Medicaid projects for various clients, including the District of Columbia, Florida, Kansas, Minnesota, Missouri, Pennsylvania, and Wisconsin. She currently provides project management support for six program offices within the Commonwealth of Pennsylvania's Department of

Human Services, where she excels in project planning, resource allocation, and budget management while facilitating effective communication and risk management.

Ashley holds a Bachelor of Arts in History and a Bachelor of Arts in Religious Studies from Arizona State University. She has a proven record of managing Medicaid managed care procurement activities and developing strategic project work plans and dashboards. With a minimum of five years of experience in Medicaid or Medicaid and CHIP managed care, Ashley is adept at collaborating with diverse project teams, leading stakeholder discussions, and formulating strategies that enhance client satisfaction. Her expertise encompasses project management, technical assistance, stakeholder engagement, and budget and contract management, making her well-equipped to lead project initiatives effectively.



### Charlie Greenberg, JD, MPH

As the **Program Administration Lead**, Charlie Greenberg brings a wealth of expertise in overseeing managed care operations and ensuring all contractual deliverables are met within the required timeframes. With over 16 years of career experience, including significant roles in consulting and direct involvement with the Texas Health and Human Services Commission, Charlie has a deep understanding of Medicaid policy, regulations, and program design.

He holds a Bachelor of Arts from the University of Texas at Austin, a Juris Doctor from the University of Texas School of Law, and a Master of Public Health from Johns Hopkins School of Public Health, providing a strong foundation in both legal and public health aspects relevant to Medicaid and managed care.

In his previous roles, Charlie has led various Medicaid expansion feasibility studies and program strategy designs, requiring coordination with multiple stakeholders, including finance and policy teams. His ability to manage deliverables effectively is complemented by strong communication skills, as evidenced by his extensive experience in stakeholder engagement and policy analysis. Charlie has worked closely with various state departments, providing guidance and consulting on Medicaid policies, which involves regular communication with leadership and staff. His proven record in program design and strategy, along with his adeptness at maintaining thorough documentation and ensuring compliance with federal and state regulations, positions him as a strong candidate for the Program Administration Lead role, where his extensive experience in Medicaid and CHIP policy, combined with his leadership in program strategy, ensures he is well-prepared to oversee complex projects and deliver results that align with contract requirements.



### Joe Schaller, BA

As the **Finance Project Lead**, Joe Schaller brings immense value to the team, leveraging his extensive background in health plan finance and operations. Joe has over 25 years of career experience, including significant roles in health plan rate development audits, financial reporting, and monitoring, which align perfectly with the responsibilities of this position. He holds a Bachelor of Science in Accounting and Finance and a Bachelor of Science in Business Administration from DeVry University.

Since joining Mercer in 2019, Joe has developed procedures and models for health plan monitoring, including quarterly and annual financial reporting, MLR reporting, and CMS-required audits. His previous experience as Chief Financial Officer at a mid-size Medicaid MCO equipped him with the skills to achieve operational efficiencies and expand business services.



### Nicole Kaufman, JD, LL.M

Analyst/Consultant, Nicole Kaufman brings a wealth of expertise in federal Medicaid regulation and policy. With over 14 years of experience, including more than five years at Mercer, she has provided managed care policy and operational consulting services to state Medicaid clients. Nicole is well-versed in crafting CMS managed care reports, including 1915(b) waiver applications, Medicaid and CHIP Program Annual Reports

(MACPARs), and Fraud, Waste, and Abuse (FWA) compliance reports.

Nicole holds a Master of Laws in Health Law and a Juris Doctor, equipping her with a strong legal foundation to navigate the complexities of Medicaid policy. Before joining Mercer, she held a senior position in the CMS Baltimore Central Office's Division of Managed Care Plans, where she was the primary author of the Medicaid Managed Care Final Rule and specialized

in negotiating complex Section 1115 demonstration waiver projects. Currently, she supports Kentucky, Missouri, and Nevada on Medicaid managed care policy, program oversight strategies, and regulatory compliance. Nicole's extensive experience and deep understanding of Medicaid policy make her an invaluable asset in ensuring compliance and delivering optimized solutions for Medicaid programs.

### **Establishing a Qualified Team for Effective Service Delivery**

To fulfill the requirements of the Medicaid Managed Care Rate Setting and Program Administration contract, it is essential to establish a qualified team of professionals. This section outlines the key staffing positions that Mercer proposes for both actuarial services and program oversight. Each position is selected based on the specific qualifications necessary to meet the Agency's needs. In addition to these key roles, Mercer will provide technical, financial, and clerical support staff to assist with administrative tasks as required.

The number of actuarial staff will be determined by individual SOWs, with annual hour estimations included for cost forecasting. **Table 5** summarizes the required qualifications for each key position, demonstrating Mercer's capability to deliver the necessary services effectively.

Table 5: Mercer Proposed Key Staff

THE REPORT		Mercer Proposed Key Staf	
Proposed Key Staff Name/Title	Role	Requirement	Overview of Qualifications
Ashley Wieser,	Project Management	The Project Management Lead will	Mercer exceeds qualifications.
BA	Lead (1 Full-Time Equivalent [FTE])	oversee that all contractual deliverables are fulfilled and provided within the required timeframes.	<b>Education Qualification:</b> Ashley holds a Bachelor of Arts in History and Religious Studies from Arizona State University and has the required minimum of five years of experience in Medicaid or Medicaid and CHIP managed care.
		The position is required to have a minimum of a bachelor's degree, with five years' experience with Medicaid or Medicaid and CHIP managed care.	Experience Qualification: Ashley's extensive background in public health includes 10 years of managing complex Medicaid projects for various clients, where she has demonstrated her ability to effectively coordinate project activities and meet deadlines. Her experience in project management equips her to ensure all deliverables align with contract requirements and are completed on schedule.
			Summary of Why Ashley is Qualified: Ashley's strong educational background, combined with her significant experience in Medicaid project management, makes her an excellent fit for the Project Management Lead position. Her proven ability to oversee project deliverables and ensure timely completion underscores her capability to fulfill the responsibilities of this role effectively.
William Aaron,	Executive Program	This position will have the ability	Mercer exceeds qualifications.
MBA	Director (1 FTE)	and authority to commit the vendor and its resources, conduct	<b>Oversight Qualification:</b> As a Principal at Mercer, William has led the restructuring and operations of

	Mercer Proposed Key Staff	
posed Key Role	Requirement	Overview of Qualifications
ff Name/Title	ensure all deliverables and services are consistent with	one of Mercer GHSC's largest state client groups, demonstrating his capability to oversee complex managed care operations. He served as TennCare Chief Financial Officer and Chief Operating Officer for many years.
	taking minutes.  This position is required to have a	<b>Education Qualification:</b> William holds an MBA, which provides him with a strong foundation in business management and strategy.
	minimum of a bachelor's degree, with three years' experience in Medicaid or Medicaid and CHIP managed care operations, either with a State Agency, Federal Agency, or rendering services	Experience Qualification: With over a decade of experience in Medicaid, William has served as Chi Financial Officer and Chief Operating Officer for TennCare, leading the restructuring and operation of one of Mercer GHSC's largest state client group and showcasing his expertise in managing complementations.
	The Executive Director must be available for quarterly meetings with BMS leadership and staff and ad hoc meetings as needed. These meetings may be virtual or on-site and will be determined prior to	Meeting Qualification: William will be available for quarterly meetings with BMS leadership and staff as well as ad hoc meetings as needed. He is prepared to attend these meetings in person or virtually, as required.
	each meeting.	Coordination Qualification: His experience in managing financial analysis and budget modeling projects indicates his ability to coordinate effective with finance teams to ensure deliverables are medium the will be available for quarterly meetings with B leadership and staff and ad hoc meetings as need.
		<b>Engagement Qualification:</b> His role in supporting Medicaid clients and leading projects related to

and the second	100	Mercer Propose	
sed Key Role	e	Requirement	Overview of Qualifications
Name/Title			capitation rates and payment reform demonstrates his ability to ensure deliverables align with contract requirements.
			Communication Qualification: William's experience in stakeholder engagement and facilitating consensus decision-making highlights h strong communication skills, which are essential formaintaining project status updates.
			<b>Documentation Qualification:</b> His background in managing projects and leading teams confirms he capable of organizing and documenting meetings effectively.
			Record Keeping Qualification: William's experience in managing financial reporting and stakeholder communication indicates he is adeptomaintaining thorough records and tracking progressions.
			Approval Process Qualification: His role in leading negotiations and managing stakeholder relationships shows he understands the important of formal approval processes and documentation.
			Summary of Why William is Qualified: William Aaron's extensive experience in Medicaid and Ch consulting, strong leadership skills, and proven ability to manage complex projects make him an excellent fit for the Executive Program Director position. His background in financial management stakeholder engagement, and oversight of management.

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roposed Key Role Requirement Overview of Qualifications taff Name/Title
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Administration Lead Program (1 FTE) Greenberg, JD, Charlie

Managed Care and PI. The Program Deputy Commissioner, Division of position would have responsibility operations and deliverables under for other projects assigned by the This position will be responsible Project Lead in the execution of for oversight of managed care he contract. As needed, the coordinate with the Finance deliverables defined in the Administration Lead will contract

meetings with BMS leadership and his position is required to have a The Program Administration Lead under contract to a State Agency. minimum of a bachelor's degree, needed. These meetings may be managed care operations, either Medicaid or Medicaid and CHIP with three years' experience in must be available for quarterly Agency, or rendering services staff and ad hoc meetings as with a State Agency, Federal

care operations ensures he can effectively fulfill the responsibilities of this role.

### Mercer exceeds qualifications.

egal and public health aspects relevant to Medicaid Education Qualification: Charlie holds a Bachelor Juris Doctor from the University of Texas School of Hopkins School of Public Health. His educational background provides a strong foundation in both of Arts from the University of Texas at Austin, a Law, and a Master of Public Health from Johns and managed care.

roles in consulting and working directly for the state egulations, and program design, which aligns well Experience Qualification: Charlie has over 16 years of career experience, including significant Human Services Commission. His experience ncludes working directly with Medicaid policy, Medicaid program, like the Texas Health and with the operational aspects of the Program Administration Lead role.

Meeting Qualification: Charlie will be available for quarterly meetings with BMS leadership and staff, prepared to attend these meetings in person or as well as ad hoc meetings as needed. He is virtually, as required.

various Medicaid expansion feasibility studies and Responsibilities Qualification: Charlie has led program strategy designs, which require

	Overview of Qualifications	
Mercer Proposed Key Staff	Requirement	
	Proposed Key Role Staff Name/Title	

virtual or on-site and will be determined prior to each meeting. This position will develop meeting agenda and send out to all parties 24 hours prior to the meeting. This position will take meeting notes, record action items, and track action item completion. The meeting notes will be approved by BMS and then sent out to meeting participants. These meetings may be virtual or on-site and will be determined prior to each meeting.

coordination with multiple stakeholders, including finance and policy teams. His role in designing program strategies and consulting on implementation demonstrates his ability to manage deliverables effectively.

Communication Qualification: Charlie's experience in stakeholder engagement and policy analysis indicates strong communication skills. He has worked with various state departments, providing guidance and consulting on Medicaid policies, which would involve regular communication with leadership and staff.

Documentation Qualification: In his consulting roles, Charlie has been involved in program design and strategy, which typically includes developing documentation, tracking progress, and ensuring compliance with federal and state regulations. His experience in creating requests for proposals and analyzing federal law also suggests he is adept at maintaining thorough documentation.

Summary of Why Charlie is Qualified: Charlie is highly qualified for the Program Administration Lead role due to his extensive experience in Medicaid and CHIP policy, including work with state Medicaid programs and Section 1115 Waivers. His leadership in designing and implementing Medicaid programs showcases his ability to manage complex projects while ensuring regulatory compliance. With advanced degrees in law and public health, he is

Mercer

roposed Key Role	<u>o</u>	Requirement	Overview of Qualifications

### Joe Schaller F

Finance Project Lead (1 FTE)

This position will be liaison with the Deputy Commissioner of Finance and the Chief Financial Officer in the oversight of finance and budget initiatives and other projects within the scope of the contract. This position will coordinate the deliverables of the actuarial vendor with BMS Finance. The Finance Project Lead will coordinate with the Program Administration Lead in the execution of deliverables in the contract.

This position is required to have a minimum of a bachelor's degree in finance, accounting, business administration, or related field with three years' experience in financial management in Medicaid or Medicaid and CHIP programs, regulations, reimbursement processes, financial analysis, budgeting, and forecasting. The

well-equipped to handle the legal and operational challenges of Medicaid managed care. Additionally, his proven track record of consulting for state agencies and engaging stakeholders further solidifies his candidacy for this position.

## Mercer exceeds qualifications.

Education Qualification: Joe holds a Bachelor of Science in Accounting and Finance and a Bachelor of Science in Business Administration, both from DeVry University, Phoenix, AZ, USA, completed in 1991 and 1990, respectively. His educational background provides a solid foundation in financial principles and business operations.

Experience Qualification: Joe has over 25 years of career experience, including five years at Mercer, where he has developed a strong expertise in health plan finance and operations. His role as Chief Financial Officer at a mid-size Medicaid MCO prior to joining Mercer showcases his extensive experience in financial management within Medicaid programs.

Responsibilities Qualification: In his current position, Joe collaborates with various specialists, including actuaries and policy experts, to deliver optimized solutions for Medicaid programs. His experience in conducting readiness reviews, data monitoring, and cost reporting development aligns well with the oversight of finance and budget

	The second second	Mercer Proposed Key Staff	一一一一一一一一一一一一一一一一一一一一一一一一一一一一一一一一一一一一一
Proposed Key Staff Name/Title	Role	Requirement	Overview of Qualifications
		Finance Project Lead must be available for quarterly meetings with BMS leadership and staff and ad hoc meetings as needed. These meetings may be virtual or on-site and will be determined prior to	initiatives required for this role. Joe's proven ability to coordinate deliverables and communicate effectively with stakeholders, including state agencies, positions him well to liaise with the Deputy Commissioner of Finance and the Chief Financial Officer.
		each meeting.	Meeting Qualification: Joe will be available for quarterly meetings with BMS leadership and staff, as well as ad hoc meetings as needed. He is prepared to attend these meetings in person or virtually, as required.
			Summary of Why Joe is Qualified: Joe Schaller's extensive experience in Medicaid financial management, strong educational background in finance and business administration, and proven track record of leading financial initiatives make him an excellent fit for the Finance Project Lead position. His ability to oversee complex financial projects, coupled with his collaborative approach to working with various stakeholders, ensures that he can effectively manage the responsibilities outlined in the contract.
Nicole Kaufman, JD, LL.M as 1 FTE	• Medicaid Policy SME (0.5 FTE) and Research	The Medicaid Policy SME shall be leveraged for consultation services on federal Medicaid regulation and	Mercer exceeds qualifications. Medicaid Policy SME (0.5 FTE) Qualifications Match:
	Analysiv Consumain (0.5 FTE)		Experience Qualification: Nicole has over 14 years of career experience, including significant roles in managed care policy and operational

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THE PERSON NAMED IN		Mercer Proposed Key Staff	THE REAL PROPERTY OF THE PARTY
sosed Key Role f Name/Title	Role	Requirement	Overview of Qualifications
	• Note: The State has confirmed in their Q&A response that a single expert may qualify as a full-time FTE for	must have experience crafting CMS managed care reports including 1915(b) waiver applications/amendments, MACPARs, and FWA compliance reports.	consulting for state Medicaid clients. Her past experience at CMS as a regulator and SME for Medicaid managed care policy further solidifies her qualifications. She has experience crafting CMS managed care reports, including 1915(b) waiver applications/amendments, MACPARs, and FWA compliance reports.
	both the Research - Analyst/Consultant 0.5 FTE and Medicaid Policy SME 0.5 FTE roles.	Analyst/Consultant minimum of a bachelor's degree, 0.5 FTE and with 10 years' experience in Medicaid Policy Medicaid or Medicaid and CHIP policy Medicaid Policy Medicaid Policy Medicaid Policy Medicaid Policy Subject polics.	Education Qualification: Nicole holds a Bachelor of Arts in History and Political Science, a Juris Doctor, and a Master of Laws in Health Law, exceeding the educational requirement.  Responsibilities Qualification: Nicole has

Responsibilities Qualification: Nicole has extensive experience negotiating with CMS on federal authorities and managed care contract approvals, demonstrating her capability to provide expert consultation on Medicaid regulations.

either with a State Agency, Federal

Agency, Expert or rendering services under contract to either

Agency type.

# Research Analyst/Consultant (0.5 FTE) Qualifications Match:

Experience Qualification: Nicole has over five years of experience providing managed care policy and operational consulting services to state Medicaid clients, which meets and exceeds the requirement.

Education Qualification: Nicole's educational background includes a Bachelor of Arts, a Juris Doctor, and a Master of Laws, fulfilling the educational requirement.

roposed Key Role	Requirement	Overview of Qualifications

Responsibilities Qualification: Nicole has experience in developing managed care contracts, conducting readiness reviews, and implementing provider reimbursement strategies, all of which align with the responsibilities of a Research Analyst/Consultant.

Summary of Why Nicole is Qualified: Nicole Kaufman's extensive experience in Medicaid policy, strong educational background, and proven ability to negotiate with CMS make her an excellent fit for both the Medicaid Policy SME and Research Analyst/Consultant positions. Her expertise in managed care policy and operational consulting ensures she can effectively fulfill the responsibilities of these roles.

Mercer proposes at least two Lead Actuaries and exceeds qualifications. The Lead Actuary will oversee that

Colby Schaffer, ASA, MAAA

approved SOW are fulfilled as

defined within the SOW.

Experience Qualification: With 18 years of experience specializing in Medicaid capitation rate development, value-based payment methodologies, and health reform modeling, Colby has led comprehensive project teams supporting multi-billion-dollar programs for various states. His previous work with West Virginia as an actuary for BMS from 2012 to 2015 and again from 2017 to 2021 highlights his deep experience in the field. He has developed over two dozen rate certifications

Colby Schaffer,Lead Actuary (1 FTE) The Lead Actuary will overs ASA, MAAA

Stewart Campbell, ASA, MAAA

This position is required to have a minimum of 10 years' experience with Medicaid or Medicaid and CHIP Managed Care rate setting and shall be either an FSA and/or an MAAA.

Medicaid Managed Care Rate Setting/Program Admin

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roposed Key Role taff Name/Title	Requirement	Overview of Qualifications	

submitted to CMS and played a key role in the adoption of expanded benefit provisions under the 1115 Medicaid Substance Use Disorder waiver.

**Professional Credentials Qualification:** Colby is an ASA and an MAAA, fulfilling the necessary credential requirements for the role.

Responsibilities Qualification: In his previous leadership roles, including Chief Actuary for Arizona's Medicaid agency and Interim Chief Financial Officer for the Oklahoma Health Care Authority, Colby has demonstrated his ability to manage complex actuarial projects and effectively communicate with stakeholders. He has also actively volunteered with the SOA and the AAA, contributing to Medicaid committees and leading the SOA's Medicaid public interest group.

Summary of Why Colby is Qualified: Colby Schaeffer's extensive experience in Medicaid capitation rate development, strong professional credentials, and proven project management skills make him an excellent fit for the Lead Actuary position. His ability to navigate complex challenges, engage with stakeholders, and certify capitation rates demonstrates his capability to effectively oversee the responsibilities of this role.

### Stewart Campbell, ASA, MAAA

**Experience Qualification:** Stewart has over 16 years of actuarial experience, including significant

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oposed Key Role	Requirement	Overview of Qualifications

for the AHCCCS further demonstrates his extensive Pennsylvania. His experience as the Lead Actuary as Connecticut, Massachusetts, New Mexico, and support for various state Medicaid programs, such roles in capitation rate development and actuarial sackground in Medicaid. Professional Credentials Qualification: Stewart is an FSA and an MAAA, fulfilling the credential requirement.

team across various actuarial and policy consulting Responsibilities Qualification: In his current role as Lead Actuary for New Mexico, Stewart leads a projects, managing timelines and ensuring deliverables are met as outlined in SOWs.

certify capitation rates, along with his experience in Actuary position. His proven ability to develop and actuarial services, strong professional credentials, Summary of Why Stewart is Qualified: Stewart and current leadership role in managing actuarial stakeholder communication and negotiation with projects make him an excellent fit for the Lead CMS, demonstrates his capability to effectively Campbell's extensive experience in Medicaid oversee the responsibilities of this role.

### Mercer exceeds qualifications.

Experience Qualification: Dave has over 15 years Medicaid programs across more than 20 states. His of actuarial experience, specifically working on

36

Staff Actuary (1 FTE) Dombrowski, ASA, MAAA, CERA Dave

deliverables defined within each The Staff Actuary will assist the Lead Actuary in providing the approved SOW.

	Mercer Proposed hey Stati	ley old!!
Proposed Key Role Staff Name/Title	Requirement	Overview of Qualifications

This position is required to have a minimum of five years' experience with Medicaid or Medicaid and CHIP managed care rate setting or other insurance pricing and shall be either an FSA) and/or an MAAA.

roles have included capitation rate development and pricing for various Medicaid services, clearly exceeding the five-year requirement.

**Professional Credentials Qualification:** Dave is an ASA and an MAAA, fulfilling the credential requirement.

Responsibilities Qualification: In his current role, Dave supports the development of actuarially sound capitation rates and provides technical assistance, which involves collaborating with the Lead Actuary and ensuring deliverables are met as outlined in SOWs.

Summary of Why Dave is Qualified: Dave Dombrowski's extensive experience in Medicaid actuarial services, strong professional credentials, and proven ability to assist in rate-setting and program development make him an excellent fit for the Staff Actuary position. His background in working with multiple state Medicaid programs and his role in developing and certifying capitation rates demonstrate his capability to meet the responsibilities of this role effectively.

# The Staff Actuary will assist the Mercer exceeds qualifications.

Experience Qualification: Garland has 16 years of career experience, including significant actuarial consulting services for state Medicaid clients. His current work involves rate setting and value-based

Garland Chan, Staff Actuary (1 FTE) FSA, MAAA

Lead Actuary in providing the deliverables defined within each approved SOW.

This position is required to have a minimum of five years' experience

Mercer

Proposed Key Role Requirement	Overview of Qualifications
taff Name/Title	

with Medicaid or Medicaid and CHIP managed care rate setting or other insurance pricing and shall be either an FSA and/or an MAAA.

contracting analysis for Puerto Rico, which align with the Medicaid experience requirement.

**Professional Credentials Qualification:** Garland is an FSA and an MAAA, fulfilling the credential requirement.

Responsibilities Qualification: In his current role, Garland supports rate setting and financial analysis for Medicaid programs, which involves collaborating with other actuaries and ensuring deliverables are met as outlined in SOWs.

Summary of Why Garland is Qualified: Garland Chan's extensive experience in Medicaid actuarial consulting, strong professional credentials, and current involvement in rate setting and value-based contracting make him an excellent fit for the Staff Actuary position. His background in supporting Medicaid clients and his role in financial analysis demonstrate his capability to effectively meet the responsibilities of this role.

Dennis Yano brings extensive experience in financial analysis and Medicaid program management to the technical support staff role. As an Associate in Mercer's Government Human Services Consulting practice, he has maintained rate models, conducted financial reviews, and developed reporting tools for states like Massachusetts, New Jersey, and Ohio, contributing to Medicaid Expansion projects and capitation rate

Technical Support Staff

Dennis Yano, BS

Elijah Chesko, MBA

Sandy Amorado, MPH

implementation. Denr	Proposed Key Role Requirement Overview of Qualific Staff Name/Title	Wiercer Proposed Key Statt
plementation. Dennis holds a Bachelor of Science	of Qualifications	

18 years in the industry.

Elijah Chesko is an ideal candidate for the

in Mathematics from Arizona State University and has over 12 years of experience at Mercer, totaling

support in this role. making him well-equipped to deliver valuable development. His ability to work effectively with and Pennsylvania. In his current position, he is experience and strong analytical capabilities in Economics, Elijah possesses a solid educational bachelor's degree in mathematics with a minor in communication skills and collaborative approach non-actuarial support staff highlights his strong managing complex data related to capitation rate multiple states, including Delaware, New Jersey, practice, he has successfully collaborated with Mercer's Government Human Services Consulting Medicaid managed care. As an Associate in Elijah Chesko is an ideal candidate for the foundation that complements his technical expertise With a Master of Business Administration and a responsible for summarizing, validating, and technical support staff role due to his extensive

**Sandy Amorado** is an excellent fit for the technical support staff role due to her strong analytical skills and proactive approach to optimizing Medicaid program efficiency and financial performance. As an Associate in Mercer's Government Human Services Consulting practice, she has been selected to

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support West Virginia by analyzing complex reports, advising executives on cost-saving strategies, and leading projects that deliver impactful solutions within scope and budget. Currently, she is involved with project teams in Nevada and Virginia.

Prior to joining Mercer, Sandy worked at Aledade, Inc., where she utilized her advanced skills in data analysis, communication, and strategic planning. Her experience in leveraging technology and collaborating across functions allowed her to identify improvement opportunities and contribute to the company's strategic direction.

With a Master of Public Health in Health Management and Policy and a Bachelor of Arts in Psychology with a minor in Leadership and Change Management, Sandy combines a solid educational background with practical experience, making her well-prepared to provide valuable support in this role.

### Section 5 Mandatory Requirements (Section 4)

4.1 Mandatory Contract Services Requirements and Deliverables: Contract Services must meet or exceed the mandatory requirements listed below. All managed care program administration requirements are applicable to both the MHT and MHP program. The fixed monthly payment for these services shall be inclusive of completing the defined activities for both programs. Actuarial services shall be provided based on independent Statements of Work (SOW) and shall be reimbursed at the prevailing hourly rate upon the issuance of an approved delivery order. The Vendor may subcontract Actuarial Services only.

### Mandatory Contract Services Requirements and Deliverables

Mercer meets all requirements.

