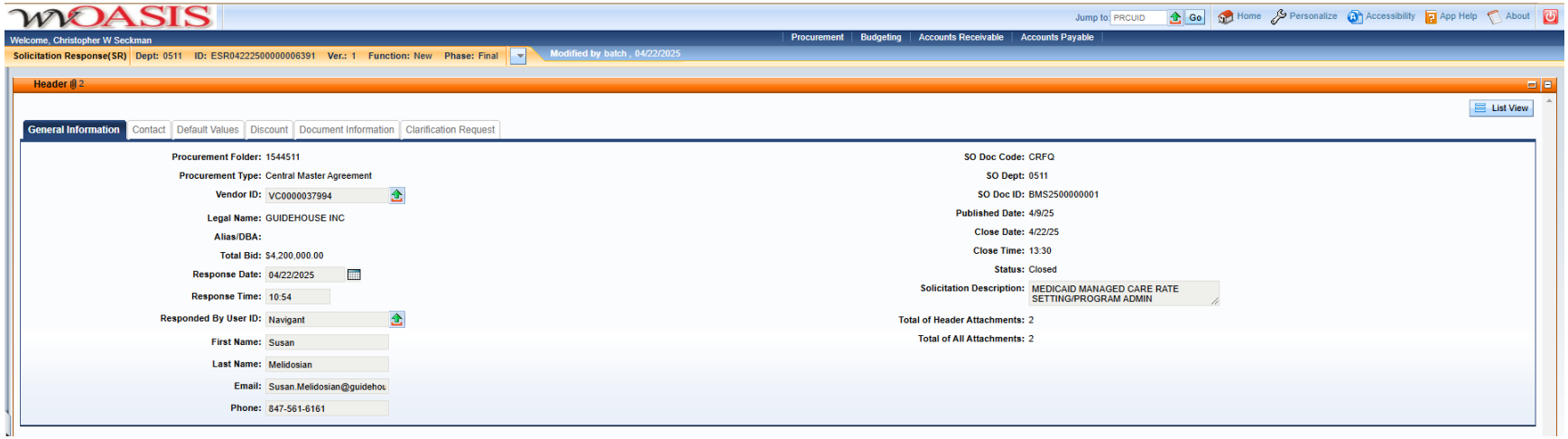
The following documentation is an electronically-submitted vendor response to an advertised solicitation from the *West Virginia Purchasing Bulletin* within the Vendor Self-Service portal at ***wvOASIS.gov***. As part of the State of West Virginia's procurement process, and to maintain the transparency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


WVOASIS
Jump to PRCUID Go
Home
Personalize
Accessibility
App Help
About
Welcome, Christopher W Seckman
Procurement | Budgeting | Accounts Receivable | Accounts Payable
Solicitation Response(SR) Dept: 0511 ID: ESR04222500000006391 Ver.: 1 Function: New Phase: Final
Modified by batch , 04/22/2025
Header 2
List View
General Information
Contact
Default Values
Discount
Document Information
Clarification Request
Procurement Folder: 1544511
Procurement Type: Central Master Agreement
Vendor ID: VC0000037994
Legal Name: GUIDEHOUSE INC
Alias/DBA:
Total Bid: $4,200,000.00
Response Date: 04/22/2025
Response Time: 10:54
Responded By User ID: Navigant
First Name: Susan
Last Name: Melidosian
Email: Susan.Melidosian@guidehou
Phone: 847-561-6161
SO Doc Code: CRFQ
SO Dept: 0511
SO Doc ID: BMS2500000001
Published Date: 4/9/25
Close Date: 4/22/25
Close Time: 13:30
Status: Closed
Solicitation Description: MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN
Total of Header Attachments: 2
Total of All Attachments: 2

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

State of West Virginia
Solicitation Response

Proc Folder:	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 ESR04222500000006391	1

VENDOR

VC0000037994
GUIDEHOUSE INC

Solicitation Number: CRFQ 0511 BMS2500000001

Total Bid: 4200000 **Response Date:** 2025-04-22 **Response Time:** 10:54:29

Comments: N/A

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

Vendor
Signature X **FEIN#** **DATE**

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

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

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
2	Staff Actuary Services				0.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
3	Technical Support Staff (non-actuary)				0.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
4	Clerical Support Staff				0.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
5	Managed Care Program Oversight Services				1900000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
6	Managed Care Oversight Ad Hoc Services				750000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments: Guidehouse proposes an hourly rate of $150.00

Extended Description:

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

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

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

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				1550000.00

Comm Code	Manufacturer	Specification	Model #
93151507			

Commodity Line Comments:

Extended Description:

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

State of West Virginia
Department of Administration
Purchasing Division
CRFQ BMS2500000001

April 22, 2025

Medicaid Managed Care Rate Setting / Program Administration

COST RESPONSE

PROVIDED TO:

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

PROVIDED BY:

Russell H. Ackerman, ASA, MAAA, FCA
Partner, Chief Actuary
1676 International Drive, Suite 800
McLean, Virginia 22102
(480) 318-9390
russ.ackerman@guidehouse.com

guidehouse.com

	Department of Administration **Purchasing Division** **2019 Washington Street East** **Post Office Box 50130** **Charleston, WV 25305-0130**	**State of West Virginia** **Centralized Request for Quote** **Service - Misc**

Proc Folder: 1544511 **Doc Description:** MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN **Proc Type:** Central Master Agreement			**Reason for Modification:**
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
US

VENDOR

Vendor Customer Code: VC0000037994

Name : Guidehouse Inc.

Address : 1676

Street : International Dr, Suite 800

City : McLean

State : Virginia **Country :** United States **Zip :** 22102

Principal Contact : Russ Ackerman

Vendor Contact Phone: 480-318-9390 **Extension:**

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

Vendor Signature X Russell H. Ackerman **FEIN#** 36-4094854 **DATE** April 22, 2025

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

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

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		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				

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 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
2	Staff Actuary Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Staff Actuary Services

$__0___Per Hour X 20,000 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	Total Price
3	Technical Support Staff (non-actuary)				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Technical Support Staff (non-actuary)

$__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	Total Price
4	Clerical Support Staff				

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	Total Price
5	Managed Care Program Oversight Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Managed Care Program Oversight Services Annual Cost

All-Inclusive Fixed Annual Amount (Inclusive of 12 Months) - **$1,900,000.00**

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
6	Managed Care Oversight Ad Hoc Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Managed Care Oversight Ad Hoc Services

$150.00 per hour X 5,000 hours Annually = **$750,000.00**

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
7	Actuarial Services Ad Hoc Services				

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	Total Price
8	Financial Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Financial Services Annual Cost

All-Inclusive Fixed Annual Amount (Inclusive of 12 Months) = **$1,550,000.00**

SCHEDULE OF EVENTS

Line	Event	Event Date
1	VENDOR QUESTION DEADLINE	2025-03-19

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

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

Appendix E Reservation of Rights

Submission of this proposal by **GUIDEHOUSE INC.**, a Delaware corporation, or any of its affiliates (the "**Vendor**"), is not an indication of Vendor's willingness to be bound by all of the terms presented in the **WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES, BUREAU FOR MEDICAL SERVICES** (the "**Agency**") Request for Proposals, pertaining to Medicaid Actuarial Services and Manages care Program Administration (the "**RFQ**"). This proposal in response to the Agency's RFQ does not constitute a contract to perform services and cannot be used to award a unilateral agreement. Final acceptance of this engagement by the Vendor is contingent upon successful completion of Vendor's acceptance procedures. Any engagement arising out of this proposal will be subject to negotiation of a mutually satisfactory vendor contract including (i) modifications to certain RFQ terms and conditions and (ii) our standard terms and conditions and fees and billing rates established therein.

Given our past history of successfully negotiating mutually agreeable terms with similar State entities, we do not anticipate any difficulty in reaching a contractual agreement (the "**Agreement**") that will enable us to provide the professional services which you are requesting, while protecting the interests of both parties.

Vendor kindly requests that the Agency consider the following revisions to the General Terms and Conditions:

1. **Section 8 – Insurance**

   Vendor must maintain:

   - Commercial General Liability Insurance in at least an amount of: $1,000,000.00 per occurrence, $2,000,000.00 in the aggregate.
   - Automobile Liability Insurance in at least an amount of: $1,000,000.00 per occurrence.
   - Professional/Malpractice/Errors and Omission Insurance in at least an amount of: $1~~0~~,000,000.00 per occurrence,$3,000,000.00 in the aggregate. Notwithstanding the forgoing, Vendor's are not required to list the State as an additional insured for this type of policy.
   - Commercial Crime and Third Party Fidelity Insurance in an amount of: $15~~,~~000,000.00 per occurrence.
   - Cyber Liability Insurance in an amount of: $1,000,000.00 per occurrence.

2. **Section 13 – Pricing**

   13. PRICING: The pricing set forth herein is firm for the life of the Contract, unless specified elsewhere within this Solicitation/Contract by the State. A Vendor's inclusion of price adjustment provisions in its bid, without an express authorization from the State in the Solicitation to do so, may result in bid disqualification. ~~Notwithstanding the foregoing, Vendor must extend any publicly advertised sale price to the State and invoice at the lower of the contract price or the publicly advertised sale price.~~

3. **Section 20 – Time**

   20. TIME: The parties shall strictly comply with all time limits established under this Contract.~~Time is of the essence regarding all matters of time and performance in this Contract.~~

4. **Section 36 – Indemnification**

   36. INDEMNIFICATION: The Vendor agrees to indemnify~~,~~ and defend~~, and hold harmless~~ the State and the Agency, their officers, and employees from and against~~: (1) A~~any third party claims or losses resulting solely and directly from ~~for~~ services rendered by ~~any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with~~Vendor in the performance of thi~~s~~e Contract. Such indemnification shall be conditioned upon the State promptly notifying the Vendor, in writing, of any such claim, permitting the Vendor the authority to settle or defend the claim (including selection of defense counsel) and reasonably cooperating with the Vendor in the defense and settlement thereof. Notwithstanding the foregoing, the Vendor shall not enter into any stipulated judgment or settlement that purports to bind the State without the State's express written authorization, which shall not be unreasonably withheld or delayed.~~; (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 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.~~

Vendor kindly requests that the Agency consider the following additions to the General Terms and Conditions:

1. **Limitation on Liability:** Notwithstanding the terms of any other provision, the total liability of Vendor and its affiliates, directors, officers, employees, subcontractors, agents and representatives for all claims of any kind arising out of the Agreement, whether in contract, tort or otherwise, shall be limited to the total fees paid to Vendor under the applicable statement of work in the preceding twelve (12) months. Neither Vendor nor Agency shall in any event be liable for any indirect, consequential or punitive damages, even if Agency or Vendor have been advised of the possibility of such damages.

2. **Consulting Services Disclaimer:** Vendor will not audit any financial statements or perform any attest procedures in the course of performing the services under the Agreement. Vendor's services are not designed, nor should they be relied upon, to disclose internal weaknesses in internal controls, financial statement errors, irregularities, illegal acts or disclosure deficiencies. Vendor is not a professional accounting firm and does not practice accounting. Vendor's services will not include legal, engineering or architectural advice or services.

3. **Standard of Care and Performance:** Vendor agrees that the services provided for under the Agreement will be performed in a professional manner in accordance with recognized professional consulting standards for similar services and that qualified personnel will be assigned for that purpose. In providing the services, Vendor and its personnel shall exercise reasonable care. Vendor cannot guarantee or assure the achievement of any particular performance objective, nor can Vendor guarantee or assure any particular outcome for the Agency or any other person as a result of the Agreement or the performance of the services contemplated thereunder.

   If, during the performance of the services, or within one (1) year following completion of the Agreement, such services will prove to be faulty or defective by reason of a failure to meet such standards, Vendor agrees that upon prompt written notification from the Agency prior

to the expiration of the one-year period following the completion of the Agreement of any such fault or defect, such faulty portion of the services will be redone at no cost to the Agency up to a maximum amount equivalent to the cost of the services rendered under the Agreement. The foregoing will constitute Vendor's sole warranty with respect to the accuracy or completeness of the services and the activities involved in its preparation, and is made in lieu of all other warranties and representations, express or implied, including any implied warranties of merchantability or fitness for a particular purpose.

4. **Intellectual Property:** Upon full payment of all amounts due Vendor in connection with the Agreement, all rights, title and interest in any information and items, including summaries, documents, reports and portions thereof Vendor provides to the Agency (collectively, the "**Vendor Deliverables**") will become the Agency's sole and exclusive property for its internal business purposes and uses pursuant to the scope set forth in the applicable statement of work, subject to the exceptions set forth hereafter. Vendor shall retain sole and exclusive ownership of all rights, title and interest in its work papers, proprietary information, processes, methodologies, know-how and software, including such information as existed prior to the delivery of the services and, to the extent such information is of general application, anything that it may discover, create or develop during provision of the services (collectively, the "**Vendor Property**"). To the extent the Vendor Deliverables contain any Vendor Property; the Agency shall be granted a non-exclusive, non-assignable, royalty-free license to use such Vendor Property solely in connection with the subject of the Agreement.

5. **Acceptance**: Receipt of a deliverable occurs when the deliverable is provided to the Agency. Receipt of services is deemed to occur when the Agency receives an invoice from Vendor for those services. Absent written notification of non-acceptance from the Agency within five (5) business days of receipt, deliverables and services will be construed as accepted. Any such notice shall specify in reasonable detail the reasons such deliverable or service has been deemed unacceptable. If the notice of non-acceptance is not sufficiently detailed to allow Vendor to determine why such deliverable or service is unacceptable, Vendor may request in writing that the Agency provide additional information. The passage of ten (10) business days from the date of such request without the provision of such additional information shall constitute final acceptance of such deliverable or service by the Agency. Within fifteen (15) days of receipt of the Agency notice, Vendor shall, at its option, either correct the problems in such deliverable or service or present the Agency with a plan to fix such problems within a reasonable period of time under the circumstances. The deliverable or service shall be deemed accepted by the Agency after comments have been incorporated and the deliverable or service re-submitted. Acceptance by the Agency shall not be unreasonably withheld or delayed.

Vendor kindly requests that the Agency consider the following revisions to the HIPAA Business Associate Addendum:

1. **Section 3(l) – Notification of Breach**

   Notification of Breach. During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology within fifteen (15) business days ~~immediately~~ by email or web form upon the discovery of any Breach of unsecured PHI; or ~~within 24 hours by e-mail or web form~~ of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI violation of this Agreement and this Addendum, or potential loss of confidential data

affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and, unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or https://apps.wv.gov/ot/ir/Default.aspx.

The Associate shall promptly upon discovery ~~immediately~~ investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within fifteen (15) business days~~72 hours~~ of the discovery, the Associate shall notify the Agency Procurement Officer, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) Date of discovery; (b) What data elements were involved and the extent of the data involved in the Breach; (c) A description of the unauthorized persons known or reasonably believed to have improperly .used or disclosed PHI or confidential data; (d) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (e) A description of the probable causes of the improper use or disclosure; and (f) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

Vendor kindly requests that the Agency consider the following addition to the HIPAA Business Associate Addendum:

1. **Unsuccessful Attempts**. Both the Agency and Associate agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur would swamp any potential benefit gained from reporting them. Consequently, both Agency and Associate agree that this Agreement shall constitute the documentation, notice and written report of such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the parties consider the following to be illustrative (but not exhaustive) of Unsuccessful Security Incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of EPHI or interference with an information system:
    a. Pings on a party's firewall;
    b. Port scans;
    c. Lost or stolen encrypted hardware, such as laptops;
    d. Attempts to log on to a system or enter a database with an invalid password or username;
    e. Denial-of-service attacks that do not result in a server being taken off-line; and
    f. Malware (e.g., worms, viruses).

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Guidehouse

State of West Virginia
Department of Administration
Purchasing Division
CRFQ BMS2500000001

April 22, 2025

Medicaid Managed Care Rate Setting / Program Administration

TECHNICAL RESPONSE

PROVIDED TO:

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

PROVIDED BY:

Russell H. Ackerman, ASA, MAAA, FCA
Partner, Chief Actuary
1676 International Drive, Suite 800
McLean, Virginia 22102
(480) 318-9390
russ.ackerman@guidehouse.com

guidehouse.com

This proposal does not constitute a contract to perform services and cannot be used to award a unilateral agreement. Any engagement arising out of this proposal will be subject to negotiation of a mutually satisfactory engagement contract.

Guidehouse

April 22, 2025

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

Via email: *crystal.g.hustead@wv.go*

RE: Medicaid Managed Care Rate Setting / Program Administration I CRFQ BMS2500000001

Dear Ms. Hustead:

Guidehouse Inc. (Guidehouse or we/us/our) appreciates the opportunity to provide the State of West Virginia, Department of Human Services, Bureau for Medical Services (State, DHS, BMS, Bureau, Department or you / your) with this Medicaid Actuarial Services and Managed Care Program Administration services proposal (the Proposal).

In working with West Virginia from 2018-2022, we have demonstrated our ability to very effectively provide the State with fully integrated actuarial, financial, and policy teams. We provided these services under a single vendor umbrella, streamlining to a single point of contact for the overall scope. This single vendor approach also eliminates potential contract coordination challenges between vendors. In our prior work, we provided key MCO transparency, rebuilding trust between the agency and the plans after a challenging period in the State-MCO relationship. We have a history of strategizing with BMS to keep contractors and State on task and focused on high impact needs and would be honored to return to the State to continue this mission.

Our proposal includes streamlined pricing for BMS, which we hope will help reduce your administrative burden by limiting the number of required work orders. It consists of the following for the one-year base contract and reflects our acceptance and understanding, in compliance with the RFQ's *Exhibit "A" Instructions for Pricing*:

Commodity Line 1: $0.00 Hourly rate

Commodity Line 2: $0.00 Hourly rate

Commodity Line 3: $0.00 Hourly rate

Commodity Line 4: $0.00 Hourly rate

Commodity Line 5: **$1,900,000** All-Inclusive Fixed Annual Amount

Commodity Line 6: $150.00 Hourly rate x 5,000 Hours = **$750,000**

Commodity Line 7: $0.00 Hourly rate

Guidehouse

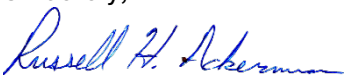
Commodity Line 8: **$1,550,000** All-Inclusive Fixed Annual Amount

Guidehouse Proposed Total of all RFQ Commodity Lines: $4,200,000

This Proposal will be used by the parties to finalize the business terms and is intended for informational purposes only. Upon finalizing the business terms, Guidehouse will prepare a definitive engagement agreement for your review and execution. This Proposal does not constitute a contract to perform services and neither party has committed to any of the terms described herein.

We would be pleased to review and discuss this Proposal with you in more detail and revise the scope, work plan, and business arrangements to best meet your needs and expectations. Please contact Russ Ackerman at 480.318.9390 or russ.ackerman@guidehouse.com with questions, for additional information, and / or discussion of next steps.

Sincerely,



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

Table of Contents

Section 1 Executive Summary

The RFQ sets forth minimum qualifications for potential vendors, related to years of experience and required staff. For your convenience, we have provided an excerpt of RFQ requirements along with Guidehouse's demonstrated compliance in this section. **Section 2** provides additional details on our vendor qualifications, and **Section 4** describes individual staffing qualifications for our engagement team.

In addition, you will see that our cost proposal is in full and complete compliance with all RFQ instructions and the Q&A responses. We are confident you will find our proposal reflects great value for the scope of services required and our commitment to BMS.

Addressing Pressing Health Issues with Innovative Solutions and Execution

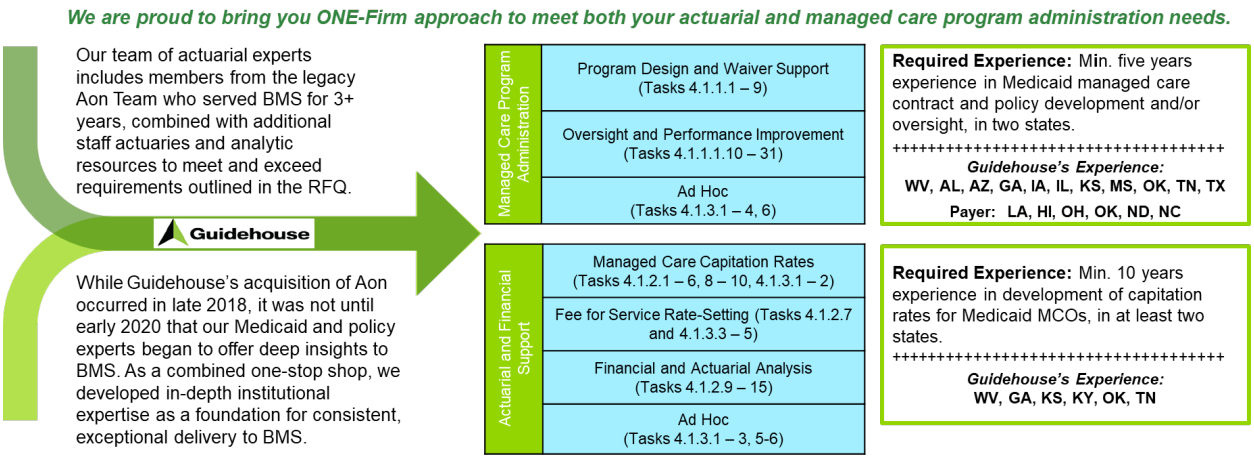
West Virginia Department of Health and Human Resources' Bureau for Medical Services (BMS) looks to build on the prior successes of the Mountain Health Trust (MHT) (inclusive of WV CHIP) and Mountain Health Promise (MHP) programs. This procurement is critical for the MHT and MHP programs' future success – to build on historical successes and support BMS' aspirations for improvement. BMS has significant interest in addressing common chronic conditions that persist in the State due to cultural norms as well as continued cost containment of excess cost growth.

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

Your Guidehouse Team: A "One-Firm" Resource

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

Figure 1. Guidehouse One-Firm Approach

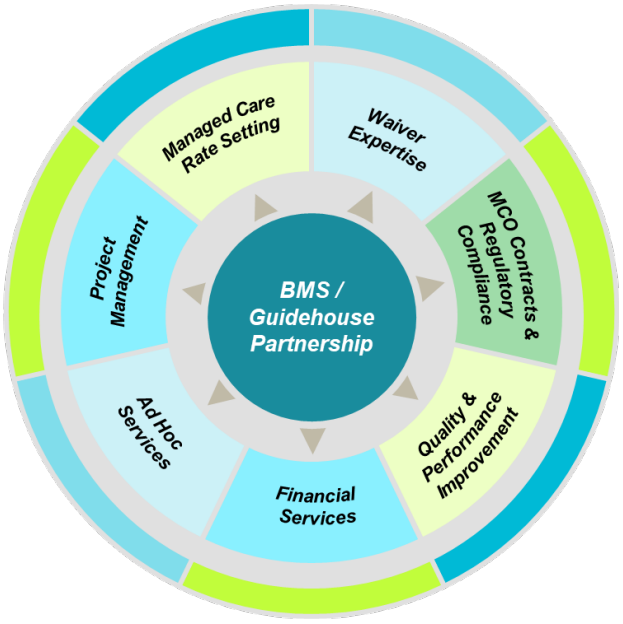


Guidehouse Offers Continuity Along with a Fresh Perspective

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

Beyond our project management expertise, we offer meaningful and actionable takeaways to strengthen programs and services. In the prior contract ending in 2022, we helped BMS with:

- **Program management:** We developed and maintained detailed work and operations plans to meet BMS' increasingly complex needs due to MHT / MHP program changes.
- **Managed care rate setting:** Our collaborative and nationally-informed approach, especially with the complexity of COVID-19 challenges, helped BMS meet CMS requirements and achieve value from the MHT and MHP programs.
- **Waiver expertise:** Our thorough and expedient approach put BMS on a smooth path to CMS approval.
- **Waiver and Federal Reporting expertise:** Our Federal reporting and actuarial teams course-corrected 1115 waiver reporting to ensure a forward path of compliance and improved processes and successfully negotiated changes with CMS.



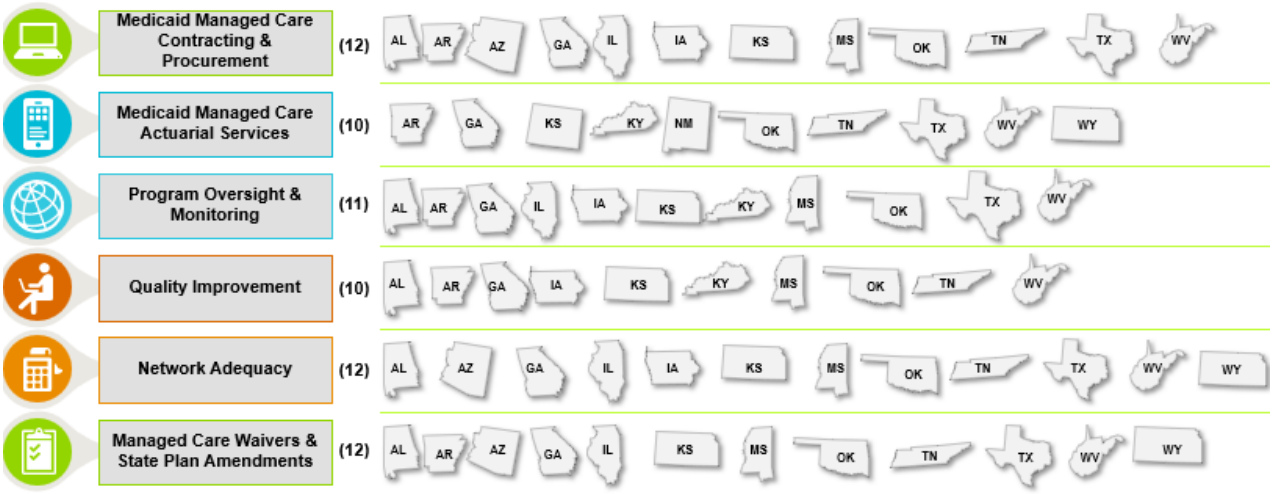
- **MCO contracts & regulatory compliance:** We completed a Compliance Review in 2020 to help confirm that MCOs were meeting contractual and federal requirements. This review served as the basis for continued performance improvement activities. We also prepared a number of contractual enhancements around care coordination, reporting requirements, EPSDT, and marketing to promote health outcomes and the member experience for MHT and MHP.
- **Quality and performance improvement:** We supported BMS in "refreshing" its Quality Strategy to more accurately describe BMS and WVCHIP's aspirations for managed care programs, and to resonate more strongly with stakeholders. We also enhanced and streamlined MCO reporting to drive meaningful operational improvements from MCOs.
- **Ad hoc services:** Our team was and will be available to respond to any ad hoc issues, legislative questions, policy requests, or budgeting support – from pharmacy high-risk pools to Drug Free Moms and Babies – all in tight timeframes as needed.

Our team was and is always prepared to further add value with additional services and expertise that are ready to deploy. **We are confident that with our expertise and continually-improved tools, we can help BMS re-imagine and enhance the MHT and MHP programs, all the while continuing to meet compliance-related milestones.**

Guidehouse Brings A National Medicaid Perspective

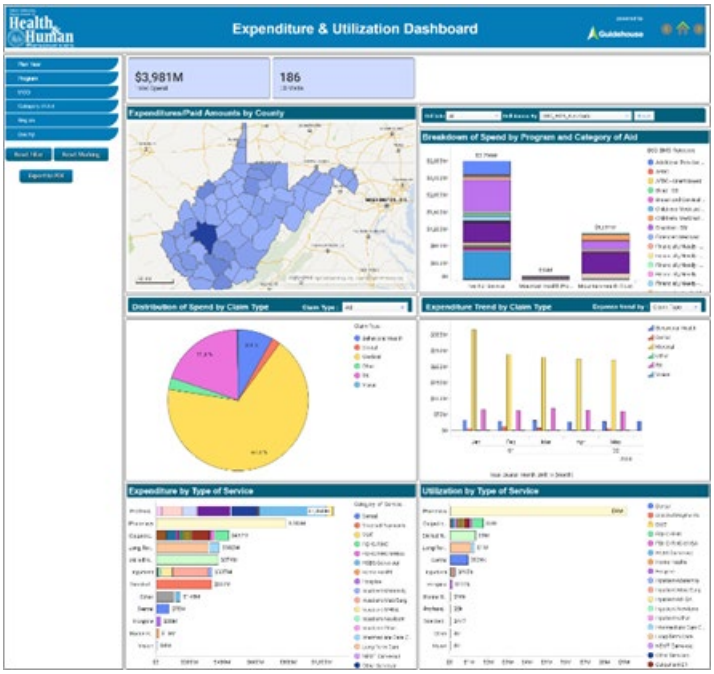
Guidehouse is a national firm backed by a long history supporting ***states, Federal agencies, and commercial payers with similar tasks – combining our legacy knowledge of West Virginia with national best practices.***

Please see below for more detail on how Guidehouse has more than 10 years of experience in developing capitation rates for Medicaid MCOs and over five years of experience in Medicaid managed care contract and policy development and/or oversight for at least five states.