Mercer is committed to meeting and exceeding the mandatory contract services requirements outlined in the solicitation for the Mountain Health Trust (MHT), Mountain Health Promise (MHP), and CHIP programs. Below are our commitments regarding the required services and deliverables:

### **Managed Care Program Administration**

Mercer is prepared to effectively provide the actuarial and consulting services required by the BMS for both Medicaid and the West Virginia Children's Health Insurance Program (WV CHIP) due to our extensive experience and expertise in healthcare management and policy analysis. Our team understands the intricacies of capitation models, Medicaid regulations, and the specific needs of vulnerable populations, allowing us to deliver tailored solutions that align with the state's objectives.

### **Actuarial Services**

Mercer attests that actuarial services will be provided based on independent SOWs that clearly outline the scope of services, deliverables, and timelines. Our experienced actuarial team will ensure all services are delivered in accordance with the requirements specified in the SOW.

These actuarial services will be reimbursed at the prevailing hourly rate upon the issuance of an approved delivery order, ensuring transparency and accountability in our billing practices.

### **Subcontracting of Actuarial Services**

Although Mercer typically provides all actuarial services in-house, we acknowledge the provision that allows for the subcontracting of actuarial services if necessary. Please see the Colby Schaeffer, ASA, MAAA, resume as a subcontractor via Incline.

### 4.1.1 Managed Care Program Administration

### **Comprehensive Program Administration Plan**

### Mercer meets all requirements.

At Mercer, we understand that effective program administration is vital for the successful implementation of Medicaid Managed Care Rate Setting in West Virginia. Our comprehensive program administration plan is designed to ensure all stakeholders — state agencies, MCOs, providers, and community advocates — are actively engaged and informed throughout the process.

We prioritize transparency and clear communication, which are essential for fostering collaboration and trust among all parties involved. Our approach includes regular meetings and timely updates to address any emerging issues, making sure stakeholders are not only informed but also have the opportunity to contribute to the decision-making process.

Our program administration plan encompasses a range of critical activities, including oversight of existing and new managed care waivers, development of quality strategies, and compliance monitoring. By actively involving stakeholders in these processes, we create a responsive Medicaid system that effectively meets the needs of West Virginia's community.

In the following section, we detail our specific qualifications and the requirements we are prepared to meet in our Managed Care Program Administration efforts.

Table 6: Managed Care Program Administration Qualifications

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
4.1.1.1	The State Medicaid Managed Care Programs, both MHT and MHP, 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.	YES	Mercer has over 40 years of experience with Medicaid managed care programs, including those operating under 1915(b) waivers. We will provide ad hoc services at an hourly rate, ensuring compliance with the requirement for an approved SOW and delivery order before commencing work.
4.1.1.2	WVCHIP delivers benefits to members using managed care under the state plan option at section 3.0 which can be found at: WV CHIP State Plan WVCHIP members participate under the MHT umbrella. Administration	YES	Mercer understands the administration and oversight requirements for WV CHIP and has extensive experience managing Medicaid programs, ensuring compliance with state plan options. We are equipped

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	and oversight requirements are the same as Medicaid but there is no associated waiver reporting and WVCHIP is not included in the Medicaid 1915(b) waiver.		to handle the unique needs of WV CHIP under the MHT umbrella.
4.1.1.3	The vendor shall ensure oversight of current and new programs developed and operating under existing managed care waivers, new waivers, or waiver renewals. There are currently two (2) Managed Care Waivers, MHT and MHP	YES	Mercer has a proven record of overseeing managed care programs, including the MHT and MHP waivers. Our team is experienced in managing both existing and new programs, ensuring compliance and effective oversight, and will deliver on this requirement.
4.1.1.4	The vendor shall draft and/or assist with waiver applications and associated quality strategies in addition to a quality strategy for WVCHIP.	YES	Our team has extensive experience in drafting waiver applications and developing quality strategies for Medicaid programs, including WV CHIP. We will assist with these requirements effectively.
4.1.1.5	The vendor shall develop correspondence, including, but not limited to, waiver applications, letters to federal entities, etc. related to waivers or other managed care program needs.	YES	Mercer has a strong background in developing necessary correspondence for Medicaid managed care programs, including waiver applications and communications with federal entities and will deliver on this requirement.
4.1.1.6	The vendor shall conduct analyses of waiver programs and develop recommendations for improving effectiveness and efficiency of waiver programs.	YES	With over 40 years of experience, Mercer is adept at conducting thorough analyses of waiver programs and providing actionable recommendations to enhance their effectiveness and efficiency and will deliver on this requirement.
<b>4.1.1.7</b> Mercer	The vendor shall assist the Agency with activities related to its 1115 Continuum. of Care wavier, including but not limited to, federal reporting requirements and other analyses, as needed,	YES	Mercer has experience working with 1115 waivers and is prepared to assist the Agency with federal reporting requirements and necessary analyses related to MCOs and will deliver on this requirement.

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	which will be administered under the managed care organizations.		
4.1.1.8	The vendor shall provide policy impact analyses and support to the Agency, 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).	YES	Our team is skilled in conducting policy impact analyses and providing comprehensive support to agencies, including document development, programmatic assessments, and strategy implementation, and will deliver on this requirement.
4.1.1.9	The vendor must agree to revise all analyses based on future releases or revisions of information at the state or federal level within a mutually agreed upon timeframe between the vendor and Agency.	YES	Mercer is committed to revising analyses as needed based on updated information from State or federal sources, ensuring timely communication and collaboration with the Agency and will deliver on this requirement.
4.1.1.10	The vendor shall monitor federal regulations and requirements for potential changes and provide analyses on program impact within thirty (30) calendar days of notification.	YES	Our dedicated compliance team continuously monitors federal regulations and is prepared to provide timely analyses of program impacts within the required timeframe and will deliver on this requirement.
4.1.1.11	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, including CMS submissions.	YES	Mercer will develop a comprehensive Operations Plan within the specified timeframe, ensuring compliance with all program requirements and CMS submissions and will deliver on this requirement.
4.1.1.12	The vendor shall develop and maintain the MCO contracts associated with both MHT and MHP in compliance with CMS. The vendor shall seek contract updates from the MCOs and BMS	YES	We have extensive experience in developing and maintaining MCO contracts, ensuring compliance with CMS regulations and timely updates

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	120 calendar days prior to contract implementation date.		from MCOs and BMS and will deliver on this requirement.
4.1.1.13	The vendor shall conduct annual network adequacy assessments to be completed by October 1st every year for both MHT and MHP, with the approach approved in writing by the Agency. The vendor shall host a network adequacy kickoff meeting 30 calendar days prior to implementation of the network adequacy assessment. The vendor must outline the expected process for the assessment to be completed.	YES	Mercer is experienced in conducting annual network adequacy assessments and will ensure our approach is approved by the Agency, including hosting kickoff meetings and outlining the assessment process and will deliver on this requirement.
4.1.1.14	The vendor shall analyze and monitor Managed Care contract performance by conducting program readiness documentation and desk reviews. This includes assessing new entrance initial go-live readiness, reviewing MCO operations, and evaluating new populations added to managed care. Ongoing reviews of the four (4) existing MCOs will also be performed as needed to ensure programmatic compliance. Readiness reviews for any new MCO entering the market must be completed within 4 (four) months. After the readiness review is completed, a detailed findings report, and the completion of the CMS readiness review tool must be submitted within 30 calendar days.	YES	Our team is well-equipped and will analyze and monitor Managed Care contract performance, conducting thorough readiness reviews and submitting detailed findings reports in compliance with CMS requirements.
4.1.1.15	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	YES	Mercer will develop comprehensive annual reports on MCO performance, addressing all required elements and ensuring timely submission within the specified timeframe.

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	end of the state fiscal year, which is June 30th. 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, program integrity, improvement strategies implemented, program goals, and other information as requested by the Agency, at no additional cost to the Agency.		
4.1.1.16	The vendor shall perform analyses and conduct ongoing monitoring of MCO provider networks and conduct quarterly analyses of the MCOs' networks against program requirements.	YES	Our team is experienced and will perform ongoing monitoring and analyses of MCO provider networks, ensuring compliance with program requirements through quarterly assessments.
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 ten (10) calendar days of request, unless otherwise noted.	YES	Mercer will develop MCO-specific reports and maps, ensuring timely submission of information within the required timeframe.
4.1.1.18	The vendor shall work with the Agency to develop a comprehensive reporting calendar for the MHT and MHP programs that comply with federal, state, and agency-specific reporting requirements as defined by the managed care contracts. The current authorities can be accessed at: medicaid.gov. WV State Code Chapter 9: https://code.wvlegi slature.gov/9/	YES	We will collaborate with the Agency to create a comprehensive reporting calendar that aligns with all federal, State, and Agency-specific requirements. Our experience in managing reporting obligations ensures we can effectively coordinate and meet all deadlines.
4.1.1.19	The vendor must identify and comply with all federal and state Medicaid and WV CHIP laws, regulations, and policies, as	YES	Mercer is committed to identifying and complying with all relevant federal and State Medicaid and WV CHIP laws

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	outlined by the CMS and the BMS, which can be accessed at: medicaid.gov, dhhr.wv.gov		and regulations. Our compliance team will continuously monitor changes in regulations to ensure our practices align with CMS and BMS guidelines.
4.1.1.20	The vendor shall analyze Early Periodic Screening, Diagnosis, and Treatment (EPSDT) service provisions and track MCO contract compliance on a quarterly basis. The vendor will prepare federal and state reports on methods to improve efficiency, effectiveness, coordination and quality of those services in West Virginia as needed. The reports will be submitted in an agreed upon format and submission standard between the vendor and the Agency. Separate analysis and reporting for Medicaid and WV CHIP may be necessary.	YES	Our team has extensive experience analyzing EPSDT service provisions and tracking MCO compliance. We will prepare detailed reports that focus on improving service efficiency and quality, ensuring timely submission in the agreed-upon format.
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. These ad-hoc reports and associated timelines will be based on an approved SOW.		Mercer will provide ad hoc reports as requested, ensuring we deliver timely and relevant information based on approved SOWs. Our analytical capabilities allow us to conduct thorough comparisons and provide insights that enhance the Managed Care program's efficiency and quality.
4.1.1.22	The vendor must provide an analysis dashboard with access for ten (10) state users for use in identifying medical service utilization patterns by category o service and medical and administrative cost profiles for al Managed Care cohorts, major lines of business, and individual Managed Care members to	f	We will develop an analysis dashboard that meets the specified requirements, providing access for State users to track service utilization patterns and cost profiles effectively. This tool will enhance the Agency's ability to monitor and improve the quality of care provided to members.

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	improve quality of care and outreach.		
4.1.1.23	The vendor must provide all data, program and regulatory analyses required to respond to Legislative, Federal, State, Budgetary, Provider, Advocacy, or other requests in a timeframe that is mutually agreed upon by vendor and agency.	YES	Mercer will provide all necessary data and analyses to respond to various requests, ensuring timely delivery based on mutually agreed-upon timelines. Our team is experienced in managing diverse requests and can adapt to the Agency's needs efficiently.
4.1.1.24	The vendor must submit within thirty (30) calendar days of award a plan to be approved by the Agency for MCO contracting, including but not limited to options for performance targets, incentives and penalties, modifications to program requirements, implementation and oversight of a Managed Care Medical Loss Ratio (MLR). Separate MLRs for Medicaid and WVCHIP will be necessary. The vendor must also address any additional requests from the Agency at no additional cost to the Agency.	YES	We will develop and submit a comprehensive MCO contracting plan within the required timeframe, addressing all necessary components, including performance targets and MLR implementation. Our commitment to addressing additional requests at no extra cost demonstrates our dedication to supporting the Agency's objectives.
4.1.1.25	The vendor shall develop a comprehensive quality assessment and performance improvement strategy, that align with federal regulations, including the Quality Improvement Systems for Managed Care (QISMC) medicaid.gov, CMS standards, and other relevant quality review programs. This strategy shall integrate input from enrollees and advocates. Annually, the vendor shall update the QISMC in	•	Mercer will develop a comprehensive quality assessment and performance improvement strategy that aligns with federal regulations and incorporates input from stakeholders. We will conduct annual evaluations and updates to the strategy, ensuring ongoing collaboration with the Agency and relevant partners to monitor and enhance the quality of care provided.

collaboration with Agency Quality

and Managed Care staff.
Collaborator engagement will

include Managed Care

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	organizations agency or other collaborators. Agency will work with these collaborators to identify options and recommendations for monitoring and evaluating the quality and appropriateness of care and service provided to enrollees. The vendor will conduct an annual evaluation of the Managed Care Quality Strategy utilizing the CMS toolkit as guidance. At the end of the three (3)-year Quality Strategy the vendor will craft an evaluation covering the entire Quality Strategy per CMS guidance and toolkit. medicaid.gov		
4.1.1.26	The vendor shall be available within one (1) business day for a virtual meeting or five (5) business days to meet in person with the Agency's Managed Care entities, provider groups, and other parties as determined necessary by the Agency, at a location to be determined based on space availability, at no additional cost to the Agency.	YES	Our team is committed to being available for meetings within the specified timeframes, ensuring effective communication and collaboration with the Agency and relevant stakeholders. We prioritize responsiveness and flexibility to accommodate the Agency's needs.
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.	YES	Mercer has extensive experience in assisting with program expansions, including developing comprehensive documentation that addresses all relevant considerations and requirements. We will work closely with the Agency to identify viable options and facilitate the implementation process.
4.1.1.28	The vendor shall assist with the development of reports for WV House Bill 4217, which can be found at: legis.state.wv.us	YES	Our team will assist with the development of reports related to WV House Bill 4217, ensuring compliance with all requirements and timelines. We will leverage

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
			our expertise to provide accurate and insightful reports that meet the Agency's needs.
4.1.1.29	The vendor shall be responsible for collecting all required reports of the MCOs, reviewing reporting for any errors or omissions, generating reports for the Agency 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. The vendor will conduct an individual MCO meeting once a month to review and discuss results from submitted reports including but not limited to the Cash Disbursement Journal, EPSDT results, and dashboard results. Separate Medicaid & WVCHIP reporting is necessary.	YES	Mercer will manage the collection and review of MCO reports, ensuring accuracy and compliance. We will maintain a tracking log of submissions and conduct monthly meetings to discuss findings and results with the Agency, facilitating transparency and accountability in MCO contract compliance.

YES

- 4.1.1.30 The vendor shall provide an electronic tool compatible with Agency Systems, which are currently Microsoft Windows 10 or equal Microsoft 365 or equal, or Google Workspace or Equal that serves as a program compliance dashboard that will allow the Agency to track at a minimum, but to be refined by the Agency:
  - 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

Mercer will provide a compatible electronic tool that serves as a program compliance dashboard, ensuring it meets all specified requirements. Our platform will allow for configurable settings to meet the Agency's needs and will support up to 10 users. We will also provide necessary training and support for MLR Audits, Incurred but not Reported (IBNR), and risk adjustment activities, ensuring effective communication and collaboration with MCOs.

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	<ul> <li>Network adequacy documents and readiness review materials</li> <li>Grievances and Appeals</li> <li>Vendor shall provide</li> <li>MCO-related training to staff and maintain a training manual for reference.</li> <li>Platform must be hosted by the vendor and allow access for up to ten (10) users at any time.</li> <li>Settings must be configurable to meet agency needs. The current agency operating system is</li> <li>Windows 10. For teleconference capabilities, the Agency currently uses Google Workspace.</li> </ul>		
4.1.1.31	The vendor shall support Program Integrity strategic planning, oversight, and coordination activities with the MCOs in collaboration with the West Virginia Program Integrity (PI) Director and Program	YES	Mercer is experienced in supporting PI activities and will collaborate with the West Virginia PI Director and Unit to ensure effective oversight and compliance with all requirements. Our team will

• Program Management Support Services

Integrity Unit. These activities

- Support BMS PI with coordination of PI activities across multiple workstreams
- PI process improvement
- Operational Support

shall include:

- Conduct a comprehensive PI risk assessment
- · Work with MCOs on validation of claims, identification of errors and policy recommendations
- Medicaid Managed Care **Program Integrity**
- Review MCO compliance plans
- · Audit claims paid to network providers

requirements. Our team will provide program management support, conduct risk assessments, and facilitate training sessions to enhance the effectiveness of PI initiatives.

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	<ul> <li>Review referrals made to BMS PI or the Medicaid Fraud Control Unit (MFCU)</li> </ul>		
	<ul> <li>Participate in internal meetings and BMS-led meetings with the MCOs and/or MFCU</li> </ul>		
	• The vendor will facilitate in collaboration with OPI the annual MCO Compliance Plan training. The training will be held on a mutually agreed upon date in November of each year.		

### 4.1.2 Actuarial Services

### **Comprehensive Approach to Medicaid Capitation Rate Development**

Since 1985, Mercer has been at the forefront of Medicaid and CHIP actuarial consulting, specializing in the development and certification of capitation rates for over 20 Medicaid programs. Our commitment to tailored methodologies ensures we meet actuarial soundness standards while addressing the unique needs of West Virginia.

### Mercer meets and/or exceeds all compliance with Key Requirements.

Table 7: Actuarial Services Experience/Qualifications

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
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 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. The vendor will host a MCO rate setting kick off meeting prior to implementation of activities to outline the process of rate development with the MCOs and	YES	Mercer has extensive experience in developing and certifying capitation rates for Medicaid managed care programs. We utilize readily available state data to set rates by various cohorts, ensuring all relevant factors are considered. We will host a kick-off meeting with MCOs to outline the rate development process and maintain ongoing communication throughout the rate-setting activities to ensure transparency and collaboration.

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	will conduct meetings throughout the rate setting process with the MCOs.		
4.1.2.2	Vendor shall develop high, mid, and low capitation rate ranges for review.	YES	Our actuarial team is skilled in developing comprehensive capitation rate ranges, including high, mid, and low estimates. We will ensure these ranges are based on thorough analyses of available data and are presented for review in a clear and understandable format.
4.1.2.3	Vendor must develop Managed Care rates at the individual MCO level, if the Agency chooses to develop MCO-specific rates based on risk stratification.	YES	Mercer will develop MCO-specific rates based on risk stratification as requested by the Agency. Our team has experience in tailoring rates to individual MCOs, ensuring they reflect the unique characteristics and risk profiles of each organization.
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 Agency staff for meetings.	YES	We will actively participate in rate-setting discussions and providing comprehensive support throughout the process. Our team will prepare all necessary documentation, including presentations and rate workbooks, to facilitate informed decision-making during meetings with Agency staff.
4.1.2.5	Vendor shall work collaboratively with Agency 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 Agency deems necessary. It is the expectation of the Agency that the vendor shall	YES	Mercer values collaboration and will work closely with Agency staff to enhance the accuracy and efficiency of data sources and methodologies used in rate development. We will attend all necessary meetings and provide innovative ideas to improve the rate-setting process. Our team will facilitate direct communication between our actuaries and the Agency to ensure seamless collaboration.

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	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 Agency. The frequency shall be on an as-requested basis. The location of the meetings will be determined by the Agency and whether they will be held in-person or virtually.		
4.1.2.6	Vendor shall provide the Agency with reports and calculations in the formats specified by the Agency, including all formulae, databases, data sets, and other documents as requested on an as needed basis in an agreed-upon standard format compliant to the data being requested.	YES	We will provide all reports and calculations in the formats specified by the Agency. Our team will ensure all necessary documentation, including formulae and data sets, is delivered in a compliant and agreed-upon standard format, facilitating ease of use and analysis by the Agency.
4.1.2.7	The vendor shall assist the Agency in identifying where rate uniformity can occur to ensure payments are made consistently across all agencies by conducting a rate uniformity workgroup and analysis of all rates currently administered in a schedule to be coordinated between the vendor and Agency. The analysis shall identify inconsistencies and recommendations to the Agency for improving its rate setting process and helping align areas that are not in uniformity.	YES	Mercer will conduct a thorough analysis of existing rates to identify opportunities for rate uniformity. We will facilitate a workgroup to discuss findings and provide recommendations to the Agency, ensuring payments are consistent across all agencies and enhancing the overall rate-setting process.
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	YES	Our actuarial team will regularly update capitation rates based on the latest data, pricing trends, and regulatory changes. We will ensure all amendments are certified and documented, maintaining compliance with the

CRFQ Section		Meets/ Exceeds Req.	Experience/Qualification
	a minimum of one time per fiscal year.		requirement to update rates at least once per fiscal year.
4.1.2.9	The vendor shall develop a transition plan for Agency approval that must be submitted to the Agency ninety (90) days in advance of the contract end date. The vendor must complete transition activities to transition all data, methodologies, documentation, and ongoing projects to the next succeeding vendor, at least sixty (60) calendar days in advance of the contract end date.	YES	Mercer will develop a comprehensive transition plan to ensure a smooth handover of all data, methodologies, and documentation to the succeeding vendor. We will submit this plan for Agency approval 90 days before the contract end date and complete all transition activities at least 60 days in advance, ensuring continuity of services.
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 Agency for review on an ad hoc basis in a format agreed upon between the vendor and Agency.	YES	Mercer will work closely with the State's fiscal agent to ensure that accurate encounter claims and eligibility data are utilized in the rate-setting process. We will conduct thorough reviews of encounter data for completeness and identify any inconsistencies, providing summary reports to the Agency as needed.
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 Agency.		Our team is experienced in collaborating with fiscal agents to ensure all reports used for state and federal reporting are complete and accurate. We will work diligently to meet the Agency's requests and ensure compliance with all reporting requirements.
	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.	; ;	Mercer has the expertise to gather, process, validate, and analyze managed care encounter and claims data, including carved-out services. We will provide technical assistance to MCOs on

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
			data-related issues, ensuring all data is accurate and effectively utilized in the rate-setting process.
4.1.2.13	The vendor shall develop methodologies for calculating Directed Payment Program amounts or other supplemental payments, and the associated preprints and quality strategies for such programs.	YES	Our actuarial team is skilled in developing methodologies for calculating Directed Payment Program (DPP) amounts and other supplemental payments. We will ensure all associated preprints and quality strategies are aligned with regulatory requirements and best practices.
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.	YES	Mercer is experienced in performing actuarial analyses and valuations related to programmatic changes. We will assess the costs and savings associated with transitioning populations from FFS to managed care, providing the Agency with valuable insights to inform decision-making.
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. The vendor must produce a quarterly report on expected total program revenues and expenditures for WV CHIP that covers the current fiscal year plus six (6) future years. The projections should consider pricing and enrollment trends plus any impacts expected from federal or state laws or regulations. Estimates for IBNR should be updated on each report. WVCHIP uses these reports to monitor program fiscal stability and prepare requests for additional federal or state funding.	YES	We are committed to transparency in our billing practices and will provide detailed billing reports with each invoice for actuarial services. These reports will outline hours billed per staffing position and staff member, ensuring clarity and accountability.

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
4.1.2.16	The vendor must annually provide assurance to the director, by letter, that all program and administrative costs, including IBNR, do not exceed 90 (ninety) percent of the funding available to the program for the applicable fiscal year.	YES	Mercer confirms that we will annually provide assurance to the director, by letter, that all program and administrative costs, including IBNR expenses, do not exceed 90% of the funding available to the program for the applicable fiscal year. This commitment ensures compliance with the specified RFQ requirement and supports our dedication to financial accountability and transparency.

# 4.1.3 Financial Services

Mercer is well-prepared to deliver a comprehensive suite of financial services tailored to the needs of Medicaid managed care programs. Our extensive experience encompasses a wide range of financial activities, including MLR template review and audit, rate studies, reimbursement support, and legislative planning. We are adept at ensuring compliance with both federal and state regulations while providing accurate financial projections and analyses. Our team is equipped to assist in the development of payment methodologies for various programs, oversee provider rate development, and support the ongoing implementation of waiver programs. With a commitment to excellence and a data-driven approach, Mercer stands ready to be a reliable partner for the Agency in achieving its financial objectives.

## Mercer meets and/or exceeds all compliance with Key Requirements.

Table 8: Financial Services Experience/Qualifications

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
4.1.3.1	The vendor shall provide financial services which will include but not be limited to MLR template review and audit, rate studies and reimbursement support, legislative planning and support, budget support, financial projections and analysis, federal and state reporting support, implementation support for all federal and state projects and rules, Directed Payment Program	YES	Mercer has extensive experience in providing comprehensive financial services to Medicaid managed care programs. Our team is skilled in MLR template review and audit, conducting rate studies, and offering reimbursement support. We have a strong background in legislative planning and budget support, ensuring compliance

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	(DPP) calculations and support, provider payment reviews, MCO tax settlement calculations, waiver support, and audit support, including IBNR calculations		with federal and state regulations. Our financial projections and analyses are data-driven, allowing us to provide accurate insights for decision-making. We also have expertise in implementing federal and state projects, including DPP calculations, provider payment reviews, and MCO tax settlement calculations. Our experience with waiver support and audit processes, including IBNR calculations, positions us as a reliable partner for the Agency.
4.1.3.2	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.	YES	Our team is well-versed in the implications of the ACA and other relevant federal and State regulations. We have a proven track record of analyzing payment accuracy and reimbursements, ensuring compliance with all applicable laws and codes. Our analytical capabilities allow us to identify discrepancies and recommend corrective actions to enhance the accuracy of payments and reimbursements.
4.1.3.3	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.	YES	Mercer has significant experience in developing payment methodologies for various programs, including long-term care, nursing home services, and Home and Community Based Services waivers. Our actuarial team utilizes best practices and data analysis to create methodologies that are equitable, sustainable, and compliant with regulatory requirements. We work collaboratively with stakeholders to ensure the methodologies

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
			meet the needs of the populations served.
4.1.3.4	The vendor shall assist with all facets of the provider rate development and implementation process.	YES	Our team is equipped to assist with every aspect of the provider rate development and implementation process. We have experience conducting thorough analyses to inform rate-setting, collaborating with stakeholders to ensure transparency, and providing ongoing support during the implementation phase. Our approach ensures rates are fair, competitive, and aligned with program goals.
4.1.3.5	The vendor shall assist in overseeing the ongoing implementation, support, federal and state reporting, and financial projections of all relevant waiver programs.	YES	Mercer is committed to overseeing the ongoing implementation and support of waiver programs. We provide comprehensive assistance with federal and state reporting requirements, ensuring all submissions are accurate and timely. Our financial projections are based on robust data analysis, allowing us to support the Agency in monitoring the financial health of waiver programs and making informed decisions for future planning.
4.1.3.6	The Vendor shall provide support for items including, but not limited to, MLR Audits, IBNR, and risk adjustment. The vendor shall host a kickoff meeting with the MCOs prior to implementation of MLR Audit activities, IBNR and risk adjustment activities to communicate expectations to the MCO  Note: The state has confirmed in their Addendum No. 2 response that CRFQ Section 4.1.1.30, Bullet		Mercer will provide a compatible electronic tool that serves as a program compliance dashboard, ensuring it meets all specified requirements. Our platform will allow for configurable settings to meet the Agency's needs and will support up to 10 users. We will also provide necessary training and support for MLR Audits, IBNR, and risk adjustment activities, ensuring effective communication and collaboration with MCOs.

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	Point 9 has been amended to		

Point 9 has been amended to CRFQ Section/Location Financial Services 4.1.3, Section 4.1.3.6.

# 4.1.4 Ad Hoc Services

Mercer is fully prepared to provide a range of ad hoc services that cater to the specific needs of the Agency. Our team is well-equipped to deliver additional consultation and actuarial services, ensuring high-quality support tailored to various requests. With fixed hourly rates for both programmatic and actuarial services, Mercer offers competitive pricing that allows the Agency to budget effectively. Our experience extends across multiple divisions of the BMS, and we are committed to conducting research and recommending best practices in key areas such as chronic care management and quality improvement. Additionally, our expertise in overseeing the implementation of relevant waivers positions us as a reliable partner for the Agency in achieving its goals.

# Mercer meets and/or exceeds all compliance with Key Requirements.

Table 9: Ad Hoc Services Experience/Qualifications

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
4.1.4.1	The vendor must provide the Agency with additional consultation and actuarial services and complete other work as requested.	YES	Mercer is well-equipped to provide additional consultation and actuarial services as needed by the Agency. Our team of experienced actuaries and consultants is adept at addressing a wide range of requests, ensuring that we can deliver high-quality support tailored to the Agency's specific needs. We have a history of successfully completing various ad hoc projects, demonstrating our flexibility and responsiveness.
	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 Agency.	YES	We are committed to providing a comprehensive SOW for each ad hoc request. Our SOWs will detail the number of project hours, the resources allocated, and the associated costs, ensuring transparency and clarity for the Agency. This structured

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
			approach allows for effective planning and management of each project.
4.1.4.3	The vendor shall provide a fixed hourly rate for programmatic services and a fixed hourly rate for actuarial services.	YES	Mercer will provide fixed hourly rates for both programmatic and actuarial services, ensuring the Agency has clear and predictable pricing for our services. Our rates are competitive and reflect the high quality of expertise and support we offer, allowing the Agency to budget effectively for ad hoc services.
4.1.4.4	The vendor shall assist with programmatic activities needed within other divisions of BMS outside of the Managed Care Unit	YES	Our team is prepared to assist with programmatic activities across various divisions of the BMS, beyond just the Managed Care Unit. We have experience collaborating with multiple divisions, ensuring our support is aligned with the overall goals of BMS and contributes to the effective delivery of services.
4.1.4.5	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.	YES	Mercer has a strong background in conducting research and providing recommendations in critical areas such as chronic care management, pharmacy, eligibility and coverage, and quality improvement. Our team utilizes evidence-based practices and data analysis to inform our recommendations, ensuring they are relevant and actionable. We are also open to exploring additional areas as requested by the Agency.
4.1.4.6	The vendor shall assist in overseeing the ongoing implementation of the State's Children with Serious Emotional Disorder (CSED) 1915( c) waiver, including those under the Mountain Health Promise	YES	Our team is experienced in overseeing the implementation of various waivers, including the CSED 1915(c) waiver and the MHP program. We will provide comprehensive support to ensure these programs are implemented

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	program and any other relevant waivers.		effectively, meeting all regulatory requirements and addressing the needs of the populations served. Our experience in waiver management positions us as a valuable partner for the Agency in this area.

# **4.1.5 Service Level Agreement**

We understand the critical role these agreements play in ensuring accountability and performance standards, and we are dedicated to meeting or exceeding the expectations set forth. Our extensive experience in rate-setting functions guarantees the timely delivery of actuarially sound rates, supported by a robust tracking system for regular performance reviews.

We acknowledge the Agency's right to review and approve the hiring of key staff, and we are committed to maintaining open communication regarding staffing decisions. Mercer will also provide a comprehensive conflict mitigation plan to address any potential conflicts of interest, ensuring transparency and integrity throughout the contract term. Our protocols for monitoring staff performance and ongoing training will ensure all team members adhere to their designated roles and responsibilities. Additionally, we confirm our compliance with the requirement to avoid any conflicting contracts with MCOs in West Virginia. By demonstrating our capacity to meet CMS reporting requirements, including certifications from multiple states, Mercer positions itself as a reliable partner in supporting the Agency's objectives and the successful implementation of Medicaid programs in West Virginia.

# Mercer meets and/or exceeds all compliance with Key Requirements.

Table 10: Service Level Agreement Experience/Qualifications

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
4.1.5.1	The vendor shall agree to be bound to all service level agreements as defined within Attachment 3: Exhibit B Service Level Agreements.	YES	Mercer is committed to adhering to all service level agreements (SLAs) outlined in Attachment 3: Exhibit B. We recognize the importance of these agreements for accountability and performance standards and are dedicated to meeting or exceeding expectations. Our extensive experience in rate-setting functions ensures timely delivery of actuarially sound rates. We will implement a robust tracking

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
			system for regular performance reviews, allowing us to assess SLA adherence and identify areas for improvement. Additionally, we will provide comprehensive documentation to ensure transparency and accountability. By maintaining open communication and engaging with stakeholders, we aim to foster collaboration that supports the successful implementation of Medicaid programs in West Virginia.

## 4.1.6 All Services

Mercer is dedicated to fulfilling the requirements in Section 4.1.6 of the CRFQ. We prioritize open communication with the Agency about staffing decisions and are ready to address any concerns that arise. Our conflict mitigation plan will ensure we handle any potential issues effectively. We also guarantee that our team will stay focused on their roles, and we have no conflicting contracts with MCOs in West Virginia. Additionally, we will provide the necessary documentation to demonstrate our ability to meet CMS reporting requirements.

### Mercer meets and/or exceeds all compliance with Key Requirements.

Table 11: All Services Experience/Qualifications

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
4.1.6.1	The vendor agrees that the Agency 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.	YES	We acknowledge the Agency's right to review and approve the hiring of key staff. Mercer is committed to maintaining open communication with the Agency regarding staffing decisions and will promptly address any concerns regarding qualifications or performance by providing suitable replacement staff as needed.
4.1.6.2	The vendor shall submit, along with their bid, a conflict mitigation plan applicable to the prime vendor and subcontractor	YES	Mercer submits a conflict mitigation plan with our bid, outlining our approach to identifying, addressing, and

CRFQ Section	WV CRFQ Requirement	Meets/ Exceeds Req.	Experience/Qualification
	for Actuarial Services. This plan must detail the vendor's approach to identifying, addressing, and mitigate any conflicts of interest that may arise during the term of the contract.		mitigating potential conflicts of interest in Appendix C. Mercer has not identified any actual or perceived conflicts in West Virginia.
4.1.6.3	The vendor must ensure that all staff performing work under this contract adhere to their designated roles and responsibilities throughout the duration of the contract.	YES	We are committed to ensuring that all staff assigned to this contract adhere strictly to their designated roles and responsibilities. Mercer has established protocols for monitoring staff performance and providing ongoing training to ensure all team members are equipped to fulfill their duties effectively.
4.1.6.4	The Prime Vendor shall not, within a five (5) year period before or at any time during the duration of the contract, hold contract(s) with any managed care organization, provider, provider group, or provider association doing business for any service related to this contract in the State of West Virginia or whose parent organization does business in the State of West Virginia.	YES	Mercer confirms that we do not hold any contracts with MCOs, providers, provider groups, or provider associations that would conflict with this requirement. We maintain strict compliance with this provision to ensure our work remains unbiased and focused on the Agency's needs.
4.1.6.5	The Vendor must demonstrate capacity to meet CMS reporting requirements by submitting with bid a minimum of two (2) certifications from at least two (2) different states submitted to CMS meeting the ninety (90) day submission guideline in the last two (2) years.	YES	Mercer provides documentation of our capacity to meet CMS reporting requirements, including at least two certifications from different states that demonstrate compliance with the 90-day submission guideline within the last two years. Our experience in meeting CMS requirements positions us well to fulfill the reporting obligations of this contract.

# Section 6 Contract Award

5.1 Contract Award: The Contract is intended to provide Agency with a purchase price for the Contract Services. The Contract shall be awarded to the Vendor that provides the Contract Services meeting the required specifications for the lowest overall total cost as shown on the Pricing Pages.

# Commitment to Competitive Pricing and Quality Contract Services

Mercer acknowledges the intent of the Contract to provide the Agency with a purchase price for the Contract Services. We understand that the award will be granted to the Vendor that meets the required specifications while offering the lowest overall total cost as indicated on the Pricing Pages.

Mercer is committed to delivering high-quality Contract Services that align with the specifications outlined in the CRFQ. We have carefully reviewed the requirements and have structured our pricing to ensure competitiveness while maintaining the integrity and quality of our services. Our pricing reflects our extensive experience and expertise, and the value we bring to the Agency.

We are confident that our proposal will meet the Agency's needs effectively and efficiently, and we look forward to the opportunity to work collaboratively with the Agency to achieve its goals. Should there be any further clarifications or discussions needed regarding our pricing or services, we are readily available to engage in those conversations. Thank you for considering our proposal.

5.2 Pricing Page: Vendor should follow the instructions for Pricing (Exhibit A) Vendor should complete the Pricing Page by providing a separate fixed yearly cost for all Managed Care Oversight and Financial Service activities; an hourly rate for each actuarial staffing level for those activities under the Actuarial Services header; and an hourly program oversight rate and hourly actuarial services rate for services rendered under the ad hoc category; an hourly rate for clerical support staff and an hourly rate for technical support staff (non-actuary). Estimated hours are for bid purposes only. Vendor should complete the Pricing Page in full as failure to complete the Pricing Page in its entirety may result in Vendor's bid being disqualified. Vendor should type or electronically enter the information into the Pricing Pages through wvOASIS, if available, or as an electronic document.

We have included our Price Quote via the wvOASIS portal. Our pricing has been entered electronically and has been uploaded as a separate electronic document.

# Section 7 Additional Information

6. Performance: Vendor and Agency shall agree upon a schedule for performance of Contract Services and Contract Services Deliverables, unless such a schedule is already included herein by Agency. In the event that this Contract is designated as an open-end contract, Vendor shall perform in accordance with the release orders that may be issued against this Contract.

# **Commitment to Collaborative Scheduling and Timely Delivery of Services**

Mercer acknowledges the importance of establishing a clear and mutually agreed-upon schedule for the performance of Contract Services and Contract Services Deliverables. We are committed to collaborating closely with the Agency to develop a performance schedule that meets the needs of both parties, and we will adhere to any timelines already included in the contract documentation. In the event that this Contract is designated as an open-end contract, we are prepared to perform in accordance with any release orders issued against it.

Our team is flexible and responsive, ensuring that we can accommodate the Agency's needs as they arise and deliver services in a timely manner. We value open communication and will work diligently to ensure that all deliverables are met according to the agreed-upon schedule, and should any changes or adjustments be necessary during the contract term, we are committed to discussing these proactively with the Agency to maintain alignment and ensure successful outcomes.

7. Payment: Agency shall pay a combination of a fixed monthly rate per MCO for managed care program management services, a fixed annual rate for Financial Services, an hourly rate for actuarial services, and an hourly rate for Ad Hoc Services as shown on the Pricing Pages, for all Contract Services performed and accepted under this Contract. Vendor shall accept payment in accordance with the payment procedures of the State of West Virginia.

# **Agreement to Payment Structure and Invoicing Procedures**

Mercer acknowledges and agrees to the payment structure outlined by the Agency, which includes a combination of a fixed monthly rate per MCO for managed care program management services, a fixed annual rate for Financial Services, an hourly rate for actuarial services, and an hourly rate for Ad Hoc Services as specified on the Pricing Pages. We understand that these rates will apply to all Contract Services performed and accepted under this Contract. Additionally, Mercer is committed to accepting payment in accordance with the payment procedures established by the State. We appreciate the clarity provided in this payment structure and are prepared to ensure our invoicing aligns with the Agency's requirements, facilitating a smooth and efficient payment process throughout the duration of the contract.

8. Travel: Vendor shall be responsible for all mileage and travel costs, including travel time, associated with performance of this Contract. Any anticipated mileage or travel costs may be included in the flat fee or hourly rate listed on Vendor's bid, but such costs will not be paid by the Agency separately.

# Responsibility for Travel Costs and Mileage

Mercer acknowledges that we will be responsible for all mileage and travel costs, including travel time, associated with the performance of this Contract. We understand that any anticipated mileage or travel costs may be incorporated into the flat fee or hourly rates provided in our bid, and we agree that these costs will not be reimbursed separately by the Agency. Our pricing structure will reflect a comprehensive approach that includes all necessary travel expenses, ensuring transparency and clarity in our proposal.

- 9. Performance of Contract Services may require access cards and/or keys to gain entrance to Agency's facilities. In the event that access cards and/or keys are required:
  - 9.1. Vendor must identify principal service personnel which will be issued access cards and/or keys to perform service.
  - 9.2. Vendor will be responsible for controlling cards and keys and will pay replacement fee, if the cards or keys become lost or stolen.
  - 9.3. Vendor shall notify Agency immediately of any lost, stolen, or missing card or key.
  - 9.4. Anyone performing under this Contract will be subject to Agency's security protocol and procedures.
  - 9.5. Vendor shall inform all staff of Agency's security protocol and procedures.

# **Compliance with Access and Security Protocols**

Mercer acknowledges and agrees to comply with all requirements outlined in 9.1–9.5 regarding access cards and keys necessary for the performance of Contract Services at the Agency's facilities. We will identify principal service personnel who will be issued access cards and/or keys to ensure that our team can perform services effectively. Mercer will take full responsibility for controlling these access cards and keys, including the payment of any replacement fees in the event that they are lost or stolen.

We understand the importance of security and will notify the Agency immediately if any access card or key is lost, stolen, or missing. Furthermore, we recognize that all personnel performing under this Contract will be subject to the Agency's security protocols and procedures, and we will ensure all staff members are informed and trained on these protocols to maintain compliance and security. We appreciate the Agency's commitment to safety and security and are dedicated to adhering to these requirements throughout the duration of the Contract.

#### 10. Vendor Default:

- 10.1. The following shall be considered a vendor default under this Contract.
  - 10.1.1. Failure to perform Contract Services in accordance with the requirements contained herein.
  - 10.1.2. Failure to comply with other specifications and requirements contained herein.
  - 10.1.3. Failure to comply with any laws, rules, and ordinances applicable to the Contract Services provided under this Contract.
  - 10.1.4. Failure to remedy deficient performance upon request.

# **Compliance and Understanding Statement**

Mercer acknowledges and fully understands the conditions outlined in Section 10 regarding Vendor Default under this Contract. We recognize that the following actions will be considered a vendor default:

- Failure to Perform Contract Services: We are committed to delivering all Contract Services in accordance with the specified requirements and standards outlined in the Contract
- Failure to Comply with Specifications: We understand the importance of adhering to all specifications and requirements contained within the Contract, and we will ensure our services align with these expectations.
- Compliance with Laws: Mercer is dedicated to complying with all applicable laws, rules, and ordinances related to the Contract Services provided. We will maintain awareness of relevant regulations and ensure that our operations are fully compliant.
- Remedying Deficient Performance: We acknowledge our responsibility to address and remedy any performance deficiencies promptly upon request from the Agency. We are committed to maintaining open lines of communication and will take immediate action to resolve any issues that may arise.

By understanding these conditions, Mercer reaffirms our commitment to fulfilling our obligations under this Contract and ensuring that we meet the Agency's expectations for performance and compliance.

- 10.2. The following remedies shall be available to Agency upon default.
  - 10.2.1. Immediate cancellation of the Contract.
  - 10.2.2. Immediate cancellation of one or more release orders issued under this Contract.
  - 10.2.3. Any other remedies available in law or equity.

# **Compliance and Understanding Statement**

Mercer acknowledges the remedies available to the Agency as outlined in Section 10.2 in the event of a vendor default. We understand that the Agency reserves the right to take the following actions:

- Immediate Cancellation of the Contract: We recognize that the Agency may choose to cancel the entire Contract if a default occurs. We are committed to performing our obligations diligently to avoid such a situation.
- Immediate Cancellation of Release Orders: We understand that the Agency has the
  authority to cancel one or more release orders issued under this Contract in the event of
  a default. We will ensure our performance meets the Agency's expectations to prevent
  any need for cancellation.
- Other Legal Remedies: We acknowledge that the Agency may pursue any other remedies available in law or equity. Mercer is dedicated to maintaining compliance and fulfilling our contractual obligations to mitigate any potential issues that could lead to the exercise of these remedies.

By understanding these potential remedies, Mercer reaffirms our commitment to delivering high-quality services and adhering to all contractual requirements. We value our partnership with the Agency and are focused on ensuring successful outcomes throughout the duration of the Contract.

#### 11. Miscellaneous:

11.1. Contract Manager: During its performance of this Contract, Vendor must designate and maintain a primary contract manager responsible for overseeing Vendor's responsibilities under this Contract. The Contract manager must be available during normal business hours to address any customer service or other issues related to this Contract. Vendor should list its Contract manager and his or her contact information below.

# **Designation of Primary Contract Manager for Effective Oversight**

Mercer agrees to designate and maintain a primary contract manager responsible for overseeing our responsibilities under this Contract. We understand the importance of having a dedicated individual to ensure effective communication and management of the Contract's requirements. Our designated contract manager will be available during normal business hours to address any customer service or other issues related to this Contract.

We are committed to providing the Agency with the necessary support and responsiveness throughout the duration of the Contract, ensuring all issues are addressed promptly and effectively. Thank you for the opportunity to confirm our agreement to this requirement.

Mercer provides the completed Miscellaneous Contract Manager form on the following page:

# REQUEST FOR QUOTATION CRFQ BMS2500000001 Medicaid Actuarial Services and Managed Care Program Administration

- 10.1.2. Failure to comply with other specifications and requirements contained herein.
- 10.1.3. Failure to comply with any laws, rules, and ordinances applicable to the Contract Services provided under this Contract.
- 10.1.4. Failure to remedy deficient performance upon request.
- 10.2. The following remedies shall be available to Agency upon default.
  - 10.2.1. Immediate cancellation of the Contract.
  - 10.2.2. Immediate cancellation of one or more release orders issued under this Contract.
  - 10.2.3. Any other remedies available in law or equity.

#### 11. MISCELLANEOUS:

11.1. Contract Manager: During its performance of this Contract, Vendor must designate and maintain a primary contract manager responsible for overseeing Vendor's responsibilities under this Contract. The Contract manager must be available during normal business hours to address any customer service or other issues related to this Contract. Vendor should list its Contract manager and his or her contact information below

Contract Manager: William Aaron, Principal

Telephone Number: +1 502 271 0435

Fax Number: N/A

Email Address: william.aaron@mercer.com

Revised 12/12/2017

22. Exceptions and Clarifications (CRFQ – Instructions to Vendors Submitting Bids):
The Solicitation contains the specifications that shall form the basis of a
contractual agreement. Vendor shall clearly mark any exceptions, clarifications, or
other proposed modifications in its bid. Exceptions to, clarifications of, or
modifications of a requirement or term and condition of the Solicitation may result
in bid disqualification.)

The following exceptions are being submitted for your review and consideration to amend should Mercer be selected as a Vendor.

### Mercer Health & Benefits LLC Request for Exceptions to CRFQ 0511 BMS2500000001

Proposed exceptions to the Solicitation.

SECTION	PROVISION	SUGGESTED CLARIFICATION
General Terms	Insurance	Modify the Section as follows: Changes in <b>bold</b> .
and Conditions Section 8		"Vendor must maintain:
		_ Commercial General Liability Insurance in at least an amount of \$1,000,000 per occurrence and \$2,000,000 aggregate.
		Automobile Liability Insurance in at least an amount of \$1,000,000 per occurrence.
		Professional Liability/Malpractice/Errors and Omission Insurance in at least an amount of \$10,000,000.00 aggregate. Notwithstanding the foregoing, Vendors are not required to list the State as an additional insured for this type of policy.
		Financial Commercial-Crime/Fidelity Bond and Third Party Fidelity Insurance in an amount of \$5,000,000.00 per occurrence and \$10,000,000.00 aggregate.
		Cyber Liability Insurance in amount of \$1,000,000 per occurrence and \$10,000,000.00 aggregate."
General Terms and Conditions Section 13	Pricing	Delete the following last sentence from the Section:
Section 13		"Notwithstanding the foregoing, Vendor must extent any publicly advertised sale price to the State and invoice at the lower of contract price or the publicly advertised price."

SECTION	PROVISION	SUGGESTED CLARIFICATION
General Terms and Conditions Section 18	Funding	Add the following new language to the end of the Section:
		"The State acknowledges and agrees that Vendor is entitled to rely on the State's execution of this
		Contractor or a statement of work, as the case may be, as certification that the State has complied with
		all applicable laws, necessary funds are available, and all necessary approvals have been obtained by the State."
General Terms and Conditions	Cancellation	Modify the Section as follows: Changes in <b>bold</b> :
Section 18		"19. CANCELLATION: The Purchasing Division Director reserves the right to cancel this Contract immediately upon 30 days written notice to the Vendor if the materials or workmanship supplied do not confirm to the specifications contained in the Contract in any material respect and the
		Vendor fails to cure such material failure within the 30 day period. The Purchase Division
		Director may also cancel any purchase or Contract upon 30 days written notice to the Vendor in
		accordance with West Virginia Code of State
		Rules §148-1-5.2.b. The Vendor may cancel this
		Contract upon 30 days written notice to the
		State, if the State materially fails to meet its
		obligations under this Contract and fails to cure such failure with the 30 day period."
General Terms and Conditions	Warranty	Modify the Section as follows: Changes in <b>bold</b> :
Section 28		"28. WARRANTY: The Vendor expressly
		warrants that the goods and/or services covered by
		this Contract will: (a) conform in all material respects to the specifications, drawings, samples,
		or other description furnished or specified by the
		Agency; and (b) be merchantable and fit for the
		purpose intended; and (e) be free from material
		defect in material or workmanship. Except as
		expressly set forth in this Contract, Vendor
		expressly disclaims any warranty, express or
		implied, including but not limited to any implied warranty of merchantability and fitness
		for a particular purpose."
General Terms and Conditions	Privacy, Security, and	Modify the Section as follows: Changes in <b>bold</b> :
Section 30	Confidentiality	"30. PRIVACY, SECURITY, AND
		CONFIDENTIALITY: The Vendor agrees that it
		will not disclose to anyone, directly or indirectly,
		any such personally identifiable information or

SECTION	PROVISION	SUGGESTED CLARIFICATION
SECTION	PROVISION	other confidential information gained from Agency, unless the individual who is subject of the information consents to the disclosure in writing or the disclosure is made pursuant to the Agency's policies, procedures, and rules (to the extent such Agency policies, procedures, and rules have been provided to Vendor and Vendor has agreed to comply with them). Vendor further agrees to comply with the Confidentiality Policies and Information Security Accountability Requirements, set forth in www.state.wv.us/admin/purchase/privacy to the extent such policies and requirements are consistent with the requirements of Vendor's own Privacy and Security Program, which is consistent with various components of industry standard frameworks for information security
		(e.g., ISO/IEC 27001/2, NIST, OWASP and other similar standards)."
General Terms and Conditions Section 31	Your submission is a Public Document	Modify the last paragraph of the Section as follows: Changes in bold.  "Submission of any bid, proposal, or other document to the Purchasing Division constitutes your explicit consent to the subsequent disclosure of the portions of the bid, proposal, or document that have not been labeled by you as "confidential," "proprietary," "trade secret," or "private" information. The Purchasing Division will not disclose any document labeled "confidential," "proprietary," "trade secret," "private," or labeled with any other claim against public disclosure of the documents, to include any "trade secrets" as defined by West Virginia Code §47-22-1 et seq. All submissions are subject to public disclosure upon without notice, unless such notice is not permitted under applicable law."
General Terms and Conditions Section 34	Vendor Non-Conflict	Add the following new language to the end of the Section:  "Notwithstanding the foregoing, it is Vendor's practice to serve multiple clients within industries including those with potentially opposing interests. Accordingly, Vendor may have served, may currently be serving, or may in the future serve other clients whose interests may be adverse to those of the State. In all such situations, Vendor is committed to maintaining the confidentiality of