Guidehouse has a bevy of tools available to BMS, some of which are familiar to the State from our prior work, but many of which are new due to our large expansion of our Digital Health practice. The State was already familiar with Guidehouse's real-time data reports and dashboard, providing real-time access to claims, encounter, and performance data. The next phase of the project would have deployed, BMS will have access and the ability to manipulate data through our interface. BMS can

drill down to compare data on MHT, MHP, and FFS by county, region, or category of aid on a variety of metrics.



Guidehouse has proven tools we have developed based on our experience in other states. These tools are ready for deployment to support the MHT and MHP programs including using robotic process automation, using key readiness review trackers and resolution logs, and using project management software and trackers.

Further, in other states Guidehouse has heavily invested in data visualization and drill down tools and has provided key State staff with access to these tools. In Tennessee, our actuarial team reviews quarterly data drill-downs using R and Power BI. The actuarial team leads presentations on findings of key cost and utilization drivers with drill downs by rate cell, category of aid, region, category of service, etc. This presentation acts as a catalyst for further experience studies and is used a catalyst for finding early warning signs of new cost drivers.

The Tennessee team also reviews MLR submissions against encounter data on a quarterly basis against encounter data to identify data anomalies and to accelerate resolution of these differences. The MLR data is analyzed at least quarterly, as well, to identify emerging trends, and given the use of a dashboard, insights are gleaned quickly due to process automation so staff time is spent drawing conclusions rather than scrubbing data.

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

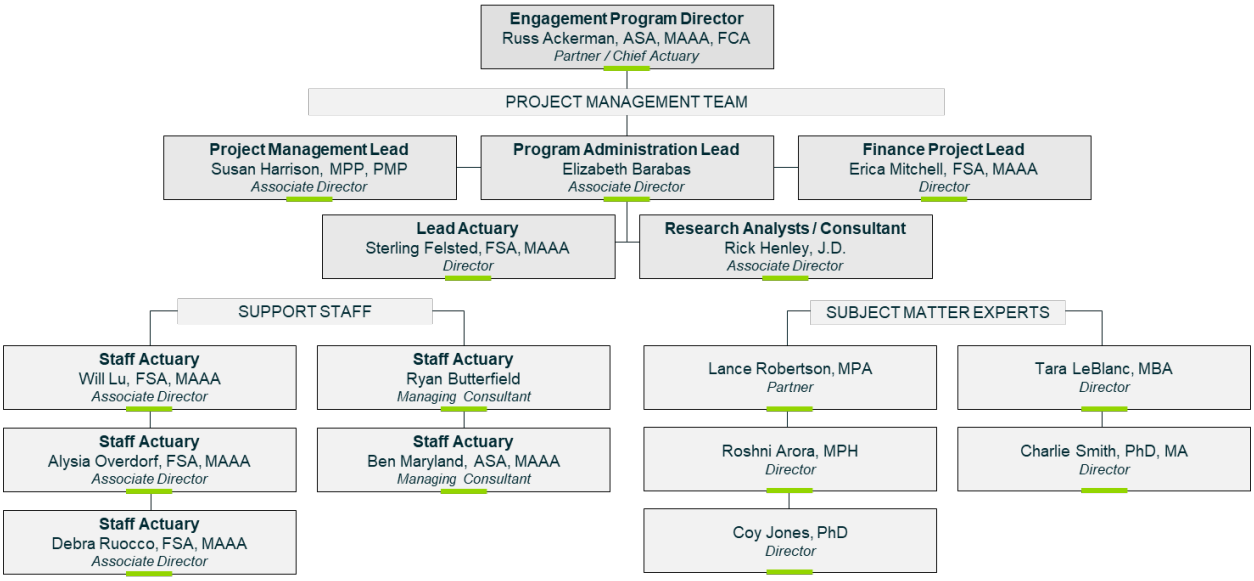
Your Guidehouse Team Meets and Exceeds All Required Staffing Requirements

Guidehouse's team includes many familiar names and faces that you are already used to working with, along with some additional team members who have experience supporting other state Medicaid agencies. We look forward to appropriate levels of on-site presence in Charleston by our actuarial and policy teams. We also plan for our larger proposed team to be in Charleston more regularly to work directly with the BMS team as requested.

Our team includes seasoned experts such as **Russ Ackerman** (actuarial and financial), **Roshni Arora** (managed care and quality), and **Lance Robertson** (former U.S. Assistant Secretary for Aging at Health and Human Services' Administration on Community Living**, Dr. Charlie Smith** (former Region VIII Director of Substance Abuse and Mental Health Services Administration (SAMHSA)), and **Tara LeBlanc** (former Louisiana Medicaid Director) – all of whom are proposed as Lead Actuary and Medicaid Policy Subject Matter Experts. On any issue that BMS faces, we can draw upon our more than 1,000 healthcare consultants to provide the required subject matter expertise.

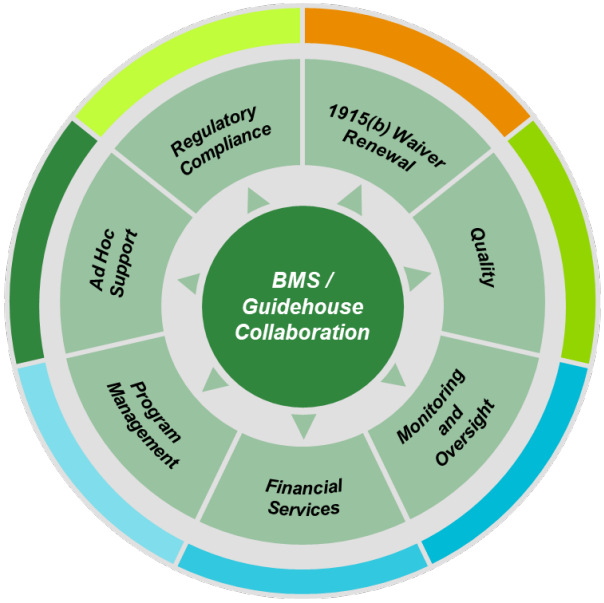
Please see the following **Figure 2** for more detail on how our team meets all RFQ staffing requirements.

Figure 2. Guidehouse Team Structure and High-Level Qualifications



Section 2 Vendor Qualifications and References

From 2018 to 2022, our Guidehouse team worked with BMS to oversee, manage, and enhance the State's MHT and MHP managed care programs, initially focusing on actuarial services and currently for all services. Throughout our tenure collaborating with BMS, Guidehouse served as a trusted advisor and extension of BMS, helping it achieve its mission and managed care program goals. Guidehouse supported BMS to make an impact on and stride towards the following:



- **Strengthening Regulatory Compliance:** Guidehouse worked with State staff to prepare Medicaid managed care MCO contracts and amendments, ensuring not only compliance with federal regulations and State law (e.g., 2020 Medicaid Managed Care Final Rule), but also enhancements to drive performance improvement. For example, we conducted a comprehensive review of federal managed care requirements to confirm all appropriate guidance was included in the MCO contracts. We also prepared a number of enhancements around care coordination, reporting requirements, EPSDT, and marketing to promote health outcomes and the member experience for MHT and MHP.

MHT Compliance Review Process & Scope

- Coordinated with other entities performing concurrent reviews (EQR, CHIP Readiness, UPIC)
- Desk review of the policies, procedures, and other relevant documentation
- Assessed MCO compliance with the following areas:
  - Administration
  - Enrollment Related Functions
  - Member Services
  - Providers and Provider Network
  - Coverage
  - Quality and Utilization Management
  - Care Coordination
  - Grievance, Appeal, and Fair Hearing Process
  - Program Integrity
  - Encounter Data
  - Systems
  - Finance
  - General Terms and Conditions

- **Preparing 1915(b) Waiver Renewal:** We leveraged our waiver expertise to refresh and populate the Bureau's 1915(b) waivers granting MHT and MHP managed care authority for on-time submission to CMS on April 1, 2021. In the first quarter of 2021, Guidehouse reviewed and revised 1915(b) waivers for the MHT and MHP programs, summarized new waiver design elements and updated the waiver responses based on policy and MCO contract changes. Guidehouse organized the waiver renewal monitoring plan and results sections for easy and streamlined CMS review and acknowledging BMS' hard work to administer and operate managed care programs responsibly.
- **Supporting Financial Projections for 1115 Continuum of Care Waiver:** In Fall 2021 and under an expedited timeframe, Guidehouse coordinated with the BMS Behavioral Health and Finance teams to calculate cost impacts for a variety of innovative new programs to support the 1115 SUD waiver renewal. The waiver also sought to increase access to services for individuals with serious mental illness (SMI) and included new services such as

supported housing, HIV/HCV education, screening, testing, and outreach, and continuity of care for justice-involved individuals for safer transitions post-incarceration.

- **Enhancing and Streamlining MCO Monitoring and Oversight:** Over the course of our prior contract, we monitored and evaluated managed care expansions, including behavioral health and SSI populations, as well as, oversaw the integration of Substance Abuse Waiver, Foster Care, and Institutions for Mental Disease services under the managed care model. We updated reporting dashboards so they were interactive, dynamic, and could be leveraged to improve MCO performance and make program decisions.
- **Promoting a Culture focused on Quality:** To accompany the 1915(b) waiver renewals to CMS, Guidehouse and BMS engaged in high-level quality discussions that:
    - Reframed the State's existing quality goals and objectives to establish actionable and aspirational goals for the State to pursue.
    - Streamlined the MHT and MHP quality strategies into one comprehensive managed care quality strategy that encompasses all of the State's managed care programs (i.e., MHT, MHP and WVCHIP).
    - Addressed CMS comments provided on the pervious iteration of the Quality Strategy.

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

- **Establishing Disciplined Program Management Tools and Timelines to Meet BMS Goals and CMS Expectations:** Guidehouse provided program management tools, timelines and trackers to monitor deliverable progress, establish expectations for Guidehouse and BMS, and motivated all parties to meet the expectations set by CMS for program document submission.
- **Addressing Ad Hoc Policy Issues and Provide Decision-Making Support:** As a trusted advisor, BMS requested Guidehouse's assistance on a range of ad hoc issues include braided foster care residential rates, CMS Managed Care 2020 Rule impact summaries and recommendations, high-cost drugs, integrating the and legislative research requests regarding competitive procurement requirements.

Combined West Virginia Familiarity with National Insights and Best Practices

In **Figure 3** below, we provide a summary of our experience in selected states across the key focus areas associated with this engagement. As illustrated in this table, we meet the RFQ requirement to have at least five years of experience in providing Medicaid managed care and Medicaid managed care contract and policy development and/or oversight as the prime contractor across numerous states. This table summarizes our experience providing managed care services represented in this RFQ; however, it is not an exhaustive list.

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

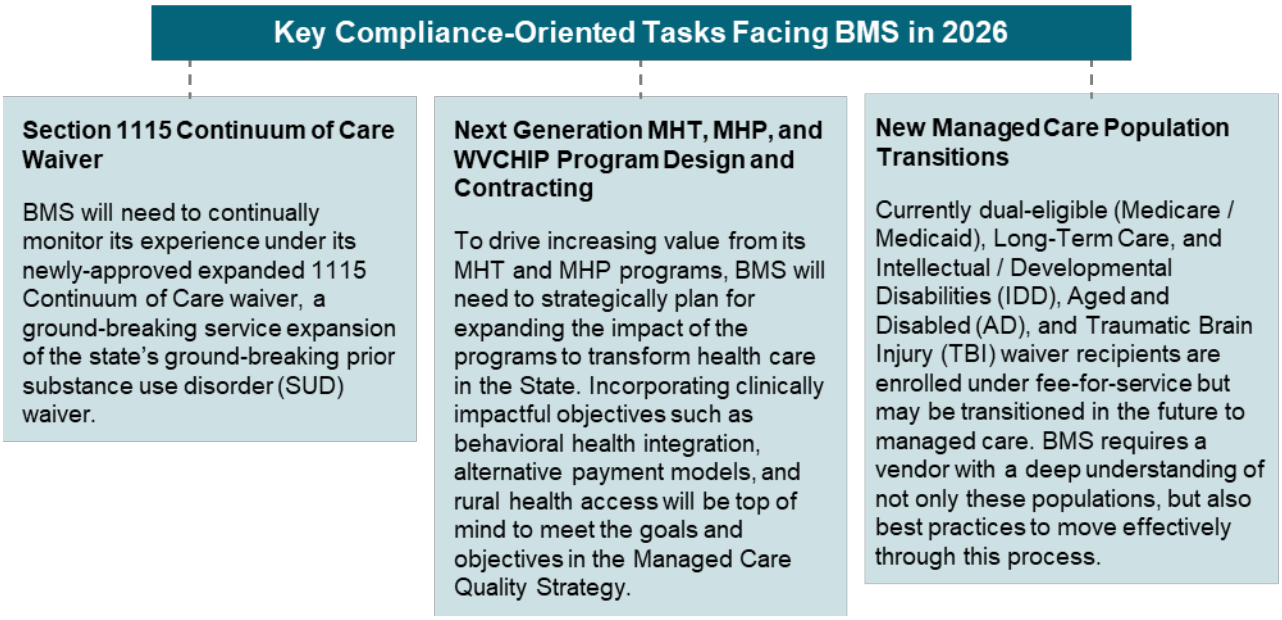


Figure 3. Guidehouse's Experience in Medicaid Managed Care Program Administration

Medicaid Managed Care Experience												
State	WV	AL	AR	AZ	GA	IL	IA	KS	MS	OK	TN	TX
Managed Care Contracting and Compliance												
Compliance with Federal Regulations	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Managed Care Contracts	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓
Managed Care Procurements		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Readiness Reviews	✓	✓			✓		✓		✓	✓	✓	✓
Managed Care Operations and Oversight												
Managed Care Monitoring	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓
Network Adequacy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dashboard / Scorecard Development	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓
Data Analysis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Annual Reports	✓							✓	✓	✓	✓	
Program Integrity	✓	✓	✓	✓					✓	✓		✓
Quality Management	✓	✓	✓		✓		✓	✓	✓	✓		
EPSDT	✓	✓	✓		✓			✓	✓	✓		
Legislative Support	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	
Managed Care Waivers												
Managed Care Waivers and Program Design	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓
Quality Strategy	✓	✓	✓		✓			✓	✓	✓		

Medicaid Managed Care Experience												
State	**WV**	**AL**	**AR**	**AZ**	**GA**	**IL**	**IA**	**KS**	**MS**	**OK**	**TN**	**TX**
Section 1115 for SUD	✓	✓						✓				
1915(c) Waivers	✓	✓	✓		✓	✓	✓	✓				
Special Populations and Models												
Foster Care Children	✓		✓		✓		✓	✓	✓	✓		✓
Long-Term Services and Supports	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Behavioral Health	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alternative Payment Models	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	
Rural Health		✓	✓		✓			✓	✓	✓	✓	
New Delivery or Payment Methodologies		✓	✓	✓	✓	✓		✓		✓	✓	

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

Guidehouse's Clients

West Virginia Department of Health & Human Resources | Bureau for Medical Services | *February 2018–February 2022*	
Key Impacts: ✓ Strengthened regulatory compliance ✓ Secured Federal approval for MHT and MHP programs ✓ Promoted a culture focused on quality ✓ Enhanced and streamlined MCO monitoring and oversight	✓ Enhanced program design for social determinants of health and care management ✓ Established disciplined program management tools and timelines ✓ Addressed ad hoc policy issues and provide decision-making tools and support
As described above, Guidehouse supported BMS in all aspects of Medicaid managed care program administration. Below we describe our experience related to managed care contracting, program oversight, and managed care waivers. Guidehouse staff worked with State staff to prepare Medicaid managed care contracts and amendments, ensuring that contract language complied with federal regulations and State law. Our staff also participated in discussions with CMS regional staff, incorporating their comments as needed. We assisted the State in bringing the MCO contract into full compliance with significant changes in federal laws and regulations coming out of the ACA and the Medicaid and CHIP Managed Care Regulations finalized in 2016. Our staff conducted multiple desk and on-site readiness reviews, created implementation tools, scoring guides, and assessed network adequacy. We monitored and evaluated managed care expansions, including behavioral health and SSI populations. We also helped integrate the Substance Abuse Waiver, Foster Care, and Institutions for Mental Disease services under the managed care model. Our team also supported BMS' robust program monitoring and oversight processes to promote compliance and improvement in health outcomes for MHT and MHP programs. Guidehouse developed a quarterly dashboard and identified questions and followed-up with MCOs to home in on specific areas for improvement. We also offered summaries and insights to inform legislative discussions.	

West Virginia Department of Health & Human Resources | Bureau for Medical Services | *February 2018–February 2022*

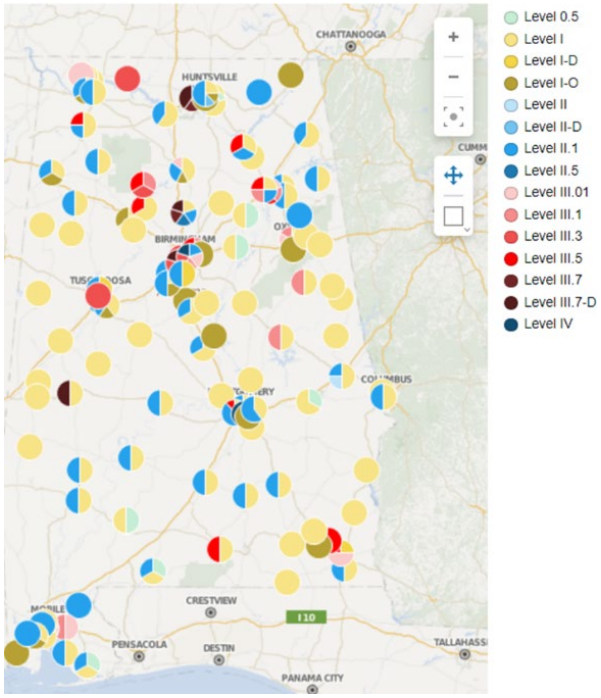
Finally, we prepared the 1915(b) waivers that authorize the MHT and MHP programs. In 2021, Guidehouse took the lead in drafting all relevant and required materials, including application language, data analysis, coordination with other contractors, and preparation of the Quality Strategy.

Alabama Medicaid Agency and Alabama Department of Mental Health | *2013–Present*

Key Impacts:

- ✓ *Designed a new Medicaid managed care program to promote care coordination and adequate access to services*
- ✓ *Successfully secured CMS approval for transition to Medicaid managed care and a DSRIP-like program*
- ✓ *Developed 1115 waiver to expand access to substance use disorder services*
- ✓ *Effectively plan, design, and implement managed care long-term services and supports program (Integrated Care Network)*

Guidehouse worked with the state of Alabama Medicaid Agency (AMA) to implement a new care delivery model that will improve beneficiary outcomes and address fragmentation in Alabama's Medicaid program. Under this new delivery system, risk-bearing, provider-based regional care organizations (RCOs) will be paid on a capitated basis to provide the full scope of Medicaid benefits, including primary, acute, behavioral, maternal, pharmacy and post-acute services.



Section 1115 SUD Demonstration

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

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

Alabama Medicaid Agency and Alabama Department of Mental Health | *2013–Present*

Waiver Demonstrations

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

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

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

Medicaid Managed Care Waiver

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

Medicaid Managed Care Contract Development

We developed a contract with AMA to be executed between AMA and its RCOs, which will govern the requirements of the RCO program. **Guidehouse led the contract development process, including compiling state and federal requirements for Medicaid managed care programs**, reviewing best practices from other state Medicaid programs, serving as the first author for contract sections and facilitating meetings with AMA staff to incorporate feedback and desired program components. Guidehouse also provided training to AMA staff regarding the contract development process and managed care requirements.

Quality Measures and Incentive Payments

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

Communications Plan

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

Health Homes

AMA currently operates a Health Home program approved by CMS through Section 2703 of the Affordable Care Act. **Guidehouse worked with AMA to integrate its Health Home program into the broader RCO**

Alabama Medicaid Agency and Alabama Department of Mental Health | *2013–Present*

program. To do so, we assisted in developing and refining AMA's procurement Health Home procurement materials, including a Health Home RFP. We also identified the components of AMA's Health Home program that must be addressed in AMA's contracts with RCOs, as RCOs will have responsibility for providing Health Home services to their eligible members. One important element of this process is structuring the program so that AMA will continue to receive enhanced federal funding for Health Home services delivered in a managed care environment.

Care Integration

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

Supporting Organizational Change

Guidehouse had worked closely with AMA on a multi-phase project to assess and determine what organizational changes will be required, the impact of these changes on existing staffing levels, roles, and responsibilities and how changes should be implemented. During the first phase of the project, Guidehouse conducted interviews with personnel from 19 departments within seven different divisions across AMA, including division deputies and department leaders. The interviews focused on understanding current processes, roles, responsibilities and assessing the ability of AMA's current organizational structure and operating capacity to successfully operate the RCO program. Guidehouse supplemented the interviews with a detailed review of internal documents, including reports, employee job descriptions, manuals, and organizational charts, to gain a more in-depth understanding of the department or AMA's functions and roles.

We also conducted research about other states that have successfully implemented managed care programs. The interviews focused on how each state structures its managed care program, as well as challenges and lessons learned from these states in monitoring managed care organizations. We continued to work to assist AMA with implementing the required organizational changes during the second phase of the project. Key activities include:

- Conducting a work allocation study to better understand the impact the RCO program will have on current staffing functions and workload, including the percentage of a staff member's time that will devoted to RCO program functions versus FFS functions. The analysis will also assist in identifying areas that will see a decrease in workload and that may be able to assist with new functions to support the RCO program.
- Working with AMA to identify internal and external candidates to fill key positions
- Updating existing position descriptions for staff assigned new functions and creating new position descriptions for areas that require an increase in staffing
- Developing and deploying training modules regarding the RCO program and Medicaid managed care concepts
- Assisting AMA with developing and executing a plan to communicate the agency-wide organizational changes
- Developing and documenting new process and procedures that AMA will require to manage and provider oversight of the RCO program

Delivery System Reform Incentive Payments (DSRIP)

Alabama Medicaid Agency and Alabama Department of Mental Health | *2013–Present*

A key component of the delivery transformation initiative is creating a payment system that incentivizes RCOs, hospitals and other providers through CMS approved funding pools. Those pools are funded through CMS approval of Designated State Health Programs (DSHP) already in existence at the State level that are leveraged to draw new Federal Matching Funds for two primary funding pools:

- Transition Pools
- Delivery System Reform Incentive Payments (DSRIP)

Guidehouse, with AMA, developed and established the Alabama DSRIP program and managed the operational and programmatic tasks that are required to appropriately administer the DSRIP program in Alabama.

Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) |*2019–present*

Key Impacts:

- ✓ *Provide full-service policy support including waiver assistance similar to the depth of policy support required for West Virginia*
- ✓ *Provide actuarial ad hoc support related to potential 1115 waiver modifications*
- ✓ *Provide strategic and financial modeling support for Medicaid and Medicaid managed care cost control measures*
- ✓ *Supported Division with Medicaid policy and financial staffing during transitions*

Policy Assistance

Throughout the engagement, we have supported DHS with all manner of policy support related to its Medicaid managed care program, including:

- Assisted in RFP development and procurement for a dental managed care contract that manages over 750,000 lives and pays over $150 million annually
- Supported procurement requirement for a Non-emergency Transportation IFB and Medicaid managed care Memorandum of Understanding and Purchasing Guidelines
- Conducted a compliance review of a Medicaid managed care organization contract for conformance with CMS requirements and suggested modifications to comply with recent CMS guidance
- Developed strategy for DHS to review and approve in-lieu of services proposed by managed care organizations
- Supported DHS with potential modifications of its 1115 waiver for its Medicaid expansion program
- Conducted a comprehensive assessment of the Medicaid program, including managed care programs to identify areas to improve fiscal sustainability
- Helped DHS evaluate and approve value-based payments proposed by managed care organizations, including providing encounter billing direction, evaluating clinical benefit, assessing proposed savings for plan and state
- Coordinated with legal and policy staff on program and policy changes for the managed care program
- Coordinated with actuaries on policy issues that impacted Medicaid managed care capitation rate setting
- Documented managed care programmatic and regulatory requirements and developed eight process flows (technical and desk-level), twelve job aids for day-to-day tasks and report development, a report inventory, a checklist of priority tasks, and timeline of key financial, membership, and compliance deadlines to support DHS managed care staff support more than 300,000 beneficiaries without missing any state or federal deadlines
- Assisted DHS with creating a unified group of procedures codes to standardize MCO billing practices for its ID/DD waiver program

Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) | *2019–present*

- Assisted in the development of a directed payment program to increase payments to Psychiatric Residential Treatment Centers (PRTC) through managed care plans, including drafting quality strategy and selecting quality measures; completed the CMS application to request for approval of the directed payment program, which was approved by CMS and paid over $5 million per year
- Assessed managed care organization contracts for third party liability cost avoidance and recovery language and recommended 12 new contractual clauses to strengthen the contract

Data Quality and MMIS Encounters

- Assisted DHS with developing an Encounter Data Quality Framework
- Conducted a comprehensive analysis of millions of encounters and evaluated all adjudication system edits and audits to recommend an appropriate disposition (evaluated over 1,000 edits / audits)
- recommended six new business operations reports to track managed care organization performance of encounter accuracy, timeliness, and completeness, and worked with the state's enterprise data warehouse to implement those reports
- Helped improve encounter accuracy, completeness, and timeliness rates (which were unusable and unknown when we began in 2019); in Q2 of FY2023, Medicaid encounter plan accuracy was above 95%, Medicaid encounter completeness was above 95%, and more than 95% of original Medicaid encounters were submitted within 30 days

Staffing Support in Transitions

- Supported DHS by seating an Interim Deputy Medicaid Director, who assisted staff with program and waiver management, task prioritization, managing relationships with multiple technical vendors, and responding to inquiries from providers and both internal and external agencies.
- Supported DHS Guidehouse by seating an Interim Medicaid Finance Chief Financial Officer who successfully served the state for more than a year by performing day-to-day finance management, implementing financial operations improvement, staff planning, training, budgeting, and forecast monitoring / reporting, quarterly payment planning, and responding to state and federal inquiries.

Arizona Health Care Cost Containment System | *1993–2018*

Key Impacts:	
✓ *Robust Medicaid managed care contract specifications and strategy for integrated physical and behavioral health service delivery platform*	✓ *Enhanced reporting requirements for MCOs and contracted providers*
	✓ *Supported organizational transformation of Medicaid agency*

Medicaid Managed Care

Over the last two decades Guidehouse has worked numerous agencies within the State of Arizona including AHCCCS, the Arizona Department of Economic Security (ADES), the Division of Disability (DDD), the Arizona Attorney General, and the Department of Health Services (DHS) on a variety of projects. Recently, our teams have supported various AHCCCS initiatives including:

- Provided project management and workgroup support to AHCCCS during the development of program and contract requirements and procurement documents for the AHCCCS Complete Care (ACC) RFP which integrated physical and behavioral health services for most Medicaid beneficiaries across Arizona.
- Provided Substance Abuse and Mental Health Block Grant (SABG/MHBG) technical assistance focused on reporting requirements and addressing social determinants of health. All requirements applied to Medicaid managed care organizations and their provider networks.

Arizona Health Care Cost Containment System | *1993–2018*

- Served as project manager to support the transition of the Department of Behavioral Health Services (DBHS) into AHCCCS, which involved leading and facilitating the operational and personnel integration of the two agencies to support a seamless transition.
- Assisted in the implementation of the State's Medicaid mental health managed care program, a component of AHCCCS' programs. We developed standards in the areas of provider network, case management, client assessment, service provision, quality assurance, and utilization review and reporting requirements.

HCBS Provider Reimbursement Rate Rebase and Ongoing Support

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

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

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

HCBS Rate Adequacy Studies

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

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

These assessments also included an assessment of the impact of Propositions 206 and 414, voter initiatives that increased Arizona's statewide and Flagstaff municipal minimum wages, on provider rates and the overall HCBS workforce. In addition, we reviewed unassigned / outstanding authorization data to determine specific services where needs have been identified by no providers are available or willing to deliver the service. The combination of these findings informed our determination of provider reimbursement rate adequacy.

In addition to the HCBS Rate Adequacy Study, Guidehouse also concluded an assessment of the adequacy of AHCCCS Fee-For- Service behavioral health provider reimbursement rates in 2019. With Guidehouse's assistance in dually analyzing clients with behavioral health needs demand for services, as well as providers' capability to deliver those services, AHCCCS can better serve their mission to provide comprehensive, quality healthcare to those in need.

To determine the adequacy of the above services, Guidehouse analyzed the following data sources:

Arizona Health Care Cost Containment System | *1993–2018*

- Three years (2015 - 2017) of behavioral health outpatient and inpatient claims and encounter data provided by AHCCCS
- Provider self-reported rate information gathered from a Guidehouse created survey
- AHCCCS Survey of Managed Care Plans
- Bureau of Labor Statistics occupational statistics for behavioral health occupations (May 2017)

Georgia Department of Community Health | *2007–2022*

Key Impacts: ✓ *Identified strategic options for Medicaid managed care program transformation*	✓ *Successfully procured Medicaid MCOs for various types of programs: TANF, SSI, and Foster Care Children* ✓ *Implemented value-based purchasing program targeted towards Medicaid managed care program for foster care children*

DCH retained Guidehouse in August 2011 to **analyze and implement strategic options for managing the financing and care of the State's Medicaid and PeachCare for Kids™** programs which cover nearly 1.7 million members. We continue to work with the State on this important initiative to transform the Medicaid program and to support improved outcomes and quality of care for members.

We began our efforts to transform the Medicaid program through an assessment of re-design options for the State. **We used a robust, structured, objective, and analytic approach to evaluating what is often a politically-charged environment that includes stakeholders and politicians with competing priorities.** Guidehouse initially conducted the following tasks to support development of a Comprehensive Design Strategy Report. Our activities included the following:

- Assessed the model and structure of Georgia's current Medicaid and PeachCare for Kids programs; this includes Medicaid funded services including developmental disabilities and behavioral health
- Conducted a national environmental scan of Medicaid and Children's Health Insurance Programs and of best practices in commercial health plans relating to delivery and financing of services
- Provided considerations and recommendations for moving ABD populations into managed care
- Determined how reform would require reengineering and restructuring of Medicaid program with a focus on the delivery system
- Identified waiver possibilities, issues regarding obtaining waivers and prepared for and participated in meetings with the Medicaid Agency and a CMS Medicaid State Technical Assistance Team (MSTAT)
- Participated in a number of meetings with State actuaries when considering budgeting and financing options
- Conducted focus groups across the State with and an online survey of providers, consumers, advocacy groups and vendors, as well as three task forces that provided ongoing input to the program design

Guidehouse performed the following activities:

- Providing trainings to staff responsible for conduct of monitoring and oversight for the Georgia Families and Georgia Families 360 programs
- Supporting the development of key program design features for Medicaid program modernization, through activities such as procurement materials to contract with a Credentialing Verification Organization to conduct credentialing for the FFS delivery system and all contracted CMOs
- Supporting re-procurements, including interviewing staff and conducting national research, identifying program enhancements, and developing re-procurement materials for the following contracts:
  - Georgia Families (including Georgia Families 360)

Georgia Department of Community Health | *2007–2022*

  - Medical Review and Compliance Vendor
  - Pharmacy Benefit Manager
  - Pharmacy Rebate Vendor
- Supporting workgroups charged with identifying key program design components and issues to consider for the proposed integrated delivery systems and program design
- Assisting with strategic planning and development of program design components
- Assisting in planning for and implementation of an expansion of the State's risk-based Medicaid managed care program, Georgia Families, to children in foster care and adoption assistance and select children in juvenile justice; helping the State to build infrastructure, processes and tools to support implementation of the new program (e.g., Readiness Review tools, use case workflows, transition work plans, etc.)
- Supporting the development of key program design features and procurement materials for a new Medical Coordination Program for members who are aged, blind, and disabled
- Participating in and advising on negotiations with CMS about innovative program design features such as opportunities to request alternative funding options
- Preparing documents to obtain federal authority for the program changes the State is implementing

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

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

Illinois Department of Healthcare and Family Services | *1992–2020*

Key Impacts: ✓ *Developed enhanced program monitoring and reporting structure*	✓ *Implemented expansion Medicaid managed care that included long-term services and supports, behavioral health, and other special populations* ✓ *Developed internal agency capacity for Medicaid managed care program administration*

For more than 20 years, Guidehouse has worked on competitively bid contracts and assisted the State of Illinois with implementation of expanded Medicaid managed care programs and development of managed care monitoring processes and tools. In particular, we have:

- Assisted with improvements to Medicaid managed care program administration, including consultation on organizational structure and optimal staffing alignment and job descriptions and desirable core skills for position vacancies, evaluation of MCO contract reporting requirements, including inventory, review, standardization and enhancement of current reports and development of standard operating procedures for analyzing those reports upon receipt.
- Assessed organizational structure and operational activities of the Medicaid agency's managed care compliance and monitoring business unit, including a comprehensive, qualitative review of program

Illinois Department of Healthcare and Family Services | *1992–2020*

documentation, structured interviews with key management and program staff stakeholders, and benchmarking other states' operational structures supporting managed care program monitoring and oversight activities.

- Provided an assessment and recommendations report and conducted strategic planning sessions with leadership, managers, and program staff to identify priority areas and plan for operational improvements and consultation and technical assistance. Focused on building resources and capacity, streamlining and documenting business processes to promote concerted monitoring and oversight of MCOs, and preparing for integration of new coordinated care initiatives.
- Provided options for refining the Bureau of Managed Care (BMC) organizational structure to align contract monitoring activities with subject matter expertise, such as quality, utilization, member grievances and appeals, care coordination and waiver services.
- Assisted with refining the managed care monitoring and performance improvement process to integrate analysis of program operations and quality data, lessons learned and best practices, and ongoing dialogue with MCOs to improve individual MCO and overall program performance.
- Provided program staff training on Medicaid managed care, data analysis, report reviews and MCO monitoring to support ongoing performance improvement efforts.
- Provided technical and planning assistance related to encounter data collection and validation activities, including development of handbooks, reports, and project guides.
- Worked with BMC staff to develop executive summaries and dashboard reports that can be used to communicate Medicaid managed care performance to Agency leadership, sister agencies and other stakeholders.
- Participated in meetings with BMC, CMS, and the Medicare-Medicaid Alignment Initiative (MMAI) MCOs to better understand how BMC can leverage MMAI MCO data to support program monitoring activities.
- Assisted the State with preparations for the implementation of expanded Medicaid managed care programs
- Assisted with review of MCO contracts for the Integrated Care Program (ICP), MMAI and Family Health Plan (FHP)/ACA Medicaid Expansion and providing recommendations to strengthen contract language and align requirements across programs, where applicable.

Iowa Department of Human Services | *2015 – 2016*

Key Impacts:

- ✓ *Conducted readiness reviews for enrollment of Medicaid members into MCOs*
- ✓ *Developed external reporting regarding MCO preparedness*
- ✓ *Prepared legislative reports*
- ✓ *Developed state Medicaid agency staff capacity*

In January 2015, Iowa Governor Terry Branstad announced plans to move the majority of members served through Iowa's existing Medicaid fee-for-service delivery system to a comprehensive risk-based managed care program, IA Health Link. The Iowa Department of Human Services (DHS) initially contracted with four Managed Care Organizations (MCOs) for this program and **engaged Guidehouse to conduct readiness reviews and to provide ongoing technical assistance in monitoring and oversight of the MCOs.**

Readiness reviews are a critical task lending to the overall success of a managed care program or any contract. One of the primary objectives of Guidehouse's initial work was to verify that the MCOs were ready to provide services for the covered population in accordance with the State's contract and state and federal laws.

Guidehouse performed six key tasks as part of this project:

Iowa Department of Human Services | *2015 – 2016*

- Developed readiness review process and governance
- Developed the readiness review tool and shared it with MCOs
- Conducted desk audits
- Conducted site visits
- Developed a report of our findings that identified areas of concerns and recommended mitigation strategies to address those concerns

DHS also requested that **Guidehouse provide technical assistance for the ongoing monitoring and proactive management** of the MCOs after program implementation. We are strategizing with DHS to establish a thorough and detailed monitoring and oversight process. Guidehouse has assisted with activities such as the creation of an MCO Reporting Manual, reporting requirements and report templates to collect information in program areas such as:

1. Operations: Claims processing, call center, grievances, and appeals, etc.
2. Finance: Third party liability, medical loss ratio, etc.
3. Quality and Access: Care coordination, clinical outcomes, utilization

We also provided training to DHS staff responsible for monitoring and oversight of the MCOs, including foundational trainings on Medicaid and Managed Care and more advanced trainings on Data Analysis and Performance Management.

Kansas Department of Health & Environment | *1994–1996, 2014–2019*

Key Impacts: ✓ *Led the relationship with CMS to provide necessary information and develop activities to complete State's Corrective Action Plan for Medicaid managed care*	✓ *Designed and helped negotiate subsequent five-year renewal of "next generation" Medicaid managed care program to include value-based purchasing, ensure program financial sustainability, and promote integration of physical health, behavioral health, and social services* ✓ *Provided interim staffing for Acting Deputy Secretary of Kansas Department of Health and Environment, interim CFO, interim Commissioner-level support for behavioral health and long-term services and supports, and other analytics and operational support*

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

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

Implementation of Organizational Assessment Recommendations

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

Kansas Department of Health & Environment | *1994–1996, 2014–2019*

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

KanCare Corrective Action Support

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

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

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

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

Substance Use Disorder (SUD) Waiver Approval and Evaluation Design

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

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

Interim Staffing Support

Kansas Department of Health & Environment | *1994–1996, 2014–2019*

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

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

Electronic Medical Record

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

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

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

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

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

Provider Network Standards for Behavioral Health and Long-Term Services

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

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

Actuarial and Analytics

Guidehouse developed and certified managed care rates involving comprehensive covered services for the following programs: TANF, CHIP, ABD non-dual eligible, former faster care children, medically needy/spenddown, Medicare-Medicaid dual eligible, 1915(c) HCBS waiver, and LTSS. We also assisted the

Kansas Department of Health & Environment | *1994–1996, 2014–2019*

State with Risk adjustment design and implementation, **DRG weight and rate development**, and Medicaid expansion enrollment and **budget analysis**.

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

1115 Waiver One-Year Renewal

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

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

1115 Waiver Five-Year Renewal

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

- Increased use of value-based purchasing contracts with MCOs
- State directed payments to support quality improvement among providers
- Increased focus on social determinants of health through expanding service coordination, including assisting members with accessing affordable housing; food security; and employment and increasing employment and independent living supports for members with behavioral health needs
- IMD exclusion waiver
- Increased use of data and analytics to achieve transformation goals

The Guidehouse team drafted the 1115 waiver renewal application, serving as the primary writer. Many of the elements included in this renewal application required Guidehouse to draw upon our deep knowledge of federal regulations to determine what was and was not permissible for KDHE to request. In addition, we provided guidance to KDHE leadership on the potential impact of initiatives requested in the 1115 waiver renewal application, such as work requirements and an IMD exclusion waiver.

Guidehouse developed a schedule to review the draft waiver with KDHE leadership and incorporate their comments and suggested modifications. Guidehouse also supported the public comment process, including drafting public notices, preparing public hearing meeting materials, preparing stakeholder engagement materials, and responding to written public comments. We also prepared KDHE leadership and State legislators with talking points about the significant changes in the 1115 renewal application and how those changes will support KDHE's objectives. Because these talking points were used with a broad audience, we focused on key messages and wrote them in an easy-to-understand manner.

Kansas Department of Health & Environment | *1994–1996, 2014–2019*

As part of KDHE's 1115 waiver renewal, **we provided guidance and expertise regarding state directed payments as described in 42 CFR 438.6(c).** We conducted visioning sessions with KDHE leadership regarding the objectives for state directed payments and the types of providers that should be eligible to receive these payments. Our team also participated in a call with CMS regarding state directed payment programs to receive the most up-to-date guidance.

Guidehouse is currently supporting KDHE in discussions and negotiations with CMS, including responding to CMS' questions on the 1115 waiver renewal application.

CMS approved Kansas's one-year waiver renewal in October 2017 and the five-year waiver renewal in December 2018.

State of Mississippi Division of Medicaid | *2010–2017*

Key Impacts:

- ✓ *Successfully implemented and operated integrated Medicaid managed care program*
- ✓ *Created robust compliance and quality improvement framework for Medicaid managed care, including completion of readiness reviews, monthly quality improvement meetings with MCOs and other partners, and encounter data validation*
- ✓ *Developed internal state agency capacity to operate and oversee Medicaid managed care program*

For seven years, Guidehouse provided technical assistance to the State of Mississippi Division of Medicaid. Guidehouse's original contract was to serve as Implementation Manager for implementation of a voluntary **coordinated care program, MississippiCAN, for high-risk Medicaid consumers.** As part of this contract, we:

- Assisted with strategic planning for implementation of contracts with two Coordinated Care Organizations (CCOs) administering the program services.
- Assisted the State with conducting readiness reviews of the CCOs, including development of a readiness review tool, training staff, and participating in readiness reviews.
- Provided training and support to the Division for data analysis and ongoing monitoring of the CCOs.
- Supported preparations for and participated in meetings with the CCOs and the State's fiscal agent.
- Made recommendations for planning for the expansion of MississippiCAN to new populations and behavioral health services.

In addition, we supported the Division in an expanded role with activities such as the following:

- Participated in ongoing strategic planning to identify opportunities to improve upon the current MississippiCAN program, prepare for program expansion activities, and streamline and improve managed care contract monitoring oversight operations and business processes.
- Conducted ongoing monitoring of the CCOs.
- **Developed tools such as reporting templates and standard operating procedures** and are analyzing reports submitted by the CCOs to identify successes and areas for improvement.
- Assisted with re-procurement of the CCOs by conducting national research of other programs to identify opportunities for the Division to consider, participating in strategic planning sessions and incorporating new and more stringent requirements into the Request for Proposals Scope of Work.
- Assisted the Division with conducting contract readiness reviews and follow-up to review findings, including strategic planning and preparation for future readiness and compliance monitoring activities.

- **Developed, standardized, and maintained a multiyear analytic database containing over five years of eligibility, fee-for-service claims, and CCO encounter data** representing approximately 750,000 annual covered lives. This analytic environment supported a variety of ad hoc and regular reporting activities, including: eligibility and enrollment trending analysis; encounter data validation; core service utilization trending (primary care visits, emergency department visits, hospital admissions and re-admissions, potentially avoidable admissions, etc.); topical focus studies (EPSDT, diabetes and other chronic and disease management conditions, medication prescribing patterns and use – including children and psychotropic and ADHD medications, and perinatal care and birth outcomes, etc.); quality and outcomes measurement; cost analysis and rate modeling; and development of standard reporting, including annual program reports and dashboards for executive, program management, and external stakeholders.
- Conducted an operational assessment and developing a one-year strategic plan for the Bureau of Program Integrity fraud, waste, and abuse operations as they relate to the CCOs and the MississippiCAN program. For this assessment, we researched national best practices at the State and Federal level, reviewed the Bureau's operations and related policies and State regulations through program and policy documentation review and focused Division staff interviews, and conducted a gap analysis to identify best practices and opportunities for improvement relative to established industry standards.

Guidehouse also provided ongoing support to the Division with a variety of quality management activities, including:

- Development of the State's MississippiCAN Quality Strategy for submission to the Centers for Medicare and Medicaid Services (CMS), which CMS approved without required modifications.
- Preparation of the Division's Quality Leadership and Quality Task Force meetings.
- Preparation of the scope of work requirements for the procurement of an External Quality Review Organization.

Oklahoma Health Care Authority | *2022–present*

Key Impacts:

- ✓ *Assisted with the 2024 launch of Medicaid managed care for Medical services including behavioral health, children in foster care and adoptive assistance, and the dental programs*
- ✓ *Strategized and implemented key OHCA goals around quality and value-based purchasing within the contract*
- ✓ *Assisted with managed care launch project management and implementation in expedited timeframe*
- ✓ *Led OHCA staff training to support successful program launch and adequate knowledge baseline managed care launch*
- ✓ *Supported contract compliance including developing a process to resolve claims submission inconsistencies*

OHCA contracted Guidehouse to provide assistance with the development and implementation of the SoonerSelect program. The State relied on Guidehouse's strategic expertise and experience in other states to leverage lessons learned in the implementation and operations of managed care. Our efforts to date include:

Contracting and Procurement

- Reviewed, modified, and updated request for proposals (RFPs) for SoonerSelect Dental, SoonerSelect Medical, and SoonerSelect Children's Specialty Program, including:
  - Identified and finalized quality metrics for all three RFPs;
  - Prepared Bidder Library forms;
  - Researched policy options and recommended substantive changes to RFPs;

Oklahoma Health Care Authority | *2022–present*

  - Drafted RFP Amendments, as necessary;
  - Prepared RFP evaluation tools and scoring summary tools; and
  - Developed case studies and questions for oral presentations of bidders.
- Facilitated RFP evaluation team consensus scoring review meetings.

Project Management and Implementation

- Provided project management support to OHCA to proactively identify policy options and related best practices to inform decisions.
- Developed a detailed Medicaid managed care implementation plan to guide internal OHCA operations and support implementation of the plan to adhere to timelines, identify necessary resources, and support agency change management.
- Identified potential risks for implementation to balance various Federal and State requirements (e.g., CMS approval).
- Assisted in facilitating SoonerSelect Implementation Workgroup meetings, agenda creation, meeting summaries, and alignment between OHCA and health plans. As part of this assistance, Guidehouse also provided subject matter expertise and one-on-one coaching to agency points of contact to advise them on issues related to the transition to managed care. Workgroups focused on the following topics:
  - Children's Specialty Program
  - Communications
  - Medical, Pharmacy, and Behavioral Health Coverage and Benefits
  - Enrollee
  - Finance
  - Legal
  - Provider
  - Quality
  - Technical (e.g., systems, information technology)
  - Utilization Management & Care Management
- Developed strategy and associated materials to facilitate interdepartmental collaboration between the SoonerSelect team and agency subject matter experts with the goal of improving monitoring and oversight of the SoonerSelect Program

Operational and Administrative Reporting

- Supported review and development of performance measures for Institutes of Mental Disease Substance Use Disorder waiver.
- Reviewed, updated, and aligned Reporting Manual, Reporting Templates, and Reporting Internal Companion Guide with Program Contracts, CMS reporting requirements, and national best practices.
- Developed an Initial Interim Report Tracking Tool to enable the State to track deliverables submitted by CEs.
- Developed a Dental Program CE Call Center Report Tracking Tool to enable consolidation of CE-submitted reports allowing the State to track daily, weekly, and monthly CE call center reports.
- Conducted an analysis of the states' medical utilization management tools to confirm effectiveness and alignment with leading practices

Network Adequacy Review

- Designed and implemented CE Network Adequacy Report files which collected current network information by county across eight (8) provider types for SoonerSelect Dental and 36 provider types for SoonerSelect Medical and SoonerSelect Children's Specialty Program.

Oklahoma Health Care Authority | *2022–present*

- Built semi-automatic tools and created processes for streamlined review of submitted reports on a bi-weekly and/or monthly cadence for all three SoonerSelect Programs, including analyzing trends of network growth for each SoonerSelect CE across submissions.
- Compared SoonerSelect CEs' reported networks against other SoonerSelect CEs serving in the same program, as well as against Oklahoma's current network under SoonerCare fee-for-service, to determine further contracting opportunities for continued network expansion for each SoonerSelect CE.
- Assisted OHCA with identifying counties across provider types where OHCA could appropriately provide an exception to SoonerSelect CEs for not meeting network adequacy standards and counties, instead, where OHCA expected SoonerSelect CEs to close the gaps in their networks.
- Trained OHCA staff on reviewing and analyzing submitted network adequacy reports, including how to summarize submitted data to adequately measure network progress over time, as well as how to effectively review data for early identification of potential flags.
- Developed summary reports of the current status of networks across provider types for submission to CMS for all three SoonerSelect Programs.
- Developed formal communication for OHCA to distribute to CEs that provides guidance on expectations related to Network Adequacy Exceptions Requests

Mental Health Parity Review

- Conducted policy review of the SoonerSelect Programs (Medical, Children's Specialty, and Dental) to confirm compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and the 2016 Centers for Medicare and Medicaid Services (CMS) Final Rule.
- Defined the scope of SoonerSelect mental health/substance use disorder (MH/SUD) services and medical/surgical (M/S) services. Classified the covered MH/SUD services and M/S services by service classification (inpatient, outpatient, emergency, and pharmacy).
- Conducted parity analysis on any SoonerSelect program quantitative limits, including an analysis of aggregate lifetime and annual dollar limits, financial requirements, and quantitative treatment limits (QTLs) within each benefit classification.
- Developed non-quantitative treatment limit (NQTL) analysis template. Identified applicable NQTLs and conducted an analysis of each SoonerSelect CEs' processes, strategies, and evidentiary standards on the application of NQTLs to services within each benefit classification.
- Developed, drafted, and finalized the SoonerSelect MHPAEA Compliance Report for submission to CMS.

Readiness Review

- Designed and implemented the CE Readiness Review approach and process including the development of a workplan.
- Developed CE Readiness Review Tools for all three SoonerSelect Programs based on SoonerSelect Contracts. The Tools assessed compliance with all relevant Federal and State requirements for the following:
  - Operations/Administration
  - Service Delivery
  - Financial Management
  - Systems Management
- Conducted multiple rounds of desk reviews for three (3) SoonerSelect Medical CEs and one (1) Children's Specialty Program CE – accounting for nearly 1,300 requirements.
- Developed CE on-site review agenda and identified preliminary questions for on-site CE reviews.

Oklahoma Health Care Authority | *2022–present*

- Developed Corrective Action Plan (CAP) process including CAP template and tracker to manage deficiencies from desk and on-site reviews.
- Assisted with the development and preparation of the Readiness Review Final Report for submission to CMS based on findings from the desk and on-site reviews.
- Supporting State's CE and Agency Readiness Review Gateway requirements reporting to CMS.

Training

- Developed SoonerSelect training plan and associated trainings to provide a uniform base of understanding of key SoonerSelect players, Medicaid managed care principles, address knowledge gaps, facilitate a smooth program implementation, and enable a strong foundation for Contracted Entity (CE) monitoring and oversight.
- Guidehouse deliver trainings that include, but not limited to the following topics:
  - Introduction to SoonerSelect & Managed Care
  - CE [MCO] Operations & Structure
  - SoonerSelect [Managed Care] Monitoring & Oversight
  - Encounter Data
  - Program Integrity
  - Quality Metrics & Programs
  - Alternative Payment Models
  - Provider Networks
  - Utilization Management
- Guidehouse is in the process of delivering trainings on enhanced monitoring and oversight concepts, processes, and procedures.

Communications

- Assisted in development of OHCA Communications Plan for SoonerSelect implementation, which was included in the State's 1915(b) waiver submission to CMS.
- Developed a Communications Toolkit to support stakeholder engagement efforts. The Toolkit is providing the State a structure to conduct outreach and communicate the State's progress toward implementing its Medicaid managed care program, SoonerSelect. The Toolkit includes:
  - A summary of stakeholder groups
  - Key messaging
  - Definitions for key terms
  - Sample talking points
  - Frequently Asked Questions
- Developed SoonerSelect Collateral including:
  - Provider Guides on provider rights, billing, contracting, and more
  - Member Guides on eligibility, enrollment, provider networks, and more
  - Targeted Guides for specific populations and providers, such as Non-Emergency Transportation (NET) information and pharmacy provider information.

Claims Review

- Assisted OHCA in developing a strategy to address inconsistencies across the CEs in the pricing and reimbursement of manually processed claims.
- Assisted OHCA with the continuous analysis of denied claims to decrease denials, particularly for behavioral health claims.

Oklahoma Health Care Authority | *2022–present*

- Collaborated with OHCA and DMH to develop a strategy to address the high volume and dollar amount of denied behavioral health claims.
- Developed CE follow-up communications related to CE denied claims to better understand denial reasons and provide CEs with guidance on billing practices specific to SoonerSelect.
- Supported SoonerSelect Team with the facilitation of denied claims working Session with CEs including agenda creation, data analysis and meeting supporting documentation.

Contract Compliance

- Supported OHCA in developing Notice of Findings and Opportunity Template and associated communications for each CE. Communications identify the following components:
  - Contract violations
  - Contract requirements
  - Associated damages
  - Discovery of issue narrative
  - Proposed resolution
  - History of previous incidents

Quality

- Supported the OHCA Quality team facilitate Value-Based Purchasing, Quality Withhold and Quality Strategy Meetings with the CEs.
- Conducted review of CE's Value-Based Payment Plans and developed communications specific to each CE, including key takeaways and follow-up questions.
- Assisted OHCA in reviewing and updating the Quality Withhold Program Measures.

State of Tennessee Division of TennCare | *July 2004 – Present*

Key Impacts:

- ✓ *Analyzing strategic options for Medicaid managed care programs, including current evaluation of design for first-in-nation Block Grant*
- ✓ *Legislative support for major program initiatives*
- ✓ *Developed telehealth initiatives and assisted in implementation*
- ✓ *Assisted in development of I/DD program*
- ✓ *Rural health taskforce*

Analyzing strategic options for Medicaid managed care programs, including current evaluation of design for first-in-nation Block Grant

Guidehouse's assistance includes the following efforts in relation to the waiver as part of the evaluation design: 1) Evaluating process for obtaining an independent entity to conduct the evaluation: Description of qualifications the entity must possess, how TN will ensure no conflict of interest and that the Evaluator will conduct a fair and impartial evaluation / prepare an objective Evaluation Report; 2) Evaluating Budget for implementing the evaluation: Total estimated cost, breakdown of estimated staff, administrative, and other costs (e.g., development of all survey and measurement instruments, data collection, data cleaning, report generation); and 3) Evaluating the timeline for conducting evaluation activities, related milestones (e.g., deliverables, procuring an outside contractor, etc.), and 4) Confirming compliance with CMS requirements

Other assistance includes:

- Helping TennCare digest all waiver approval requirements, develop plan for monitoring adherence
- Advise on policies and strategies impacting different populations

State of Tennessee Division of TennCare | *July 2004 – Present*

- Assist the State in meeting other STCs. For example: Implementation Plan: Within 90 days of approval, TN must submit an Implementation Plan to cover key policies being tested and strategic approach to implementing these policies, including timelines and milestones
- Shared Savings Quality Measures Protocol: No later than 60 calendar days after the demonstration approval, TN must submit a protocol that includes:
  - At least 10 quality metrics from the Medicaid Adult, Child, and Maternity Core Sets (at least 3 applicable to each population impacted by the demonstration) to be monitored for performance measurement in order to access shared savings
  - A mathematical representation by which to document how shared savings are earned and spent
  - Reporting on Shared Savings Quality Measures:
    - Quarterly/annual monitoring reports

Assisted in development of Patient-Centered Medical Homes and Tennessee Health Link

The Guidehouse team worked closely with TennCare, TennCare's three health plans, and the Patient-Centered Medical Homes (PCMH) and Tennessee Health Link (THL) practices to implement practice transformation. We led the following activities:

- *Assessments*. The Guidehouse team developed assessments to evaluate the readiness of practices to achieve the PCMH and behavioral health home models and conducted the assessments onsite for each of the participating practices.
- *One-on-One Practice Coaching*. Guidehouse practice transformation coaches used the assessment results to provide regular, in-person coaching and technical assistance to shepherd primary care practices through the NCQA PCMH recognition process, to help THL practices transition to the Health Home model, and to assist all practices with quality measure improvement. The team also developed a customized curriculum of evidence-based practices that they used during coaching sessions and which practices accessed on demand.
- *Group Training and Collaboration*. Guidehouse conducted nearly 200 learning collaboratives and 30 conferences across Tennessee to educate providers on key topics, initiatives, and share leading practices. We managed all aspects of these trainings including logistics and meeting planning, content development, facilitation, and evaluation. We also worked with Community Mental Health Centers (CMHCs) to identify leading practices in the delivery of mental health and substance use services, including:
- *Remote Training*. Guidehouse conducted more than 35 webinars and video trainings across a wide range of topics to help practices to operate more effectively, learn about TennCare initiatives, and address common challenges identified through coaching and collaboratives. The topics included behavioral health crisis planning and coordinating the behavioral health continuum of care.