SECTION	PROVISION	SUGGESTED CLARIFICATION
General Terms and Conditions Section 35	Vendor Relationship	each client's information and will abide by non-disclosure procedures (such as firewall protocols and other safeguards) to ensure that all confidences are protected."  Modify the second paragraph of the Section as follows: Changes in bold.  "Subject to the applicable limitations on liability under this Contract, Vendor shall hold harmless the State, and shall provide the State and Agency with a defense against any and all claims including, but not limited to, the foregoing payments, withholdings, contributions, taxes, Social Security taxes, and employer income tax returns. Provided, however, Vendor shall have no responsibility for any claims to the extent they are attributable to the acts or omissions of an indemnified person or any third party other than Vendor's subcontractors."
General Terms and Conditions Section 36	Indemnification	Modify the Section as follows: Changes in bold.  "36. INDEMNIFICATION. Subject to the applicable limitations on liability under this Contract, &The Vendor agrees to indemnify, defend, and hold harmless the State and the Agency, their officers, and employees from and against: (1) Any claims or losses for services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the Contract; (2) Any claims or losses resulting to any person or entity injured or damaged by the Vendor, its officers, employees, or subcontractors, by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under the Contract in a manner not authorized by the Contract, or by Federal or State statutes or regulations; and (3) Any material failure of the Vendor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws. Provided, however, Vendor shall have no responsibility for any claims to the extent they are attributable to the acts or omissions of an indemnified person or any third party other than vendor's subcontractors."
General Terms and Conditions Section 38	Conflict of Interest	Add the following new language to the end of the Section:

SECTION	PROVISION	SUGGESTED CLARIFICATION
General Terms and Conditions Section 40	Background Check	"Notwithstanding the foregoing, it is Vendor's practice to serve multiple clients within industries, including those with potentially opposing interests. Accordingly, Vendor may have served, may currently be serving, or may in the future serve other clients whose interests may be adverse to those of the State. In all such situations, Vendor is committed to maintaining the confidentiality of each client's information and will abide by non-disclosure procedures (such as firewall protocols and other safeguards) to ensure that all confidences are protected."  Insert the following language to the beginning of the Section:  "To the extent set forth in an applicable statement of work,"
General Terms and Conditions  — New Section 47 — Provision of Information and Assistance	Provision of Information and Assistance	"47. PROVISION OF INFORMATION AND ASSISTANCE: The State will provide the Vendor all necessary and reasonably requested information, direction, and cooperation to enable the Vendor to provide the services, and any direction (whether verbal or written) shall be effective if contained expressly in the applicable statement of work or if received (whether verbally or in writing) from a person known to Vendor or reasonably believed by Vendor to be authorized to act on the State's behalf. The Vendor shall use all information and data supplied by or on behalf of the State without having independently verified the accuracy or completeness of it. If any documentation or information supplied to the Vendor at any time is incomplete, inaccurate, or not up-to-date, or if its provision is unreasonably delayed, or if adequate access to (and being able to spend time with) employees of the State and other individuals (including third parties such as the State's other advisers) is not provided, then the Vendor will not be responsible for any delays or liability arising therefrom, and will be entitled to propose additional fees to the State in respect of any resulting additional work required to be carried out."
General Terms and Conditions — New Section	Personal Information	Insert the following new Section 48:  "48. PERSONAL INFORMATION: Each party and its respective affiliates will comply with their

SECTION	PROVISION	
SECTION 8 — Personal Information	PROVISION	respective obligations arising from data protection and privacy laws in effect from time to time to the extent applicable to this Contract and the services. This includes, without limitation, (i) the obligation, if any, of the State to obtain any required consent(s) in respect of the transfer of information to the Vendor by the State or any third party relating to an identified or identifiable individual that is subject to applicable data protection, privacy or other similar laws ("Personal Information"), (ii) any obligation with respect to the creation or collection of additional Personal Information by the Vendor, and (iii) any obligation with respect to the use, disclosure, and transfer by the Vendor of Personal Information as necessary to perform the services or as expressly permitted under this Contract."
General Terms and Conditions — New Section 49 — Advice on Legal Matters	Advice on Legal Matters	Insert the following new Section 49:  "49. ADVICE ON LEGAL MATTERS: The Vendor is not engaged in the practice of law and the services provided hereunder, which may include commenting on legal issues or drafting documents which could constitute legal advice, do not constitute and are not a substitute, for legal
General Terms and Conditions — New Section 50 — No Third Party Beneficiaries	No Third Party Beneficiaries	advice."  Insert the following new Section 50:  "50. NO THIRD PARTY BENEFICIARIES: Neither this Contract nor the provision of the services is intended to confer any right or benefit on any third party. The provision of services under this Contract cannot reasonably be relied upon by any third party."
General Terms and Conditions — New Section 51 — Ownership of Work; Intellectual Property		Insert the following new Section 51:  "51. OWNERSHIP OF WORK; INTELLECTUAL PROPERTY:  (a) All materials prepared by the Vendor specifically and exclusively for the State pursuant to this Contract (the "Work") shall be owned exclusively by the State. Notwithstanding anythin to the contrary set forth in this Contract, the Vendor will retain all copyright, patent, and other intellectual property rights in the methodologies, methods of analysis, ideas, concepts, know-how, models, tools, techniques, skills, knowledge, and experience owned or possessed by the Vendor

SECTION	PROVISION	SUGGESTED CLARIFICATION
		before the commencement of, or developed or
		acquired by the Vendor during or after, the
		performance of the services, including, without
		limitation, all systems, software, web applications
		(including, without limitation, text, software,
		music, sound, photographs, graphics, videos or
		other images, the structure, all technical and
		graphical materials, and all technical information
		and the look and feel thereof and any
		modifications or enhancements), specifications,
		documentation (including formats of reports,
		standard materials, and derivatives thereof), and
		other materials created, owned, or licensed and
		used by the Vendor or its affiliates or
		subcontractors in the course of providing the
		services (the "Intellectual Property") and the
		foregoing shall not be deemed to be Work and the
		Vendor shall not be restricted in any way with
		respect thereto. It is understood and agreed that the
		Work will inherently contain and/or embed
		Intellectual Property. The Vendor hereby grants
		the State a non-exclusive, non-transferable right to
		use such Intellectual Property solely for purposes
		of utilizing the Work for its internal business
		purposes and otherwise in accordance with the
		terms of this Contract and the applicable statement
		of work.
		(b) The State also acknowledges and agrees that
		the State acquires no rights in or to Intellectual
		Property solely by virtue of entering into this
		Contract or receiving the services under this
		Contract. The State agrees to secure and protect
		each module, software product, all documentation,
		and all other portions of Intellectual Property in
		order to protect all of the Vendor's rights therein.
		(c) The State will not publish or otherwise disclose
		any advice given to the State or other material or
		Work supplied by the Vendor in connection with
		the services to any third party, other than its legal
		counsel or financial advisors on a confidential and
		non-reliance basis, without the Vendor's prior
		written consent or use such advice or material or
		Work other than as mutually contemplated in
		writing. The Vendor disclaims and does not accept
		any liability or responsibility to any third party to
		whom any advice given or other materials or Work
L	<u> </u>	supplied by the Vendor under this Contract are

SECTION	PROVISION	SUGGESTED CLARIFICATION
DECITO	THO ( ADIOI)	disclosed, made available or otherwise
		disseminated or into whose possession such advice
		or material may come. Any use of or reliance upon
		such advice or materials by any third party will be
		at their exclusive risk.
		at their exercisive risk.
		(d) Where the Vendor is requested to use or
		incorporate State intellectual property in the
		provision of the services, the State hereby grants
		the Vendor a non-exclusive, perpetual, transferable
		license to use such material solely in connection
		with the Contract."
Specifications	Service Level	Modify the Section as follows: Changes in <b>bold</b> .
Section 4.1.5	Agreement	g
— Service	J	"4.1.5.1 The vendor shall agree to be bound to all
Level		service level agreements as defined within
Agreement		Attachment 3: Exhibit B Service Level
		Agreements."
Specifications	All Services	Add the following <b>bolded</b> changes to the Section:
Section 4.1.5-		, and the second
Section 4.1.6.4		"4.1.6.4 Unless the vendor has made prior
		disclosure thereof to the State, Tthe Prime
		Vendor shall not, within a five (5) year period
		before or at any time during the duration of the
		contract, hold contract(s) with any managed care
		organization, provider, provider group, or provider
		association doing business for any service related
		to this contract in the State of West Virginia or
		whose parent organization does business in the
		State of West Virginia. Notwithstanding the
		foregoing, it is Vendor's practice to serve
		multiple clients within industries, including
		those with potentially opposing interests.
		Accordingly, Vendor may have served, may
		currently be serving, or may in the future serve
		other clients whose interests may be adverse to
		those of the State. In all such situations, Vendor
		is committed to maintaining the confidentiality
		of each client's information and will abide by
		non-disclosure procedures (such as firewall
		protocols and other safeguards) to ensure that
Cassifications	Vendor Default	all confidences are protected."
Specifications Section 10.1 —	v endor Detault	Modify the Section with the following <b>bolded</b>
Vendor Default		changes:
vendor Default		"10.1. The following shall be considered a Vender
		"10.1. The following shall be considered a Vendor default under this Contract:
		default under uns contract.

SECTION	PROVISION	SUGGESTED CLARIFICATION
		10.1.1. <b>Material Ff</b> ailure to perform Contract Service in accordance with the requirements contained herein.
		10.1.2. <b>Material F</b> failure to comply with other specifications and requirements contained herein.
		10.1.3. <b>Material Ffailure</b> to comply with any laws, rules, and ordinance applicable to the Contract Services provided under this Contract.
		In each case where the Vendor has failed to cure such material within thirty (30) days of being notified of same."
Confidentiality Policies and	Introduction	Add the following new language to the end of the Section:
Information Security Accountability Requirements, Section 1  Confidentiality Policies and	Definition of Confidential	"As referred to herein "personally identifiable information" means information that identifies or relates to an identifiable individual as defined by, and is subject to protection under, Applicable Privacy Laws to the extent such information is provided by or on behalf of the State to the Vendor or collected by the Vendor as part of the services pursuant to this Contract. As referred to herein "Applicable Privacy Laws" means the applicable data protection or privacy laws and/or regulations that govern the use, disclosure, collection, handling, retention, or other processing of personally identifiable information in connection with the services provided under this Contract."  Insert the following new language to the end of the Section:
Information Security Accountability Requirements, Section 2.2	Information	"Confidential Information does not include information which (i) the Vendor must by applicable law, legal process, or regulatory requirements disclose, (ii) is either already in the public domain or enters the public domain through no fault of the Vendor, (iii) is available to the Vendor from a third party who, to the Vendor's
		knowledge, is not under any non-disclosure obligation to the State, or (iv) is independently developed by the Vendor without reference to any Confidential Information of the State."
Confidentiality Policies and Information Security	Definition of Security Incident	Modify the Section as follows: Changes in <b>bold</b> .  "2.3 Security Incident means any known, successful or unsuccessful attempt by an

SECTION	PROVISION	SUGGESTED CLARIFICATION
Accountability Requirements, Section 2.3		authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any personally identifiable information."
Confidentiality Policies and Information	Background	Modify the second paragraph of the Section as follows: Changes in bold.
Security Accountability Requirements, Section 3 — second paragraph		"Utilization of safeguards can greatly minimize potential exposure to sensitive information, and vendors are expected to adhere to industry standard prevailing best practices in the management of data collected by, or on behalf of, the State, and in the Vendor's possession for a business purpose. Even when sound practices and safeguards are in use, exposures can occur as the result of a theft, loss, or compromise of data, or systems containing data. At these times, vendors must be accountable for the loss of data in their possession by immediately promptly (and in any event within seventy-two (72) hours of becoming aware) reporting the security incident surrounding the loss, and by absorbing any reasonable cost associated with the legally required appropriate response actions deemed by the State to be reasonable and necessary. Additional Vendor funding may be needed for legally required activities, such as: rapid notification to affected persons, and, where legally required, provision of a call center to handle inquiries. Notification and legally required call handling will use a State-approved specified method, format, language, and personnel staffing level."
Confidentiality Policies and Information Security Accountability Requirements, Section 4.3.3	Policy	"4.3.3 In no circumstance shall a vendor use Confidential Information, or data, in any way detrimental to the Agency or to any individual whose records reside in the vendor's control. This prohibition shall not be construed to curtail a vendor's whistleblower rights under Federal and State law. If, in the process of making a good faith report under the provisions of W. Va. Code § 6C-1-1 et seq. or the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), (Pub. L. No. 104-191) as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act"), any associated regulations and the Federal regulations published at 45 CFR parts 160 and 164 (sometimes

SECTION	PROVISION	SUGGESTED CLARIFICATION
		collectively referred to as "HIPAA") or any other
		relevant whistleblower law, a vendor finds it
		necessary to disclose Confidential Information to
		an appropriate authority in accordance with those
		statutes, the disclosure will not be treated as a
		Breach of the vendor's Privacy and Security
		Program (which is consistent in all material
		respects with Agency's security, privacy, or confidentiality policies), as long as the
		confidential nature of the information is explicitly
		conveyed to the authorized recipient."
Confidentiality	Policy	Modify the Section as follows: Changes in <b>bold</b> .
Policies and	Toney	wieding the Section as follows. Changes in bold.
Information		"4.3.4 The State may periodically monitor and/or
Security		audit use of the information systems and other
Accountability		record-keeping <b>procedures</b> systems at a Vendor
Requirements,		location or a State location in an effort to ensure
Section 4.3.4		compliance with this policy. In addition, the State
		may audit, and <b>propose <del>require</del></b> strengthening of,
		Vendor policies and/or practices as they impact
		security of State data within the Vendor's
		possession. Any such audit shall be subject to
		the following requirements: i) audits may be
		performed once per year or more frequently if
		required by Applicable Privacy Laws; ii) at
		least thirty (30) days prior to the proposed
		audit date, the State must submit an audit plan
		which at least describes the proposed scope,
		duration, and start date of the audit; and iii)
		audits must be conducted during regular
		business hours, subject to Vendor's policies,
		and may not unreasonably interfere with Vendor's business activities. The Vendor will
		work cooperatively with the State to agree on a
		final audit plan. Any request for Vendor audit
		assistance requiring the use of resources
		different from or in addition to those required
		for provision of the services will be considered
		an additional service for which reasonable
		additional fees may be proposed by Vendor.
		Vendor reserves the right to require the State's
		written agreement to pay for such fees before
		providing such audit assistance. The State may
		use a third party to perform the audit on its
		behalf, provided the third party is mutually
		agreed to by the State and Vendor and executes
		a confidentially agreement acceptable to
		Vendor before the audit. Company must
		provide Vendor with any audit reports

SECTION	PROVISION	SUGGESTED CLARIFICATION
		generated in connection with any audit at no
		charge unless prohibited by law. The State may
		use the audit reports only for the purposes of
		meeting its audit requirements under
		Applicable Privacy Laws and/or confirming
		compliance with the requirements of this policy
		The audit reports shall constitute Confidential
		Information of the parties under the Contract."
Confidentiality	Notification of	Modify the Section as follows: Changes in <b>bold</b> :
Policies and	Breach	but as reaches. Changes in bold.
Information		"4.4.2 Notification of Breach.
Security		STORES.
Accountability		4.4.2.1 Upon the discovery of Breach of security
Requirements,		of Confidential Information, if the Confidential
Section 4.4.2		Information was, or is reasonably believed to
		have been, acquired by an unauthorized person,
		the Vendor shall notify the individuals identified
		in 4.4.2.3 promptly (and in any event within
		seventy-two (72) hours) immediately by
		telephone call plus e-mail, web form, or fax; or,
		- I in, or iun, or,
		4.4.2.2 Within seventy-two (72) 24-hours by
		e-mail or fax of any suspected Security Incident,
		intrusion or unauthorized use or disclosure of
		Confidential Information, in violation of the
		underlying eContract and this Notice, of potential
		loss of confidential data affecting the underlying
		contract.
		4.4.2.3 Notification required by the above two
		sections shall be provided to:
		(1) the Agency contract management
		(1) the Agency contract manager whose contact information may be found at
	1	www.state.wv.us/admin/purchase/vrc/agencyli.htm
		and,
		(2) unless otherwise directed by the Agency in
		writing, the Office of Technology at
		incident@wv.gov.
		4.4.2.4 The Vendor shall immediately investigate
		such actual or suspected Security Incident,
		Breach, or unauthorized use or disclosure of
		Confidential Information. Within 72 hours of the
		discovery, if an actual Breach has occurred, the
		Vendor shall notify the individuals identified in
	1	the multiplicate individuals identified in
	II.	4 4 2 3 of the following (to 4)
		4.4.2.3 of the following (to the extent known): (a) What data elements were involved and the extent

SECTION	PROVISION	SUGGESTED CLARIFICATION
		records or affected individual's data); (b) The identity of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or Confidential Information; (c) A description of where the Confidential Information is believed to have been improperly transmitted, sent, or utilized; (d) A description of the probable causes of the improper use or disclosure; and (e) Whether any Federal or State Applicable Privacy Laws requiring individual notifications of Breaches involving personally identifiable information are triggered.
		determine additional specific actions that will be required of the Vendor under Applicable Privacy Laws for mitigation of the Breach, which for Breaches involving personally identifiable information may include notification to the individual or other authorities.
		4.4.2.6 All associated <b>reasonable</b> costs shall be borne by the Vendor. This may include, but not be limited to costs associated with notifying affected individuals <b>for Breaches involving personally identifiable information</b> ."
Confidentiality Policies and Information	Policy	Add the following new language to the end of the Section:
Security Accountability Requirements, Section 4.6	Pormitted Uses	"Notwithstanding the foregoing, but subject to the confidentiality obligations under the Contract, Vendor may (i) retain copies of State information that is required to be retained by law or regulation, (ii) retain copies of its work product that contain State information for archival purposes or to defend its work product, and (iii) in accordance with legal, disaster recovery, and records retention requirements, store such copies and derivative works in an archival format (e.g., tape backups), which may not be returned or destroyed upon the State's request."
HIPAA Business Associate	Permitted Uses and Disclosures	Add the following new language to the end of the Section:
Addendum Section 2B		"provided, however, that this obligation shall apply solely to the extent such Policies Standards are consistent in all material respects with Contractor's own internal corresponding policies and standards."

Safeguards	Associate's subcontractors shall agree to substantially the same restrictions, conditions, and requirements that apply to the Associate.
Agent's Subcontractors' Compliance	Associate shall notify Agency, to the extent required by law, of subcontractors that will receive PHI. Subcontractors shall be bound by terms substantially similar to those to which Associate is subject.  Subcontracts are confidential and cannot be
Federal and Agency Access	disclosed.  To the extent such release does not jeopardize the confidentiality, integrity, or proprietary nature of Associate's privacy and security practices, Associate may provide to Agency copies of such internal practices, books, and records.  Upon written request, Associate can provide Agency with a summary of Associate's information, privacy, and cyber security program. Associate's subcontractors should not be obligated to provide any such information to Agency.
Security	Associate maintains an information security program that is considered consistent with various components of industry standard frameworks for information security (e.g., ISO/IEC 27001/2, NIST, OWASP, and other similar standards).
Notification of Breach	Associate shall provide notice within three (3) business days after determining the occurrence of such an event.  The parties acknowledge and agree that this section constitutes notice by Associate to Agency of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to Agency shall be required. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Associate's firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of PHI.  Notice of Breach may include, to the extent
	Subcontractors' Compliance  Federal and Agency Access  Security  Notification of

SECTION	PROVISION	SUGGESTED CLARIFICATION		
SECTION		<ul> <li>a. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known.</li> <li>b. A description of the types of Unsecured PHI that were involved in the Breach.</li> <li>c. A brief description of what Associate is doing to investigate the Breach, to mitigate losses, and to protect against any further Breaches.</li> <li>d. A designated contact for the client to ask questions or learn additional information.</li> </ul>		
		substantially similar notice requirements.  Associate shall pay the actual reasonable costs for		
		notifications and credit monitoring services that are required by applicable law.		
HIPAA Business Associate Addendum Section 4.b	Duties at Termination	Associate's duties of assistance on accounting of disclosures shall survive as required by applicable law.		
HIPAA Business Associate Addendum Section 4.c	Termination for Cause	Associate should be afforded a 30-day cure period for a material breach, unless cure is not possible.		
HIPAA Business Associate Addendum Section 4.d	Judicial or Administrative Proceedings	Associate is a large company and this termination should be limited to violations in connection with services provided to Agency by Associate. Any costs associated with the prosecution should be as decided by the trier of fact.		
HIPAA Business Associate Addendum Section 5.h	Additional Terms and Conditions	Any additional terms and conditions should be as mutually agreed.		
Confidentiality Policies and Information Security Accountability Requirements	Notification of Breach	The Vendor shall immediately investigate such actual or suspected Security Incident, Breach, or unauthorized use or disclosure of Confidential Information. Within 72 hours of the discovery, if an actual Breach has occurred, the Vendor shall notify the individuals identified in 4.4.2.3 of the following (to the extent known): (a) What data elements were involved and the extent of the data involved in the Breach (e.g., number of records or affected individual's data); (b) The identity of the		

SECTION	PROVISION	SUGGESTED CLARIFICATION
		unauthorized persons known or reasonably
		believed to have improperly used or disclosed PHI
		or Confidential Information; (c) A description of
		where the Confidential Information is believed to
		have been improperly transmitted, sent, or
		utilized; (d) A description of the probable causes
		of the improper use or disclosure; and (e) Whethe
		any Federal or State Applicable Privacy Laws
		requiring individual notifications of Breaches
		involving personally identifiable information
		are triggered. Notification shall take the form of
		a phone call, which may be followed in writing
		and shall include the name and phone number
		of the Mercer representative that Client may
		contact to obtain updates. Mercer agrees to
		keep Client informed of progress and actions
		taken to resolve the Security Incident.

# Section 8 Required Forms

Mercer provides the completed and signed Addendum Acknowledgement Form on the following page.

# ADDENDUM ACKNOWLEDGEMENT FORM SOLICITATION NO.: CRFQ BMS25\*01

**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)

[٧	<b>/</b> ]	Addendum No. 1	[	]	Addendum No. 6
[🗸	<b>/</b> ]	Addendum No. 2	[	]	Addendum No. 7
[	]	Addendum No. 3	[	]	Addendum No. 8
[	]	Addendum No. 4	[	]	Addendum No. 9
[	]	Addendum No. 5	[	]	Addendum No. 10

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

Mercer Health & Benefits LLC

Company

Authorized Signature

April 21, 2025

Date

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



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

			Reason for Modification:
Proc Folder:	1544511		
Doc Description	n: MEDICAID MANAGED (		
Proc Type:	Central Master Agreeme	nt	
Date Issued	Solicitation Closes	Solicitation No	Version
2025-03-12	2025-04-02 13:30	CRFQ 0511 BMS2500000001	1

#### **BID RECEIVING LOCATION**

**BID CLERK** 

DEPARTMENT OF ADMINISTRATION

PURCHASING DIVISION 2019 WASHINGTON ST E

CHARLESTON

WV 25305

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VENDOR

Vendor Customer Code: VS0000002401

Vendor Name: Mercer Health & Benefits LLC

Address: 2325

Street: East Camelback Road, Suite 600

City: Phoenix

Zip: 85016 Country: United States of America State: AZ

Principal Contact: William Aaron

Vendor Contact Phone: +1 502 271 0435 Extension: N/A

FOR INFORMATION CONTACT THE BUYER

Crystal G Hustead (304) 558-2402

crystal.g.hustead@wv.gov

Vendor

**DATE: April 21, 2025** FEIN#: 34-2015463 Signature X

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

Date Printed: Mar 12, 2025

Page: 1

FORM ID: WV-PRC-CRFQ-002 2020/05



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: 1544511

Doc Description: MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN

Reason for Modification:

ADDENDUM 1

TO EXTEND BID OPENING

Proc Type:

Central Master Agreement

 Date Issued
 Solicitation Closes
 Solicitation No
 Version

 2025-03-26
 2025-04-22
 13:30
 CRFQ
 0511
 BMS2500000001
 2

### **BID RECEIVING LOCATION**

BID CLERK

DEPARTMENT OF ADMINISTRATION

PURCHASING DIVISION

2019 WASHINGTON ST E

CHARLESTON WV 25305

US

**VENDOR** 

Vendor Customer Code: VS0000002401

Vendor Name : Mercer Health & Benefits LLC

Address: 2325

Street: East Camelback Road, Suite 600

City: Phoenix

State : AZ Country : United States of America Zip :85016

Principal Contact : William Aaron

Vendor Contact Phone: +1 502 271 0435 Extension: N/A

FOR INFORMATION CONTACT THE BUYER

Crystal G Hustead (304) 558-2402

crystal.g.hustead@wv.gov

Vendor

Signature X FEIN#: 34-2015463

DATE: April 21, 2025

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

Date Printed: Mar 26, 2025

Page: 1

FORM ID: WV-PRC-CRFQ-002 2020/05



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: 1544511

Doc Description: MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN

Reason for Modification:

Addendum No. 2

Proc Type:

Central Master Agreement

Date Issued Solicitation Closes Solicitation No Version CREO 0511 BMS2500000001 3 2025-04-22 13:30 2025-04-09

#### **BID RECEIVING LOCATION**

**BID CLERK** 

DEPARTMENT OF ADMINISTRATION

PURCHASING DIVISION 2019 WASHINGTON ST E

CHARLESTON 25305 WV

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**VENDOR** 

Vendor Customer Code: VS0000002401

Vendor Name: Mercer Health & Benefits LLC

Address: 2325

Street: East Camelback Road, Suite 600

City: Phoenix

State: AZ

Country: United States of America

Principal Contact: William Aaron

Vendor Contact Phone: +1 502 271 0435 Extension: N/A

FOR INFORMATION CONTACT THE BUYER

Crystal G Hustead (304) 558-2402

crystal.g.hustead@wv.gov

Vendor

Signature X

FEIN#: 34-2015463

**DATE: April 21, 2025** 

Zip: 85016

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

Date Printed: Apr 9, 2025

Page: 1

FORM ID: WV-PRC-CRFQ-002 2020/05

# Appendix A Resumes

Mercer provides our key staff, technical, finance, and clerical support resumes on the following page.



# Ashley Wieser Associate



# **Summary of Experience**

Ashley, an Associate in Mercer's Government Human Services Consulting practice, brings immense value to the team. Specifically for the State of West Virginia, we chose her to support you because she brings 10 years of public health experience in managing and supporting complex Medicaid projects and initiatives for various clients, including the District of Columbia, Florida, Kansas, Minnesota, Missouri, Pennsylvania, and Wisconsin, among

# Role: Project Management Lead

- 10+ years managing and supporting complex Medicaid projects and initiatives
- Bachelor of Arts in History and Religious Studies

others. Currently, she provides project management support for six program offices in the Commonwealth of Pennsylvania's Department of Human Services, assisting with project planning, resource needs, and budgets while facilitating effective communication and risk management.