Assisted in development of I/DD program

Our Guidehouse team was instrumental in assisting the State in developing, framing, and implementing TennCare's ECF CHOICES I/DD program in managed care. This included assistance with identifying and evaluating the most suitable MCO for the program for procurement, reviewing and setting administrative framework and financial readiness, and implementing the program as a startup component of managed care

Rural health taskforce

In 2022 and 2023, Guidehouse partnered with the State of Tennessee Department of Health to convene a Rural Health Care Task Force to "improve health access and outcomes for rural Tennesseans." The Task Force was comprised of 34 public and private stakeholders including State agency commissioners, providers, payers, academic institutions, insurers, retail corporations, nonprofit organizations, and legislators. Guidehouse supported Task Force meeting preparation (i.e., data analysis, leading practice research, agenda and materials, and prep meetings), facilitation, and follow-ups. The Task Force convened

State of Tennessee Division of TennCare | *July 2004 – Present*

from May 2022 – July 2023 and the Department publicized the final report[1], written by Guidehouse, and a high-level summary document on June 30, 2023.

State of Texas Health and Human Services Commission | *1996-1998, 2005-2009; 2014-2015; 2019-Present*

Key Impacts: ✓ *Transitioning current DSRIP initiatives to managed care directed payment programs* ✓ *Supporting stakeholder and provider engagement efforts related to directed payment transition*	✓ *Effective management and reporting to CMS for DSRIP* ✓ *Robust program monitoring and oversight of managed care network adequacy*

Directed Payment and DSRIP Reporting

Guidehouse assisted the state with two directed payment programs. The first targets inpatient and outpatient hospitals as well as academic physicians and is financed primarily by provider taxes. The second program targets physicians employed by acute care hospitals and is also financed by provider taxes. Guidehouse assisted the state in soup-to-nuts preprint support: from percentage of Medicare modeling; to average commercial rate data collection, scrubbing, and analysis; to integrating the quality strategy into the program; to full preprint writing and support of CMS questions.

We reviewed multiple types of providers including local health departments, outpatient clinics, physicians, rural health clinics, and community mental health centers, and providing both policy support and detailed financial analysis. Policy support ranged from a national scan of other states' preprints; providing a detailed list of considerations for all allowable directed payment methodologies for distributing funding including for value-based payments; assisting in determining which methodologies were optimal to operationalize. Financial analysis ranged from percentage of Medicare and average commercial rate analysis to determine maximum payment amounts under the program, to determining maximum amount of payments under a cost report framework for rural health clinics and community mental health centers. Several iterations of the analysis were performed to continually incorporate stakeholder feedback from senior leadership and providers.

Office of Inspector General

Guidehouse conducted two projects for the Texas HHSC Office of the Inspector General (OIG). The first project was a high-level review of the OIG's oversight of HHSC and the second was an in-depth assessment of the initial findings. Guidehouse performed an in-depth analysis of OIG to include an organizational assessment of its current functions and structure to determine the best organizational structure and improve critical processes; incorporate best practices into the structure, processes, and systems; assess current technology capabilities and current and future needs; and recommend options to increase the efficiency and effectiveness of OIG activities that will realize the HHSC-OIG mission and the vision; and assist in the implementation of recommendations from previous internal reviews. A key focus of the assessment is the oversight and management of Medicaid managed care.

Network Composition Compliance Assessment

Our consultants provided technical assistance to the Texas Health and Human Services Commission (The Commission) to evaluate Provider Network Composition Compliance for all of its Medicaid and Children's Health Insurance Program (CHIP) Managed Care Organization (MCO) contracts. The assessment included an evaluation of the Accuracy of Provider Directory information, a Geo-Access Assessment of the provider network files and an evaluation of the MCO's strategies for monitoring provider network compliance.

[1] Tennessee Rural Health Care Task Force Releases Recommendations

State of Texas Health and Human Services Commission | *1996-1998, 2005-2009; 2014-2015; 2019-Present*

In the evaluation of the Accuracy of Provider Directory data, we sampled each MCO's network, stratifying by program and service delivery area. Our consultants compared the sampled records to the hard copy provider directories and submitted provider contracts and Department of Insurance applications (or other approved submissions). Results were logged in a customized database that automated comparative analysis for each evaluation. We also conducted telephone surveys to evaluate Primary Care Physician (PCP) Open Panel status and Specialists appointment scheduling times.

To evaluate Network Composition Compliance, we conducted a Geo-Access assessment using MCO network files. We then incorporated MCO self-reported data to supplement our findings due to underlying issues the MCO's experienced in producing the network files.

Finally, we completed desk reviews and telephone interviews to evaluate the MCOs' efforts to monitor the composition of their networks and provider availability.

The Commission used our reports to evaluate ongoing monitoring efforts and to report to the Texas Legislature and other stakeholders regarding the network composition of Medicaid and CHIP MCOs.

Systems Readiness Review of Managed Care Organization Selected to Provide Comprehensive Health Care for Children in Foster Care

We provided assistance to the State of Texas Health and Human Services Commission to assess the systems readiness of Superior Health Plan Network (Superior), the Managed Care Organization (MCO) selected to provide comprehensive health care for foster care children in the State of Texas as of April 1, 2008. Our consultants conducted a multi-phased readiness review, beginning with a desk review of Superior's policies and procedures for the new systems, which was then supplemented with an on-site review of their claims and data processing systems approximately three months prior to the effective date of the foster care managed care program. In addition to standard managed care readiness review activities, our consultants needed to ensure that specific initiatives included within the managed care program for foster care children could be supported by Superior's system. For example, our readiness review included a focus on Superior's ability to accept the State's Daily Notification File, which was created for this new program so foster children can immediately get services from providers upon entry into the program without any lag in provider notification regarding the child's eligibility. Another key feature of our readiness review work included an assessment of Superior's ability to support Health Passport, the first state electronic health record. Health Passport was designed to allow providers and foster parents to view foster children's available health records online. Based on our onsite readiness review activities, we identified areas for further development and review during the final three months before the system went live.

Our work included comprehensive preliminary and final reports with recommendations to the State regarding Superior's readiness to implement this program. The report assessed Superior's readiness to accept and download various interface files from the State's administrative services contractor, enrollment broker, Department of Family and Protective Services, drug vendor and providers to populate the Health Passport.

During the completion of the readiness review, our consultants developed a comprehensive systems readiness review tool by reviewing contract documents and Superior's proposal. We developed tracking mechanisms for documents received from the State and Superior. During the desk review, we reviewed Superior's Joint Interface, Disaster Recovery, Business Continuity, Risk Management, and Systems Quality Assurance plans to assess their compliance with the contract and their ability to carry out the functions required. As part of the on-site review, we designed test data scenarios to determine whether the Health Passport and claims and data processing systems were functioning correctly and would process correct claims and eligibility data and reject incorrect or missing data. Our review included real-time demonstrations of Superior's ability to accept this test data and process it through their systems.

Compliance with RFQ Requirements

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

Actuarial and Financial Services Qualifications

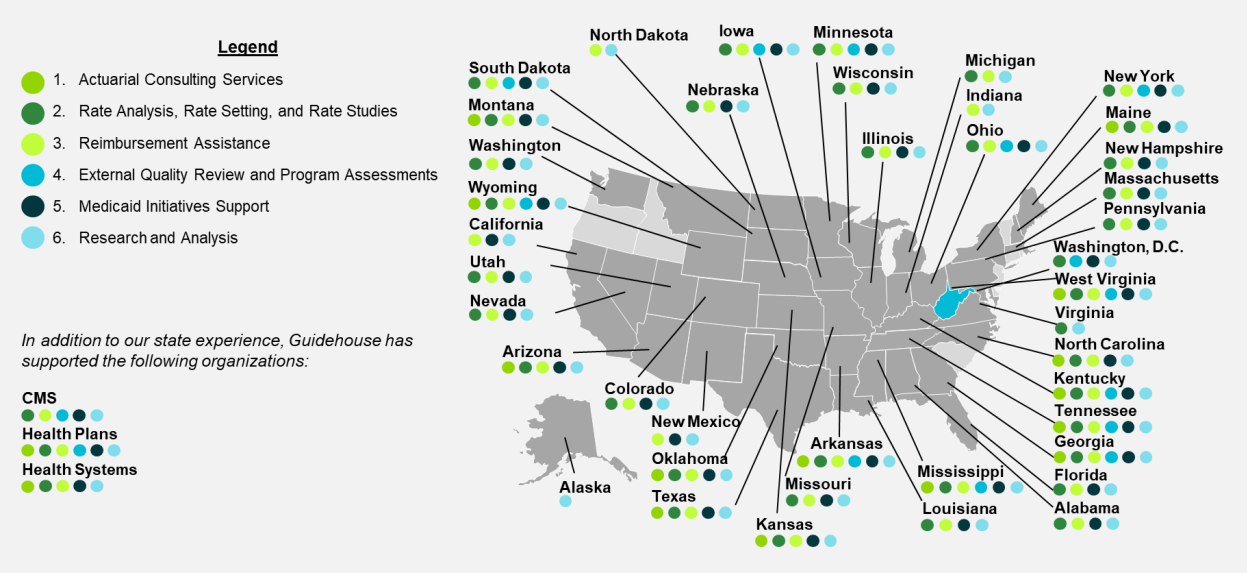
Guidehouse has worked in almost every Medicaid program in the country, serving as an innovative catalyst and providing technical support to state Medicaid agencies and administrations – executing and transforming their actuarial practices, reimbursement strategy, and managed care program design. Our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

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

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

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

Figure 4. Overview of Guidehouse Experience



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

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

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

Our Work with West Virginia to Provide Actuarial Services

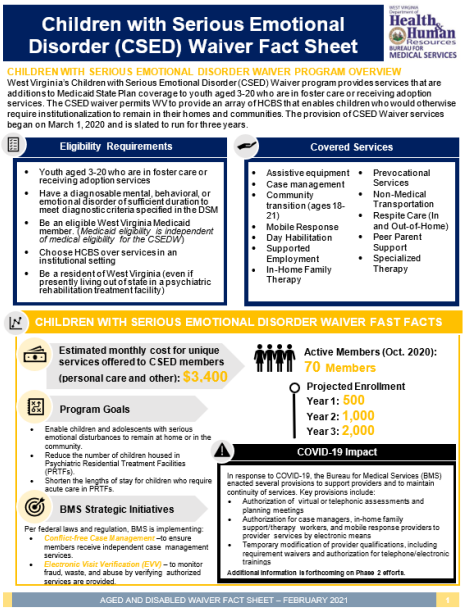
From 2018 to 2022, our Guidehouse team worked with the West Virginia Bureau for Medical Services (BMS) to oversee, manage, and enhance the State's Mountain Health Trust and Mountain Health Promise managed care programs, **initially focusing on actuarial services and for the latter part of the contract, for all services including financial and ad hoc services**. Throughout our tenure collaborating with BMS, Guidehouse served as a trusted advisor and extension of BMS, helping it achieve its mission and managed care program goals. Guidehouse supported BMS to make an impact on and stride towards the following:

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

the policy and financial landscape across the United States. With uncertain outlook and new challenges, Guidehouse led, with BMS leadership, eFMAP budget modeling of enrollment changes due to unemployment and reverification suspension and including various COVID-related program changes. Work was utilized for key NAMD survey used to support FMAP lobbying efforts on behalf of states. Guidehouse further supported the State by developing utilization projections, rate adjustments, and financial support for SPA and 1115 Waiver submissions related to the COVID-19 PHE.

- **Establish a Strong Foundation for MCO Programmatic and Policy Innovation:** Guidehouse provided ongoing financial and actuarial support to inform BMS programmatic and policy decisions and enable the State to make fiscally responsible decisions regarding future plans for BMS and its programs. Since 2019, Guidehouse has finalized multiple years of original and midyear rates including rate certifications, amendments and support of CMS negotiations. Guidehouse also assisted the State in revising its strategy for midyear rates payment (to be based on entire year enrollment instead of final six months; will save State money in times of increasing enrollment). Rates work also led to the development of a new program change tracking tool to be used by State for FFS and managed care.

- **Support Legislative Process and Priorities:** Throughout the State's legislative sessions, Guidehouse has provided actuarial support to inform policy-making and establish actuarially sound budgets. For example, for the 2021 legislation session, Guidehouse created nine (9) program fact sheets/issue briefings to support BMS leadership. BMS leadership used the fact sheets to support their conversations with Legislators and to respond to questions raised during the Legislative session. Guidehouse prepared the following materials:



  - SFY 2021 Budget Fact Sheet
  - Medicaid Fact Sheet
  - COVID-19 Issue Briefing
  - BMS Agency Fact Sheet
  - Specific Program Fact Sheets (e.g., Adult Dental, 1915(c) waiver services, etc.)

Combined West Virginia Familiarity with National Insights and Best Practices

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

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

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

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

Medicaid Actuarial and Financial Services								
State	**WV**	**GA**	**KS**	**KY**	**OK**	**TN**	**TX**	**WY**
Capitation Rate Setting	✓	✓	✓	✓	✓	✓		
Capitation Rate Ranges		✓	✓	✓		✓		
Support for Rate Setting Meetings	✓	✓	✓	✓	✓	✓		✓
Encounter Data Analysis and Review Against MLR reports	✓	✓	✓	✓	✓	✓		
Directed Payment Programs	✓	✓	✓		✓	✓	✓	
Data Modeling	✓	✓	✓	✓	✓	✓	✓	✓
Financial Data Management	✓	✓	✓	✓	✓	✓	✓	✓
Alternative Payment Models		✓	✓	✓	✓	✓	✓	
Budget Neutrality	✓	✓	✓			✓	✓	
Cost Effectiveness	✓	✓	✓		✓	✓		✓
Trend Analysis	✓	✓	✓	✓	✓	✓	✓	✓
Statistical Analysis	✓	✓	✓	✓	✓	✓	✓	✓
Risk Adjustment	✓	✓	✓	✓	✓	✓		✓
CMS Negotiations	✓	✓	✓	✓	✓	✓		
Pharmacy Savings	✓	✓	✓	✓		✓		
Legislative Inquiries	✓	✓	✓	✓	✓	✓		✓

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

Guidehouse's Clients

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

West Virginia Department of Health & Human Resources | Bureau for Medical Services | *2018–Present*

Guidehouse and our staff worked with the State of West Virginia providing actuarial services including the development of MCO capitation rates, amending prior year capitation rates, directed payments approach, CMS pre-prints for 42 CFR 438.6 (c), budget neutrality and cost effectiveness, MLR compliance, policy support, pharmacy savings analysis, annual IBNR valuation of FFS part of Medicaid program, revenue code pricing, fiscal impact analysis of 1115 SUD waiver, and presentations to state staff and the MCOs. Populations covered under the MCO capitation rates include TANF, Pregnant Women, Children with Special Health Care Needs (CSHCN), SSI (Disabled), and ACA Expansion members, and Guidehouse created the rates for the newly-transitioned Foster Care Program under the MHP program.

Our extensive tenured actuarial expertise and experience with West Virginia DHHR and BMS included all current contractual components related to actuarial services plus support of CHIP and FFS financial analysis where requested by BMS. Further detailed examples of our extensive and highly valued actuarial service to the State's programs included:

- MHT and MHP State Fiscal Year Rate Setting
- MHT Revenue Neutral Risk Adjustment, including: 1) Developing and refining risk adjustment methodology scenarios for the different populations; then studying, testing and communicating scenario results to BMS for decisions, where actuarial models to assess and re-assess the following:
  - When and how previously determined approaches will be applied and implemented
  - Base data criteria
  - Usage of national versus state specific weights
  - The application of prospective or concurrent factors
  - Addressing risk adjustment for new managed care enrollment
  - Enrollment churn and movement between MCOs
- MHT, MHP, and other extensive Actuarial Support, wherein addition to capitation rate development, there are other actuarial items that rely on rates and underlying data and models. Guidehouse provided actuarial support for these items although the items do not all require submission to CMS nor the MCOs or actuarial certification. Based on our experience in working with BMS in the past, these items included the following high-level tasks: Responding to BMS requests that address external inquiries from the legislature or even advocacy groups and provider associations. Additional coordination for items such as the MCO contracts or the Annual Report to the State to ensure all is in sync with the rate certifications. Furthermore, cost effectiveness assessments and any other analysis tied to the rate development. A list of our experience in supporting BMS includes:
  - Mid or Partial Year Program Changes
  - MLR Actuarial Validation and CMS Submission, Risk Corridor
  - Directed Payment Program (DPP) and other Hospital Based Physician Reimbursement Calculations
  - Fiscal Impact Analyses and Legislative Response Support
  - Actuarial Coordination with Managed Care Contract
  - IBNR for FFS Programs
  - Medicaid Fee Schedule Analysis and Development
  - Actuarial Input for Annual Report
  - Pharmacy Carve-out Analysis
  - 1915(b) Cost Effectiveness Support as Needed
  - 1115 SUD Budget Neutrality
  - ARPA support and modeling
- MHT and MHP Analytics of Actuarial Data

West Virginia Department of Health & Human Resources | Bureau for Medical Services | *2018–Present*

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

BMS previously received under our current contract all supporting documentation and evidence of each of these actuarial services provided by our Guidehouse actuarial team. If BMS would like us to re-provide any evidential documentation, we will be happy to reproduce all necessary documents to BMS upon request.

Georgia Department of Community Health | *2007–2022*

Key Impacts:	✓ Ensured compliance with CMS regulations and guidance
✓ *Developed capitation rates for Medicaid managed care programs that have achieved* a projected revenue for FY22/23 of $7B+ with 2.0M+ members	✓ Launched addition of over $1.5B in new directed payments across five programs, including an additional $1.1B in FY23.

From 2009 – 2022, Guidehouse served as the actuary of record to the State of Georgia for the development of actuarially sound MCO capitation rates, including assistance with CMS certifications, the production of databooks, and all related documentation and reviews. At a high-level, key work duties we performed include:

Georgia Department of Community Health | *2007–2022*

- Construct actuarially sound premium rates that adequately balance limited State resources with carrier profit-driven expectations
- Navigate through the CMS guidance, review, and approval process
- Assess the impact of pharmacy spread pricing and carrier consolidation
- Increase transparency of rate development process with MCOs
- Midyear and annual Medicaid managed care capitation rate setting
- Medicaid NEMT program capitation rate development
- Annual analysis of Incurred but not Reported (IBNR) payments for the Medicaid Fee-For-Service (FFS) program
- Risk adjustment methodology and calculations
- Directed payment calculations, program development, stakeholder engagement, quality goals, and preprint development
- Value-based payment and withhold development for Georgia Families 360 program
- 1115 waiver support including Planning for Healthy Babies (Family Planning), Georgia Pathways (extension of coverage to certain members under 100% of Federal Poverty Level), and post-partum coverage extension
- American Rescue Plan Act of 2021 (ARPA) support

Closely collaborating with the State, we developed actuarially sound rates for the Medicaid managed care programs. The projected capitation revenue for FY23 was $6.2B+ with 2.0M+ members. In developing rates for Georgia's new pathways program, we considered the impact of work requirements, FPL mandates, category of aid requirements, and other rate setting related techniques. We also assisted in transitioning the foster care and adoption assistance programs from FFS to managed care.

Guidehouse developed Medicaid managed care capitation rates for the TANF / Children's Health Insurance Program, family planning, foster care and adoptive assistance, and Georgia Pathways programs. In collaboration with Georgia, the project team worked to make sure that the program is reasonably funded through actuarially sound assumptions and development. We assisted in the development of risk adjustment analysis for different programs and populations with the intention of rebalancing funds to the appropriate risk of members. Additionally, we managed various ad hoc projects. Examples of Guidehouse's work included:

- **Rate Development.** Initiate data requests and perform intake / validation for the reasonability and accuracy of data, construct actuarial modeling, and present rates and provide documentation for the respective programs. Work included trend development, service/population carve-in/out analysis, fee schedule pricing, diagnosis related group re-pricing, efficiency adjustments, administrative cost development, in lieu of service pricing, kick payments, risk adjustment, withhold arrangements, and rate certifications
- **Other Actuarial Support.** Provide other actuarial support such as: NEMT rate setting, fiscal impact analyses and legislative response support, IBNR for FFS Medicaid program, Medicaid fee schedule analysis and development, MLR and risk corridor remittance actuarial validation, and ARPA application development
- **Staff Transitions.** Work with additional staff at the Department of Community Health (DCH) to deepen our relationship with their policy team and increase value as a trusted advisor
- Guidehouse identified pharmacy spread pricing issues and helped the State move from spread pricing to passthrough pricing, saving Georgia's programs $50M in each of SFY20, SFY21, and each future year, or $150M over the first three years. In 2020, Guidehouse developed a comprehensive actuarial pharmacy carve-out analysis. Factors in the analysis included unit cost re-pricing, trends, rebates, utilization shifts, PBM administrative fees, risk margin, and premium tax, and HIF.

Georgia Department of Community Health | *2007–2022*

- Our actuarial team implemented a novel approach to risk adjustment which was completed twice a year so MCOs have a shorter tail on risk adjustment accruals. Our work used local weight for the Chronic Illness and Disability Payment System (CDPS) model. The team adjusted the model over the years in collaboration with health plans to address issues such as improved risk adjustment assumptions for new MCO members.
- Guidehouse assisted Georgia in adding over $1.5B in new directed payments across five programs, including an additional $1.1B in FY23 alone. Impacted providers included hospitals, teaching physicians, and level 1 trauma centers. The FY23 increased payments allowed the State to redirect more than $100M in Disproportionate Share Hospital funds to rural providers, advancing the State's goals to direct additional funding to most at-risk hospitals considering increasing number of rural hospital closures in recent years. Guidehouse led weekly meetings with the hospital association's consultant for improved stakeholder engagement.
- Our team developed the application for Georgia to potentially acquire an additional nearly $300M in American Rescue Plan Act of 2021 (ARPA) funding to the benefit of state programs.
- Our annual IBNR process included two sets of calculations. Reports and an actuarial certification based off the test calculations are sent to DCH in early July, while final calculations are sent to DCH in late August. The purpose of the test calculations is to prepare for the tight turnaround (two weeks after receiving data) for the final calculations. We have also been able to share important insights with the state as the result of our IBNR analysis, such as when in 2019 we identified unreasonably high trends in the independent lab category of service which subsequently led to an investigation by the attorney general's office into several providers' billing practices. In the many years that Guidehouse has performed IBNR calculations for DCH, no deadlines have been missed for either the test calculations or final calculations. Every year, the certified final calculations have been accepted by DCH's auditors, and over the course of our contract, no rework of calculations or results has been warranted or requested.
- Our actuaries were instrumental in the development of Georgia NEMT program rates, including consideration for regional variation in the developed capitation rates among the five regions, with the rate in the highest region being over double that of the lowest region. To decrease the amount of regional variation, we have applied regional smoothing factors while maintaining budget neutrality. More recently, the main challenges caused by the public health emergency related to Georgia NEMT have been managing increased enrollment. Due to the suspension of reverification, and decreased NEM trips because of corresponding increased telehealth utilization. Guidehouse worked with the State to gauge the impact of these new challenges and incorporate the impacts into new capitation rates.

Due to our long tenure with the State, Guidehouse staff often possessed the deepest historical knowledge of the program and rationales for prior decisions which we frequently shared with State employees. We provided an overview of capitation rate setting to State staff at least annually. We worked with the State to follow CMS regulations and guidance.

Kansas Department of Health & Environment | *2014–2019 (Previous work: 1994–1996)*

Key Impacts:	
✓ *Developed capitation rates for Medicaid managed care programs that included a number of different populations, including 1915(c) long-term services and supports waiver populations*	

Guidehouse developed and certified managed care rates involving comprehensive covered services for the following programs: TANF, CHIP, ABD non-dual eligible, former faster care children, medically needy/spenddown, Medicare-Medicaid dual eligible, 1915(c) HCBS waiver, and LTSS. We also assisted the

Kansas Department of Health & Environment | *2014–2019 (Previous work: 1994–1996)*

State with Risk adjustment design and implementation, DRG weight and rate development, and Medicaid expansion enrollment and budget analysis.

Guidehouse's actuarial team, which was formerly Aon's Medicaid actuarial practice, developed and certified managed care rates involving comprehensive covered services for the following programs: TANF; CHIP; aged, blind, and disabled; non-dual eligible; former foster care children; medically needy / spend down; Medicare-Medicaid dual eligible; 1915(c) HCBS waiver; and LTSS. We also assisted the State with risk adjustment design and implementation, DRG weight and rate development (fee-for-service rate-setting), and Medicaid expansion enrollment and budget analysis.

KDHE operates its Medicaid managed care program under an 1115 waiver. The 1115 waiver was expiring, and KDHE needed assistance with its waiver renewal applications and related delivery system reform design and strategy. KDHE engaged Guidehouse to provide support with its waiver development and approval activities. We participated in weekly calls with CMS, developed public notice materials, and provided comments on presentations used for the public hearings.

Following CMS approval of Kansas' one-year 1115 waiver renewal, Guidehouse assisted the State with drafting a concept paper for a five-year 1115 waiver renewal application that outlined the major changes that KDHE was interested in pursuing. It covered topics such as increased use of value-based purchasing contracts with MCOs, state directed payments, Institution for Mental Disease (IMD) exclusion waiver (SUD), and increased use of data and analytics to achieve transformation goals.

We prepared KDHE leadership and State legislators with talking points about the significant changes in the 1115 waiver and how those changes support KDHE's objectives. Following the development of the five-year waiver renewal application, which included an IMD exclusion, Guidehouse helped draft the State's SUD Implementation Plan. Guidehouse provided complete SUD Implementation Plan development support. CMS approved Kansas's one-year waiver renewal in October 2017, their five-year waiver renewal in December 2018, and their SUD Implementation Plan in August 2019.

Kentucky Department for Medicaid Services (DMS) | *2014–2017*

Key Impacts: ✓ *Developed capitation rates for Medicaid managed care programs*	✓ *Corrected prior actuarial capitation rate issues identified* ✓ *Prepared rate setting analyses for 1915(c) waivers*

Guidehouse has developed and certified managed care rates involving comprehensive covered services for the following programs: TANF, CHIP, ABD non-dual eligible, Former foster care children, NEMT, Medicare-Medicaid dual eligible, and Mental and Behavioral health services.

Guidehouse also provided risk adjustment analysis for all populations, including implementation of risk adjustment for the ACA expansion population. Additionally, Guidehouse assisted the Commonwealth in determining budget neutrality in preparation for their 1115 waiver.