Her previous roles include managing Medicaid managed care procurement activities and developing strategic project work plans and dashboards for various clients. Ashley has a proven track record of collaborating with diverse project teams, leading stakeholder discussions, and formulating strategies to enhance client satisfaction. Ashley has successfully developed stakeholder engagement strategies, facilitated feedback sessions, and contributed to comprehensive reporting, demonstrating her commitment to informed decision-making and effective planning. Her expertise encompasses project management, technical assistance, stakeholder engagement, and budget and contract management.



#### Education

2015 Bachelor of Arts in History, Arizona State University, Tempe, AZ, USA

2015 Bachelor of Arts in Religious Studies, Arizona State University, Tempe, AZ, USA



# Years of Experience

10 Mercer Experience

13 Career Experience



# **Relevant Experience**

# **Project Management**

# 2023-present Commonwealth of Pennsylvania, Department of Human Services

- Deliver comprehensive project management support by overseeing project staffing and resource needs, managing budgets, and facilitating communication channels; monitoring and escalating risks to Client Service Leaders and the Client Manager; and participating in the development, review, and finalization of work products and deliverables
- Assist in the development of project plans by collaborating with stakeholders to define
  objectives, deliverables, and timelines; monitor and update project plans regularly to
  reflect progress and changes; and maintain comprehensive decision, issue, and risk
  logs, including documentation of scope changes
- Develop, update, and monitor project management tools, including utilization and staffing metrics dashboards, as well as weekly and monthly status reports
- Provide overall support and management to ensure the timely completion of deliverables and specific tasks for the client
- Manage contract and compliance requirements, delivering monthly, quarterly, and annual reports
- Formulate strategies to meet client expectations and assist in the development and implementation of strategic plans

#### 2015–2022 Mercer GHSC

- Developed strategic project work plans, timelines, and dashboard reports, ensuring adherence to Mercer's standards
- Managed Medicaid managed care procurement activities, including strategic planning, project dashboards, and workgroup coordination
- Oversaw multiple complex projects from initiation to completion, ensuring timely delivery within budget and achieving high stakeholder satisfaction
- Collaborated with project teams across sectors, leading stakeholder discussions and defining project scope to address inquiries effectively
- Managed project budgets, including invoicing and financial reporting, while negotiating resource requirements amid competing priorities
- Provided editorial peer review of documents to ensure quality prior to final production and distribution
- Established and maintained client subject files, personal working files, and legal documents as needed
- Organized project workflows, communicated anomalies to internal teams and clients, and provided insights and guidance for issue resolution
- Coordinated and facilitated project meetings, managing the quality and timeliness of deliverables to ensure that they are client-ready
- Supported sales initiatives and business development opportunities, acting as a trusted advisor to facilitate decision-making

# Stakeholder Engagement

# 2016–2017 State of Nebraska, Department of Health and Human Services

- Supported the Department of Health and Human Services in redesigning the Medicaid Long-Term Services and Supports delivery system
- Scheduled and facilitated stakeholder feedback sessions across the State to gather insights and perspectives
- Contributed to the development and submission of a comprehensive final report

# 2015–2017 State of Missouri, Department of Mental Health

- Developed a stakeholder engagement strategy and communications plan, leading to comprehensive and timely information gathering and reporting that informs decision-making and planning
- Scheduled and facilitated stakeholder feedback sessions, achieving high participation rates and obtaining valuable insights



# William Aaron, MBA Principal



# **Summary of Experience**

William, a Principal in Mercer's Government Human Services Consulting (GHSC) practice, brings immense value to the team. Specifically for the State of West Virginia, we chose him to support you because William has worked with an array of state Medicaid clients in various ways, including designing and implementing a new assessment and corresponding supplemental payment programs; managed care organization (MCO) procurement question design and facilitating consensus

# Role: Executive Program Director

- ✓ 25+ years in Medicaid Operations
- Principal at Mercer and former CFO/COO at TennCare, specializing in Medicaid financing, policy, strategy, and operations
- Master of Business Administration

decision-making; identifying Medicaid cost-containment strategies; and helping lead the restructuring and operations of one of Mercer GHSC's largest state client groups.

Before joining Mercer, William worked for more than a decade for TennCare, Tennessee's Medicaid program. He served as Chief Financial Officer (CFO) and Chief Operating Officer, where he led the program's financial, managed care, information technology, and member enrollment/eligibility functions. William played a key role in maintaining sustainable expense growth trends while also driving innovation in multiple payment and delivery systems. As CFO, he produced annual operating budgets that consistently reduced state expenses and increased federal reimbursements while preserving services for enrollees and advancing the program's goals. He was a primary architect of the TennCare III 1115 waiver that is projected to provide significant additional federal funding to the state for the next decade. He has worked extensively with a wide range of stakeholders, including elected legislative and executive leaders, advocacy groups, and professional associations. His direct expertise in Medicaid financing, policy, strategy, and operations is available to help states facing an array of challenging problems.



#### Education

- 1998 Master of Business Administration, Owen Graduate School of Management, Vanderbilt University, Nashville, TN, USA
- 1989 Bachelors of Arts in Political Science, Vanderbilt University, Nashville, TN, USA



# Years of Experience

- 3 Mercer Experience
- 25+ Career Experience



# **Relevant Experience**

# Financial Analysis and Budget Modeling

#### 2022-present Mercer GHSC

- Manage Mercer GHSC subcontract to provide state with identified Medicaid spending reductions
- Provide strategic support for pharmacy management redesign, management of MCO program integrity compliance, and the migration of populations from fee-for-service to managed care

# 2011–2022 State of Tennessee, Division of TennCare

- Developed the annual operating budget for over \$13 billion in total expenses
- Identified annual budget reductions with a recurring annual impact of hundreds of millions of dollars, with minimal or no impacts on services or enrollees
- Created and approved financial impact assessments for all proposed legislation affecting the agency; worked with the legislative Fiscal Review office to ensure our analyses were understood and accepted
- Created financial impact projections for all new programs and material program changes, including support for 1115 waiver amendments and State Plan Amendment (SPA) changes
- During the Coronavirus Disease 2019 (COVID-19) Public Health Emergency, adjusted MCO full-risk capitation rates to ensure MCO profits were appropriate, resulting in significant savings for the State

# **Medicaid Financing**

#### 2022-present Mercer GHSC

 Manage project with client state to establish new hospital assessment and accompanying supplemental payment programs; responsibilities include financial modeling, stakeholder communication, strategic analysis, and policy analysis

#### 2011–2022 State of Tennessee, Division of TennCare

- Served as the primary architect of the TennCare III 1115 waiver, which provides a 10-year framework in which the State is projected to bring significant new levels of federal funding to the State
- Established new assessments for nursing facilities and Emergency Medical Services providers
- Reviewed, streamlined, and documented internal processes for federal financial reporting
- Established new directed payments
- · Led the transition of pass-through payments to directed payments

# Organizational and Staffing Analysis Design/Redesign

#### 2022-present Mercer GHSC

 Lead the organizational assessment of one of Mercer GHSC's largest state client teams

- Support the implementation of organizational redesign to increase integration across rate setting and operational teams
- Serve as the chief operating lead for state client team, with particular responsibility for subcontractor onboarding and management, contract compliance, and team member retention

#### 2011–2022 State of Tennessee, Division of TennCare

- Led the transition of the drug rebate function from internal staffing to an external contractor, resulting in a significant increase in rebates and the successful redeployment of State employees
- Led the internal process assessment, review, and redesign efforts for financial and other functions
- Established the requirements for the identification and documentation of key business processes, cross-training to ensure successful business operations, and succession planning
- Led the assessment of internal third party liability functions and the transfer of those functions to another part of the agency for greater success

# Waiver Design and Development

# 2011–2022 State of Tennessee, Division of TennCare

- Provided strategic leadership on all initiatives requiring 1115 waiver amendments or State Plan changes
- Provided financial modeling and impact projections
- Worked with CMS as part of TennCare's negotiation team on both the 2016 1115 waiver renewal and the 2021 TennCare III 1115 waiver

# **Capitation Rate Development** — Acute Care

#### 2011–2022 State of Tennessee, Division of TennCare

- Directed the development of full-risk capitation rates for Medicaid populations by contracted actuaries
- Managed the provision of data on claims, encounters, trends, State priorities, program changes, and other material sources/impacts
- Led decision-making on final rates, including projections of the financial impact to the State and to MCOs
- Led negotiations with MCOs and navigated the rates to CMS approval

# Capitation Rate Development — Behavioral Health

#### 2011–2022 State of Tennessee, Division of TennCare

- Directed the development of full-risk capitation rates for Medicaid populations by contracted actuaries with behavioral health as an integrated benefit
- Managed the provision of data on claims, encounters, trends, State priorities, program changes, and other material sources/impacts
- Led decision-making on final rates, including projections of the financial impact to the State and to MCOs
- Led negotiations with MCOs and navigated the rates to CMS approval

# Capitation Rate Development — Dual Eligibles

#### 2011–2022 State of Tennessee, Division of TennCare

- Directed the development of full-risk capitation rates for Medicaid populations by contracted actuaries, including dual eligibles
- Managed the provision of data on claims, encounters, trends, State priorities, program changes, and other material sources/impacts
- Led decision-making on final rates, including projections of the financial impact to the State and to MCOs
- Changed the approach to risk adjustment for duals cap rates based on evaluation of data
- Led negotiations with MCOs and navigated the rates to CMS approval

# **Capitation Rate Development — LTSS**

#### 2011–2022 State of Tennessee, Division of TennCare

- Directed the development of full-risk capitation rates for Medicaid populations by contracted actuaries, including long-term services and supports (LTSS) rates
- Managed the provision of data on claims, encounters, trends, State priorities, program changes, and other material sources/impacts
- Led decision-making on final rates, including projections of the financial impact to the State and to MCOs
- Implemented site-of-service MCO-level rate adjustments to address imbalances and preserve incentives
- Established cap rates for new limited benefit programs
- Led negotiations with MCOs and navigated the rates to CMS approval

# Cost Reporting Development and Monitoring

#### 2011–2022 State of Tennessee, Division of TennCare

- Led an intensive review of Federally Qualified Health Center/ Rural Health Clinic (FQHC/RHC) policies and payments, identifying significant suspected fraud, waste, and abuse
- Led the effort to establish new rules to govern the calculation of prospective payment system rate for FQHCs/RHCs
- Established new monthly financial monitoring reports for pharmacy, dental, and targeted LTSS programs
- Created new dashboards for executive-level financial monitoring; drove change across organization to make understanding cost a part of all program decisions and implementations

# **Care Coordination and Case Management Services**

#### 2011–2022 State of Tennessee, Division of TennCare

 Helped address long-standing issues around case management by behavioral health providers through the implementation of behavioral health home program

 Implemented further changes in case management by behavioral health providers by better aligning incentives through payment changes

# **Contractor Performance Reviews**

#### 2011–2022 State of Tennessee, Division of TennCare

- Regularly reviewed and assessed the performance of full-risk MCOs regarding the timeliness and accuracy of claims payments, appropriate Medical Loss Ratios, and other critical performance metrics
- Established the first retrospective annual review of MCO administrative funding for accuracy and appropriateness
- Led comprehensive performance reviews of internal agency functions and related contracted services

# Data Mining, Analytics, and Visualization

#### 2011–2022 State of Tennessee, Division of TennCare

- Implemented a coordinated analytics/informatics strategy across the agency to meet rapidly changing and growing demands
- Directed the creation of multiple dashboards and visualization tools, including those for COVID-19-related cases, expenses, and projections
- Created financial visualization tools to support the analysis of potential expense reductions and projections

#### **Dental Services**

#### 2011–2022 State of Tennessee, Division of TennCare

- Reviewed and approved dental provider rates
- Developed and monitored incentive payment structure for contracted Dental Benefit Managers
- · Created financial projections for program changes and expansions to new populations

# Medicaid/CHIP Policy and Regulations

#### 2011–2022 State of Tennessee, Division of TennCare

- Supported all 1115 waiver amendments and SPA changes with strategic and financial consultation
- Directed the implementation of CMS managed care financial regulations
- Advised top executive and legislative leadership on impacts of changes in federal policy

# Pharmacy Management Strategies

# 2011–2022 State of Tennessee, Division of TennCare

 Created monthly monitoring and reporting process for Pharmacy expenses, including drug-level analyses of expenditures, identification of variances, and tracking/projection of rebates

# **Pharmacy Purchasing Strategies**

#### 2011–2022 State of Tennessee. Division of TennCare

Supported efforts to improve rebate collections from 340B facilities for non-340B physician-administered drugs

# Procurement Strategy, Contracts, and Support

#### 2011–2022 State of Tennessee, Division of TennCare

- Managed the agency's procurement and contracting functions
- Designed and reviewed Requests for Proposals across a wide array of services
- Led the MCO procurement process, one of the largest and most complex in the nation
- Supported the design and deployment of training for targeted State staff on procurement and contracting responsibilities

# Program Design, Planning, and Strategy

#### 2011–2022 State of Tennessee, Division of TennCare

- Led and supported the design and implementation of multiple new programs, including the expansion of services to new populations, such as individuals with Intellectual Disabilities and Developmental Disabilities (ID/DD)
- Supported the development and launch of Katie Beckett program, which includes a first-of-its-kind diversion program approved by CMS

# **Provider Fee Development**

#### 2011–2022 State of Tennessee, Division of TennCare

- Led the development and deployment of new price- and quality-based nursing facility per diem rate structure to broad acclaim
- Developed administrative cost structures for new programs in support of ID/DD populations

# **Quality and Performance Measurement**

#### 2011–2022 State of Tennessee, Division of TennCare

- Supported a variety of efforts to incorporate performance measurement into programs, including the TennCare III 1115 waiver, a new physician Upper Payment Limit program, a new nursing facility per diem rate structure, and other delivery system reform initiatives
- Managed the implementation of a new evidence-based budgeting process
- Worked with stakeholders to design new performance-based directed payments

# **Risk Adjustment**

#### 2011–2022 State of Tennessee, Division of TennCare

 Managed MCO capitation rate risk adjustment process to account for policy-related impacts on member enrollment, changes in membership during reverification, and a site-of-service adjustments to address structural imbalances in nursing facility enrollment across MCOs

# **Risk Mitigation Strategies**

#### 2011–2022 State of Tennessee, Division of TennCare

- Established risk corridors for MCOs during the COVID-19-related Public Health Emergency
- Developed updated capitation rates to ensure that MCO profits were appropriate
- Identified providers at the greatest risk early in the pandemic and provided targeted funding to support network adequacy

#### Social Determinants of Health

# 2011–2022 State of Tennessee, Division of TennCare

Supported the development and deployment of a state strategy focused on Social
Determinants of Health, including pilot programs with the MCOs and the establishment
of infrastructure to support the deployment of a broader effort to connect enrollees in a
closed-loop referral system with existing community resources

# Stakeholder Engagement

# 2011–2022 State of Tennessee, Division of TennCare

- Served as primary point of contact and relationship manager for an array of critical stakeholders, including the state's associations for hospitals, nursing facilities, FQHCs, and rural health providers
- Successfully enlisted stakeholder participation in program design and support for implementation

# Value-Based Purchasing and Payment Reform

#### 2011–2022 State of Tennessee, Division of TennCare

- Led strategic and financial work in support of delivery system reforms, including
  Episodes of Care, medical homes in primary care and behavioral health, and a
  successful targeted effort to drive greater levels of weaning patients from ventilators
- Designed payment structures to support quality outcomes through MCOs



# Charlie Greenberg, JD, MPH Principal



# **Summary of Experience**

Charlie, a Principal in Mercer's Government Human Services Consulting practice, brings immense value to the team. Specifically for the State of West Virginia, we chose him to support you because he provides consulting services to Mercer's state Medicaid clients on various issues, including Medicaid Policy and Regulations, Section 1115 Waivers, Medicaid financing, and Supplemental and Directed Payments.

# Role: Program Administration Lead

- √ 15+ years consulting for State Medicaid Programs
- ✓ Robust background in Medicaid policy, financing, and program design
- ✓ Juris Doctor and Master of Public Health

Before joining Mercer, Charlie was employed by a large public medical school and a state Medicaid program, where he performed policy analysis, implementation, and stakeholder engagement.



#### Education

- 2011 Master of Public Health, Johns Hopkins School of Public Health, Baltimore, MD, USA
- 2007 Juris Doctor, University of Texas School of Law, Austin, TX, USA
- 2004 Bachelor of Arts, University of Texas at Austin, Austin, TX, USA



# Years of Experience

- 2 Mercer Experience
- 16 Career Experience



# Relevant Experience

# Program Design, Planning, and Strategy

# 2024-present State of Colorado, Department of Health Care Policy and Financing

Consult on issues related to proposed Health-Related Social Needs (HRSN) 1115
 Waiver

# 2023-present New Mexico, Human Services Department

Lead the Medicaid expansion feasibility study

# 2022-present State of Oregon, Oregon Health Authority

- Design the program strategy for the implementation of the HRSN program, including the development of program structure, definition of services, and guidance related to 1115 Waiver requirements
- Design a program strategy for the Basic Health Plan, including guidance on federal requirements and program structure
- Consult on issues related to the approved HRSN 1115 Waiver, including program implementation and rate setting

# Program Design, Planning, and Strategy

# 2022–2023 Defense Health Agency

- Provided guidance on the creation of Request for Proposal for a healthcare demonstration, including analysis of federal law, determination of program design, and response to industry comments
- Provided guidance on the implementation of alternative payment models, including assistance in the creation of and participation in simulations

# 2022-present State of Connecticut, Department of Social Services

 Consult on issues related to the proposed 1115 Waiver, including Special Terms and Conditions, Budget Neutrality review, and HRSN implementation

# 2022-present State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

- Provide guidance on multiple Medicaid and CHIP policies, including Directed Payments, 1115 Waivers, federal matching requirements, and proposed regulations
- Design a program strategy for Nursing Facility rate rebasing project, including stakeholder engagement and policy development

# **Medicaid Financing**

# 2022-present State of Nevada, Department of Health and Human Services, Division of Health Care Finance and Policy

- Develop a hospital tax program for Nevada, including the development of strategy and analysis of modeling and federal regulations
- Develop an Inpatient and Outpatient Upper Payment Limit supplemental payment program for Nevada, including the development of strategy, payment processes, and analysis of modeling and federal regulations
- Develop an Inpatient and Outpatient Directed Payment program for Nevada, including the development of strategy, payment processes, and analysis of modeling and federal regulations
- Research Graduate Medical Education policy and program options
- Analyze the nursing facility tax program and associated supplemental payment programs



# Joe Schaller Principal



# **Summary of Experience**

Joe, a Principal in Mercer's Government
Human Services Consulting practice, brings
immense value to the team. Specifically for the
State of West Virginia, we chose him to
support you because he has a strong
background in health plan finance and
operations, including extensive experience
with health plan rate development audits,
health plan reporting and monitoring, and
administrative rate development. Joe has

# Role: Finance Project Lead

- 25+ years of experience in finance and operations
- Former CFO at a midsize Medicaid MCO
- ✓ Bachelor of Science in Accounting and Finance

developed procedures and models for health plan monitoring, including quarterly and annual health plan financial reporting, Medical Loss Ratio (MLR) reporting, CMS-required triannual audits, and risk corridor reporting. He has also performed reviews and analyses of health plan data submitted for financial monitoring related to all of these items.

Before joining Mercer in 2019, Joe served as Chief Financial Officer at a midsize Medicaid managed care organization, where he helped the company achieve operational efficiencies and expand its business into other services and states.

Since joining Mercer, Joe leverages his finance and operations background to collaborate with various Mercer specialists, including actuaries, clinicians, and policy experts, to deliver optimized solutions for states' Medicaid programs.



#### Education

1991 Bachelor of Science in Accounting and Finance, DeVry, Phoenix, AZ, USA

1990 Bachelor of Science in Business Administration, DeVry, Phoenix, AZ, USA



# **Years of Experience**

5 Mercer Experience

25+ Career Experience



# Relevant Experience

#### Readiness Reviews

# 2023–2024 State of New Mexico, Human Services Department

- Confirmed that each health plan had all contractual items in place for the start of the new program
- Reviewed the financial projections for health plans to ensure they would meet the contractual financial ratios and profitability requirements
- Performed readiness reviews of the financial requirements for each health plan for a new Medicaid program

# **Data Monitoring and Quality**

# 2020–2024 State of California, Health and Human Services Agency, Department of Health Care Services

- Created a new template for health plan quarterly financial reporting, as well as the review process for the agency
- Created a new standardized template to capture relevant financial information, incorporating feedback from stakeholders and implementing it across all health plans
- Created summary reports and review processes to assist the agency with its full reporting and monitoring requirements
- Assisted the agency by reviewing results, answering staff questions, and discussing outcomes with health plans

# 2019–2020 State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

- Reviewed the financial performance of the health plan by analyzing both external and internal financial reports to determine actual profitability; gathered additional data to obtain a more detailed picture of the cost structure of administrative functions performed by the local entity and corporate office allocations
- Conducted on-site interviews with staff to understand processes for identifying high-cost items and areas of concern; discussed all related party arrangements to determine the true costs of managing the population

# **Cost Reporting Development and Monitoring**

# 2019–2024 State of California, Health and Human Services Agency, Department of Health Care Services

- Performed desk and on-site audits of the information provided by health plans for rate development by testing and validating data against health plan detail information
- Performed on-site reviews of health plan processes and systems to ensure data accuracy
- Reviewed related party transactions to help determine the actual cost structure of health plans
- Prepared a final audit report for public distribution

# 2019–2024 State of California, Health and Human Services Agency, Department of Health Care Services

- Reviewed MLR information submitted by health plans
- Oversaw the process of comparing MLR data to that submitted by health plans for rate setting and quarterly financial reports; researched variances to identify potential errors in the MLR submissions and communicated necessary corrections to the health plans for resubmission



# Nicole Kaufman, JD, LL.M Principal



# Summary of Experience

Nicole, a Principal in Mercer's Government Human Services Consulting practice, brings immense value to the team. Specifically for the State of West Virginia, we chose her to support you because for over five years, she has provided managed care policy and operational consulting services to Mercer's state Medicaid clients, including request for proposal development and readiness reviews, reviews of managed care contracts to ensure federal regulatory compliance and incorporation of best practices, implementation of provider reimbursement strategies such as directed payments, and negotiations with the Centers for Medicare & Medicaid Services (CMS) on federal authorities and managed care contract approvals. Nicole currently supports Kentucky, Missouri, and Nevada on Medicaid managed care policy and program oversight strategies, Medicaid regulatory compliance, dual eligible special needs plan oversight, and Medicaid financial policy.

# Role: Medicaid Policy Subject Matter Expert and Research Analyst/Consultant

- √ 14+ years of managed care policy and operational consulting for state Medicaid clients
- Subject Matter Expert for Medicaid managed care policy and served as the primary author of CMS Medicaid Managed Care Final Rule (April 2016) and Proposed Rule (June 2015)
- Experience crafting CMS managed care reports including 1915 (b) waiver applications/amendments.

  Medicaid and CHIP Program
  Annual Report (MACPAR) and Fraud. Waste. Abuse (FWA) compliance reports
- ✓ Juris Doctor and Master of Laws in Health Law

Before joining Mercer in 2016, Nicole held a senior position in the CMS Baltimore Central Office's Division of Managed Care Plans. Nicole was the subject matter expert for Medicaid managed care policy and served as the primary author of CMS' Medicaid Managed Care Final Rule (April 2016) and Proposed Rule (June 2015). Nicole also specialized in the negotiation of complex Section 1115 demonstration waiver projects that involved delivery system integration and Delivery System Reform Incentive Payment programs. From 2022 to 2023, in her Managing Director position with another consulting firm, Nicole revised the Certified Community Behavioral Health Clinic reimbursement guidance for managed care delivery systems. She also presented this topic to planning grant and current demonstration states on behalf of CMS. Nicole returned to Mercer in January 2024.