Guidehouse helped the Commonwealth redesign all of their 1915(b) and (c) waivers. We successfully developed and certified past years' NEMT rate ranges (SFY14 and SFY15) that were previously deemed non-compliant by CMS due to non-submission; and re-developed and re-certified both SFY15 traditional/non-expansion and CY14-SFY15 ACA expansion rate ranges developed and certified past years' NEMT rate ranges (SFY14 and SFY15) that were previously deemed non-compliant by CMS due to non-submission.

Oklahoma Health Care Authority | *2022–Present*	
Key Impacts: ✓ *Developed capitation rates for Medicaid managed care programs* ✓ *Corrected prior actuarial capitation rate issues identified* ✓ *Assisted with budget projections and 1915(b) cost effectiveness, including upcoming cost effectiveness amendment related to the PHE*	✓ *Developed presentations for CFO to support budget increases related to managed care and ACA Medicaid Expansion* ✓ *Ensured rate certifications appropriately reflected state directed payment programs and implemented SDP integrated into capitation rates*

Guidehouse serves as Oklahoma's Medicaid managed care rate-setting actuary, developing and certifying rates for its Medical (TANF adults and children, pregnant women, and Expansion populations), Children's Specialty program (CSP) (foster care and adoption assistance), and Adult and Child dental programs. We have assisted the State with all aspects of its actuarial rate-setting ahead of and including the launch of the Dental program into managed care in February 2024 and the Medical and CSP programs in April 2024. Rate development includes over five directed payment programs with over $2 billion in annual SDPs.

As part of the managed care procurement, Guidehouse supported the State in developing actuarially sound rates. In the first few months of that expedited work, Guidehouse's actuarial and data teams identified significant financial improvements for OHCA's managed care launch. These included:

- Identification of duplicate dental claims in the data extract used as a basis of the State's previous actuarial consulting firm, lowering projected capitation rates by roughly $26M across nine-month rating period. This projected cost avoidance largely offset the $30M cost of the State adding expanded adult dental benefits to the TANF Parent/Caretaker and Expansion populations.
- Identification of a $12M cost avoidance in program change expense for psychiatric residential treatment facility fee schedule changes effective January 1, 2021.
- Up to $16M potential savings through provider recoveries for serious mental illness / substance use disorder residential provider overpayments starting in October 2020.

Given the managed care launch was at the tail-end of PHE redeterminations, Guidehouse worked with the State to adjust base data to reflect only those claims of members who remained in the program. As a result, Guidehouse identified an acuity increase of over 10% for the remaining population. Oklahoma has continued to experience inflated trends as a result of the pandemic and subsequent redeterminations. As emerging experience has reflected unprecedented changes, Guidehouse has worked with the State to complete a full mid-year rate rebasing for FY25. We are in the midst of working with the State to further drill into categories of service with significant utilization shifts including behavioral health, non-ER outpatient, and pharmacy claims.

Guidehouse provides additional full-service financial and actuarial services on an ad hoc basis, similar to many services previously provided to West Virginia. Some examples of ad hoc support include:

- Providing guidance on in lieu of services including approvals and drafting of accompanying amendments
- Advising the State on its forthcoming withhold program including providing a deep understanding of the reasonably achievable standards required in rate-setting
- Performing a deep dive into emerging experience to support the CFO's presentation to legislators about needed budget increases
- Advising on the State's launch of a 1915b waiver including supporting and advising their consultant on CMS approval requirements and ensuring a sound cost effectiveness submission and language
- Segmenting capitation rates into portions eligible for enhanced FMAP claiming such as CCBHC claims, Indian Health Services referrals, and the CHIP population

Oklahoma Health Care Authority | *2022–Present*

- Informing the Federal reporting team on strategies states are deploying to ensure appropriate Federal matching rates
- Developing and reviewing quarterly reporting for MCOs who chose to waive the State's copays
- Responding to legislative requests on CME and limiting member FQHC visits to four per month.

Tennessee Division of Health Care Finance and Admin. (TennCare) | *2004–present*

Key Impacts: ✓ *Developed rates for TennCare's managed care programs, CY20 projected $7.2B* ✓ *Developed I/DD program capitation rates*	✓ *Developed Expansion and Block Grant Analyses Developed reverification adjustment methodology that has survived intense and prolonged scrutiny of MCOs, CMS, and other actuarial firms*

Guidehouse performs all work related to MCO managed care rates for TennCare, including the creation of a databook, certifications, reviews with CMS, and necessary documentation. We provided actuarial, data and financial services currently provided by three MCOs along with reconciliations for PCP enhancement, Directed Payments, annual Medicaid budget and Comptroller reports, visual analytics with in-depth claim and membership movement analysis, dashboard development, and policy/program design support. Populations included TANF, disabled, dual-eligible, and LTSS. TN also required input on reforming hospital reimbursement, detailed analysis of state budget needs for Medicaid, development of an annual comptroller report, evaluation of programs, and ad hoc actuarial, financial,1115 and policy support.

Guidehouse assists the State with all aspects of Medicaid managed care capitation rate setting. We have assisted with the following tasks: developing actuarially sound capitation rates, creating databooks, assisting with certifications, reviewing with the Centers for Medicare and Medicaid Services (CMS) and stakeholders, and assisting with all related documentation. Guidehouse's team provided actuarial services for rate-setting related to three MCOs. Our work also included reconciliations for primary care physician enhancement and health insurance provider fee reimbursement, annual Medicaid budget and comptroller reports, visual analytics with in-depth claim and membership movement analysis, dashboard development, Medical Loss Ratio (MLR) analysis and monitoring of results, and policy / program design support. For Tennessee MCOs, we developed actuarially sound risk-adjusted capitation rates for Temporary Assistance for Needy Families (TANF), disabled, dual-eligible, and Long-term Support Services (LTSS) populations. TennCare, the State of Tennessee's managed Medicaid agency, required input on reforming hospital reimbursement, detailed analysis of State budget needs for Medicaid, evaluation of programs, and ad hoc actuarial, program integrity, legislative, and policy support. Guidehouse's team also developed, implemented, and monitored the risk payment methodology for the MCOs. The engagement focused on the following four objectives:

- Develop managed care capitation rates for TennCare's programs, including acute care and LTSS
- Ensure financial viability of Medicaid programs
- Efficiently and proactively track, analyze, and manage risks to TennCare's program
- Assist with additional budgetary review and program needs on an ongoing basis

Guidehouse assisted with the following actions:

- Rate Setting: Regularly process and validate claims and enrollment data, develop actuarial models and assumptions, present rates, provide documentation, and provide ongoing rate support between the State, MCOs, and CMS
- Financial and Budgetary Projections: Develop annual budget projections for the State as well as provide an annual report that compiles cost projections for both managed care and fee-for-service programs

Tennessee Division of Health Care Finance and Admin. (TennCare) | *2004–present*

- Other Actuarial Support: Risk adjustment in various forms, directed payment analysis and calculations, Medicare repricing, fiscal impact analyses and legislative response support, incurred but not reported valuation, quarterly review of MCO MLR submissions

Texas HHSC | *1996–1998, 2005–2009, 2014–2015, 2019–2024*

Key Impacts:	
✓ *Transitioning DSRIP initiatives to managed care directed payment programs*	✓ *Supporting stakeholder and provider engagement efforts related to directed payment transition*

Directed Payment

Guidehouse assisted the state with two directed payment programs. The first targets inpatient and outpatient hospitals as well as academic physicians and is financed primarily by provider taxes. The second program targets physicians employed by acute care hospitals and is also financed by provider taxes. Guidehouse assisted the state in soup-to-nuts preprint support: from percentage of Medicare modeling; to average commercial rate data collection, scrubbing, and analysis; to integrating the quality strategy into the program; to full preprint writing and support of CMS questions. We also incorporated the programs into the state's managed care contracts and rate certifications.

Guidehouse assisted the Texas Health and Human Services Commission in migrating their legacy Delivery System Reform Incentive Payment (DSRIP) program to managed care directed payments. We reviewied multiple types of providers including local health departments, outpatient clinics, physicians, rural health clinics, and community mental health centers, and providing both policy support and detailed financial analysis. Policy support ranged from a national scan of other states' preprints; providing a detailed list of considerations for all allowable directed payment methodologies for distributing funding including for value-based payments; assisting in determining which methodologies were optimal to operationalize. Financial analysis ranged from percentage of Medicare and average commercial rate analysis to determine maximum payment amounts under the program, to determining maximum amount of payments under a cost report framework for rural health clinics and community mental health centers. Several iterations of the analysis were performed to continually incorporate stakeholder feedback from senior leadership and providers.

Wyoming Department of Health | *1992–Present*

Key Impacts:	✓ *Developed Wyoming's first PACE payment rates*
✓ *Developed sound rate setting methodology for select facilities*	✓ *Transitioned ambulatory surgery center reimbursement methodology to a prospective methodology*

Guidehouse assisted Wyoming with modeling potential reimbursement approaches including APR-DRGs for hospitals, bundled payments, and prospective payments for ambulatory surgery centers (ASCs). Highlights of our work with Wyoming in the recent years includes:

- Managing Medicaid rate analysis and rate setting practices to establish reimbursement methodologies, including general research, policy analysis, analysis of State and Federal rules and regulations, and administrative support
- New payment policies developed, include rates for hospitals physicians, ASCs, community mental health centers (CMHCs), rural health clinics (RHCs), federally qualified health centers (FQHCs), and psychiatric residential treatment facilities (PRTFs). As part of the methodology support, Guidehouse assists the State to coordinate, facilitate, and present to provider groups and the State Legislature on various payment and reform activities.

Wyoming Department of Health | *1992–Present*

- Developed Wyoming's first PACE, led the analysis to develop the per member per month rates, and prepared the State Plan materials to explain the methodology.
- Assessed the dual-eligible population, compared performance to national trends, and identified options for transforming the care delivery mechanism.
- Transitioned Wyoming's current ASC reimbursement methodology to a prospective payment methodology. This includes quarterly and/or annual analyses of the outpatient prospective payment system, inpatient hospital level of care reimbursement system, hospital intergovernmental transfer payment program and private hospital tax program, hospital disproportionate share hospital (DSH) payment program, physician RBRVS reimbursement system, FQHC and RHC rates, and PRTF rates.

Guidehouse also analyzed health home, ACO options, and alternative delivery systems that emphasized integrated care, preparation of the Wyoming Medicaid Reimbursement Benchmarking Study, which provides the Division with a strategic overview of Medicaid programs and expenditures; development of numerous written reports and communications on behalf of the Division, including reports to the legislature, Office of the Governor, Healthcare Commission, Department of Education, and several other sectors of the State government; and development of numerous waiver programs, state plan amendments, and other policies that require working with and negotiating with CMS.

Rate Study of HCBS for Individuals with Developmental Disabilities, Including Cost and Wage Survey Process and Extensive Stakeholder Input

Guidehouse supported the Wyoming Department of Health (WDH), Behavioral Health Division (BHD) to conduct a **rate study** for Wyoming's three disability HCBS 1915(c) waivers: The Acquired Brain Injury (ABI) waiver; the Comprehensive waiver; and the Supports waiver. This rate study supported the requirement of *WY Stat §42-4-120 (g)* that BHD rebase its rates every two to four years.

Guidehouse worked closely with BHD and key stakeholders to conduct the rate study and develop proposed waiver program rates which included **acuity-based tiered rates based on an ICAP assessment**. We **gathered cost and wage data from providers and other state and national data sources** to develop an independent rate build-up methodology for each waiver service included in the rate study. The independent rate build-up methodology was comprised of direct care and indirect care components, and resulting rates were not modified to presume a predetermined budget impact.

As part of the rate study process, **we developed a preliminary budget impact estimate** based on the rate assumptions developed at that point in the project. WDH included this estimate in its budget **presentation to the Joint Appropriations Legislative Committee**. Following the presentation, Guidehouse continued to refine rate assumptions to address additional questions and policy concerns from the Steering Committee. As a result of this additional work, Guidehouse developed the final model that the Steering Committee recommended. We estimated impact of this final rate model and drafted Appendix I to document the revised rate methodology which **CMS-approved and BHD implemented statewide**.

HCBS Rate Study for Long-Term Care and Assisted Living Facility Services, Including Cost and Wage Survey Process and Extensive Stakeholder Input.

Guidehouse assisted the Wyoming Department of Health with a cost and rate study for its long-term care and assisted living facility 1915(c) waiver services. The rate study included facilitating provider technical advisory groups to discuss cost and wage data, model assumptions and rate setting issues. The team collected cost and wage information from service providers through a customized survey tool and developed rate models and components, rate recommendations, and related fiscal impacts.

Guidehouse has substantial experience in fee-for-service (FFS) rate-setting, providing FFS rate-setting support across a wide breadth of including institutional providers, acute hospitals and nursing facilities, outpatient services, including clinics and FQHCs, and home-based community services (HCBS). Projects range from methodological rate reviews, to rate re-design and rebasing existing rates. We work closely with states and stakeholders coordinating requested changes and

responding to questions from all involved including the federal government. Guidehouse would be pleased to assist West Virginia in this work. **Figure 6** demonstrates Guidehouse's FFS rate-setting work in eight selected states.

Figure 6. Guidehouse's FFS Rate-Setting Experience by State

	State	KY	ME	MT	OK	SD	TN	VA	WY
Provider Type	Acute Care Facility							✓	✓
	Intermediate Care Facility		✓		✓		✓		✓
	Brain Injury			✓				✓	
	Nursing Facility		✓	✓			✓	✓	
	FQHC / Clinic	✓	✓		✓		✓		✓
	Physician				✓		✓		✓
	Home & Community Based Services (HCBS)	✓		✓	✓	✓	✓		✓
	Specialty Care	✓					✓	✓	✓

Compliance with RFQ Requirements

Guidehouse affirms that it is qualified and well-prepared to execute all mandatory contract services requirements and deliverables. We will meet or exceed all mandatory requirements listed in Section 3 of the RFQ.

Section 3 Mandatory Requirements

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

Figure 7. Mandatory Requirement Crosswalk

	Meet or Exceed	
Mandatory Requirement	**Yes**	**No**
§4.1.1 Managed Care Program Administration		
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.	✓	
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.	✓	
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.	✓	
4.1.1.6 The vendor shall conduct analyses of waiver programs and develop recommendations for improving effectiveness and efficiency of waiver programs.	✓	
4.1.1.7 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, 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).	✓	
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.	✓	
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.	✓	
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.	✓	
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 120 calendar days prior to contract implementation date.	✓	
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	✓	

Mandatory Requirement	Meet or Exceed: Yes	Meet or Exceed: No
process for the assessment to be completed.		
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.	✓	
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 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.	✓	
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.	✓	
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: https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-final- rules/index.html#:~:text=On%20January%2017%2C%202017%2C%20CMS%20released%20a%20final,under%20Medicaid%20managed%20care%20contracts%20and%20rate%20certifications. WV State Code Chapter 9: https://code.wvlegislature.gov/9/	✓	
4.1.1.19 The vendor must identify and comply with all federal and state Medicaid and WVCHIP laws, regulations, and policies, as outlined by the CMS and the BMS which can be accessed at: https://www.medicaid.gov/medicaid/managed-care/index.html. https://dhhr.wv.gov/bms/Members/Managed%20Care/Pages/default.aspx	✓	
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 WVCHIP may be necessary.	✓	
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.	✓	

Mandatory Requirement	Meet or Exceed: Yes	Meet or Exceed: No
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 of service and medical and administrative cost profiles for all Managed Care cohorts, major lines of business, and individual Managed Care members to 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.	✓	
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.	✓	
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) https://www.medicaid.gov/medicaid/quality-of-care/medicaid- managed-care-quality/state-quality-strategies/index.html, 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 collaboration with Agency Quality and Managed Care staff. Collaborator engagement will include Managed Care 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. https://www.medicaid.gov/medicaid/downloads/managed-care- quality-strategy-toolkit.pdf.	✓	
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.	✓	
4.1.1.27 The vendor shall assist in developing options for program expansion and assist in implementation of program expansion, including preparation of documents outlining options for program expansions, including cost savings, policy considerations, risks issues, agency and bureau coordination requirements, and legal constraints, etc.	✓	
4.1.1.28 The vendor shall assist with the development of reports for WV House Bill 4217 . which can be found at: http://www.legis.state.wv.us/Bill Status/bills text.cfm?billdoc=H B4217%20SUB%20ENR.htm&yr=2014&sesstype=RS&billtype= B&houseorig=H&i=4217	✓	
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.	✓	

Mandatory Requirement	Meet or Exceed: Yes	Meet or Exceed: No
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 • Network adequacy documents and readiness review materials • Grievances and Appeals • Vendor shall provide MCO-related training to staff and maintain a training manual for reference. • Platform must be hosted by the vendor and allow access for up to ten (10) users at any time. • Settings must be configurable to meet agency needs. The current agency operating system is Windows 10. For teleconference capabilities, the Agency currently uses Google Workspace. • 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.	✓	
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 Integrity Unit. These activities shall include: • Program Management Support Services • Support BMS PI with coordination of PI activities across multiple workstreams • PI process improvement • Operational Support • 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 • Review referrals made to BMS PI or the Medicaid Fraud Control Unit (MFCU) • Participate in internal meetings and BMS-led meetings with the MCOs and/or MFCU • 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.	✓	
Actuarial Services (§4.1.2)		
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,	✓	

Mandatory Requirement	Meet or Exceed: Yes	Meet or Exceed: No
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 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.	✓	
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.	✓	
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.	✓	
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 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.	✓	
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.	✓	
4.1.2.8 Vendor shall update the capitation rates based on data, pricing trends, changes resulting from federal and/or state requirements, program changes and certify such amendments, at a minimum of one time per fiscal year.	✓	
4.1.2.9 The vendor shall develop 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.	✓	
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.	✓	
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.	✓	

Mandatory Requirement	Meet or Exceed: Yes	Meet or Exceed: No
4.1.2.12 The vendor must gather, process, validate and analyze Managed Care encounter and claims data, including carved out services and provide technical assistance to the Managed Care organizations on data issues.	✓	
4.1.2.13 The vendor shall develop methodologies for calculating Directed Payment Program amounts or other supplemental payments, and the associated preprints and quality strategies for such programs.	✓	
4.1.2.14 The vendor must perform actuarial analysis and valuation of the costs or savings established by implementing programmatic changes, including, but not limited to, the transitioning of populations from FFS to managed care or alternate coverage options.	✓	
4.1.2.15 The vendor must agree to provide a detailed billing report with each invoice for actuarial services, which details the hours billed per staffing position, per staff member. 4.1.47 The vendor must produce a quarterly report on expected total program revenues and expenditures for WVCHIP 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.	✓	
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.	✓	
Financial Services (§4.1.3)		
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 (DPP) calculations and support, provider payment reviews, MCO tax settlement calculations, waiver support, and audit support, including IBNR calculations.	✓	
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.	✓	
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.	✓	
4.1.3.4 The vendor shall assist with all facets of the provider rate development and implementation process.	✓	
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.	✓	
Ad Hoc Services (§4.1.4)		
4.1.4.1 The vendor must provide the Agency with additional consultation and actuarial services and complete other work as requested.	✓	
4.1.4.2 The vendor shall provide a Statement of Work, including but not limited to, the number of project hours, resources to be used, and cost affiliated with each ad hoc request for review	✓	

Mandatory Requirement	Meet or Exceed: Yes	Meet or Exceed: No
by the Agency.		
4.1.4.3 The vendor shall provide a fixed hourly rate for programmatic services and a fixed hourly rate for actuarial services.	✓	
4.1.4.4 The vendor shall assist with programmatic activities needed within other divisions of BMS outside of the Managed Care Unit	✓	
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.	✓	
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 program and any other relevant waivers.	✓	
Service Level Agreement (§4.1.5)		
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.	✓	
All Services (§4.1.6)		
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.	✓	
4.1.6.2 The vendor shall submit, along with their bid, a conflict mitigation plan applicable to the prime vendor and subcontractor 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.	✓	
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.	✓	
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.	✓	
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.	✓	

Service Level Agreement (§4.1.5)

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.

Guidehouse understands and will comply with this requirement.

All Services (§4.1.6)

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.

Guidehouse understands and will comply with this requirement.

4.1.6.2 The vendor shall submit, along with their bid, a conflict mitigation plan applicable to the prime vendor and subcontractor 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.

Conflict Mitigation Plan

Based on Guidehouse's conflict check procedures, Guidehouse is not aware of any circumstances that would constitute a conflict of interest or that would otherwise impair Guidehouse's ability to provide objective assistance to the State under this engagement.

Conflict Mitigation Strategies

Guidehouse uses a conflict-of-interest process to identify client relationships that may constitute a conflict of interest or that would otherwise impair our ability to provide objective assistance. Our determination of conflicts is based primarily on the substance of our work as opposed to the parties involved. Guidehouse maintains standard conflict of interest procedures and implements an ethical screen when appropriate.

Ethical Screen (Ethical Wall)

An ethical screen is used when knowledge and activities performed by different practice groups within Guidehouse require separation. In such an instance, an ethical screen or "wall" is created. The ethical screen document, distributed to all employees on the relevant project teams, lays out the duties and responsibilities for each Guidehouse employee subject to the ethical screen. Each employee must read and electronically acknowledge the requirements and restrictions listed in the screen. A record of the screen is tracked and maintained electronically in our system. All signatories of the screen are expected to abide by all the requirements of the screen. If necessary, data storage and collection for related client data can be further protected with the use of separate network drives / servers to house information. Access to stored information can be restricted through the use of passwords.

Guidehouse has processes in place to establish ethical walls and physically quarantine projects. We have done this on a number of high profile and sensitive engagements. The key features of an ethical wall include the following:

- No member of TEAM A will discuss or otherwise share information relating to their engagement with any member of TEAM B and vice-versa.
- No member of TEAM A may share secretarial coverage with any member of TEAM B.
- Guidehouse's IT network and network servers will provide appropriate segregation and security between the files maintained by TEAM A and TEAM B to the extent deemed advisable.
- Active case files kept at employees' desks or in offices will be clearly marked as confidential.
- To the extent necessary, Guidehouse can physically secure a team's workspace requiring special access rights.
- These restrictions will continue until all engagements are concluded. Each member of TEAM A and TEAM B by his / her signature acknowledges these restrictions and agrees to uphold them.

Should Guidehouse determine that there is the potential for a conflict of interest, we will immediately engage the State, discuss the issue and collectively determine the most appropriate course of action to remediate/mitigate.

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.

Guidehouse understands and agrees to this requirement.

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.

Guidehouse understands and agrees to this requirement.

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.

Examples of Guidehouse Capitation Rate Certification meeting CMS reporting requirements is located in Appendix D of this proposal.

Section 4 Engagement Team

Guidehouse Government Practice houses nationally recognized healthcare experts across disciplines and perspectives. Our team offers years of experience and comprehensive subject matter expertise in areas such as, but not limited to, Actuarial Standards and Processes, Medicaid Policy and Operations, Provider Strategy and Operations, Population-Focused Expertise (e.g., the aging population, individuals with intellectual and developmental disabilities, and rural health), HCBS, Provider Reimbursement, Program Integrity, Change / Program Management, Training, Stakeholder Communication, etc. This allows BMS immediate access to a variety of in-house experts to accomplish any requirements under this RFQ.

Guidehouse has staffed thousands of large and small projects, including projects like this one. Staffing needs commonly fluctuate over the life of engagements in terms of number of staff, level of staff, and required areas of staff expertise. Guidehouse is adept at adjusting project staffing and bringing in new team members to maximize both cost effectiveness and project efficiency, while adjusting to the needs of BMS. Our project management team will coordinate our in-house resource managers so that we provide you with the right staff composition.

On the following pages we have identified our proposed BMS project staff who have the experience required to meet and exceed all the requirements outlined in this RFQ.

Guidehouse Proposed Key Staff

Under the Executive Leadership of Russ Ackerman, our proposed Project Management team will be the main contacts for BMS throughout the contract and will lead our larger teams' efforts.

Russ Ackerman, ASA, MAAA, FCA
Partner I Chief Actuary

Executive Program Director: Provide oversight of engagement, commit company resources to perform services and provide deliverables consistent with the contract requirements. Attend quarterly meetings with BMS leadership and staff, and ad hoc meetings as needed.

Russ has previously served West Virginia under our prior 2018-2022 contract with BMS for these same services, and has deep familiarity with the actuarial needs.

Required Qualifications

- ✓ Over 30 years of Medicaid health care experience including overall strategies, actuarial requirements, financial management practices, financial and eligibility data, analytics, and modeling.
- ✓ Partner and Chief Actuary leading all Guidehouse actuarial initiatives
- ✓ Bachelors of Science, Statistics, Brigham Young University
- ✓ Associate of the Society of Actuaries
- ✓ Member of the American Academy of Actuaries
- ✓ Fellow of the Conference of Consulting Actuaries

Susan Harrison, MPP, PMP
Associate Director

Project Management Lead: Coordinate the work schedule of our consulting team to implement the project work plan. Responsible for team management and the timely completion of all deliverables.

Required Qualifications

- ✓ Over 20 years of federal, state, and local government experience
- ✓ Over 15 years Medicaid / Medicaid Chip Managed Care
- ✓ Master of Public Policy, University of Maryland
- ✓ Project Management Professional (PMP)

Elizabeth Barabas
Associate Director

Program Administration Lead: Provide oversight of managed care operations and contract deliverables. Coordinate with the Finance Project Lead in the execution of contract deliverables. Attend quarterly meetings with BMS leadership and staff, and ad hoc meetings as needed. Prepare and distribute meeting materials 24 hours prior to meeting and take notes and track action items. Provide additional support as requested by the Deputy Commissioner, Division of Managed Care and Program Integrity.

Liz has previously served West Virginia under our prior 2018-2022 contract with BMS for these same services, and has deep familiarity with the program needs.

Required Qualifications

- ✓ Over 7 years of federal, state, and local government experience, including past experience working with West Virginia BMS
- ✓ 7 years of Medicaid / Medicaid Chip Managed Care operations
- ✓ Master of Public Health, Health Policy, Washington University in St. Louis

Erica Mitchell, FSA, MAAA
Director

Finance Project Lead: Liaison with the Deputy Commissioner of Finance and the Chief Financial Officer in the oversight of finance and budget initiatives in the scope of the contract. Attend quarterly meetings with BMS leadership and staff, and ad hoc meetings as needed. Coordinate actuarial vendor deliverables with BMS Finance. Work with Program Administration Lead to execute deliverables under the contract.

Erica has previously served West Virginia under our prior 2018-2022 contract with BMS for these same services, and has deep familiarity with the program and actuarial needs.

Required Qualifications

- ✓ Over 18 years of Medicaid, Medicare, Commercial and Individual healthcare and actuarial experience with a focus on pricing
- ✓ Six years State Agency regulations, reimbursement processes, financial analysis, budgeting, and forecasting
- ✓ Bachelor of Arts, Economics and Mathematics, Emory University
- ✓ Fellow of the Society of Actuaries
- ✓ Member of the American Academy of Actuaries

Sterling Felsted, FSA, MAAA
Director

Lead Actuary: Oversee the actuarial deliverables are fulfilled as defined in each approved Statement of Work.

Sterling has previously served West Virginia under our prior 2018-2022 contract with BMS for these same services, and has deep familiarity with the actuarial needs.

Required Qualifications

- ✓ 15+ years of Medicaid and CHIP Managed Care rate setting
- ✓ Fellow of the Society of Actuaries and a Member of the MAAA
- ✓ Bachelor of Science, Mathematics, Brigham Young University
- ✓ Fellow of the Society of Actuaries
- ✓ Member of the American Academy of Actuaries

Rick Henley, J.D.
Associate Director

Research Analysts / Consultant: Assist with policy research and development, contract development and maintenance, contract compliance and reporting and other MCO oversight activities as outlined in the contract.

Required Qualifications

- ✓ Over 14 years of state public service with Medicaid in both a programmatic and legal capacity inclusive of managed care, contractual, and regulatory compliance
- ✓ Louisiana State Bar Association, Good Standing

- ✓ Juris Doctorate, Louisiana State University Law School (1998)

Roshni Shah Arora, MPH
Director

Medicaid Policy Subject Matter Expert: Consult on federal Medicaid regulation and policy and serve both the program oversight contract development and actuarial services sections. Experienced in 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.

Roshni has previously served West Virginia under our prior 2018-2022 contract (and prior contracts) with BMS for these same services, and has deep familiarity with the program needs.

Required Qualifications

- ✓ More than 17 years of experience working with government-sponsored programs including Medicaid, CHIP, and uninsured programs
- ✓ Development of healthcare policies and programs including design, implementation, monitoring, operations, organizational readiness, as well as care management, network adequacy, and federal and regulatory compliance
- ✓ Master of Public Health, Health Policy and Management, Columbia University

Under the leadership and oversight of our Lead Actuary, Sterling Felsted, our **Staff Actuarial** team Ryan Butterfield, Will Lu, Ben Maryland, Alysia Overdorf, and Debra Ruocco, will provide the deliverables required under this contract. Each member of our team is FSA and MAAA certified and has more than 5 years of rate setting experience in Medicaid or Medicaid and CHIP managed care or other insurance pricing.

Our Project Team will be augmented with additional subject matter experts who were in your seat as former State executives, **including former Medicaid Executive Directors, former Director for a state's Office of Behavioral Health, and a former U.S. Assistant Secretary for Aging at Health and Human Services.** Additionally, we will reach back to other practice leaders, directors, clinicians, and analytical and administrative support staff to provide the exceptional services and deliverables this contract requires.

Detailed professional resumes can be found in Appendix B.

Section 5 Key Assumptions

- **Price:** If the information provided by the State either in writing or in the RFP omits or misrepresents any materially relevant facts that would have altered any fixed pricing estimates and/or recommended solutions, Guidehouse reserves the right to renegotiate a revised budget based upon the actual circumstances.
- **Staff:** The ability to staff certain personnel to a project is dependent upon availability at the time of project kickoff. In the event the personnel listed herein become unavailable for any reason, Guidehouse will propose alternate individual(s) of like experience and expertise, such determination shall be made in Guidehouse's reasonable discretion, acceptance by the State shall not to be unreasonably withheld or delayed.
- **Change in Scope:** Please note that changes, including an alteration to the scope or approach, additional meetings, or other changes or delays requested by the State that would (i) materially increase Guidehouse's level of effort, (ii) include additional business processes, (iii) add unanticipated complexity to the project, (iv) or lengthen the timeline, will likely result in an increase in fees equal to the changes. Guidehouse will work closely with the State to execute an amendment to the agreement addressing the change in scope and fees.
- **State Responsibilities:** The State agrees to fulfill data and information requests as soon as possible including providing required documents (a list will be provided) prior to the project start date and as needed throughout the project. Failure to provide the requested data may impact Guidehouse's ability to provide the deliverables and meet the timeline outlined in the Scope and Approach Section. If the State cannot provide the requested data, Guidehouse will work closely with the State to execute an amendment to the agreement addressing the change in scope, fees, and timeline.
- **State Resources:** The State shall provide the necessary program managers and or team to work alongside Guidehouse throughout the project. Failure to provide adequate State resources may result in potential changes to scope, fees, and timeline. Guidehouse will work closely with the State to execute an amendment to the agreement addressing the change in scope, fees, and timeline. The information provided by the State to Guidehouse shall be considered "as is" and Guidehouse will not validate or confirm the accuracy of the data and information provided. The State shall confirm a high level of participation of management team, medical staff, and others, as appropriate, in Leadership Committee meetings, interviews, work group activities, data gathering, analysis, and other related activities of the process. For the best possible outcome, we will work closely with your management team. The State shall provide access to an office or conference room that can be used for interviews, if necessary.
- **Acceptance:** Subject to any acceptance language or procedures in the agreement to the contrary, draft deliverables will be provided to the State according to the timelines agreed in the proposal or as may be revised and agreed to. The State will conduct review and provide feedback over a period of three business days. The State will have two (2) business days to complete final review and acceptance of final deliverables. If no comments or decision on acceptance or rejection is received within five (5) business days, the deliverable will be deemed accepted.

Appendix A Required Forms

Designated Contact Certification

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:	Russ Ackerman, ASA, MAAA, FCA, Partner & Chief Actuary
Telephone Number:	480.318.9390
Fax Number:	703.506.6740
Email Address:	russ.ackerman@guidehouse.com

Designated Contact Form

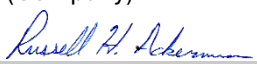
DESIGNATED CONTACT: Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

(Printed Name and Title)	Russ Ackerman, ASA, MAAA, FCA, Partner & Chief Actuary
(Address)	1676 International Dr, Suite 800, McLean, Virginia 22102
(Phone Number) / (Fax Number)	480.318.9390 /
(email address)	russ.ackerman@guidehouse.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.

Guidehouse Inc.
(Company)



(Signature of Authorized Representative)

Russell H. Ackerman, ASA, MAAA, FCA I Partner & Chief Actuary
(Printed Name and Title of Authorized Representative) (Date)

480.318.9390 (p) I 703.506.6740 (f)
(Phone Number) / (Fax Number)

russ.ackerman@guidehouse.com
(Email Address)

Addendum Acknowledgement Form

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFQ BMS2S00000001

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

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

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

- ☒ Addendum No. 1
- ☒ Addendum No. 2
- ☐ Addendum No. 3
- ☐ Addendum No. 4
- ☐ Addendum No. 5
- ☐ Addendum No. 6
- ☐ Addendum No. 7
- ☐ Addendum No. 8
- ☐ Addendum No. 9
- ☐ Addendum No. 10

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

Guidehouse Inc.
Company

Russell H. Ackerman
Authorized Signature

April 22, 2025
Date

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

Addendum 1 – To Extend Bid Opening

	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	**Reason for Modification:**
Doc Description:	MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN	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: VC0000037994

Vendor Name : Guidehouse Inc.

Address : 1676

Street : International Dr, Suite 800

City : McLean

State : Virginia **Country :** United States **Zip :** 22102

Principal Contact : Russ Ackerman

Vendor Contact Phone: 480-318-9390 **Extension:**

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

Vendor Signature X Russell H. Ackerman **FEIN#** 36-4094854 **DATE** April 22, 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

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

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		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				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Lead Actuary Services

$_____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	Total Price
2	Staff Actuary Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Staff Actuary Services

$_____Per Hour X 20,000 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	Total Price
3	Technical Support Staff (non-actuary)				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Technical Support Staff (non-actuary)

$_____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	Total Price
4	Clerical Support Staff				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Clerical Support Staff

$_____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	Total Price
5	Managed Care Program Oversight Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Managed Care Program Oversight Services Annual Cost

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

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
6	Managed Care Oversight Ad Hoc Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Managed Care Oversight Ad Hoc Services

$____ 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	Total Price
7	Actuarial Services Ad Hoc Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Actuarial Services Ad Hoc Services

$____ 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	Total Price
8	Financial Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Financial Services Annual Cost

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

SCHEDULE OF EVENTS

Line	Event	Event Date
1	VENDOR QUESTION DEADLINE	2025-03-19

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

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

Addendum 2 Vendor Question Response

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			**Reason for Modification:**
Doc Description: MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN			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 BMS2500000001	3

BID RECEIVING LOCATION

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

VENDOR

Vendor Customer Code: VC0000037994
Vendor Name : Guidehouse Inc.
Address : 1676
Street : International Dr, Suite 800
City : Mclean
State : Virginia **Country :** United States **Zip :** 22102
Principal Contact : Russ Ackerman
Vendor Contact Phone: 480-318-9390 **Extension:**

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

Vendor Signature X Russell H. Ackerman **FEIN#** 36-4094854 **DATE** April 22, 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.

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BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
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Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Lead Actuary Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Lead Actuary Services

$_____Per Hour X 5,000 Hours Annually

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

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Staff Actuary Services

$_____Per Hour X 20,000 Hours Annually

INVOICE TO		SHIP TO	
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Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
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Comm Code	Manufacturer	Specification	Model #
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Extended Description:
Technical Support Staff (non-actuary)

$_____Per Hour X 5,000 Hours Annually

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

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Clerical Support Staff

$_____Per Hour X 5,000 Hours Annually

INVOICE TO		SHIP TO	
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BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
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Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
5	Managed Care Program Oversight Services				

Comm Code	Manufacturer	Specification	Model #
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Extended Description:
Managed Care Program Oversight Services Annual Cost

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

INVOICE TO		SHIP TO	
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US		US	

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

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Managed Care Oversight Ad Hoc Services

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

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Actuarial Services Ad Hoc Services

$____ per hour X 5,000 hours Annually

INVOICE TO		SHIP TO	
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BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
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Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
8	Financial Services				

Comm Code	Manufacturer	Specification	Model #
93151507			

Extended Description:
Financial Services Annual Cost

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

SCHEDULE OF EVENTS

Line	Event	Event Date
1	VENDOR QUESTION DEADLINE	2025-03-19

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

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

Appendix B Biographies of Proposed Guidehouse Team

Russell H. Ackerman, ASA, MAAA, FCA

Partner and Chief Actuary

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

SUMMARY OF QUALIFICATIONS

Russ is Guidehouse's Chief Actuary and is responsible for all actuarial and associated analytics for the firm. He has 30+ years of experience in consulting, health plan, and Managed Care Organization (MCO) environments; and is responsible for assisting states with Medicaid managed care program development, capitation, and rate setting efforts. Throughout his consulting career, he has consulted governments and agencies on their overall strategies, actuarial requirements, financial management practices, financial and eligibility data, analytics, and modeling. His work includes leading and performing work for all aspects of Managed Care and Fee-for-Service Medicaid programs. In the past, Russ also worked for a large Midwestern health plan in corporate finance leadership and chief actuary roles with oversight over all government-sponsored, commercial, and retail lines of business, including Medicaid, Medicare, Individual, Large and Small Group, and Provider Accountable Care Organizations (ACOs) business.

Russ has led actuarial consulting services for Arizona, Georgia, Idaho, Kansas, Kentucky, Massachusetts, Mississippi, North Carolina, Ohio, Tennessee, Texas, and West Virginia. Russ has led projects for these states and their agencies on Medicaid rate setting strategies, risk adjustment implementations, Long-Term Services and Supports (LTSS), Home and Community Based Services (HCBS), Intellectual or Developmental Disabilities (IDD), and other specific population strategies. This work includes related financial data modeling, analysis, pricing activities, and decision facilitation for 1115 waivers (including budget neutrality), 1915b, c, and b/c combo waivers, state innovation model (SIM) strategies, and development and implementation of both ACOs and Patient-Centered Medical Homes (PCMHs) to serve Medicaid and other higher-risk populations. Russ also has significant experience assisting states with the design and implementation of alternative payment methods.

Russ has led projects that serve as the basis for various states' governors' and legislative stakeholders' decisions for Medicaid strategy, rural health initiatives, pharmacy financing approaches, and general healthcare reform. He is an active Member of the American Academy of Actuaries (MAAA) and its Medicaid and Medicare Committees, an Associate of the Society of Actuaries (ASA) and its Health Section Medicaid and Public Health Subcommittees. He is also a Fellow in the Conference of Consulting Actuaries (FCA). He participates regularly in industry associations and conferences.

RELEVANT EXPERIENCE

- Leads all actuarial activities for Guidehouse Healthcare
- Strategy and actuarial leader for multiple state Medicaid programs
- Medicaid managed care, state agency, legislative and other stakeholder facilitation
- Oversight of all actuarial rate-setting and analytics for Medicaid clients and providers

- Medicaid waiver and demonstration program strategies
- Corporate finance and chief actuary for a large midwestern health plan
- Corporate improvements affecting all actuarial, reserving, capitalization, pricing, underwriting, financial reporting, and operations across all health insurance lines of business
- Experience in executive, management, actuarial, pricing, reserving, underwriting, and financial consulting
- Consulting large corporations on benefit design, pricing, underwriting activities, and healthcare funding mechanisms

WORK HISTORY

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

CERTIFICATIONS, MEMBERSHIPS, AND AWARDS

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

EDUCATION

- Bachelor of Science, Statistics, Brigham Young University

Susan Harrison, MPP, PMP

Associate Director

sjharrison@guidehouse.com
Boston, Massachusetts
Direct: 410.353.6800

SUMMARY OF QUALIFICATIONS

Susan is a proven mission-driven healthcare operations and policy leader able to produce superior results by successfully designing, driving, implementing, and executing large-scale programs and projects. She is skilled at leading effective teams that provide value and cost savings within the healthcare market. Susan understands the voice of consumers and is skilled at brokering consumer and payer relationships to achieve solution-focused mutually beneficial outcomes. She is a respected leader and effective communicator with the ability to build and sustain diverse teams, establishing a high-performing mission-driven culture while achieving organizational goals. Susan successfully aligns strategy to organizational mission and business needs.

Susan led project management and network management in preparation for Oklahoma's transition to Medicaid managed care. She has over 20 years of federal, state, and local government experience including leading the Maryland and Massachusetts Medicaid program integrity, compliance, and provider network enrollment and engagement offices.

AREAS OF EXPERTISE

- **Industry Expertise:** Over 20 years experience in Medicare, Medicaid, CHIP, Medicaid Managed Care and Medicaid FFS. Deep expertise in government healthcare programs and value-based payment systems. Led successful large-scale program implementations including consumer and provider enrollment, provider network adequacy review, claims payment, billing, behavioral health, and pharmacy benefit expansion efforts. Led successful initiatives in federal and state compliance and anti-fraud initiatives. Experience collaborating with both public and private sectors overseeing contracts and procurement activities
- **Operations:** Known for solution-focused problem-solving. Skilled leader in planning, prioritizing, organizing, developing, and improving the overall quality of operational and organizational processes and systems. Able to lead large-scale implementations, workflows, and processes within government healthcare programs. Provides exceptional management of general business operations, and is accountable for administrative and service budgets resulting in favorable recoupments and cost containment. Implemented automation solutions resulting in higher value work, eliminating waste, and optimizing value.
- **Implementation:** Executive sponsor for major Medicaid program implementations, contract transitions, and organizational growth initiatives. Adept at understanding the voice of customer perspectives and working collaboratively in the interests of the consumer with organizational goals and objectives in mind. Builds exceptional relationships with providers, payers, consumers, and advocates.

PROFESSIONAL EXPERIENCE

Policy and Compliance

- Oversaw Medicaid MCO network adequacy review for the Oklahoma Health Care Authority (OHCA)
    - Designed and implemented Contracted Entity (CE) Network Adequacy Report files that collected current network information by county across eight provider types for SoonerSelect Dental and 36 provider types for SoonerSelect Medical and SoonerSelect Children's Specialty Program.
    - Conducted network adequacy review of pharmacies for SoonerSelect Medical and SoonerSelect Children's Specialty Program by analyzing network adequacy on a zip code level basis rather than by county to ensure adequate access to pharmacy services and a more detailed review of the reported networks.
    - Assisted OHCA with identifying counties across provider types where OHCA could appropriately provide an exception to SoonerSelect CEs for not meeting network adequacy standards. Also assisted OHCA with identifying counties where OHCA expected SoonerSelect CEs to close the gaps in their networks.
    - Trained OHCA staff on reviewing and analyzing submitted network adequacy reports, including how to summarize submitted data to adequately measure network progress over time, as well as how to effectively review data for early identification of potential flags.
    - Developed summary reports of the current status of networks across provider types for submission to CMS for all three SoonerSelect Programs.
- Executive sponsor for $90M state Medicaid major IT (IT), pharmacy, and long-term-care projects including IT procurement, contract monitoring, PMO, and technical support. Monitored progress of projects and approved completed projects for technical accuracy and monitored adherence to established CMS and Maryland Department of IT (DoIT) policies, procedures, and standards. Implemented the electronic health record (EHR) incentive program, distributing $10M in meaningful use payments to providers. Supervised 60 employees
    - Implemented Medicaid behavioral health (BH) program claims payment integration with an annual spend of $1B, aligning and reducing authorization requirements
    - Developed and implemented an integrated care management system to support all in-home Medicaid long-term supports and services with an annual savings of $10M
    - Drove executive procurement team for Maryland Medicaid restructuring transition process and the proposal development and execution of a $297M contract for a new Medicaid management information system (MMIS)

Project Management

- Directed state enterprise project management office (PMO), overseeing a large portfolio of strategic projects and managing $3M in public and private vendor relationships including process improvements, systems integration, and compliance. Collaborated with public entities, private sector, and clinical systems to evaluate complex problems and implement meaningful solutions
    - Aligned project management and process improvement to support cross-solution set projects including the MassHealth Medicaid roadmap for behavioral health reform

Medicare and Medicaid Health Policy Analysis

- Served as the key liaison between Medicaid programs and the Office of Systems, Operations, and Pharmacy (OSOP) on project implementation issues and lead analyst regarding budget and

audit issues. Responded to requests from the Office of Governmental Affairs, other agencies or administrations, and director, deputy secretary, and secretary regarding Medicaid program, provider, and recipient questions or concerns. Led voice of customer and change management workgroups. Supervised six employees

  - Transitioned vendor utilization management for hospital and long-term supports and services, decreasing response time for authorizations
  - Implemented ICD-10 on time and under budget
  - Adopted innovative provider enrollment system resulting in shorter response time from Medicaid to providers with an annual savings of $5M

- Analyzed and evaluated complex medical and scientific information. Developed and implemented technology assessments, procurements, and national coverage determinations (NCDs) related to Medicare coverage issues. Prepared internal technology assessments, issue papers, policy options papers, and press office roll-out documents including press releases, Q&As, and high-priority congressional correspondence. Represented the division and group at briefings and other meetings with senior CMS and departmental officials, congressional staff, special interest groups that represent health organizations, and other members of the public

Medicaid Program Integrity

- Directed all Medicaid program integrity (PI) and third-party liability (TPL) efforts, and managed $250M in annual vendor contracts. Oversaw all compliance activities for internal and external auditing entities including The Office of the State Auditor, the Medicaid Fraud Control Unit at the Attorney General's Office; The Centers for Medicare and Medicaid Services; and the U.S. Health and Human Services. Supervised 25 state staff and 130 vendor staff
  - Generated over $150M in annual PI member and provider cost savings and operational improvements for MassHealth
  - Generated over $400M in annual TPL and premium assistance program savings
  - Decreased audit findings by $300M from 2018 to 2019 reducing operational risk

WORK HISTORY

- Associate Director, Guidehouse (2022 – Present)
- Senior Director, Project and Program Management, UMASS Medical School (2000 – 2022)
- Director, Program Integrity, MassHealth (2017 – 2022)
- Director, Policy and Compliance, Maryland Medicaid (2012 – 2017)
- Special Assistant to Executive Director, Maryland Medicaid (2007 – 2012)
- Special Assistant to Director, Centers for Medicare and Medicaid Services (2003 – 2007)
- Policy Analyst, Centers for Medicare and Medicaid Services (2003 – 2004)
- Senior Manager, Chesapeake Bay Foundation (1998 – 2001)

CERTIFICATIONS, MEMBERSHIPS, AND AWARDS

- Project Management Professional (PMP) Certification, Project Management Institute

EDUCATION

- Master of Public Policy, University of Maryland
- Bachelor of Science, Biology and Environmental Science, Dickinson College

Elizabeth Barabas, MPH

Associate Director

ebarabas@guidehouse.com
Philadelphia, Pennsylvania
Direct: 312.583.5766

SUMMARY OF QUALIFICATIONS

Elizabeth has experience in project management and data analytics supporting Medicaid reimbursement systems, with a focus on rate setting for hospitals, clinics, and waiver programs. She has acted as a project manager for several large-scale Medicaid projects. She also has significant expertise in supplemental payments and federal compliance demonstrations such as UPLs. Elizabeth is also skilled in data programming and statistical analysis.

AREAS OF EXPERTISE

- Project Management
- Stakeholder Facilitation and Engagement
- Implementation and Operations of 1915(c) waiver programs
- Analysis of Medicaid Claims Data and Relevant Payment Mechanisms
- Federal Upper Payment Limit (UPL) Demonstrations for Institutional and Professional Services
- Healthcare Cost Estimation using Detailed Costing Methodology, Provider-Reported Data, and / or Publicly Available Data
- Home and Community-Based Services (HCBS) Rate Setting
- Hospital Supplemental Payment Programs
- Medicare Healthcare Cost Report Information System (HCRIS) Hospital Cost Reports
- Programming in SAS, Stata, and SPSS Software
- Rate Determination for Hospitals, Clinics, and Waiver Programs
- Statistical Analysis of Health Policy using Advanced Statistical Methods

PROFESSIONAL EXPERIENCE

Project Management

- Manages day-to-day client contact, including internal preparation, deliverable management, and external management of multiple weekly meetings with agenda creation, time management, and call leadership (Alaska Department of Health, Texas Medicaid, West Virginia Bureau for Medical Services, Kentucky Department for Medicaid Services)
- Develops and delivers detailed invoices at regular intervals, including oversight of a budget of more than $2M and tracks hours of more than 30 individual employees (Alaska Department of Health, Texas Medicaid, Wyoming Medicaid)
- Develops data-focused deliverables and presentations and value messaging for client and stakeholder consumption (All)

- Prepares and manages stakeholder communication, including verbal and written engagement such as Frequently Asked Questions documents, presentations and webinars, one-pagers, formal meeting minutes, individual email responses, and legislative documents. (Alaska Department of Health, Kentucky Department for Medicaid Services, Virginia Department of Medical Assistance Services)

Government Payment Transformation

- Conducted targeted Stakeholder Engagement with providers, Medicaid beneficiaries, and advocates through in person and virtual engagement, including focus groups, webinars, Frequently Asked Questions documents, formal public comment processes, and one on one meetings (Alaska Department of Health, Kentucky Department for Medicaid Services, Virginia Department of Medical Assistance Services)
- Conducted physician and professional UPL demonstrations in compliance with CMS requirements using the Average Commercial Rate methodology and Medicare Equivalence Ratio methodology (Wyoming Department of Health). Assisted the State in developing supplemental payment programs based on these UPL demonstrations
- Conducted inpatient, outpatient, and clinic UPL demonstrations in compliance with CMS requirements to assist states with annual reporting using detailed estimated claim cost, claim payments, claim charges, and supplemental payment data to build cost-based inpatient and outpatient hospital UPL models (Wisconsin Department of Health Services and Wyoming). Assisted Wyoming in developing payment-based and charge-based clinic UPL demonstrations
    - Priced Medicare payments using claim line healthcare common procedure coding system codes and Medicare fee schedules
- Inpatient and outpatient hospital rate setting and reimbursement development and implementation (Wisconsin)
    - Detail costing of claims using cost-to-charge ratios and per diems developed from Centers for Medicare and Medicaid Services (CMS) HCRIS cost reports
    - Used 3M Core Grouping Software to group Medicaid claims for all patients refined diagnosis-related groups and enhanced ambulatory patient grouping payment simulations
    - Pulled from a variety of data sources to model hospital rates with the provider and rate-year-specific parameters, keeping in mind hospital type and the need for per diem payments when necessary
    - Calculated numerous types of supplemental payment programs, including implementation of some of these programs
    - Calculated qualified rate adjustment supplemental payments for non-state government-owned hospitals (Wyoming Medicaid):
        - Detail costing of claims using updated revenue codes and CMS HCRIS cost reports
        - Modeled claim cost using cost-to-charge ratios and per diems to determine supplemental payment amounts for qualifying hospitals
    - Created and implemented a new professional services supplemental payment program for physicians and other professional services at hospitals (Wyoming Medicaid):
        - Collected and analyzed commercial claims data and fee schedules

        - Modeled "Average Commercial Rates" and estimated Medicare payments across all existing procedure codes to determine qualifying supplemental payments
    - Calculated small and big disproportionate share hospital payments (Wisconsin Medicaid) using relevant eligibility criteria
    - Calculated other UPL-based supplemental payment programs, including rural payments, critical care payments, and others (Wisconsin Medicaid)
- HCBS waiver rate setting and reimbursement methodology, including (Kentucky Department of Medicaid Services, Oklahoma Medicaid):
    - Development of detailed provider cost surveys
    - Analysis of provider surveys and third-party data sources
    - Close work with stakeholders to get rate buy-in throughout the rate development process
    - Development of cost-based rates focused on parity across varying waiver populations where possible while also reflecting the complexities of the evolving COVID-19 emergency and economic landscape

Directed Payment Programs

- Helped transition from a delivery system reform incentive payment program to a directed payment program including average commercial rate review, Medicare pricing methodology, cost report review, and general preprint support for multiple service types, including (Texas Medicaid):
    - Community Mental Health Centers
    - Rural Health Clinics
    - Local Health Departments
    - Hospitals
    - Outpatient Clinics
- Oversaw project management, including spearheading client communication, creating deliverables, scheduling meetings, documenting meetings, tracking deliverables, organizing workstream leads, and disseminating information from the client to the internal team (Texas Medicaid)

Healthcare Reform

- Researched and wrote a policy brief on the economic and health impacts of Medicaid Expansion in Montana for the State Legislature that ultimately contributed to Montana's re-funding of Medicaid Expansion (Montana Hospital Association)
    - Analyzed claims, cost reports, and other available data to determine the cost-effectiveness of implementing Medicaid Expansion
    - Reviewed health and economic impacts of Medicaid reform across the State and in comparison, to nearby, similar states as well as in comparison to national benchmarks

Behavioral Health

- Researched how social media is used as an intervention tool for mental illnesses including depression, anxiety, disordered eating, and addiction

  - Created and conducted more than 500 surveys geared toward young adults struggling with mental illness who turned to social media as an outlet
  - Performed statistical analyses of survey results
  - Presented at the Institute for Public Health Conference
- Researched the impact of state and federal policy changes affecting cannabis addiction trends
  - Identified key variations in cannabis policy across all 50 states and the District of Columbia
  - Analyzed medical and recreational dispensary practices over time, including detailed analyses of compliance with state policy and effects of compliance on statewide cannabis use

OTHER RELEVANT EXPERIENCE

- Analyzed changes in seven major statewide policies regarding needle exchange programs across all 50 states and the District of Columbia over a three-year period using advanced statistical modeling methodologies to determine the effects of these programs on HIV/AIDS transmission
  - Conducted literature reviews on related research to determine a novel research topic
  - Used multiple advanced statistical techniques, including panel regression modeling with both fixed and random effects
  - Presented at the annual American Public Health Association conference
- Created and implemented evaluation plans and protocols for tobacco-related policies and community-focused mental health programs in St. Louis County
  - Evaluated local policy changes to assess effectiveness and scalability
  - Helped facilitate participatory budgeting and community proposal requests for a $5,500,000 federal mental health community-based grant
  - Analyzed, synthesized, and disseminated quantitative and qualitative data for a variety of audiences and decision-makers, including politicians, local health departments, and community members, including the creation of infographics and dissemination templates
- Performed field interviews and literature reviews to identify critical solutions for easily treatable and preventable diseases in low-income populations
- Demonstrated proficiency in data analysis tools: SAS, Stata, and SPSS

WORK HISTORY

- Associate Director, Guidehouse (2018 – Present)
- Research Assistant, Washington University School of Medicine, Department of Psychiatry (2016 – 2018)
- Assessment, Evaluation, and Policy Intern, St. Louis County Department of Public Health (2017)

EDUCATION

- Master of Public Health, Health Policy, Washington University

- Bachelor of Arts, Global Health, Washington University

Erica Mitchell, FSA, MAAA

Director

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SUMMARY OF QUALIFICATIONS

Erica has more than 18 years of experience in healthcare and actuarial consulting and has worked across numerous healthcare lines of business including Medicaid, Commercial, Individual, and Medicare with a deep focus on pricing. Her multi-functional role includes frequent collaboration with policy and financial reporting teams so that managed care organization contracts are properly updated and communicated, that CMS-64 reporting is consistent with approved waivers, and rate development is consistent with contracts and clinical policies.