# **Education**

2008 Master of Laws in Health Law, Saint Louis University, School of Law, St. Louis, MO, USA

2007 Juris Doctor, Southern Illinois University, School of Law, Carbondale, IL, USA

2003 Bachelor of Arts in History and Political Science, University of Illinois, Champaign, IL, USA



# **Years of Experience**

- 7 Mercer Experience
- 14 Career Experience



# Relevant Experience

# **Federal Regulation Implementation**

# 2024–2025 Commonwealth of Kentucky, Department for Medicaid Services

 Served as project and policy lead to facilitate implementation and overall compliance across the following federal rules: Medicaid and CHIP Managed Care, Access and HCBS, Section 504 of the Rehabilitation Act, Older Americans Act, HCBS Settings, and Adult Protective Services

# Procurement Strategy, Contracts, and Support

# 2024–2025 State of Nevada, Department of Health and Human Services, Division of Health Care Finance and Policy

Provided comprehensive support in the development of a request for proposal for Nevada's managed care program focusing on policy development to support programmatic goals, design of state oversight mechanisms, and a complete restructuring of the State's managed care contract

# 2017–2022 Puerto Rico, Health Insurance Administration, Administración de Seguros de Salud (ASES) de Puerto Rico

- Supported Puerto Rico in developing and implementing provider reimbursement strategies to comply with Congressional directives, expand the service array, and stabilize the provider network through directed payments and other strategies
- Drafted State Plan Amendments to address the Coronavirus Disease 2019 Public Health Emergency
- Supported drafting of the request for proposal for a comprehensive redesign of Puerto Rico's Medicaid managed care program, drafted the model managed care contract, facilitated the consensus process for evaluation of bids, and participated in readiness reviews across several subject matter areas

# **Readiness Reviews**

#### 2025–2025 State of Ohio, Department of Medicaid

 Directed and supported the State and Mercer subject matter teams during the desk review process for the Ohio MyCare readiness review

# Program Design, Planning, and Strategy

# 2024–2025 State of Nevada, Department of Health and Human Services, Division of Health Care Finance and Policy

- Provided technical assistance and design recommendations to revise Nevada's Dual Eligible Special Needs Plans (D-SNP) State Medicaid Agency Contract and to create D-SNP annual reporting requirements
- Drafted D-SNP training materials to support the ongoing state oversight of the D-SNP program



# Colby Schaeffer, ASA, MAAA Partner (Incline)



# **Summary of Experience**

Colby, a Founding Partner and Actuary at Incline Actuarial Group, will help lead the Mercer team utilizing his significant experience with West Virginia's Medicaid program. He has more than 10 years of experience with Medicaid and Children's Health Insurance Progam (CHIP) Managed Care rate setting. He has developed more than two dozen rate certifications that have been successfully submitted to the Centers for

# Role: Lead Actuary

- √ 10+ years of actuarial experience in over 15 different states Medicaid programs.
- Associate of the Society of Actuaries (ASA)
- Member of the American Academy of Actuaries (MAAA)

Medicare & Medicaid Services (CMS). Colby has led comprehensive project teams supporting multi-billion-dollar programs for states such as Arizona, Georgia, Oklahoma, Tennessee, and West Virginia in addition to the Medicaid actuarial support he has provided for numerous other states. He has deep experience working with the State of West Virginia as an actuary representing the Bureau for Medical Services (BMS) from 2012 to 2015 and again from 2017 to 2021. In his time supporting BMS, Colby developed the Hospital Directed Payment Payment, which involved meeting the hospital association and working directly with CMS to navigate challenges amidst Medicaid Expansion. He certified the first set of capitation rates for the Affordable Care Act (ACA) Expansion population, pharmacy carve-in (and carve-out), behavioral health carve-in, adult dental benefit add-on, and the foster care population (Mountain Health Promise). Colby also played a key role working with the State on the adoption of expanded benefit provisions under the 1115 Medicaid Substance Use Disorder waiver.

Although Colby has primarily worked in consulting, his experience also includes working for a major health insurance company, as well as having leadership roles with two different State Medicaid agencies where he was the Chief Actuary for Arizona's Medicaid agency and then, most recently, supporting Oklahoma Health Care Authority as Interim Chief Financial Officer. In addition to his work experience, Colby has actively volunteered with the Society of Actuaries (SOA) and American Academy of Actuaries (AAA). Through volunteering, he has engaged in multiple Medicaid committees, supported actuarial thought leadership in Medicaid, and served as leader of the SOA's Medicaid public interest group for the last five years. Colby also led the national impact study and development of a publicly available working model on the Medicaid Unwinding for the SOA.



# **Education**

2007 Bachelor of Science in Mathematics, Pennsylvania State University, State College, PA, USA



# **Certifications and Licenses**

2014 Associate of the Society of Actuaries (ASA), Society of Actuaries

2014 Member of the American Academy of Actuaries (MAAA), American Academy of Actuaries



# **Professional Affiliations**

Associate, Society of Actuaries

Member, American Academy of Actuaries



# **Years of Experience**

2 Mercer Experience

18 Career Experience



# Relevant Experience

# Financial Analysis and Budget Modeling

## 2025-present State of Oklahoma, Health Care Authority

- Present budget appropriations request to State Senate, namely questions around sustainability of ACA Expansion costs and the post-unwinding impact on Medicaid
- Estimate the fiscal impact of new policy and programmatic changes, such as revisions to provider reimbursement levels, newly covered benefits, and state legislative changes, to support Oklahoma's state budget projections

#### 2021–2023 State of Arizona, Health Care Cost Containment System

- Presented to Arizona's Joint Legislative Budget Committee on fiscal impact of annual changes in capitation rates with delineation on what is legislative mandated
- Evaluated the fiscal impact of new policy and programmatic changes, such as revisions to provider reimbursement levels, newly covered benefits, and state legislative changes, to support Arizona in internal leadership meetings

#### 2020–2021 State of Oklahoma, Health Care Authority

 Certified essential health benefits actuarial certification for benefit and network needs with respect to the ACA Expansion population in Oklahoma Medicaid

# 2017–2021 State of West Virginia, Bureau for Medical Services

- Evaluated fiscal impact of proposed legislative changes
- Compiled Incurred but Not Reported (IBNR) valuation for entire Medicaid program, including both fee-for-service (FFS) and managed care expenditures
- Calculated managed care savings estimates for evolving Medicaid program
- Developed budgeted tiered rates for 1915(c) waiver population covering Intellectually and Developmentally Disabled population

• Supported West Virginia's legislative inquiries related to the financial performance of the managed care organizations (MCOs)

# 2015–2021 State of Georgia, Department of Community Health

- Presented to Governor's Office Budget Committee on impacts of federal health reform
- Compiled annual IBNR valuation report for entire Georgia Medicaid program, including both FFS and managed care expenditures

# 2014–2014 Health Strategies of New Hampshire

Developed pro forma with specific pricing build-up designed for ACA Expansion benefit scenarios to build on a micro-simulation model estimate of projected base costs and enrollment in New Hampshire's Medicaid program

# Value-Based Purchasing and Payment Reform

#### 2025-present State of Oklahoma, Health Care Authority

 Engage in internal workgroups in the development of the primary care spending target for Oklahoma MCOs where, through state statute, spending is to not be less than 11% of total healthcare expenses on primary care services

#### 2023-present Gloria Gates Care

 Enable a Medicaid-focused primary care practice startup to transform rural healthcare by switching from a primarily FFS model to nearly complete capitation for both primary care and other preventive services

#### 2020–2021 State of Oklahoma, Health Care Authority

 Certified essential health benefits actuarial certification for benefit and network needs with respect to the ACA Expansion population

# 2015–2021 State of Tennessee, TennCare

Supported the actuarial and financial aspects of the design and implementation of the
Employment and Community First CHOICES program, which provides long-term
services and supports (LTSS) to individuals with intellectual or developmental
disabilities, helping individuals gain independence and live in the community or with
their families, offering services such as job skills training, employment assistance, peer
support, and mental health treatment

# **Capitation Rate Development — Acute Care**

# 2024—present Commonwealth of Virginia, Department of Medical Assistance Services

- Developed acuity adjustment factors to account for the Medicaid unwinding
- Modeled implementation of enhanced federal match for family planning and mobile crisis services for Virginia's Medicaid program

# 2023-present State of New Mexico, Health Care Authority

 Provided actuarial support to the development of actuarially sound capitation rates for New Mexico's Medicaid Managed Care Program for the Temporary Assistance for

Needy Families (TANF), Supplemental Security Income (SSI), and Expansion populations

# 2023–2023 Society of Actuaries, Health Research Council

 Led the writing of a national research paper, which included modeling of scenarios for how Medicaid programs across the country would be financially impacted by the unwinding of Medicaid continuous coverage provisions

#### 2021–2023 State of Arizona, Health Care Cost Containment System

 Provided actuarial support to the development of actuarially sound capitation rates for Arizona's Medicaid Managed Care Program for TANF, SSI, and Expansion populations, which were part of annual reviewed of Arizona Health Care Cost Containment System Completed Care capitation rates before submission to CMS

# 2017–2021 State of West Virginia, Bureau for Medical Services

- Developed and certified actuarially sound capitation rates for West Virginia's Medicaid Managed Care Program for the TANF and Expansion populations
- Developed documentation of actuarially sound rate development for submission to CMS and provided support to West Virginia in responding to CMS inquiries, resulting in the approval of capitation rates
- Provided support to West Virginia in communicating the actuarially sound capitation rates to MCOs, which included presenting the actuarially sound rate development process, responding to MCO inquiries, and evaluating MCO feedback, resulting in MCO acceptance of the capitation rates
- Evaluated the financial impact of capitation rate development and State budgets for new policy and programmatic changes, including revisions to provider reimbursement levels, newly covered benefits, State legislative changes, and minimum wage ordinances

# 2015–2021 State of Georgia, Department of Community Health

- Developed and certified actuarially sound capitation rates for Georgia's Medicaid Program for the TANF, Planning for Healthy Babies, and Foster Care populations
- Developed documentation of actuarially sound rate development for submission to CMS, resulting in the approval of capitation rates
- Provided support in communicating actuarially sound capitation rates to MCOs, which
  included presenting rate development process, responding to MCO inquiries and
  evaluating MCO feedback, resulting in MCO acceptance of the capitation rates
- Evaluated the financial impact of capitation rate development and State budgets for new policy and programmatic changes, including revisions to provider reimbursement levels, newly covered benefits, and State legislative changes
- Certified separate non-emergency medical transportation rates paid to brokers servicing acute care needs

## 2015–2020 State of Tennessee, TennCare

- Assisted in developing actuarially sound capitation rates for Tennessee's Medicaid Managed Care Program for the TANF, SSI, Dual-Eligibles, and LTSS cohorts
- Assisted in developing documentation of actuarially sound rate development for submission to CMS and provided support to Tennessee in responding to CMS inquiries, resulting in the approval of capitation rates

- Provided support to Tennessee in communicating the actuarially sound capitation rates to MCOs, which includes presenting the actuarially sound rate development process, responding to MCO inquiries, and evaluating MCO feedback, resulting in MCO acceptance of the capitation rates
- Evaluated the financial impact of capitation rate development and State budgets for new policy and programmatic changes, including revisions to provider reimbursement levels, newly covered benefits, and State legislative changes

#### 2012–2015 State of West Virginia, Bureau for Medical Services

- Developed and certified actuarially sound capitation rates for West Virginia's Medicaid Managed Care Program for the TANF and Expansion populations
- Developed documentation of actuarially sound rate development for submission to CMS and provide support to West Virginia in responding to CMS inquiries, resulting in the approval of capitation rates
- Provided support to West Virginia in communicating the actuarially sound capitation rates to MCOs, which included presenting the actuarially sound rate development process, responding to MCO inquiries, and evaluating MCO feedback, resulting in MCO acceptance of the capitation rates
- Evaluated the financial impact of capitation rate development and State budgets for new policy and programmatic changes, including revisions to provider reimbursement levels, newly covered benefits, State legislative changes, and minimum wage ordinances

# **Risk Mitigation Strategies**

#### 2023–2024 National Association of Medicaid Directors

- Led the development and presentation to about 50 different State Medicaid leaders
  with backgrounds in finance, policy, and operations as part of a skills-based training
  series titled, "Bridging Finance & Policy: Interdisciplinary Decision-Making in Medicaid."
- Created an executive decision-making tool made available to all attendees that was
  used in multiple case studies to see how it can be used for matters of fiscal impact
  studies, risk mitigation strategies, legislative requests, and impacts to waivers.

# 2021–2023 State of Arizona, Health Care Cost Containment System

- Increased standard reinsurance deductible over multiple years, resulting in an increase
  from the long-standing \$35,000 attachment point all the way up to \$150,000, which
  involved not only changes to State policy and the capitation rates, but also significant
  stakeholder management with the MCO association
- Implemented new risk corridor for Coronavirus Disease 2019-related costs, as well as made updates to other tiered risk corridors impacting Arizona Medicaid MCOs

#### 2017–2021 State of West Virginia, Bureau for Medical Services

- Implemented the inaugural Chronic Illness and Disability Payment System plus Pharmacy (CDPS+Rx) risk adjustment in West Virginia's capitation rates
- Developed informational documents on risk mitigation options, facilitated stakeholder discussions with West Virginia and the MCOs, and provided support throughout the decision-making process on various changes to capitation carve-outs and risk corridors

#### 2012–2015 State of West Virginia, Bureau for Medical Services

- Modeled carve-in and carve-out studies for the managed care program, as well as other risk mitigation strategies for both the MCOs and State
- Contributed to the writing and review process of the West Virginia MCO contracts, ensuring agreement on the language by the MCOs

# **Capitation Rate Development — Behavioral Health**

# 2023-present State of New Mexico, Health Care Authority

 Provide actuarial support to the development of actuarially sound capitation rates for New Mexico's Medicaid Managed Care Program covering behavioral health services

#### 2021–2023 State of Arizona, Health Care Cost Containment System

- Developed and certified actuarially sound capitation rates for Arizona's Regional Behavioral Health Authority Program for the TANF, SSI, and Expansion Populations
- Developed documentation of actuarially sound rate development for submission to CMS, resulting in the approval of capitation rates
- Provided support in communicating the actuarially sound capitation rates to MCOs, which included presenting the actuarially sound rate development process, responding to MCO inquiries, and evaluating MCO feedback, resulting in acceptance of the capitation rates
- Evaluated the completeness and accuracy of encounter and sub-capitated data submitted by MCOs to ensure data was appropriate for the development of rates

#### 2012–2015 State of West Virginia, Bureau for Medical Services

 Developed the first set of capitation rates for West Virginia's Medicaid program that included the carve-in of behavioral health services for TANF and Expansion populations

## Capitation Rate Development — LTSS

# 2023-present State of New Mexico, Human Services Department

 Provide actuarial support to develop actuarially sound capitation rates for New Mexico's Medicaid Managed Care Program covering LTSS

#### 2021–2023 State of Arizona, Health Care Cost Containment System

- Developed and certified actuarially sound capitation rates for Arizona's Medicaid Managed Care Program for the LTSS populations
- Developed documentation of actuarially sound rate development for submission to CMS in responding to CMS inquiries, resulting in the approval of capitation rates
- Evaluated the financial impact of capitation rate development and State budgets for new policy and programmatic changes, including revisions to provider reimbursement levels, newly covered benefits, State legislative changes, and minimum wage ordinances

# 2015–2021 State of Tennessee, Department of Health and Human Services, TennCare

- Developed and certified actuarially sound capitation rates for Tennessee's Medicaid Managed Care Program for the LTSS populations (called CHOICES), which include both Dual Eligibles and Medicaid-only members
- Assisted in developing documentation of actuarially sound rate development for submission to CMS and provided support to TennCare in responding to CMS inquiries, resulting in the approval of capitation rates
- Provided support to TennCare in communicating capitation rates to MCOs, which
  includes presenting the actuarially sound rate development process, responding to
  MCO inquiries, and evaluating MCO feedback, resulting in MCO acceptance of the
  capitation rates
- Evaluated the financial impact of capitation rate development and State budgets for new policy and programmatic changes, including revisions to provider reimbursement levels, newly covered benefits, and State legislative changes

#### **Provider Reimbursement Rates**

# 2023-present Gloria Gates Care

- Develop a manual rate model to price out the value of their services, including cost savings generated by provider's delivery care model for Pennsylvania Medicaid MCOs covering CHIP, TANF, ACA Expansion, and dual eligible special needs plan (D-SNP) (dual eligibles with or without LTSS)
- Certify actuarial memorandums outlining the pricing methodology and value proposition that was leveraged in multiple successful contract negotiations for this risk-bearing Medicaid-focused primary care practice startup
- Create dashboards analyzing market opportunities for new clinics and studies on the inclusion of transportation and behavioral health services

#### 2017–2021 State of West Virginia, Bureau for Medical Services

- Analyzed changes to West Virginia's fee schedules and subsequent impact to providers
- Developed budgeted tiered rates paid to providers and caregivers for 1915(c) waiver population covering the Intellectually and Developmentally Disabled population

# **Risk Adjustment**

# 2021–2023 State of Arizona, Health Care Cost Containment System

- Reviewed impact of the CDPS+Rx risk scores on different Arizona MCOs
- Transitioned State agency workforce to take on risk adjustment modeling responsibilities over a multi-year effort working with an outside contractor, as well as ensuring data and coding capabilities were ready for project effort

# 2018–2021 State of West Virginia, Bureau for Medical Services

 Led the implementation of the CDPS+Rx risk adjustment model for West Virginia's Medicaid managed care capitation rates in the Mountain Health Trust program, effective with the State Fiscal Year 2019 (SFY19) rates.

# 2016–2018 State of Georgia, Department of Community Health

- Led the implementation of the CDPS+Rx risk adjustment model for Georgia's Medicaid managed care capitation rates, effective with the SFY18 rates.
- Managed stakeholder feedback from health plans by walking through proposed methodology an entire year prior to implementation and securely sharing patient level data

# 2015–2020 State of Tennessee, TennCare

 Certified capitation rates for Non-CHOICES program, which included analysis of the impact of annual updates to Adjusted Clinical Group risk adjustment methodology on capitation rates

# **Medicaid Financing**

# 2025-present State of Oklahoma, Health Care Authority

- Provide interim Chief Financial Officer support at Oklahoma Health Care Authority
  evaluating impacts to Medicaid financing through the post-unwinding, initial year of
  managed care rollout and federal changes (including cashflow analysis and working
  with legislature)
- Manage stakeholders to move forward new 438.6(c) directed payments for submission to CMS including working with providers and ensuring appropriate language is established for state plan amendment

#### 2021–2023 State of Arizona, Health Care Cost Containment System

- Oversaw documentation of 438.6(c) directed payments for submission to CMS and provided financial and actuarial review support within Arizona agency in responding to CMS inquiries, resulting in the approval of 438.6(c) directed payments
- Engaged in internal Arizona workgroups determining American Rescue Plan Act (ARPA) funding application and then estimated managed care expenditures relevant to the increased Federal Medical Assistance Percentage as legislated ARPA

# 2017–2021 State of West Virginia, Bureau for Medical Services

- Evaluated impact of potential federal health reform with scenario modeling on the impact to how the Medicaid program is funded through block grants and per capita caps
- Oversaw documentation of 438.6(c) directed payments for submission to CMS and provided financial and actuarial review support to West Virginia in responding to CMS inquiries, resulting in the approval of 438.6(c) directed payments

#### 2012–2015 State of West Virginia, Bureau for Medical Services

 Evaluated impact of changes to managed care program and changes to Federal Medical Assistance Percentage through ACA Expansion and development of directed payments

# Waiver Design and Development

# 2017–2021 State of West Virginia, Bureau for Medical Services

Calculated cost effectiveness for 1915(b) Mountain Health Trust waiver

• Evaluated the financial impact and budget neutrality of West Virginia's 1115 substance use disorder waiver when it was being implemented

# 2019–2020 State of Wyoming, Department of Health

- Calculated cost effectiveness for 1915(b) waiver that covered statewide Care
  Management Entity program to provide targeted case management services via a
  high-fidelity wraparound delivery model for Medicaid eligible youth four years to 20
  years old with serious emotional disturbance or serious and persistent mental illness
  who are high utilizers of behavioral health services
- Developed tiered rates for different acuity levels requiring case management

#### 2016–2016 State of Kansas

 Supported 1915(c) waiver integration efforts for Kansas Medicaid to ensure budget neutral impact with alignment of FFS rates across the separate waivers by working with State agency, certifying actuaries, and clinical staff



# Stewart Campbell, ASA, MAAA Senior Principal



# **Summary of Experience**

Stewart, a Principal and Actuary in Mercer's Government Human Services Consulting practice, brings immense value to the team. Specifically for the State of West Virginia, we chose him to support you because Stewart provides actuarial consulting services to develop capitation rates reflective of the efficient managed care environments expected by state clients. He also supports his clients during negotiations with contractors and the Centers for Medicare & Medicaid Services (CMS). Stewart's experience at Mercer includes capitation rate development and actuarial support on various projects for

# Role: Lead Actuary

- √ 16+ years of actuarial experience
- Significant roles in capitation rate development and actuarial support for various state Medicaid programs
- Associate of the Society of Actuaries
- Member of the American Academy of Actuaries
- ✓ Bachelor of Science in Mathematics

Connecticut, Massachusetts, New Mexico, and Pennsylvania. Outside of Mercer, he has Medicaid experience with the Arizona Health Care Cost Containment System (AHCCCS), where he served as the Lead Actuary for AHCCCS' Regional Behavioral Health Authority Program.

Since April 2019, Stewart has been working with New Mexico and currently serves as the Lead Actuary. In this role, he leads Mercer's team for New Mexico across actuarial and policy consulting projects, while managing timelines and staff. Throughout his career, Stewart has developed and certified capitation rates for several states across lines of business, including acute, behavioral health, managed long-term services and supports, and adult expansion. He is also experienced in managed care program and benefit design, encounter and financial data validation and analysis, and stakeholder communication support.



#### **Education**

2008 Bachelor of Science in Mathematics, Arizona State University, Tempe, AZ, USA



# **Certifications and Licenses**

2015 Associate of the Society of Actuaries (ASA)

2015 Member of the American Academy of Actuaries (MAAA)



# **Professional Affiliations**

Associate, Society of Actuaries

Member, American Academy of Actuaries



# Years of Experience

- 11 Mercer Experience
- 16 Career Experience



# **Relevant Experience**

#### PACE

# 2024-present State of New Mexico, Human Services Department

- Developed the Amount that Would have Otherwise been Paid (AWOP) for New Mexico's Program of All Inclusive Care for the Elderly (PACE), which include both Dual Eligibles and Medicaid-only members
- Developed documentation of the AWOP development for submission to CMS and provided support to New Mexico in responding to CMS inquiries, resulting in the approval of the AWOP and PACE capitation rates

#### **Capitation Rate Development — LTSS**

#### 2024—present State of New Mexico, Human Services Department

- Developed and certified actuarially sound capitation rates for New Mexico's Medicaid Managed Care Program for the Long-Term Services and Supports populations, which include both Dual Eligibles and Medicaid-only members
- Developed documentation of actuarially sound rate development for submission to CMS and provided support to New Mexico in responding to CMS inquiries, resulting in the approval of capitation rates
- Provided support to New Mexico in communicating the actuarially sound capitation
  rates to managed care organizations (MCOs), which includes presenting the actuarially
  sound rate development process, responding to MCO inquiries, and evaluating MCO
  feedback, resulting in MCO acceptance of the capitation rates
- Evaluated the financial impact of capitation rate development and state budgets for new policy and programmatic changes, including revisions to provider reimbursement levels, newly covered benefits, state legislative changes, and minimum wage ordinances

#### 2021–2022 State of New Mexico, Human Services Department

- Developed and certified actuarially sound capitation rates for New Mexico's Medicaid Managed Care Program for the Long-Term Services and Supports populations, which include both Dual Eligibles and Medicaid-only members
- Developed documentation of actuarially sound rate development for submission to CMS and provided support to New Mexico in responding to CMS inquiries, resulting in the approval of capitation rates

- Provided support to New Mexico in communicating the actuarially sound capitation rates to MCOs, which includes presenting the actuarially sound rate development process, responding to MCO inquiries, and evaluating MCO feedback, resulting in MCO acceptance of the capitation rates
- Evaluated the financial impact of capitation rate development and state budgets for new policy and programmatic changes, including revisions to provider reimbursement levels, newly covered benefits, state legislative changes, and minimum wage ordinances

#### 2011–2013 State of New Mexico, Human Services Department

- Assisted in developing actuarially sound capitation rates for New Mexico's Medicaid Managed Care Program for the Long-Term Services and Supports populations, which include both Dual Eligibles and Medicaid-only members
- Assisted in developing documentation of actuarially sound rate development for submission to CMS and provided support to New Mexico in responding to CMS inquiries, resulting in the approval of capitation rates
- Provided support to New Mexico in communicating the actuarially sound capitation rates to MCOs, which includes presenting the actuarially sound rate development process, responding to MCO inquiries, and evaluating MCO feedback, resulting in MCO acceptance of the capitation rates
- Evaluated the financial impact of capitation rate development and state budgets for new policy and programmatic changes, including revisions to provider reimbursement levels, newly covered benefits, and state legislative changes

#### **Provider Reimbursement Rates**

#### 2023–2024 State of New Mexico, Human Services Department

- Provided support in developing New Mexico's fee-for-service fee schedule provider reimbursement rates for professional services, benchmarked to Medicare provider reimbursement rates
- Provide support to New Mexico in responding to CMS inquiries, resulting in the approval of state plan amendment for the fee-for-service fee schedule provider reimbursement rates

# **Medicaid Financing**

#### 2021–2022 State of New Mexico, Human Services Department

 Estimated managed care expenditures relevant to the increased Federal Medical Assistance Percentage as legislated by the American Rescue Plan Act (ARPA) to support New Mexico's ARPA Spending Plan

#### 2019–2024 State of New Mexico, Human Services Department

- Developed documentation of 438.6(c) directed payments for submission to CMS and provided support to New Mexico in responding to CMS inquiries, resulting in the approval of 438.6(c) directed payments
- Provided 438.6(c) directed payment support to New Mexico, which includes reviewing New Mexico's documentation to the Managed Care Organizations and developing separate payment term directed payment amounts for providers

 Developed documentation of separate payment term directed payments for submission to CMS and provided support to New Mexico in responding to CMS inquiries

#### **Risk Mitigation Strategies**

#### 2021–2021 State of New Mexico, Human Services Department

- Led the development, stakeholdering, and analyses to support New Mexico's implementation of a new risk mitigation option effective January 1, 2022, with options focused on risk pools and expansion of risk adjustment, with New Mexico ultimately selecting a high-cost member risk pool
- Developed informational documents on risk mitigation options, facilitated stakeholder discussions with New Mexico and the MCOs, and provided support throughout the decision-making process
- Designed and modeled the process for developing premiums for the high-cost member risk pool, which would be implemented alongside capitation rates
- Developed documentation of the high-cost member risk pool for submission to CMS and provided support to New Mexico in responding to CMS inquiries, resulting in the approval of the high-cost member risk pool and associated capitation rates
- Contributed to the writing and review process of the MCO contracts, ensuring agreement on the language by the MCOs

#### **Risk Adjustment**

# 2020–2020 State of New Mexico, Human Services Department

 Assisted New Mexico in transitioning from the Medicaid Pharmacy risk adjustment model to the Chronic Illness and Disability Payment System plus Pharmacy risk adjustment model, including the development of New Mexico-specific cost weights