In her six years in the Medicaid space, she has served as the co-lead actuary for two states for the past three years and is currently co-lead actuary for another state. Her work includes rate setting, cost-effectiveness, budget neutrality, ad hoc modeling, and directed payment support for both financial modeling and preprint development, and is known as an industry expert in this space. She has also presented on high-cost drug risk mitigation methods for MCOs and States in Medicaid.

Erica has 11 years as a consulting actuary and seven years as a health plan actuary. She graduated from Emory University with a Bachelor of Arts in Economics and Mathematics. She is a credentialed Fellow of the Society of Actuaries (FSA) and a Member of the American Academy of Actuaries (MAAA). She is an industry expert within these professional bodies' Medicaid Committees.

PROFESSIONAL EXPERIENCE

Supplemental Payments

- Led the analysis of West Virginia's SB 546, a new Medicaid Managed Care Directed Payment program to support the State's recruitment and retention of physicians employed by acute care hospitals. The analysis included a review of resulting Medicaid payment rates after fee schedule changes as a percentage of Medicare reimbursement and average commercial rates and a discussion of state quality strategy integration into payment methodology. Work included stakeholder vetting and communication, preprint development and support, and minimum fee schedule analysis. A new preprint was launched in near-record time (two weeks)
- As part of ongoing review and support of West Virginia's Directed Payment Program (DPP) under 43 CFR 438.6, participated in stakeholder discussions on quality models and withholds and the possible future changes of DPP as CMS guidance evolves. Supported state in annual DPP renewal, including implementation of the new annual strategy to improve state funding based on tax receipt projections and analysis of resulting Medicaid payments as a percentage of Medicare and average commercial rates. Drafted responses to CMS questions and supported state in calls with CMS
- Led Georgia's addition of more than $1.5B in new directed payments across five programs, including an additional $1.1B in FY23. FY23 payment increases allowed the State to redirect more than $100M in Disproportionate Share Hospital funds to rural providers. Impacted providers included hospitals, teaching physicians, and level 1 trauma centers

- Led Texas actuarial / policy project to transition roughly $2B in Delivery System Incentive Payments to directed payments. Work began with an initial review of provider types receiving DSRIP funding, including hospital services, physician services, and a variety of clinic types such as Community Mental Health Clinics, Local Health Departments, and Rural Health Clinics, to better determine how these providers might appropriately transition to directed payments and available financing for the State share of payments
- Worked with the State and relevant stakeholder groups to assess the feasibility of a variety of DPP strategies, including those that have been approved in other states and innovative strategies that are brand new but are likely to be defensible to CMS. The strategies presented tie to State quality goals and aim to connect provider quality with payment

Rate Setting

- Led rate setting for West Virginia from 2019 to 2022
- Co-led Georgia rate setting in 2019, 2020, and 2022 and co-lead actuary for Oklahoma from 2022 to the present day
- Co-led development of West Virginia rates for a new managed care program for foster care children, including cost-effectiveness submission and support on CMS questions. Supported a risk adjustment analysis used to reflect the changing acuity of the population as enrollment increased within the capitation rates, saving the state approximately $5M in the four-month initial launch of the program. Subsequently defended this downward adjustment to the incoming MCO using in-depth durational analyses
- As part of the annual rate setting process and legislative support, analyzed financial impacts of various Medicaid program changes ranging from fee schedule changes to delayed implementation of new DRG payment methodologies for a select number of facilities. Additional analyses include:
    - Stayer / leaver / joiner analyses to determine the impact of re-verification during a public health emergency
    - Trend drivers
    - High-cost drug risk pool modeling
    - Addition of Substance Use Disorder (SUD) benefits for 1115 waiver renewal / expansion
    - COVID-19 modeling including impact of stay-at-home orders on member utilization
    - American Rescue Plan (ARP) financing strategies including maximum funding available to the state and mechanisms to spend the new funds
- Piloted actuarial trend methodology to support Montana's fee-for-service nursing facility rate development. Brought new rigor and credibility to the trend development process, leading to more effective rate defense to provider stakeholders in the current, high-inflation environment. The methodology is subsequently being rolled out to other states including Maine
- Led the state in exploring high-cost drug risk mitigation techniques under the managed care framework, including driving stakeholder engagement conversations across state teams, financial analysis to support decision-making, and policy discussions

Financial Modeling / Ad Hoc Analysis

- Supported state ad hoc analyses on Medicaid expenditures for legislative actions, including increasing the state minimum smoking age to 21, expanding telehealth access for managed

care Medicaid members, and expanding school-based services, including revisions to medical necessity criteria

- As part of annual IBNR work on behalf of one State's fee-for-service Medicaid program, noted excessive trends for a particular service category, leading to attorney general investigations into several providers' billing practices
- Developed and supported 2019 and 2021 cost-effectiveness submission for West Virginia for 1915(b) and 1915(c) waivers (new and existing programs), including both the numeric components of the submission as well the accompanying narrative
- Reviewed CMS-64 data provided by the state and made adjustments to the base period data used in the 2019 and 2021 submissions for data anomalies related to directed payments and State-to-MCO risk corridor payouts, garnering CMS approval
- Led conversations with CMS on behalf of West Virginia's Deputy Commissioner of Finance to help uncover several issues related to CMS' analysis of cost-effectiveness
- Led West Virginia's 1115 Substance Use Disorder and Institutions for Mental Disease budget neutrality and cost projections for its January 2023 waiver renewal. Cost projections included several new benefits, including housing supports, and were put together in four weeks
- Presented West Virginia's risk corridor strategy to NAMD CFOs on a national call during the COVID-19 pandemic at the request of West Virginia's Deputy Commissioner, Finance, and Administration

Social Determinants of Health (SDOH)

- Led strategic discussions with state Medicaid programs on methodologies for the incorporation of state SDOH objectives into payment models. States include Tennessee, Georgia, and Arizona, and discussions covered payment models ranging from value-based payment methodologies; to integrating withholds into capitation rates while maintaining actuarial soundness; updating risk adjustment methodologies; to changing in-lieu-of-service offerings
- Participated in National Alliance to impact the SDOH (NASDOH) meetings to develop recommendations to CMS and the Office of the Actuary on clarifications needed in the Medicaid SDOH arena around medical loss ratio formulas and allowable expenditures in capitation rate development

WORK HISTORY

- Director, Guidehouse (2019 – Present)
- Actuarial Consultant, Horizon Actuarial Services (2017 – 2018)
- Actuarial Director, Aetna (2016 – 2017)
- Vice President, Aon (2013 – 2016)
- Actuarial Consultant, Coventry Health Care, an Aetna Company (2009 – 2011)

CERTIFICATIONS, MEMBERSHIPS, AND AWARDS

- Fellow of the Society of Actuaries (FSA)
- Member of the American Academy of Actuaries (MAAA)

EDUCATION

- Bachelor of Arts, Economics and Mathematics, Emory University

Sterling Felsted, FSA, MAAA

Director

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SUMMARY OF QUALIFICATIONS

Sterling is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. He has 15 years of actuarial consulting experience, with the most recent 13 focused on Medicaid work. In his current role, he provides project management and client interfacing for the firm's Medicaid clients. He orchestrates the development of the annual capitated rates as well as providing oversight on all ad hoc requests.

PROFESSIONAL EXPERIENCE

- Medicaid actuarial subject matter expert as client lead for Tennessee, signing actuary for West Virginia, manager of cost-effectiveness for Wyoming, with supporting roles for additional actuarial projects in Arkansas, Georgia, Kansas, Kentucky, and commercial clients
- Provides point of contact client support and project management for TennCare, Tennessee's Medicaid Program, leading client meetings, responding to ad hoc requests, leading annual capitation rate development, and signing rate certifications
- Oversees Medicaid rate-setting for acute, long-term care, CHIP, and PACE populations, including:
  - Project planning the overall process and providing guidance and follow-up on specific tasks
  - Processing, cleaning, aggregation, and validation of client data
  - Model development and validation
  - Impact estimation of legislated benefit / program changes
  - Development and application of trend, managed care, and benefit adjustment factors
  - Calculation and presentation of risk-adjustment of capitation rates
  - Presentation of the final rates to clients and related parties (including MCOs)
  - Report creation according to CMS requirements and client preferences
  - Responsible for communications with CMS on behalf of clients and project deliverables
- Determined, calculated, presented, and defended methodologies for accounting for population acuity changes resulting from inconsistent Medicaid redetermination efforts by States
- Serves as a subject matter expert with regards to changing Medicaid acuity levels related to the COVID-19 pandemic and later unwinding, even presenting various solutions to other actuaries (https://contingencies.org/experts-explain-whats-next-for-medicaid-after-great-unwinding/)
- Assists with Block Grant, Medicaid Expansion, and general waiver support, including cost effectiveness / budget neutrality demonstrations

- Produces the actuarial review of TennCare's entire program (including managed care and FFS components), signing since the FY15 report
- Managed, signed, and presented the annual IBNR valuation report for Georgia's Medicaid program
- Prepares analyses and other reports for Medicaid plans, including IBNP / IBNR reserve reports, cost impact estimates, budget projections, and other ad hoc requests
- Instrumental in defining how directed payments are handled within TennCare's managed care capitation rate framework
- Developed and maintained the actuarial team's IBNR model
- Developed methodology to bring hospital reimbursement levels into greater alignment
- Drafts and signs actuarial statements of opinion, including a memo for West Virginia's Medicaid program estimating savings resulting from carving out pharmacy services from managed care
- Manages and mentors junior staff to develop actuarial skills, project knowledge, professionalism, and technical skills
- Creates and conducts training for the Actuarial team

WORK HISTORY

- Director, Guidehouse (2010 – Present)
- Global Benefits Analyst, Aon (2009 – 2010)

CERTIFICATIONS, MEMBERSHIPS, AND AWARDS

- Fellow of the Society of Actuaries (FSA)
- Member of the American Academy of Actuaries (MAAA)

EDUCATION

- Bachelor of Science, Mathematics, Brigham Young University

Richard Lee Henley, J.D.

Associate Director

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SUMMARY OF QUALIFICATIONS

Richard (Rick) brings a unique and detailed mix of legal, policy, regulatory, and IT expertise in health and human services. Before joining Guidehouse, Rick began his career as an attorney with the Louisiana Department of Health and Hospitals. While Rick oversaw litigation involving a wide array of health-related matters, he primarily practiced in federal court handling and overseeing litigation involving complex Medicaid regulatory issues including Olmstead-type litigation, contractual disputes, and pharmaceutical issues. Rick was lead trial counsel on two major Olmstead-type class action lawsuits. He oversaw settlement compliance and reporting which resulted in the successful implementation and dismissal of court-approved Consent Decrees.

Leading the Policy and Program Division of the then-newly-formed Office of Aging and Adult Services, Rick worked very closely with Louisiana's designated Medicaid agency. He was instrumental in restoring the State's largest waiver for elders and persons with physical disabilities to cost-neutrality. He spearheaded initiatives to bring managed LTSS in Louisiana, implement the first self-directed option in the State, and to utilize scientifically-based resource allocation methodologies for the provision of 1915(c) and state plan service authorization.

Later moving to the private sector, Rick worked in government relations where he educated legislators and governmental staff on Medicaid rules and regulations. He has also testified to legislative committees on a wide array of health and human services topics. Given the federal initiatives to align health and human services policy with informational technology initiatives, Rick was later chosen to lead business development efforts for several large IT companies. Rick provided guidance to several States on the design, development, implementation, and operation of several large enterprise IT initiatives involving Medicaid, long-term supports and services, Comprehensive Child Welfare Information Systems, behavioral health, and Title III and Title IV-e.

In his current role with Guidehouse, and as a former state government leader, Rick works closely with local, state, and federal leadership on maintaining federal /state regulatory compliance. He keeps abreast of current changes in federal and state health and human services (including Medicaid) policy. He regularly provides guidance on the interpretation of the same to current and potential state clients and where needed, assists in the development of corrective action plans to ensure future compliance.

AREAS OF EXPERTISE

- Health and Human Services Rules, Regulations, Policies, Guidance, etc.
- Policy Research
- Contract Development and Interpretation
- Inter-Agency Collaboration
- Request for Proposal Development and Evaluation

- Managed Care
- Enterprise IT Solutions for Health and Human Services Programs
- Analytical and Problem-Solving
- Legislative Engagement and Advocacy

PROFESSIONAL EXPERIENCE

Healthcare Consulting

- Worked in a staff augmentation role for the Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services as Deputy Director. Worked on several major initiatives including, but not limited to overall 1915(c) waiver improvement, managed care oversight and collaboration with PASSE, modernize and improve Older Americans Act and Adult Protective Services systems, development of Arkansas' State Plan on Aging, PACE expansion, oversaw ARPA funds, creation and implementation of executive dashboard, and increased self-direction participation
- Oversees statewide project in Delaware concerning CMS Reporting and Provider Reimbursement initiatives for state's managed care program
- Led a team that assisted in drafting and developing of over 30 Quality Improvement Plans required by CMS for a state to be achieve and maintain compliance with applicable federal regulations
- Provide Medicaid regulatory expertise to a wide array of state clients

Policy Development

- Served as an assistant to the Assistant Secretary for all matters relating to policy development and implementation of all programs that OAAS was charged with administering through the development, revision, and interpretation of various policies
- Developed, interpreted, monitored, enforced, and intervened as necessary to confirm compliance with more than $400M worth of Memorandums of Understanding between the OAAS and Program Offices. Monitored performance provided by Department of Health and Hospitals (DHH) Program Offices and Medicaid; assured adherence to budgeted MOU funding; resolves or directed resolution of problems, complaints, disagreements, and disputes among the various parties; determined need for modification and stipulated corrections or adjustments
- Monitored and intervened as necessary to confirm compliance with relevant laws, standards / regulations, contracts, court stipulations and settlements, deadlines, formats, and accuracy requirements. Participated in and recommended the drafting of legislation, numerous contracts and Request for Proposals, policy manuals, and guidelines
- Skillfully managed a division staffed with 21 employees
- Chaired committee in charge of drafting various Request for Proposals including, but not limited to, proposal to bring managed long-term supports and services care to Louisiana

Government Healthcare IT Solutions

- Was responsible for sales for a full book of the company's IT solutions in the U.S. Southeast Region including but not limited to, data warehouse, analytics, claims, encounters, LTC, utilization management, pharmacy benefits management, third-party liability, provider

management, and payment development methodology. Territory initially included all 50 states but later modified to Arkansas, Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Florida, Alabama, and Mississippi. Was also responsible for outreach to key Medicaid personnel and stakeholders

- Spearheaded effort to identify and team with a technology partner that resulted in positive procurement results

Legal Experience

- Lead Trial Attorney for several complex federal question cases involving LTC and pharmaceutical matters in the Eastern, Middle, and Western District of Louisiana cases as well as the U.S. Fifth Circuit Court of Appeals
- State legal counsel for the Pharmaceutical and Therapeutic Committee
- Handled and coordinated a wide array of legal matters concerning claims of contractual non-compliance/enforcement, pharmaceutical matters, policy interpretations, etc.

WORK HISTORY

- Associate Director, Guidehouse (2022 – Present)
- Business Development Executive, FEI Systems (2018 – 2022)
- Sales Executive, Government Healthcare Solutions, Conduent State Healthcare, LLC (2014 – 2017)
- Regional Director, Government and Community Relations, Seniorlink, Inc (2014 – 2017)
- Division Director, Policy Development, Louisiana Department of Health and Hospitals (DHH) / Office of Aging and Adult Services (2006 – 2014)
- Attorney Supervisor, Bureau of Legal Services, Department of Health and Hospitals, Bureau of Legal Services, Baton Rouge, Louisiana (2002 – 2006)
- Attorney One, Two, and Three, Department of Health and Hospitals / Bureau of Legal Services, Baton Rouge, Louisiana (1998 – 2006)

CERTIFICATIONS, MEMBERSHIPS, AND AWARDS

- Louisiana State Bar Association, Good Standing
- Notary Public, Louisiana

EDUCATION

- Juris Doctorate, Louisiana State University Law School (1998)
- Bachelor of Science, History, Magna Cum Laude, Murray State University, December (1994)

Roshni Shah Arora, MPH

Director

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SUMMARY OF QUALIFICATIONS

Roshni has more than 17 years of experience in the healthcare industry working with government-sponsored programs, including Medicaid, Medicare, CHIP, and uninsured programs. Roshni has led engagements specializing in healthcare service delivery system activities, including Medicaid managed care initiatives for more than 12 state agencies and implementation of Medicaid programs on behalf of payers. She has vast experience leading stakeholder engagement, policy analysis, and strategy implementation efforts to develop healthcare policies and programs. These delivery system engagements include assisting states and payers with all phases of a program lifecycle: design, implementation, monitoring, operations, organizational readiness, as well as care management, network adequacy, and federal and regulatory compliance.

In addition to directing our policy and program support for the States of Oklahoma and West Virginia to operate their Medicaid managed care programs, she has led many projects on designing, implementing, and evaluating healthcare programs. For example, she is supporting the Tennessee Governor's Office and Department of Health in its efforts to convene a statewide Rural Health Task Force to address key healthcare issues including access to care, workforce development, and social determinants of health. Roshni also supports payers in their planning and design efforts to pursue new Medicaid managed care markets including strategy, technical writing, and analysis.

Roshni played an interim Commissioner level role for Kansas to address critical behavioral health and long-term services and support priorities. Specifically, she managed the development and CMS approval of Kansas' Section 1115 waiver demonstration application, which included preparation of application materials, coordination of public comment and stakeholder feedback responses, and participation in CMS discussions and negotiations. Roshni prepared Kansas' SUD Implementation Plan for the Section 1115 waiver demonstration application. Roshni also assisted KDADS with operational and technical support, including Long-Term Services and Supports (LTSS) stakeholder engagement, behavioral health, data analytics, and the development of Department strategic planning objectives.

AREAS OF EXPERTISE

- Manages projects focused on strategic planning, design, implementation, operation, and evaluation of healthcare delivery systems and healthcare reform options. Has experience supporting multiple multi-million-dollar engagements
- Supports clients with building processes and strategies for monitoring program performance driving quality improvement and developing tools to facilitate program monitoring and operations
- Leads engagements to demonstrate compliance with relevant federal and state regulations for state Medicaid agencies and health plans
- Experienced in supporting state program integrity units and Office of Inspector General (OIG) operations for fraud, waste, and abuse compliance within managed care environments

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

Professional Experience

Medicaid Managed Care

- Supports initiatives to design, implement, and operate Medicaid managed care programs in states such as Alabama, Kansas, Illinois, Mississippi, Oklahoma, Pennsylvania, and West Virginia. Work has involved:
  - Supported the evaluation of program design considerations through research, analysis, and stakeholder engagement
  - Supported the management and oversight of Medicaid managed care for LTSS
  - Developed reporting templates, dashboards, and other reports to collect and disseminate performance data (quality, operational, and financial) to internal and external stakeholders
  - Supported quality improvement and performance monitoring, including development and update of the federally-required Quality Strategy and establishing performance through metrics such as Healthcare Effectiveness Data and Information Set (HEDIS® Consumer Assessment of Healthcare Providers and Systems (CAHPS®), and other state-generated measures
  - Assessed and developed organizational structures, processes, policies, and procedures to promote effective program monitoring and continuous performance improvement
  - Conducted data analysis to identify performance opportunities and successes and evaluate program effectiveness
  - Facilitated stakeholder workgroups consisting of agency staff, providers, health plan executives, and consumers to identify health plan and program performance measures
  - Conducted reviews of state agencies and health plans to assess readiness before the program go-live
  - Developed and provided feedback on procurement materials, including Medicaid managed care organization contracts, Requests for Proposals, responses to bidder questions, and proposal scoring tools
  - Trained agency staff on subject matter, such as Medicaid and managed care, and skills, such as data analysis and program monitoring
- Managed the development and CMS approval of Kansas' Section 1115 waiver demonstration application, which included preparation of application materials, coordination of public comment and stakeholder feedback responses, and participation in CMS discussions and negotiations. This work resulted in CMS approval to enable Kansas Medicaid program operations from 2019 – 2023, and implementation of improvement initiatives (e.g., new funding allowances for substance use disorder services)
- Provided interim staffing support at the commissioner level to the Kansas Department for Aging and Disability Services to provide strategic expertise on LTSS, behavioral health, data analytics, and other operational issues. In this capacity, represented and guided KDADS through issues such as:
  - LTSS stakeholder engagement
  - CMS section 1915(c) waiver renewals

  - Provider network adequacy and monitoring
  - Quality improvement framework and processes
  - KanCare managed care organization (MCO) monitoring and oversight
  - Realignment of LTSS Commission to improve efficiency and performance
  - Coordination with Medicaid agency
  - Development of State policies and procedures for reporting and investigating adverse incidents
  - State legislature testimony
  - KanCare pay for performance program
  - Strategic planning objectives presented to legislative committees (Available at: http://www.kslegislature.org/li/b2019_20/committees/ctte_jt_robert_g_bob_bethell_joint_committee_1/documents/testimony/20190827_05.pdf)
- Prepared the Kansas' SUD Implementation Plan for the Section 1115 waiver demonstration application, which included:
  - Reviewing the current Medicaid State Plan and MCO contracts
  - Developing recommendations for a proposed "future state" and "summary of actions needed"
  - Facilitating discussions with CMS and between sister agencies (e.g., Medicaid agency and aging and disability services agency)
  - Preparing an operational project plan to implement the SUD Implementation Plan upon approval by CMS
  - Estimating the difficulty level to meet CMS' required milestones to prepare the State with discussions with CMS
  - Recommending a stakeholder communication plan and preparing supporting communication materials
- Supported strategic planning for senior leadership from the Florida Agency for Health Care Administration's Division of Medicaid to prioritize activities in 2017-2020. Led interviews with senior leaders to understand their roles, activities, and approaches for oversight, monitoring, performance management, and ongoing challenges
- Facilitated strategic planning session using a decision making framework to prioritize agency activities and establish goals for 2017-2020 to achieve short- and long-term program goals
- Managed daily project operations for a technical assistance contract with West Virginia's Bureau for Medical Services, which included serving as the primary point of contact with the client, contracted MCOs, CMS, and other vendors. Supported the State with the expansion of managed care including SSI beneficiaries and new services (e.g., behavioral health, dental, and pharmacy services)
- Prepared the 1915(b), quality strategy, and other supporting documentation to obtain federal authority for program changes. Provided strategic support for implementation activities such as phased-expansion schedule, stakeholder communications, and supported readiness reviews
- Assisted the Georgia Department of Community Health in developing and implementing a value-based purchasing model for select Georgia Medicaid managed care programs. Designed

a collaborative process with vendors, identified key priority areas, developed an incentive payment model, and prepared performance measurement specifications

- Provided recommendations for combining New York's Medicaid managed care contract for the special needs plan (SNP) program for Medicaid-eligible individuals with HIV / AIDS into the mainstream Medicaid managed care program contract. As a result, the State adopted a single managed care contract for these programs, facilitating contract oversight and vendor monitoring
- Assisted multiple Medicaid MCOs in responding to state Requests for Proposals to participate in mandatory Medicaid managed care programs. Reviewed health plan policies and procedures, interviewed health plan staff and executives, and drafted responses to RFP questions

Federal Initiatives

- Led an engagement for a large national health plan (Part C, Part D, Medicare-Medicaid) to overhaul existing policy infrastructure to develop a comprehensive set of policies addressing Medicare and Medicare-Medicaid products. Tasks included policy life cycle management design, development of a policy template, policy research and development, and procedure review. The policy research and development component incorporated a review of all relevant regulatory frameworks, including federal and state regulations, federal and state guidance, and contracts with government purchasers. After the project, led the review and update of more than 400 policies
- Through a multi-year contract with the Agency for Healthcare Research and Quality (AHRQ), coordinated and provided onsite and individualized technical assistance to 17 states for selected areas of interest related to Medicaid care management
    - Facilitated peer-to-peer learning across the states through in-person meetings and web conferences on topics such as program design, procurement, measurement, evaluation, communications, and continuous quality improvement. Developed resources such as issue briefs and a technical assistance website for states
    - Designed and coordinated a day-long session at the National Academy for State Health Policy conference to disseminate lessons learned about Medicaid care management
    - Developed a toolkit, "Designing and Implementing Medicaid Disease and Care Management Programs: A User's Guide"
- Developed network adequacy criteria used by CMS for evaluating Medicare Advantage applications. Established criteria requirements and exceptions, documented detailed business requirements for automating review and evaluation of application data, and drafted communication materials
- Supported CMS in the development of the Medicaid and CHIP Program System (MACPro) by designing standardized templates for the 1937 Benchmark State Plan Amendment to facilitate consistent state reporting and streamline review, resulting in a more streamlined, efficient, and transparent process and data for state partners and researchers
- Assisted in the development of a Medicaid managed care oversight guide to facilitate CMS review of Medicaid managed care programs. Managed a scan of existing Medicaid managed care contractual requirements and identified leading practices

Healthcare Reform

- Leading support to the Tennessee Governor's Office and Department of Health in its efforts to convene a statewide Rural Health Task Force to address key healthcare issues including access to care, workforce development, and social determinants of health. The Task Force will develop a report with recommendations to the Governor for consideration
- Led technical assistance to California's Department of Health Care Services for its Student Behavioral Health Incentive Program to distribute $389M to increase access to preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers for children in public schools. Specific actions include facilitation of stakeholder meetings, review of submitted deliverables from Medicaid health plans, and analysis of program data to identify the impact of health outcomes
- Serving as a subject matter expert to the North Carolina Department of Health and Human Services to stand up its Office of Health Equity and incorporate diversity, equity, and inclusion principles within all health programs within the agency
- Led support to the Tennessee Governor's Office and Department of Finance and Administration to complete a Listening Tour and convene a Healthcare Modernization Task Force. Leading stakeholder engagement, policy analysis, and strategy implementation efforts to develop healthcare policy and program options to address the most pressing challenges facing the State
- Provided recommendations to Arizona Health Care Cost Containment System (AHCCCS) to improve its data collection and use of Social Determinants of Health (SDoH) ICD-10 codes. Support included the completion of a national survey and review of SDoH leading practices, an inventory of federal compliance requirements for Mental Health and Substance Abuse Block Grant reporting, and the development and execution of training for providers and contracted health plans
- Assisted the District of Columbia to engage public and private sector stakeholders in developing the District's proposal for innovative payment and service delivery models. Tasks include data collection and research, stakeholder engagement, meeting facilitation, development of policy recommendations, financial modeling, and communications activities. Developing the District's State Health System Innovation Plan (SHIP) that the District will submit to CMS
- Conducted a study for the Association of Community-Affiliated Health Plans to identify the benefits and challenges associated with leveraging Medicaid safety net health plans for health reform

Medicaid Performance Management and Sustainability

- Serving as a subject matter expert to CMS in monitoring access to coverage and program integrity in Medicaid and CHIP, with a particular focus on eligibility and enrollment policy and program operations at the state level
- Led the analysis of the impact of Medicaid expansion on Montana's economy and access to care, given that legislation authorizing Montana's Medicaid expansion program was set to expire in June 2019. Presented its findings to stakeholders in Montana and members of the media in March 2019: https://www.navigant.com/insights/healthcare/2019/hospital-funded-study-medicaid-expansion

- Reviewed national leading practices for collecting information on SDoH and Mental Health Block Grant / Substance Abuse Block Grant reporting requirements and identified opportunities for improvement for the AHCCCS
- Assessed Mississippi's Medicaid managed care program to improve operational and program performance. The assessment focused on areas such as monitoring and oversight, data analytics, enrollment, quality management, and care management
- Supporting engagements to assess and improve program integrity functions in Alabama, Mississippi, Texas, and West Virginia. Project work has involved:
    - Assessing organizational structure and processes to improve critical processes, especially in the context of increased managed care enrollment
    - Building agency program integrity capacity through the development of policies and procedures and staff training
    - Developing strategic work plans to prioritize agency activities
    - Developing reporting templates to collect contractor data for program integrity activities
- Provided consultation on organizational structure and development to the Illinois Bureau of Managed Care to identify operational and structural efficiencies. Facilitated strategic planning to determine priorities to improve the Bureau's oversight of current and new programs. Proposed recommendations for organizational realignment to increase functional efficiency
- Conducted an analysis for Arizona to identify potential cost savings that would decrease adverse impacts on the health status of AHCCCS beneficiaries. For each proposed area, identified and estimated the projected cost savings and identified advantages and the potential for adverse effects on the target population, exacerbation of related chronic conditions, cost shifting to other covered services, and delayed access to care
- Provided technical assistance to West Virginia on overall quality improvement, program monitoring, and oversight. Reviewed all MCO deliverables and prepared a quality dashboard to highlight key issues. Coordinated with the State's EQRO to identify interventions to improve performance
- Led the collection and analysis of information on Medicaid primary care case management (PCCM) programs, including beneficiary access, cost-sharing, and associated disease management and care management components, for New York to use in considering a future PCCM program as an alternative to full-risk managed care in rural areas. Evaluated beneficiary access to primary care and specialist providers in New York's Medicaid managed care program through the conduct of focus groups
- Assessed the performance of Connecticut's HUSKY Program, a capitated Medicaid managed care to compare the policy alternatives of retaining HUSKY versus adopting a "managed fee-for-service" model of coverage for the Connecticut Association of Health Plans
- Developed an independent assessment of New Mexico's managed care program, Salud! and behavioral health managed care programs, assessing access, quality, and cost-effectiveness

Other Relevant Experience

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

Work History

- Director, Guidehouse (2012 – Present)
- Consultant, The Lewin Group (2006 – 2012)

Education

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

Staff Actuaries

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SUMMARY OF QUALIFICATIONS

Ryan has three years of experience in healthcare and actuarial consulting with a primary emphasis on Medicaid managed care rate setting. His roles across multiple state Medicaid programs are generally focused on actuarial rates setting, with equal focus on both the development and consistency of the methodologies with CMS standards. Additionally, Ryan frequently performs analyses of macroeconomic events such as the COVID-19 Pandemic and the resulting social and legal consequences on Medicaid programs and similar fiscal impact models depending on client needs, including state legislature proposals.