# Capitation Rate Development — Acute Care

# 2019-present State of New Mexico, Human Services Department

- Develop and certify actuarially sound capitation rates for New Mexico's Medicaid Managed Care Program for the Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), and Expansion populations
- Develop documentation of actuarially sound rate development for submission to CMS and provide support to New Mexico in responding to CMS inquiries, resulting in the approval of capitation rates
- Provide support to New Mexico in communicating the actuarially sound capitation rates to MCOs, which includes presenting the actuarially sound rate development process, responding to MCO inquiries, and evaluating MCO feedback, resulting in MCO acceptance of the capitation rates
- Evaluate the financial impact of capitation rate development and state budgets for new policy and programmatic changes, including revisions to provider reimbursement levels, newly covered benefits, state legislative changes, and minimum wage ordinances

# 2016–2016 Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health

- Developed and certified actuarially sound capitation rates for Massachusetts'
   MassHealth Program for the TANF, SSI, and Expansion populations
- Developed documentation of actuarially sound rate development for submission to CMS, resulting in the approval of capitation rates
- Provided support in communicating the actuarially sound capitation rates to MCOs, which includes presenting the actuarially sound rate development process, responding to MCO inquiries, and evaluating MCO feedback, resulting in MCO acceptance of the capitation rates
- Evaluated the financial impact of capitation rate development and state budgets for new policy and programmatic changes, including revisions to provider reimbursement levels, newly covered benefits, and state legislative changes

# 2014–2015 Commonwealth of Pennsylvania, Department of Human Services, Office of Medical Assistance Programs

- Assisted in developing actuarially sound capitation rates for Pennsylvania's Medicaid Managed Care Program for the TANF, SSI, and Expansion populations
- Assisted in developing documentation of actuarially sound rate development for submission to CMS and provided support to Pennsylvania in responding to CMS inquiries, resulting in the approval of capitation rates
- Provided support to Pennsylvania in communicating the actuarially sound capitation rates to MCOs, which includes presenting the actuarially sound rate development process, responding to MCO inquiries, and evaluating MCO feedback, resulting in MCO acceptance of the capitation rates
- Evaluated the financial impact of capitation rate development and state budgets for new policy and programmatic changes, including revisions to provider reimbursement levels, newly covered benefits, and state legislative changes

# Financial Analysis and Budget Modeling

# 2019-present State of New Mexico, Human Services Department

- Present to New Mexico the key drivers of year-over-year capitation rate changes to support inquiries from the legislature
- Estimate the financial impact of new policy and programmatic changes, such as
  revisions to provider reimbursement levels, newly covered benefits, state legislative
  changes, and minimum wage ordinances, to support New Mexico's state budget
  projections
- Support New Mexico's legislative inquiries related to the financial performance of the MCOs

# Value-Based Purchasing and Payment Reform

#### 2018–2019 Premera Blue Cross

- Contributed analytics, including financial impacts, to the implementation of a value-based program arrangement focused on quality improvement for anesthesiology provider groups
- Coordinated projects with various internal and external stakeholders

 Supported cross-sector efforts in designing and evaluating value-based purchasing strategies for commercial lines of business, such as bundled payments, quality incentive programs, and select centers of care

# 2015–2016 State of Connecticut, Department of Social Services

- Supported the design and implementation of Connecticut's Medicaid Quality
   Improvement and Shared Savings Program
- Assisted in communicating Connecticut's Medicaid Quality Improvement and Shared Savings Program to stakeholders, including presenting the program design to Connecticut's Council on Medical Assistance Program Oversight, provider groups, and member advocates
- Assisted in responding to stakeholder inquiries and evaluating stakeholder feedback, resulting in key stakeholder buy-in and support for the program

# Capitation Rate Development — Behavioral Health

#### 2017–2017 State of Arizona, Health Care Cost Containment System

- Developed and certified actuarially sound capitation rates for Arizona's Regional Behavioral Health Authority Program for the TANF, SSI, and Expansion Populations
- Developed documentation of actuarially sound rate development for submission to CMS, resulting in the approval of capitation rates
- Provided support in communicating the actuarially sound capitation rates to MCOs, which includes presenting the actuarially sound rate development process, responding to MCO inquiries, and evaluating MCO feedback, resulting in MCO acceptance of the capitation rates
- Evaluated the completeness and accuracy of encounter and sub-capitated data submitted by MCOs to ensure the data was appropriate for the development of actuarially sound capitation rates

# **Program Design, Planning, and Strategy**

# 2011–2013 State of Connecticut, Department of Social Services

Supported the design of Connecticut's Dual Demonstration

# Waiver Design and Development

# 2011–2013 State of New Mexico, Human Services Department

- Led the budget neutrality development for New Mexico's 1115 Waiver Demonstration, including model design, evaluation of financial and encounter data, review of eligibility data, trend analyses, and savings analyses
- Evaluated the financial impact of budget neutrality for new policy and programmatic changes, including the implementation of new programs, newly covered benefits, and expansion of membership



# Dave Dombrowski, ASA, MAAA Principal



# **Summary of Experience**

Dave, a Principal and Actuary in Mercer's Government Human Services Consulting practice, brings immense value to the team. Specifically for the State of West Virginia, we chose him to support you because Dave has over 15 years of actuarial experience working on over 20 different states' Medicaid programs.

Currently, Dave serves as a consulting actuary for California. Some highlights of his work include the development of fee schedules for behavioral health programs in multiple states,

# **Role: Staff Actuary**

- √ 15+ years of actuarial experience in over 20 different states' Medicaid programs
- Associate of the Society of Actuaries
- Member of the American Academy of Actuaries
- Charted Enterprise Risk Analyst
- ✓ Bachelor of Arts in Mathematics

acute care rate setting and rate negotiation, managed long-term services and supports, regulatory program change cost projections, reserving, and budget projections.

Before rejoining Mercer in 2024, Dave worked as a regulator for the Department of Insurance in Montana. He has also held positions as a corporate executive at a Fortune 50 insurer and as an opining actuary at a large dental insurance company.



# Education

- 2007 Graduate Certificate in Applied Statistics, Northern Arizona University, Flagstaff, AZ. USA
- 2006 Bachelor of Arts in Mathematics, University of North Carolina at Greensboro, Greensboro, NC, USA
- 2004 Bachelor of Business Administration, Management Information Systems, Western Michigan University, Kalamazoo, MI, USA



# **Certifications and Licenses**

- 2012 Associate of the Society of Actuaries (ASA)
- 2012 Member of the American Academy of Actuaries (MAAA)
- 2012 Chartered Enterprise Risk Analyst (CERA), Society of Actuaries



#### **Professional Affiliations**

Associate, Society of Actuaries

Member, American Academy of Actuaries



# **Years of Experience**

- 5 Mercer Experience
- 18 Career Experience



# Relevant Experience

# **Medicaid Financing**

# 2023-present State of California, Health and Human Services Agency, Department of Health Care Services

- Develop strategies with DHCS for the pricing and implementation of the Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM) program
- Incorporate FQHC APM payments into capitation rates and provide documentation to the Centers for Medicare & Medicaid Services (CMS)

# **Capitation Rate Development**

# 2023-present State of California, Health and Human Services Agency, Department of Health Care Services

- Support the development of actuarially sound capitation rates for the Medi-Cal
   Mainstream managed care program, which covers approximately 13.5 million lives
- Support DHCS in technical assistance sessions, including producing information-sharing exhibits, providing presentations of the rate development process to the health plans, and facilitating written and verbal Q&A sessions with the health plans
- Develop documentation of actuarially sound rate development for submission to CMS and provide support to the DHCS in responding to CMS inquiries

#### **Dental Services**

# 2023-present State of California, Health and Human Services Agency, Department of Health Care Services

- Develop and certify actuarially sound capitation dental rates for the Medi-Cal Dental Managed Care program, which covers approximately 900,000 lives across two counties
- Support the State in technical assistance sessions, including producing
  information-sharing packages, providing presentations of the rate development process
  to the health plans, and facilitating written and verbal Q&A sessions with the health
  plans
- Develop documentation of actuarially sound rate development for submission to CMS and provide support to the State in responding to CMS inquiries

#### 2015–2018 Delta Dental of Illinois

 Served as the appointed actuary responsible for performing reserving analysis and issuing the actuarial opinion for the year-end financial statements of a dental insurance company.

- Conducted pricing of dental products and filed rates with Departments of Insurance in over 40 states
- Performed annual budget projection analysis

#### **Defrayal Analysis**

#### 2022–2023 State of Montana, Commissioner of Securities and Insurance

- Analyzed claims submitted by health plans to determine their eligibility for defrayal
- Collaborated with CMS to understand and apply the applicable regulations for defrayal

#### Regulatory Rate Review

#### 2022–2023 State of Montana, Commissioner of Securities and Insurance

- Performed regulatory review of Medicare Supplement actuarial memoranda and rate filings submitted by health insurance companies to ensure compliance with State laws
- Analyzed trends, rates, and program changes submitted by the company

#### 2021–2022 State of Montana, Commissioner of Securities and Insurance

- Performed regulatory reviews of property and casualty rate filings submitted by insurance companies to ensure compliance with State regulations for Property and Casualty Insurance; included reviewing various lines of insurance, such as pet insurance, homeowners, automobile, general liability, business owners, crop/hail, and cyber
- Reviewed actuarial memoranda and rate filings for regulatory compliance
- Submitted objections to companies when their filings were found to be non-compliant
- Collaborated with companies to facilitate their filing process and ensure compliance with Montana state regulations

#### Reinsurance

#### 2023–2023 State of Montana, Commissioner of Securities and Insurance

 Served on the board of the Montana Reinsurance Association, a program sponsored by CMS that provides reinsurance for the Affordable Care Act program against large claimants; ensured compliance with various regulatory requirements

#### **Provider Fee Development**

#### 2019–2020 Michigan, Department of Health and Human Services

- Led the project as both the project and client lead to develop Mental Health and Behavioral Health fee schedule based on reliable data sources
- Conducted interviews with providers to gather detailed information about the services they offered, which informed the development of a fee schedule supported by robust data
- Presented the resulting fee schedule to client and provider stakeholders
- Developed and analyzed cost reporting information submitted by providers, which was utilized in rate development

## 2019–2019 Behavioral Healthcare, Developmental Disabilities and Hospitals State of Rhode Island

- Conducted interviews with providers to gather detailed information about the services they offered, which informed the development of a fee schedule supported by robust data
- Presented resulting fee schedule to client and provider stakeholders
- Developed and analyzed cost reporting information submitted by providers, which was utilized in rate development

#### Capitation Rate Development — Behavioral Health

## 2019–2019 Commonwealth of South Carolina, Department of Health and Social Services

Developed home- and community-based provider rates using a market-based approach

#### 2018–2020 Michigan, Department of Health and Human Services

- Developed actuarially sound capitation rates for the State's Medicaid program, covering all Medicaid populations
- Developed rate adjustments for relevant category of service, including analyzing trends, assessing the impact of program changes, and applying appropriate utilization management, reimbursement, and operations efficiency adjustments
- Provided support to the State in capitation rate negotiations with managed care organizations (MCOs)
- Developed a data book summarizing financial statements and encounter data used for analyzing capitation rates and developing rate bids
- Developed documentation of actuarially sound rate development for submission to CMS and assisted the State in responding to CMS inquiries, resulting in approval

#### Data Monitoring and Quality

#### 2018–2020 Michigan Department of Health and Human Services

- Analyzed financials submitted by Community Mental Health and Prepaid Inpatient Health Plans and compared them to the submitted encounter data
- Worked with plans to identify and rectify any discrepancies, ensuring that data could be used in rate setting and other analyses

#### **Capitation Rate Development — Acute Care**

#### 2018–2019 Alaska Department of Health and Social Services

- Developed rates for Request for Proposal to transition fee-for-service members to managed care
- Developed actuarially sound capitation rates for the State's Medicaid program, covering all Medicaid populations
- Developed rate adjustments for relevant category of service, including analyzing trends, assessing the impact of program changes, and applying appropriate utilization management, reimbursement, and operations efficiency adjustments
- Provided support to the State in capitation rate negotiations with MCOs

- Developed data book summarizing financial statements and encounter data used by MCOs for analyzing capitation rates and developing rate bids
- Developed documentation of actuarially sound rate development for submission to CMS and assisted the State in responding to CMS inquiries, resulting in approval

#### 2013–2015 State of Florida, Healthy Kids Corporation

- Served as the certifying health plan actuary responsible for developing rates for the Florida CHIP program
- Analyzed claims, trends, incurred but not reported (IBNR), program changes, and the competitive landscape to develop rates that supported the actuarial memoranda produced in the project
- Responded to inquiries from the actuary of Florida Healthy Kids regarding the rates developed

#### Capitation Rate Development — LTSS

#### 2013–2015 State of Florida, Agency for Health Care Administration

- Served as a planning actuary, providing support for rate negotiations between the plan and the State
- Collaborated with the plan association to successfully request rate adjustments that reflected experience significantly different from the rates provided by the State actuary
- Worked with the State to implement rate adjustment for vent-dependent community members
- Presented various plan support tasks, including annual budget projections, to executives
- Developed IBNR model used for monthly reserve calculations
- Analyzed detailed claims payments for accuracy and appropriateness



### Garland Chan, FSA, MAAA Senior Associate



#### **Summary of Experience**

Garland, a Senior Associate and Actuary in Mercer's Government Human Services
Consulting practice, brings immense value to the team. Specifically for the State of West Virginia, we chose him to support you because he provides actuarial consulting services to Mercer's state Medicaid clients. Before joining Mercer, he spent 15 years at Blue Shield of California, where he supported provider contract negotiations and conducted trend analysis.

#### **Role: Staff Actuary**

- 15+ years of actuarial healthcare experience
- Fellow of the Society of Actuaries
- Member of the American Academy of Actuaries
- Bachelor of Arts in Mathematics

Garland currently allocates his time equally between projects in Puerto Rico and Massachusetts. He is involved in rate setting and value-based contracting analysis for Puerto Rico, as well as supporting the Program Management Report for Massachusetts.



#### Education

1997 Bachelor of Arts in Mathematics, University of Washington, City, State, USA



#### **Certifications and Licenses**

**2014** Fellow of the Society of Actuaries (FSA)

2012 Member of the American Academy of Actuaries (MAAA)



#### **Professional Affiliations**

Fellow, Society of Actuaries

Member, American Academy of Actuaries



#### Years of Experience

1 Mercer Experience

16 Healthcare Experience



#### **Relevant Experience**

#### **Cost Reporting Development and Monitoring**

2024-present Puerto Rico, Health Insurance Administration, Administración de Seguros de Salud (ASES) de Puerto Rico

Monitor the FFY24 financials for Medical Loss Ratio reconciliation

2024—present Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health

Support the revamping of data and models for the Program Management Report

#### Financial Analysis and Budget Modeling

2024—present Puerto Rico, Health Insurance Administration, Administración de Seguros de Salud (ASES) de Puerto Rico

Support Puerto Rico's rate setting and value-based contracting analysis

#### Capitation Rate Development — Acute Care

2024–2024 Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health

Supported the capitation rate process for Health-Related Social Needs



## Dennis Yano Associate



#### **Summary of Experience**

Dennis, an Associate in Mercer's Government Human Services Consulting practice, brings immense value to the team. Specifically for the State of West Virginia, we chose him to support you because he maintains and updates rate models; performs financial reviews; builds and refines financial reporting, dashboards, incurred but not reported (IBNR) factors and

#### **Role: Technical Support Staff**

- √ 15+ years of experience in financial analysis and Medicaid program management
- Bachelor of Science in Mathematics

trend templates; projects enrollment; calculates program changes and non-medical benefits; processes internal billing and client invoices; and completes various ad hoc analyses for the Massachusetts and New Jersey teams. His clients have included Massachusetts (MassHealth), New Jersey, and Ohio on capitation rates. Additionally, Dennis worked on the implementation and review of the Medicaid Expansion projects for these states.

Before joining Mercer in 2012, Dennis worked as an analyst for Blue Cross Blue Shield of Arizona (BCBSAZ), where he focused on individual and group pricing, benefit adjustments, enrollment tracking and projections, IBNR analyses, forecasting, and creating, updating, and rebuilding multiple databases in SAS for the Actuarial department. During his six years with BCBSAZ, he also created the Project Manager, a program in Visual Basic for Microsoft Applications (VBA) that tracked projects and tasks for employees in the Actuarial department. He also utilized VBA to create a program for sales that tracked small group business opportunities and sales. In his last two years, he assisted in BCBSAZ's initial planning stages for the implementation of the Patient Protection and Affordable Care Act.

Before attending Arizona State University, Dennis enlisted in the US Navy for six years as a nuclear electrician's mate on the USS Abraham Lincoln (CVN-72), where he helped monitor and maintain the electrical equipment in the nuclear power plant. He also qualified for the most senior electrical watch station, which he stood for the duration of the Lincoln's participation in Operation Iraqi Freedom/Operation Enduring Freedom until his honorable discharge in 2004. Through his enlistment in the Navy, Dennis gained experience training junior personnel, considering alternative options, and planning and implementing complex tasks.



#### **Education**

2006 Bachelor of Science in Mathematics, Arizona State University, Tempe, AZ, USA



#### Years of Experience

12 Mercer Experience

#### 18 Career Experience



#### **Relevant Experience**

#### Financial Analysis and Budget Modeling

## 2016–2020 Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health

- Developed budget model for managed care organization/accountable care organization (MCO/ACO) to project the impact of price normalization, administration, underwriting gain, and program changes
- Analyzed and reported on the fiscal impact of carving out of delivery and high-cost drug claims for the MCO/ACO programs
- Developed savings estimates for state-specific pharmacy initiatives, including pharmacy carve out, script limit, utilization management mandates, drug coverage modifications, supplemental rebates, and specialty pharmacy reimbursement
- Developed a budget model that projects costs associated with moving clients out of nursing homes into the community to support a rebalancing initiative
- Analyzed data for MCO/ACO to determine the cost-effectiveness of clinical efficiencies, including PAPE, APAD, LANE, PPA, and others
- Estimated the potential financial implications of introducing Medicaid managed care
  into MassHealth, including an analysis of historical program expenses and a
  comparison of key metrics to other state Medicaid programs; conducted research on
  other managed care savings studies to assess potential areas of savings for
  MassHealth through managed care
- Provided MassHealth with a projection model for budget estimates related to abortion services and the Special Kids Special Care population, allowing the Commonwealth to monitor trends and develop budget requests

## 2012–2020 State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

- Developed budget model for acute and managed long-term services and supports (MLTSS) to project the impact of additional projects
- Analyzed, monitored, and reported the fiscal impact of carving in Aged, Blind, and Disabled (ABD) with Medicare pharmacy costs, subutex, and atypical antipsychotics to the acute care program between State Fiscal Year 2013 (SFY2013) and SFY2018
- Developed savings estimates for state-specific pharmacy initiatives, including pharmacy carve out, script limit, utilization management mandates, drug coverage modifications, supplemental rebates, and specialty pharmacy reimbursement
- Developed a budget model that projects costs associated with moving clients out of nursing homes into the community to support a rebalancing initiative
- Maintained the model for acute and MLTSS programs to determine the cost effectiveness of the DMAHS program
- Provided DMAHS with a projection model for budget estimates related to all services and populations, allowing the State to monitor trends and develop budget requests

#### 2012–2016 State of Ohio, Department of Medicaid

 Developed budget models for Ohio to project the impact of capitation rates and associated program changes

 Developed savings estimates for state-specific pharmacy initiatives, including pharmacy carve out, script limit, utilization management mandates, drug coverage modifications, supplemental rebates, and specialty pharmacy reimbursement

#### **Data Monitoring and Quality**

## 2016–2020 Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health

- Conducted MCO claims and encounter reviews, assessed the Commonwealth's encounter data systems and processes, and developed data quality benchmarks
- Analyzed and reported on managed care encounter data quality, including the development of financial reports
- Developed encounter data submission and error reports, and provided ongoing feedback to MCOs and MassHealth on improvement opportunities
- Evaluated the completeness and accuracy of encounter data submitted by MCO/ACO
  plans to ensure that it is appropriate for use in capitation rates and health-based risk
  adjustment

## 2012–2020 State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

- Conducted MCO claims and encounter reviews; assessed the State's encounter data systems and processes; and developed data quality benchmarks
- Analyzed and reported on managed care encounter data quality, including the development of the Statistical Analytics Report that allow DMAHS and participating Medicaid MCOs to review data by category of service (COS) and MCO
- Developed encounter data submission and error trending reports and provided ongoing feedback to MCOs and DMAHS on improvement opportunities
- Provided direct technical assistance to DMAHS in improving encounter data reporting, including an analysis of individual MCOs encounter submissions, on-site reviews of claims systems, and encounter data management practices
- Evaluated the completeness and accuracy of encounter data submitted by New Jersey Medicaid MCOs to ensure that it was appropriate for use in capitation rate setting and health-based risk adjustment
- Conducted encounter data validation in accordance with 42 CFR § 438.602(e) in New Jersey and provided actionable feedback on quality improvement opportunities for five MCOs and protocols for oversight of the State's encounter data management and reporting practices

#### 2012–2016 State of Ohio, Department of Medicaid

- Analyzed and reported on managed care encounter data quality, including the development of the quarterly and annual Cost Reports, which are used as the source for the Dashboards that allow Ohio to identify reporting issues in the data
- Developed encounter data submission and error trending reports and provided ongoing feedback to MCOs and Ohio on improvement opportunities
- Provided direct technical assistance to Ohio Medicaid MCOs in improving encounter data reporting, including an analysis of individual MCO encounter submissions, on-site reviews of claims systems, and encounter data management practices
- Developed a comprehensive report on data quality, including areas for improvement and corrective action plans, resulting in eventual rate adjustments

- Evaluated the completeness and accuracy of encounter data submitted by Ohio Medicaid MCOs to ensure that it was appropriate for use in health-based risk adjustment
- Conducted encounter data validation in accordance with 42 CFR § 438.602(e) in Ohio and provided actionable feedback on quality improvement opportunities for six MCOs and protocols for oversight of the State's encounter data management and reporting practices

#### Cost Reporting Development and Monitoring

## 2016–2020 Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health

- Developed financial cost reporting templates and submission and validation processes for the plans in MassHealth
- Supported MassHealth with quarterly and annual financial monitoring of plans in the MCO/ACO program
- Developed new financial monitoring tools on behalf of MassHealth to support the Centers for Medicare & Medicaid Services (CMS) requirements, such as medical loss ratio reporting and the health insurers' providers fee

#### 2012–2016 State of Ohio, Department of Medicaid

- Developed financial cost reporting templates and submission and validation processes for the MCOs in the Ohio Medicaid program
- Supported the Ohio Department of Medicaid with monthly, quarterly, and annual financial monitoring of MCOs in the Acute and Duals Demonstration programs, including analyzing dashboards to illustrate the major key drivers of change
- Developed new financial monitoring tools on behalf of Ohio to support CMS requirements, such as medical loss ratio reporting and Federal Medical Assistance Percentage (FMAP) calculations
- Created and maintained MCO cost report templates, documenting audit, and review procedures

#### **Capitation Rate Development** — Acute Care

## 2016–2020 Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health

- Performed rate development and certification for acute care services, which includes efficiency adjustments and support such as negotiations, TA sessions, and navigating CMS approval process
- Developed and certified actuarially sound capitation rates for MassHealth, including TANF and SSI, covering approximately 4.56 million lives from the RY2017 to RY2020 periods
- Developed and implemented supplemental (kick) payments for qualified applied behavioral analysis and abortion services
- Developed rate adjustments for the pharmacy category of service, including the
  development of pharmacy trends with consideration of brand drugs, specialty drugs,
  and patent expirations in the pipeline; analyzed state-level and managed care
  market-level pharmacy rebates; assessed the impact of pharmacy program changes;

- and applied appropriate utilization management, reimbursement, and operations efficiency adjustments
- Developed and implemented clinical efficiency adjustments in the capitation rates for APAD, PAPE, LANE, and PPA between RY2018 and RY2020, resulting in \$211 million in savings
- Developed data book summarizing Price Normalization for use by MassHealth and MCO/ACO entities in analyzing capitation rates and developing rate bids
- Developed documentation of actuarially sound rate development for submission to CMS and provided support to MassHealth in responding to CMS inquiries, resulting in the approval of RY2017 through RY2020 capitation rates
- Performed review of rates submitted by MCOs to support MassHealth in evaluating payment rates for the MCO/ACO program

## 2012–2020 State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

- Performed rate development and certification for acute care services, including efficiency adjustments and support such as negotiations, TA sessions, and navigating CMS approval process
- Developed actuarially sound capitation rates for New Jersey's Acute and MLTSS
  programs, including Parents in AFDC, NJC Adults, NJC Parents, Children in AFDC,
  KidCare D, ABD with Medicare, ABD without Medicare, ABD FIDE-SNP, and Maternity,
  covering approximately 14 million lives between SFY2013 and SFY2021
- Developed, monitored, and coordinated project supplemental (kick) payments for dual eligible special needs plan (D-SNP) (ABD FIDE-SNP) and maternity rate cells
- Developed rate adjustments for all categories of service, including the development of trends, application of appropriate utilization concerns, and efficiency adjustments
- Developed and implemented the Medical Management adjustments in the capitation rates for Acute rates, which included results from LANE, PPA, readmissions, MAC, Rx Clinical Edits, and HCPCS Review, resulting in \$477 million in savings between SFY2017 and SFY2020
- Developed financial reporting and summarizing for use by the State of New Jersey and the Medicaid MCOs in analyzing capitation rates
- Developed documentation of actuarially sound rate development for submission to CMS and provided support to New Jersey DMAHS in responding to CMS inquiries

#### 2012–2016 State of Ohio, Department of Medicaid

- Performed rate development and certification for acute care services, which included base adjustments, efficiency adjustments, program changes, and non-medical development
- Developed and certified actuarially sound capitation rates for the Ohio Department of Medicaid, including Covered Families and Children (CFC), ABD, and Extension (Medicaid Expansion) populations, covering approximately 5 million lives during the second half of the CY2013–CY2015 rate setting periods
- Developed and implemented supplemental payments for delivery
- Developed rate adjustments for all categories of service, including the review of pharmacy trends, managed care market-level pharmacy rebates, assessment of the impact of pharmacy program changes, and application of appropriate utilization management, reimbursement, and operational efficiency adjustments
- Implemented clinical efficiency adjustments in the capitation rates for all rate cells, including LANE and PP, resulting in \$37 million in savings for CY2015

- Developed data book summarizing Covered Families and Children (CFC), ABD, and Extension (Medicaid Expansion) populations for use by the MCOs and Ohio's Department of Medicaid in analyzing capitation rates and underlying data reporting
- Developed documentation of actuarially sound rate development for submission to CMS and provided support to the Ohio Department of Medicaid in responding to CMS inquiries for the CY2013B–CY2015 capitated rates
- Performed a review of rates submitted by MCOs to support Ohio in evaluating payment rates for acute care capitation rates

#### Medicaid Financing

## 2013–2016 State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

 Developed strategies with New Jersey DMAHS for enhanced claiming methodologies for Preventive Services, Money Follows the Person, and Balancing Incentive Program between SFY2014 and SFY2015

#### Program Design, Planning, and Strategy

## 2012–2020 State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

- Developed new programs, designed program expansion for new populations, and provided strategic planning on program development
- Designed program strategy for the New Jersey Medicaid expansion in 2014, including the development of program goals, processes, procedures, and recommendations
- Provided program design and strategy consulting related to Medicaid expansion, including alternative benefit package design, financial cost estimates for the expansion population under various delivery options, and recommendations for federal authority options
- Designed and developed a new coordinated system of care for the New Jersey
  Medicaid Expansion populations, including the design of the request for Medicaid
  authority, solicitation of stakeholder input, development of reimbursement methodology
  and payment rates, and the establishment of DMAHS' operational structure to deliver
  services under this new model

#### 2012–2016 State of Ohio, Department of Medicaid

- Designed the program strategy for Ohio's managed care and MyCare programs, including the development of program goals, processes, procedures, and recommendations
- Provided program design and strategy consulting related to Medicaid expansion, including alternative benefit package design, financial cost estimates for the expansion population under various delivery options, and recommendations for federal authority options
- Designed and developed a new coordinated system of care for dual-eligible enrollees, including the design of the request for Medicaid authority, solicitation of stakeholder input, development of reimbursement methodology and payment rates, and the establishment of the Ohio MyCare operational structure to deliver services under this new model

#### Procurement Strategy, Contracts, and Support

## 2012–2020 State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

 Developed a comprehensive requirement gathering and stakeholder feedback elicitation process to assist New Jersey DMAHS in the evaluation of options for the acute and MLTSS programs

#### **Contractor Performance Reviews**

## 2012–2020 State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

- Developed financial cost reporting templates and submission and validation processes for the MCOs in New Jersey Medicaid
- Supported DMAHS with monthly, quarterly, and annual financial monitoring of Medicaid MCOs in the acute and MLTSS programs, including the Statistical Analytic Report and Cost Comparison Report
- Developed new financial monitoring tools on behalf of DMAHS to support CMS requirements, such as medical loss ratio reporting

#### **Capitation Rate Development — LTSS**

## 2012–2020 State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

- Developed rate adjustments for MLTSS categories of service, including the development of base adjustments, trends, and program changes
- Developed documentation of actuarially sound rate development for submission to CMS and provided support to New Jersey in responding to CMS inquiries

#### Capitation Rate Development — Dual Eligibles

## 2012–2020 State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

- Supported DMAHS and Medicaid MCOs by providing technical and reporting assistance for the ABD FIDE-SNP
- Developed, monitored, and coordinated project supplemental (kick) payments for D-SNP (ABD FIDE-SNP) and maternity rate cells
- Developed rate adjustments for all categories of service, including the development of trends, and applying appropriate utilization concerns and efficiency adjustments
- Developed and certified actuarially sound capitation rates for New Jersey DMAHS ABD FIDE-SNP from SFY2013 through SFY2016, covering approximately 66,000 lives
- Developed documentation of actuarially sound rate development for submission to CMS and provided support to DMAHS in responding to CMS inquiries
- Performed a review of rates submitted by MCOs to support DMAHS in evaluating and negotiating payment rates for acute care capitation

#### 2012–2016 State of Ohio, Department of Medicaid

- Developed and implemented the demonstration years of Ohio's MyCare program, a
   Duals Demonstration/Integration program, and produced actuarially sound capitation
   rates
- Developed and implemented separate payments for Opt-In and Opt-Out members
- Developed rate adjustments for all categories of service, including the development of trends, assessing program changes, and applying appropriate efficiency adjustments
- Developed data book summarizing MyCare for use by the Ohio Department of Medicaid and the Medicaid-participating MCOs in analyzing capitation rates and developing rate bids
- Developed documentation of actuarially sound rate development for submission to CMS and provided support to the Ohio Department of Medicaid in responding to CMS inquiries for the CY2014–CY2015 capitated rates
- Performed a review of rates submitted by MCOs to support Ohio in evaluating payment rates for MyCare capitation rates

#### Data Mining, Analytics, and Visualization

## 2012–2020 State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

- Performed data management and analysis to inform decisions, provide actionable data, and monitor improvement activities, including data visualization, dashboarding, online public reporting, and annual expenditure reports (displaying results from underlying analytics/monitoring); data mining for clinical drivers and solutions; geospatial mapping/network adequacy assessments; surveillance
- Developed a web-based financial reporting system that captures MCO financial submissions on a quarterly and annual basis; produced standardized benchmarking dashboard reports and Cost Comparison Reports, providing DMAHS with insight into the financial performance of MCOs
- Developed and implemented a financial reporting system in DMAHS for acute and MLTSS programs to allow MCOs to submit financial reports electronically
- Developed pharmacy dashboards summarizing key cost and utilization of information for drugs by Therapeutic Class and Behavioral Health Classifications, allowing DMAHS to monitor and address trends in real time

#### 2012–2016 State of Ohio, Department of Medicaid

Developed and implemented financial dashboards in Ohio for Acute care and the Duals
Demonstration program to allow MCOs and the State of Ohio to review financial
reports easily with key metrics on medical spend, non-medical expenses, and key
healthcare ratios

#### Regulatory Compliance and Monitoring

#### 2012–2016 State of Ohio, Department of Medicaid

 Conducted encounter data validation in accordance with 42 CFR § 438.602(e) in Ohio and provided actionable feedback on quality improvement opportunities for six MCOs, as well as protocols for oversight of Ohio's encounter data management and reporting practices

#### Risk Adjustment

## 2012–2013 State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

- Conducted risk adjustment strategy research and design, including the application of capitation rates using tools such as Medicaid Rx, Chronic Illness and Disability Payment System (CDPS), and Adjusted Clinical Groups; functional-based risk adjustment for LTC/LTSS
- Implemented health-based risk adjustment using the CDPS plus Pharmacy model, including the development of DMAHS-specific CDPS cost weights

## Elijah Chesko, MBA Associate



#### **Summary of Experience**

Elijah, an Associate in Mercer's Government Human Services Consulting practice, brings immense value to the team. Specifically for the State of West Virginia, we chose him to support you because he is an analyst for Medicaid managed care rate setting teams working for multiple states including, but not limited to, Delaware, New Jersey, and Pennsylvania. His duties include summarizing, validating, and

#### **Role: Technical Support Staff**

- 10+ years of experience in financial analysis and working on Medicaid Managed Care rate setting teams
- Master of Business Administration and Bachelor of Science in Mathematics (Statistics)

completing base data; managing managed care organization (MCO) efficiency adjustments and annual program changes; applying trend factors; and summarizing and presenting final rates. Elijah also regularly collaborates with non-actuarial support staff, including informatics, clinicians, and pharmacists.



#### **Education**

- 2021 Master of Business Administration, Grand Canyon University, Phoenix, AZ, USA
- 2014 Bachelor of Science in Mathematics (Statistics), Minor in Economics, Arizona State University, Tucson, AZ, USA



#### **Years of Experience**

- 11 Mercer Experience
- 13 Career Experience



#### Relevant Experience

#### Capitation Rate Development — LTSS

## 2023—present Commonwealth of Pennsylvania, Department of Human Services, Office of Long-Term Living

Perform summary, validation, and completion of base data, management of MCO
efficiency adjustments and annual program changes, application of trend factors, and
summary and presentation of final rates

#### Capitation Rate Development — Acute Care

## 2014—present Commonwealth of Pennsylvania, Department of Human Services, Office of Medical Assistance Programs

Perform summary, validation, and completion of base data, management of MCO
efficiency adjustments and annual program changes, application of trend factors, and
summary and presentation of final rates

2018-2024	Commonwealth of Virginia, Department of Medical Assistance
	Services
2014-2017	State of Delaware, Department of Health and Social Services,
	Division of Medicaid and Medical Assistance

Performed summary, validation, and completion of base data, management of MCO
efficiency adjustments and annual program changes, application of trend factors, and
summary and presentation of final rates.



## Cassandra "Sandy" Amorado, MPH Associate



#### **Summary of Experience**

Sandy, an Associate in Mercer's Government Human Services Consulting practice, brings immense value to the team. Specifically for the State of West Virginia, we chose her to support you because she proactively optimizes Medicaid program efficiency and financial performance by analyzing complex reports, advising executives on cost-saving

#### **Role: Technical Support Staff**

- Experience in financial analysis and Medicaid program management
- Master of Public Health Health Management and Policy

strategies, and leading projects to deliver high-impact solutions within scope and budget. Sandy is currently part of the Nevada and Virginia project teams.

Before joining Mercer, Sandy worked for Aledade, Inc., where she leveraged advanced skills in data analysis, communication, and strategic planning while utilizing technology and collaborating cross-functionally to identify improvement opportunities and contribute to the company's strategic direction.



#### Education

- **2022** Master of Public Health Heath Management & Policy, Saint Louis University, St. Louis, MO, USA
- 2020 Bachelor of Arts in Psychology, Minor in Leadership and Change Management, Saint Louis University, St. Louis, MO, USA



#### Years of Experience

- <1 Mercer Experience</p>
- 2 Career Experience



#### Relevant Experience

#### Data Mining, Analytics, and Visualization

2024-present State of Nevada, Department of Health and Human Services, Division of Health Care Finance and Policy

- Work on risk corridors, rebate pass-throughs, and Federal Medical Assistance Percentage family planning
- Engage in developing the Nursing Facility Tax Payment model

## 2024-present Commonwealth of Virginia, Department of Medical Assistance Services

- Conduct analyses related to weight management agents, the removal of the Coronavirus Disease 2019 vaccine, and state-directed payments
- Work on Nurse Facility Value-Based Purchasing and trend evaluation

# Appendix B Actuarial Credentials

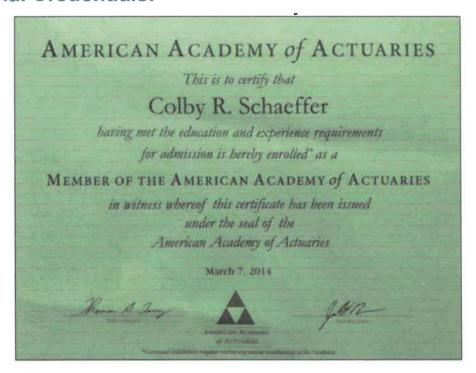
- 7. REQUIRED DOCUMENTS: All of the items checked in this section must be provided to the Purchasing Division by the Vendor as specified:
- ✓ LICENSE(S) /CERTIFICATIONS/ PERMITS: In addition to anything required under the Section of the General Terms and Conditions entitled Licensing, the apparent successful Vendor shall furnish proof of the following licenses, certifications, and/or permits upon request and in a form acceptable to the State. The request may be prior to or after contract award at the State's sole discretion.
- ✓ Fellows of the Society of Actuaries
- ✓ Member of the American Academy of Actuaries

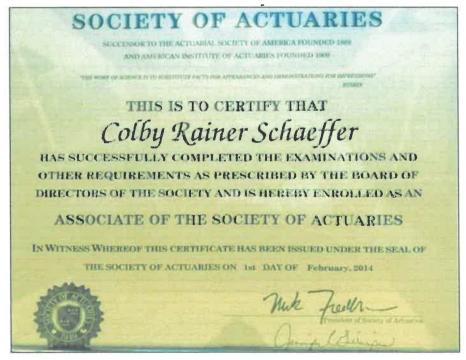
The apparent successful Vendor shall also furnish proof of any additional licenses or certifications contained in the specifications regardless of whether or not that requirement is listed above.

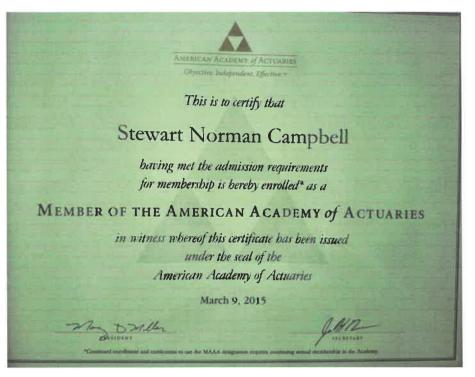
## **Confirmation of Staff Qualifications and Licensing Compliance**

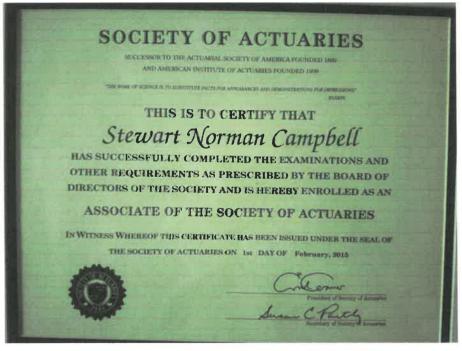
We confirm that our staff meets all the specified requirements outlined in the solicitation documents. Our team includes FSAs and MAAAs. On the following page, please find proof of these licenses and certifications.

#### **Actuarial Credentials:**









## AMERICAN ACADEMY of ACTUARIES

This is to certify that

## David Dombrowski

having met the education and experience requirements for admission is hereby enrolled as a

## MEMBER OF THE AMERICAN ACADEMY of ACTUARIES

in witness whereof this certificate has been issued under the seal of the American Academy of Actuaries

May 15, 2012





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and the Secretary or around another by as the Academ



This document certifies that

## David Dombrowski

having agreed to comply with the Code of Professional Conduct, disciplinary scheme and Continuing Professional Development requirements

#### SOCIETY OF ACTUARIES

and having also met the educational requirements of the CERA global syllabus has been awarded the designation

#### CHARTERED ENTERPRISE RISK ANALYST

by the

CERA Global Association

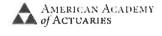
This certificate is issued by the

#### SOCIETY OF ACTUARIES

on April 27th, 2012



Bradley M. Smith



March 21, 2025

#### Verification of Membership

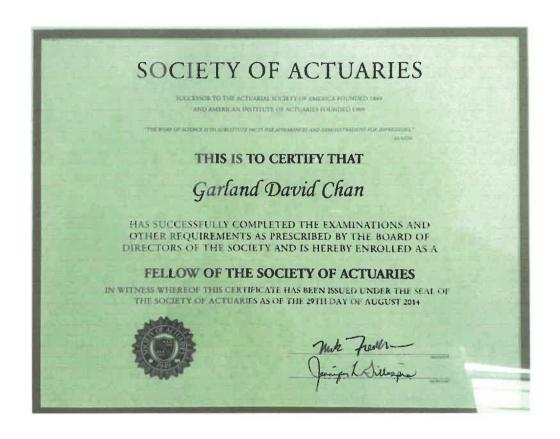
Garland Chan 201 Hale Street San Francisco, CA 94134 United States

As of March 21, 2025, Garland Chan, is a member of the American Academy of Actuaries (Academy). If you need further assistance, please don't hesitate to contact an Academy membership department staff member by calling (202) 223-8196.

Thank you,

Membership Department American Academy of Actuaries 1850 M Street, NW Suite 300 Washington, DC 20036 (202) 223-8196

1850 M Street NW Suite 300 Washington, DC 20036 Telephone 202 223 8196 Facsimile 202 872 1948 www.actuary.org



# Appendix C Conflict Mitigation Plan

Mercer's legal team has reviewed Mercer's systems and relationships. To the best of our knowledge and ability, we do not believe there are any instances that would present the appearance of a potential conflict of interest in West Virginia.

### **Mercer GHSC Management of Conflicts of Interest**

Management of potential conflicts of interest is extremely important to GHSC. Under no circumstances will GHSC ever use client information, leverage existing or potential client relationships, or take any action in a way that puts the interests of GHSC or our clients above the interest of another client. GHSC adheres to both the Mercer US Management of Business Conflicts of Interest Policy, as well as the broader Marsh and McLennan Companies Business Conflicts of Interest Policy. GHSC uses these policies to establish a framework for managing conflicts of interest. Summaries of these policies can be provided upon request. The below outlines the process used by GHSC to both identify and resolve any perceived conflicts of interest that may be of concern in connection with the West Virginia, CRFQ 0511 BMS2500000001 Medicaid Managed Care Rate Setting/Program Admin.

#### **Mercer GHSC Public Sector Focus**

One of the byproducts of being a nationally operated group dedicated to the public sector is the ability to identify and avoid potential conflicts of interest with our firm's multitude of clients. To accomplish this, market space lines have been established by Mercer (US). GHSC was established within Mercer's H&B LLC practice to consult with singular, full-time focus on government entities and specifically avoid any conflicts of interest across our various consulting practices. GHSC exercises great caution to protect our reputation as an independent, trusted advisor to its clients, studiously avoiding any conflicts of interest by working almost exclusively on the state side in publicly financed healthcare programs. Because we have established these clear guidelines regarding our consulting engagements, we rarely encounter potential conflicts of interest.

If potential conflicts should arise, GHSC will disclose the potential conflict to all parties and present solutions to avoid any conflict of interest to the mutual satisfaction of all parties. Solutions may include establishing appropriate safeguards such as keeping separate teams, restricting access to files, and establishing process firewalls to avoid any conflict of interest.

### Access to Data, Client, and Project Information

All computers within Mercer require multi-level authentication for access by individual staff, making data at the individual level secure. Each Mercer (US) operating company and business unit has shared drives on the network used to store files and working documents. These shared drives are only able to be accessed and viewed by employees of the individual business unit, which prevents unauthorized access to GHSC's shared drives by any Mercer (US) employee who is not part of GHSC. Only project team members have permissions within the system to access data and/or information for the network drive containing specific Mercer

project information. Only members of these project teams have permissions within the system to access data and/or information for the network drives containing their respective project information.

Permissions to GHSC network folders containing project information are assigned by Mercer's IT team and approved by the Project Team Lead. Access to these drives will be promptly removed if a team member leaves the project. GHSC also takes the additional measure of separating data and information on regional drives to further limit access to information and reduce the potential for exposure.

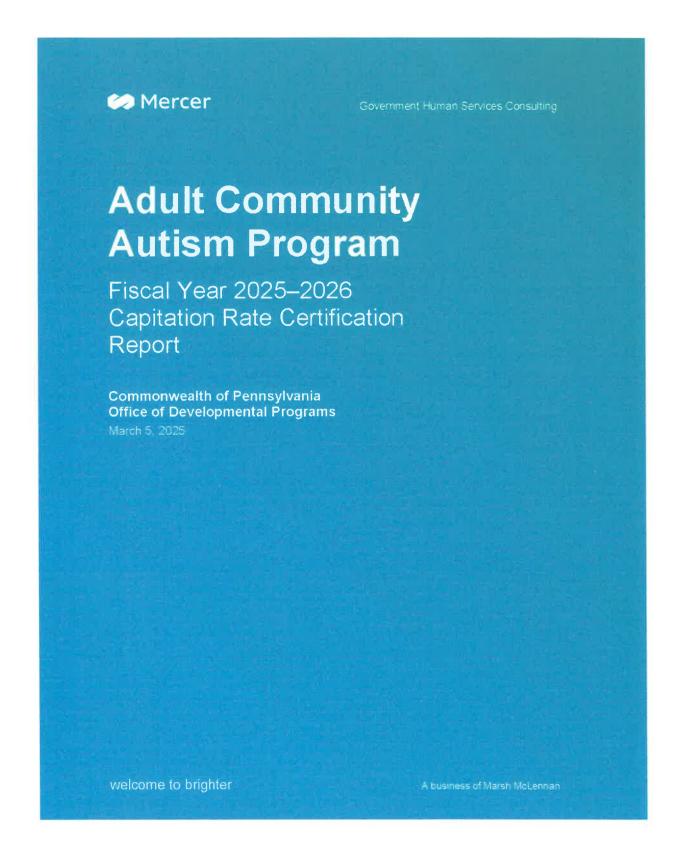
#### Dialogue

All GHSC colleagues understand the need for client confidentiality and preventing real or apparent conflicts of interest. GHSC will institute additional communication protocols that apply to all members of the project team with the goal of further preventing the appearance of a conflict of interest. Project team members will be instructed not to discuss any aspect of the project with any Mercer (US) employee outside the client team (that includes employees of GHSC or any other Mercer (US) operating company or business unit not assigned to the project).

In addition, members of the project team will be instructed not to communicate in any way (including email, phone, or in person) with any entities who may have the potential to create the appearance of a conflict of interest. If inbound communications are received by members of the project team that may present the appearance of a conflict, they are to be forwarded directly to the Project Lead.

# Appendix D Program Certification

To comply with the **RFQ requirement 4.1.6.5**, on the following page, Mercer is providing the title page and certification page including dates submitted for the following states: Pennsylvania and Puerto Rico.



Adult Community Autism Program

Chice of Developmental Proglams

for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual costs will differ from these projections. Mercer has developed these rates on behalf of the Commonwealth to demonstrate compliance with the CMS requirements under 42 CFR § 438.4 and in accordance with applicable laws and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rates may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rates by MCOs for any purpose. Mercer recommends that any MCO considering contracting with the Commonwealth should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with the Commonwealth.

The Commonwealth understands that Mercer is not engaged in the practice of law or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends the Commonwealth secure the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

This certification report assumes that the reader is familiar with the Pennsylvania Medicaid program, Medicaid eligibility rules, and actuarial rating techniques. It has been prepared exclusively for the Commonwealth and CMS and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

The Commonwealth agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will be deemed final and acceptable to the Commonwealth if nothing is received by Mercer within such 30-day period.

If you have any questions, or would like to discuss this information further, please contact Tom Dahl at tom.dahl@mercer.com.

Sincerely,

Tom Dahl, FSA, MAAA

Principal

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Mercer Health & Benefits LLC 2325 East Camelback Road, Suite 600 Phoenix, AZ 85016 www.mercer-government.mercer.com

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#### Government Human Services Consulting

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Final and Confidential — Not for Public Disclosure

Edna Y. Marin Ramos, MA
Executive Director
Puerto Rico Health Insurance Administration
1549 Calle Alda
Urb. Caribe
San Juan, PR 00926-2712

June 13, 2023

Subject: Calendar Year 2024 Platino Certification Report

#### Dear Edna:

The Administración de Seguros de Salud (ASES) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rates for the Medicare Platino Program (Platino). The Platino program is a dual-eligible special needs plan (D-SNP) that provides "wrap-around" coverage for Medicaid state plan services not covered by Medicare. The "wrap-around" services consist mainly of prescribed drugs and dental services.

The Platino program is jointly funded by Puerto Rico and the Federal government. The Federal funds are limited to those available under the Enhanced Allotment Plan (EAP) drawn down at the Federal Match Assistance Percentage. Once the funds in the EAP grants are exhausted during the Federal Fiscal Year (FFY), any additional expenditure may be covered by Medical Assistance Program (MAP) funds. If MAP funds are also exhausted during the FFY, then any additional expenditure must be covered with local Puerto Rico funds.

According to Actuarial Standard of Practice (ASOP) 49, actuarially sound is being defined by Mercer as follows: Medicaid capitation rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. For this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, cost of capital and government mandated assessments, fees, and taxes.

In certifying to the actuarial soundness of the premium of \$20 PMPM for Calendar Year (CY) 2024, Mercer also reviewed the comments in the letter from the Long Term Care Medicaid Subcommittee of

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<sup>&</sup>lt;sup>1</sup> Please see page two of the ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification, from the Actuarial Standards Board, https://www.actuariatstandardsboard.org/wp-cortent/upicads/2015/03/asop049



Government Human Services Consulting

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Roxanna K. Rosario Serrano, BHE, MS Executive Director Puerto Rico Health Insurance Administration 1549 Calle Alda Urb. Caribe San Juan, PR 00926-2712

June 6, 2024

Subject: Calendar Year 2025 Platino Wrap-around Premium

#### Dear Roxanna:

Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, was retained by the Administración de Seguros de Salud (ASES) to develop actuarially sound capitation rates for the Medicare Platino Program (Platino). The Platino program is a dually eligible special needs plan that provides "wrap-around" coverage for Medicaid State Plan services not covered by Medicare. The "wrap-around" services consist mainly of the member cost sharing for the prescribed drugs under Medicare Part D. Mercer's recommended Platino premium for calendar year (CY) 2025 is \$80.00 per member per month (PMPM).

#### **Program History**

The Platino program began on January 1, 2006, after the passage of the Medicare Modernization Act. It allows dual eligible individuals residing in a Medicare Advantage Organization's (MAO) service area to enroll with a Medicare Advantage plan with prescription drug coverage. The Platino program was originally intended to assist dual eligible individuals with the cost of prescription drug benefits, but it may also include other wrap-around services. Wrap-around services in general are a "non-covered benefit under the MAO supplementary benefit coverage and included as covered services in the Medicaid State Plan.

There are four MAOs serving the Platino population in Puerto Rico:

- · Humana Health Plans of Puerto Rico, INC. (Humana)
- MCS Advantage, INC. (MCS)
- · Medicare y Mucho Mas Healthcare, LLC. (MMM)
- · Triple-S Advantage, INC. (Triple-S)

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