Relevant Experience

- Medicaid capitation rate setting (Actuarial)
- Actuarial data analytics

Professional Experience

TennCare Actuarial Experience

- Provided actuarial support in the development of actuarial sound managed care Capitation Rates for Calendar Years 2021, 2022, and 2023. Contributions include analysis of historical claims and membership data, development of trend models, fiscal analysis of legal, regulatory, and programmatic changes, risk adjustment, incorporating state-directed payments, and making sure appropriate certification of rates conforming to CMS standards
- Provided ad hoc actuarial support for state needs including time-sensitive legislative budget requests, TennCare historical performance compared to Medicare and Commercial healthcare, modeling of COVID impacts to the TennCare program, fiscal projections of potential programmatic changes, introduced coverage for new services, change in payment structures for the ECF CHOICES populations and PCMH organizations, and the impacts of Tennessee Hospital Association rate variation
- Provided additional quality assurance of the rate setting process through the creation of a parallel rate setting process using an unrelated methodology for the accuracy of the capitated rates

Other Actuarial Experience

- Provided actuarial analysis and support for rate-setting for West Virginia and Georgia from 2020 to 2022, including similar analysis to those performed for TennCare's rate setting process. Additionally, for West Virginia, Ryan helped develop appropriate completion and reporting of CMS-64 Payments

- Provided an independent analysis of risk adjustment methodologies comparing ACG and multiple CDPS methodologies
- Incorporation of additional rate setting quality assurance measures through the introduction of separately programmed independent analysis data

Work History

- Managing Consultant, Guidehouse (2020 – Present)

Certifications, Memberships, and Awards

- Fellow of the Consulting Conference of Actuaries (FCA)
- Member of the American Academy of Actuaries (MAAA)

Education

- Bachelor of Business Administration, Risk Management and Insurance, University of Georgia
- Certificate of Actuarial Science, Distinguished Honors

Will Lu, FSA, MAAA

Associate Director

wlu@guidehouse.com
Atlanta, Georgia
Direct: 404.575.3813

SUMMARY OF QUALIFICATIONS

Will is an actuary with 19 years of experience in health actuarial profession. Prior to joining Guidehouse, Will worked at leading consulting firms as a consulting actuary / project manager for seven years with increased responsibility, serving clients from managed care organizations, provider groups / healthcare systems, to employer groups and start-ups in the Medicare, Commercial, and Medicaid markets. Will has extensive experience in benefit pricing, rate filing / certification, risk adjustment, financial projection, and predictive analytics. In the Medicaid space, he's also worked on capitation rate adequacy analysis, budget forecasting, and modeling the financial impact of legislative changes.

Will has also 12 years of experience as a health plan actuary, where he worked extensively on claims data analysis, provider contracting support, and value-based care analytics. He is a results-driven problem solver with strong analytical skills, effective communication, strategic thinking and a client-focused mindset.

Relevant Experience

- Medicare advantage (MA) bids
- Actuarial modeling
- Risk adjustment
- Provider contracting analytics

Professional Experience

Medicare Advantage Did Development

- Led a team of actuarial consultants to develop MA bids for three clients from A to Z, including processing claims data, setting up MA pricing model, building assumptions, projecting risk scores incorporating risk model change / coding intensity / population change, pricing various benefit design options inclusive of supplemental benefits and EGWP plans, compiling proforma, and responding to CMS desk reviewer questions.

Risk Adjustment

- Led two separate actuarial teams to run the monthly / quarterly risk score / CMS revenue projections accounting for data submission accruals / adjustments for both Part C and Part D for each demographic cohort and specific coding initiatives.
- Responsible for producing data leakage reports that track the diagnoses that get dropped in each step of the data submission / adjudication process and quantifies the potential revenue loss and risk adjustment data validation (RADV) exposures.

Actuarial Modeling

- Led many actuarial modeling projects, a few examples are:
  - *Actuarial Values:* Developed a model to produce an estimate of the pmpm values of plan liabilities and benefit ratios based on user inputs of benefit design, market / region, enrollment mix, and differentiating the general enrollment plans verses SNP plans.
  - *Induced Utilization Factor:* Developed a stochastic model to calculate the induced utilization factor for various service categories based on customized current utilization level and choice of client specific experience data or benchmark data
  - *MA Market New Entrant Feasibility Model:* Developed a model to estimate the membership, revenue, claims cost, admin, and profit margin for the first five years of an MA market new entrant based on the MCO's strategy, benefit designs, covered population, market conditions, and industry trend.
  - *Medicare Supplemental Benefit Pricing Model:* Develop a model to price the net cost to MCOs for various coordination of benefits (COB) scenarios.
  - *Employer Group Stop Loss Model:* Developed a Monte Carlo simulation model to price the cost of stop loss contracts.

Predictive Analytics

- Risk Score Suspecting: Analyzed suspecting opportunities for three clients from 2021 to 2023, responsible for running a proprietary analysis to generate a target list of chart-chases that are most likely to capture missing diagnoses based on medical claims history, pharmacy claims information, provider billing patterns, and customized provider specialty index.

Benefit Pricing / Rate Filing

- Priced various benefit designs for individual marketplace plans and completed ACA rate filings for two clients from 2018 to 2021

Budget Development and Financial Projections

- Developed budgets / financial projections for two Medicaid clients from 2021 to 2024

Work History

- Associate Director, Guidehouse (2025 – Present)
- Actuarial Manager, Optum Insight (2021 – 2025)
- Associate Director, ChenMed Inc. (2020 – 2021)
- Actuary, Milliman Inc. (2018 – 2020)
- Actuary, Humana Inc. (2014 – 2018)
- Associate Actuary, Premera Blue Cross (2016 – 2014)

Certifications, Memberships, and Awards

- Fellow of Society of Actuaries (FSA)
- Member of American Academy of Actuaries (MAAA)

Education

- Master of Science, Florida State University (2000 – 2002)
- Bachelor of Science, Shanghai JiaoTong University (1996 -2000)

Ben Maryland, ASA, MAAA

Managing Consultant

bmaryland@guidehouse.com
Marietta, Georgia
Direct: 770.865.5252

SUMMARY OF QUALIFICATIONS

Ben is a consulting actuary with seven years of experience in health insurance. More than five years of that experience has been in Medicaid plan actuarial support in general actuarial exercises like reserving and forecasting, along with other initiatives such as Value-Based Purchasing support, Value-Added Benefit pricing, Actuarial Memorandum development, and more. He gained experience in project management and analyst training through these roles, leading teams through project inception to completion. Ben supported several different Medicaid markets while providing Medicaid plan support including Massachusetts, Georgia, New Hampshire, and Ohio. Ben is an Associate of the Society of Actuaries (ASA) and a Member of the American Academy of Actuaries (MAAA). He is pursuing the Fellow of the Society of Actuaries (FSA) designation.

Areas of Expertise

- Medicaid rate analysis
- IBNR and medical forecasting
- SQL, Excel, and other data analysis supports

Professional Experience

Medicaid Plan Support

- Primary owner and leader of all actuarial work in support of health plans, including but not limited to: IBNR development, medical cost forecasting cycles, risk corridor analysis, rate adequacy research, audit compliance support, MLR template completion and validation, provider payment analysis, and more.
- Supported RFP efforts in developing Value-Added Benefit pricing, using internal and external sources, and providing feedback to respondent teams.
- Led the development of annual actuarial opinions and memorandums in accordance with NAIC instructions discussing actuarial accrual development across.

Value Based Purchasing and Actuarial Support

- Supported the development of an actuarial service team with a focus in providing actuarial insight to Value Based Purchasing programs across numerous Medicaid markets
- Developed Stop Loss Pricing Model used in Value-Based Purchase contracts across several products and markets
- Created Benchmark Targeting Model, along with supporting models to forecast targets based on Medicaid rate changes and risk adjustment
- Developed Provider Risk Adjustment Normalization module and ensured proper application in provider benchmarking

- Created Benchmark Targeting Model, along with supporting models to forecast targets based on Medicaid rate changes and risk adjustment
- Developed Provider Risk Adjustment Normalization module and ensured proper application in provider benchmarking

Work History

- Managing Consultant, Guidehouse (2025 – Present)
- Manager, Actuarial Services, Molina Healthcare (2021 – 2024)
- Senior Actuarial Consultant, Aetna, CVS Health (2019 – 2021)
- Actuarial Analyst, Centene (2018 – 2019)

Certifications, Memberships, and Awards

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

Education

- Bachelor of Science, Actuarial Science, Florida State University (2014 – 2018)

Alysia Overdorf, FSA, MAAA

Senior Consultant

aoverdorf@guidehouse.com
Nazareth, Pennsylvania
Direct: 610.393.7725

SUMMARY OF QUALIFICATIONS

Alysia has a background in Actuarial Science with experience in both the commercial space and the Medicaid space. Her current work is in the Medicaid space and is focused on Medicaid Managed Care capitation rate development for both Medical and Dental programs. This includes program change modeling, trend development, seasonality, managed care savings, and providing legislative support. She also has experience with hospital Medicaid revenue strategy including modeling value-based payment and risk-based contract opportunities, providing negotiating strategies for state reimbursement rates, assessing supplemental payment opportunities, and assessing sufficiency of claim coding. Alysia's prior experience in the commercial space focused on self-insured employer groups, including setting premium equivalents, incurred but not reported (IBNR) reserves, plan design, employee contribution modeling, and individual stop loss modeling.

Alysia has experience working with the Microsoft Office Suite, including Excel, Word, and PowerPoint. She is a Fellow of the Society of Actuaries (FSA) and a Member of the American Academy of Actuaries (MAAA).

Relevant Experience

Medicaid Actuarial

- Capitation rate development of both medical and dental managed care programs including:
  - Program changes
  - Trend development by looking at four years of data as well as external sources
  - Seasonality
  - Managed care savings
  - Modeling for SUD 1115 Waiver
  - Risk corridor calculations
  - CMS certification
- Support of legislative questions, including creating budget estimates for a proposed adult vision program
- Development of Hospital Medicaid revenue strategies including:
  - Modeling of value-based payment and risk-based contract opportunities under different levels of risk and possible future scenarios
  - Development of negotiating strategies for increasing state base rates for Medicaid
  - Assessing supplemental payment opportunities

- Assessing adequacy of ICD-10 claim coding

Commercial Actuarial

- Support of self-insured employer groups including:
  - Development of premium equivalents for self-insured medical, dental, and vision employee benefits
  - Calculation of IBNR reserves
  - Modeling the impact of plan design changes and employee contribution changes
  - Individual stoploss modeling and assessment of stoploss contracts

Work History

- Senior Consultant, Guidehouse (2021 – Present)
- Health and Benefits Actuarial Analyst, Aon (2019 – 2021)

Certifications, Memberships, and Awards

- Fellow of the Society of Actuaries (FSA)
- Member of the American Academy of Actuaries (MAAA)

Education

- Master of Science, Actuarial Science, Temple University
- Bachelor of Science, Mathematics, Music, Elizabethtown College

Debra Ruocco, FSA, MAAA

Associate Director

druocco@guidehouse.com
Saco, Maine
Direct: 207.671.3886

SUMMARY OF QUALIFICATIONS

Debra is an actuary with 20 years of experience in health insurance with expertise in commercial pricing, provider contracting, and public policy. As a health plan actuary, she has worked in several commercial healthcare lines of business including, individual, small group, and large group. Many work experiences have included an integral liaison role to take advantage of the combination of Debra's robust problem solving and analytical abilities with her strong verbal and written communication skills. As a consulting actuary, Debra assists provider groups in improving their Medicare Advantage shared risk contracts with payers and is a member of the managed care rate development teams for Oklahoma and Tennessee Medicaid programs.

Areas of expertise

- Analytical Skills
- Commercial Pricing
- Medicaid Rate Setting
- Provider Contracting
- Public Policy

Professional Experience

Provider Shared Risk Contracts for Medicare Advantage

- Collaborated with internal and external data teams to assess quality of payer data and provided guidance to client about better ways to use data to track performance and alert them to potential risks
- Evaluated past performance of shared risk contracts by provider network configuration, product, and categories of service to provide a detailed analysis of client's current financial position
- Performed actuarial modeling to project future performance of existing contracts and identified risks associated with potential contract term changes, including increased provider risk share. Financial forecasts included a range of performance scenarios and analysis of CMS benchmarks, trends, and risk adjustment model changes and their impact on client contracts
- Identified potential protections and key contract terms to focus on in negotiations with payers
- Developed concise and impactful presentations to communicate findings and recommendations to clients

Medicaid Actuarial Rate Development

- Developed capitation rates for Oklahoma's Medicaid medical and dental programs for FY25 that included projection of trend, impact of program changes, and measuring managed care savings
- Developed MLR template for medical and dental MCOs (Managed Care Organizations).
- Developed template for the state to track actual enrollment and budget compared to projections
- Completed and presented market research on Medicaid admin fees which led to redesigning the type and amount of Oklahoma's admin fees
- Led project to investigate existing risk adjustment anomalies among contracting entities; analysis included introduction of alternative risk adjustment methodology to highlight potential flaws in risk measurement of existing Tennessee methodology
- Performed a national survey of Medicaid DPP (Directed Payment Programs) that pay providers up to 100% of commercial rates to quantify the prevalence of this type of payment model. Survey results informed state Medicaid client's response to hospitals that are pushing for payment up to 100% of commercial rates

Large Group Commercial Pricing

- Designed enterprise target rate tools and analyses to upgrade reporting capabilities and inform leadership's strategic and financial decisions for fully insured Large Group (LG) business worth more than $14B in premium
- Managed and improved the Elements of Margin (EoM) reporting and analysis processes for fully insured LG business to support segment-wide initiatives to improve margins
- Developed EoM capabilities at a group-specific level in the enterprise LG rating tool to improve underwriting negotiations, rating, and reporting
- Supported 14 state pricing teams by developing enterprise-leading practices and standardizing pricing tools

Public Policy

- Acted as the actuarial liaison between the pricing and public policy teams
- Crafted policy positions and developed advocacy materials with a focus on actuarial issues, i.e., reinsurance, risk adjustment, MLR, the rate review process, and COVID-19
- Evaluated proposed legislation and regulations to assess impacts on the company and developed recommendations and solutions
- Participated in workgroups run by external associations to identify public policy issues impacting the company and to influence the external groups' policy positions and strategies to support enterprise goals more effectively

Commercial Pricing

- Collaborated with local pricing teams on the peer review of rate developments and filings for various products, including Commercial (Legacy and ACA), Medicare Supplement, Medicare Part D Wrap, Federal Employee Plans, and Stop Loss
- Developed a tool to automate a large portion of the ACA annual review process. Streamlined several other team processes via automation, including quarterly reporting

- Assisted the Enterprise Pricing team during two annual ACA cycles by acting as a lead developer of ACA pricing tools and exhibits used to price businesses with more than $10B in premiums
- Led the team that designed and now maintains the Actuarial Knowledge Library, which is an enterprise resource for all actuaries in the company

Healthcare Contracting

- Responsible for contracting unit cost planning process for half of the health plans
- Led the implementation of the Provider Contracting Database (PCD), which analyzed the financial impact of various contract scenarios, for the Medical Contracting organization
- Major contributor to the development of PCD analytical tools
- Authored all training materials and conducted training on PCD and accompanying report modules
- Tools informed and improved contracting negotiations for all local health plans

Healthcare Financial Reporting

- Responsible for analysis and calculation of monthly reserves for half of the company's health plans
- Collaborated with pricing and accounting in the semiannual rate review process
- Streamlined and automated reserve process to eliminate two positions
- Developed tools to improve analysis of conservatism, trend, and other reserve factor

Work History

- Associate Director, Guidehouse (2023 – Present)
- Associate Actuary, Elevance Health (2012 – 2023)
- Director, CIGNA (1994 – 2002)

Certifications, Memberships, and Awards

- Fellow of Society of Actuaries (1999)
- Member of the American Academy of Actuaries (2000)

Education

- Bachelor of Arts in Mathematics, Mount Holyoke College (1990 – 1994)

Appendix C Actuarial Certifications

Russell H. Ackerman | Partner | Engagement Program Director

The Actuarial Directory

Russell H Ackerman

ASA MAAA FCA

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

Designations

ASA 2007
MAAA 2007
FCA 2015

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

Industry

Consulting

Primary area of practice

Health

Specializations

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

Society of Actuaries Sections

Health
Social Insurance & Public Finance

Sterling Felsted | Director | Lead Actuary

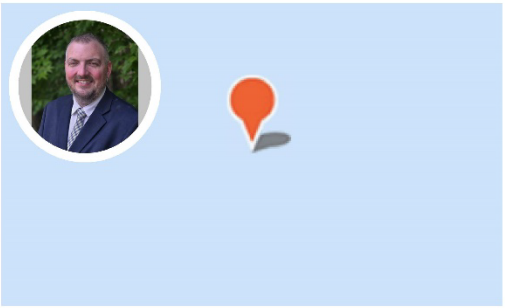
The Actuarial Directory

Sterling Arthur Felsted

FSA MAAA

163 George Wynn Rd
Palmetto
Georgia 30268-8581
United States

Email sterling.felsted@gmail.com
Tel +1(312)805-0169



Designations

MAAA 2014
FSA 2021

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

Industry

Consulting

Primary area of practice

Health

Specializations

Academic/Education
Financial Reporting
Health Insurance - Commercial
Health Insurance – Public Systems
Long Term Care Insurance
Predictive Analytics
Product Pricing/Development
Regulatory
Risk Management
Valuation/Reserving

Erica Mitchell | Director | Finance Project Lead

The Actuarial Directory

Erica A Mitchell

FSA MAAA
Director

Guidehouse Consulting

5170 Peachtree Rd Building 200
Suite 100
Atlanta
Georgia 30341
United States

Email erica.mitchell@guidehouse.com

Designations

MAAA 2006
FSA 2010

SOA CPD attestation status

Compliant(2023-2024)
Compliant(2022-2023)

Academic degrees

B.A.

Industry

Healthcare: Health Insurance

Primary area of practice

Health

Specializations

Employee Health Benefits
Health Insurance - Commercial
Health Insurance – Public Systems
Underwriting

Society of Actuaries Sections

Health

Ryan Butterfield | Managing Consultant | Staff Actuary

The Actuarial Directory

Ryan Butterfield

ASA MAAA

Designations

ASA 2024
MAAA 2024

SOA CPD attestation status

Compliant(2023-2024)
Compliant(2022-2023)

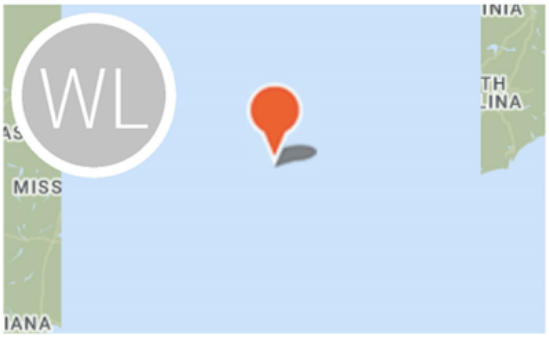
Will Lu | Associate Director | Staff Actuary

The Actuarial Directory

Wei Lu

FSA MAAA
Associate Director

5710 Peachtree Rd Building 200, Suite 100
Chamblee
Georgia 30341
United States



Designations

MAAA 2007
FSA 2011

SOA CPD attestation status

Compliant(2023-2024)
Compliant(2022-2023)

Primary area of practice

Health

Society of Actuaries Sections

Health

Ben Maryland | Managing Consultant | Staff Actuary

The Actuarial Directory

Benjamin Maryland

ASA MAAA

Tel **+1(770)865-5252**

Designations

ASA 2022
MAAA 2023

SOA CPD attestation status

Compliant(2022-2023)
Non-compliant(2023-2024)

Academic degrees

B.S.

Industry

Healthcare: Health Insurance

Primary area of practice

Health

Specializations

Health Insurance - Commercial

Society of Actuaries Sections

Health
Social Insurance & Public Finance

Alysia Overdorf | Associate Director | Staff Actuary

The Actuarial Directory

Alysia Marie Overdorf

FSA MAAA

Designations

MAAA 2022
FSA 2023

SOA CPD attestation status

Compliant(2022-2023)
Compliant(2023-2024)

Debra Ruocco | Associate Director | Staff Actuary

The Actuarial Directory

Debra Marie Ruocco

FSA MAAA

Email druocco@guidehouse.com
Tel +1(207)671-3886

Designations

FSA 1999
MAAA 2000

SOA CPD attestation status

Compliant(2023-2024)
Compliant(2022-2023)

Industry

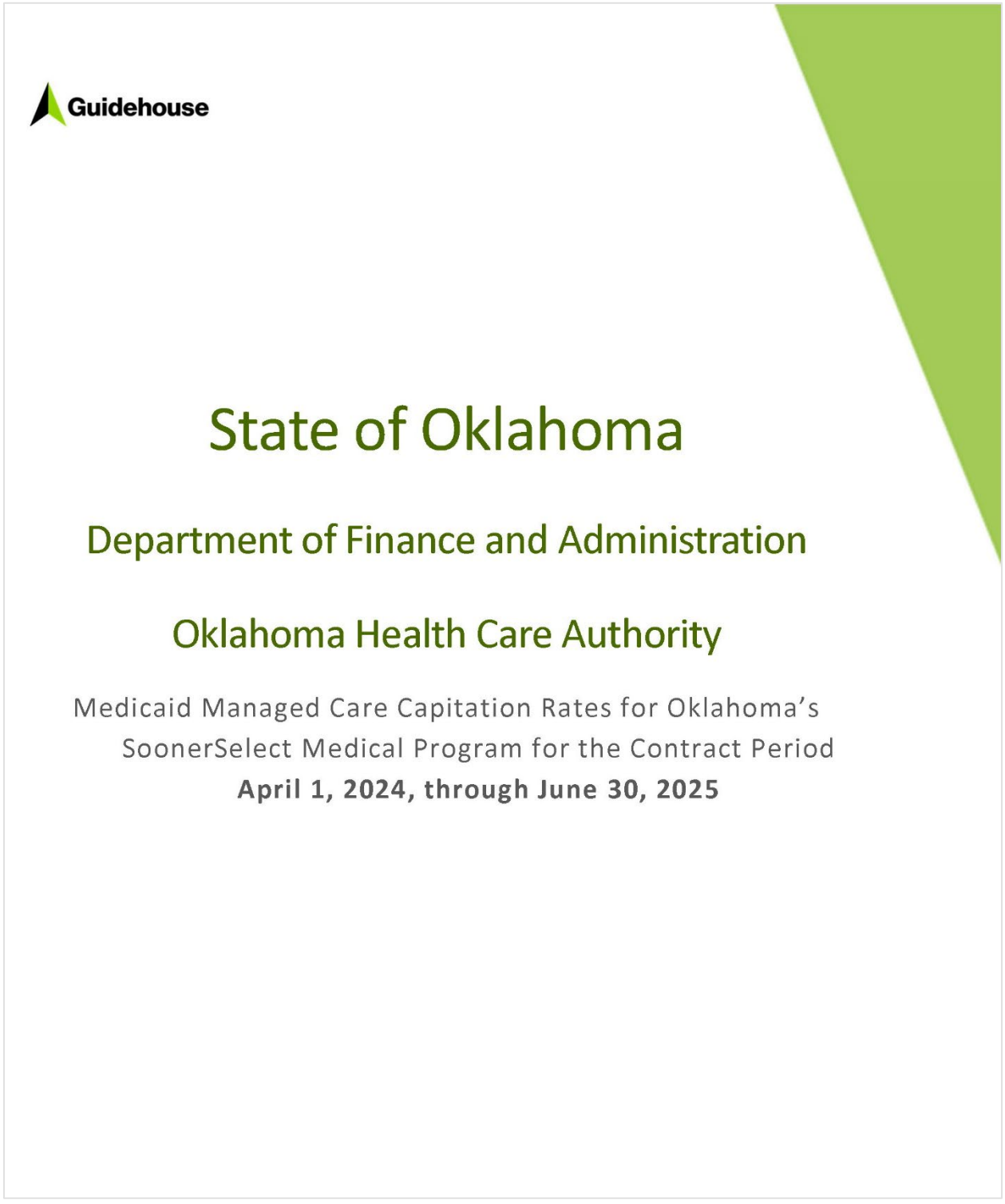
Healthcare: Health Insurance

Primary area of practice

Health

Appendix D CMS Reporting Requirement Samples

Exhibit 1 – Oklahoma Health Care Authority Medicaid Managed Care Capitation Rates for SoonerSelect Medical Program (April 1, 2024 – June 30, 2025)



Guidehouse

November 1, 2023

Mr. Aaron Morris
Oklahoma Health Care Authority
Chief Financial Officer
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Subject: Actuarially Sound Medicaid Managed Care Capitation Rates for Oklahoma Managed Care Entities for the period April 1, 2024, through June 30, 2025 (SoonerSelect Medical Benefits)

Dear Mr. Morris:

We have calculated the actuarially sound capitation rates for the State's SoonerSelect Medical benefits for the Managed Medicaid Program for the contract period April 1, 2024, through June 30, 2025.

The total capitation rates are broken into two distinct pieces in this report:

1. The development of the 'core' capitation rates before the addition of directed payments.
2. The directed payment amounts incorporated into the capitation rates.

The following report describes the data, assumptions, and methodologies used to develop these rates.

Please let us know if you have any questions or concerns regarding the capitation rates or documentation.

Sincerely,

Khisamiddin Bobomurodov, FSA, MAAA
November 1, 2023

Melanie Bell, ASA, MAAA
November 1, 2023

Guidehouse

Actuarial Certification

We, Khisamiddin Bobomurodov and Melanie Bell, are employed with the firm Guidehouse. We are members of the American Academy of Actuaries and the Society of Actuaries. We meet the requirements for an actuary as set forth in 42 CFR § 438.2 and the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board. We have been contracted on behalf of Oklahoma Health Care Authority and are generally familiar with the program, eligibility rules, and benefit provisions.

The capitation rates provided within this certification are considered actuarially sound for purposes of 42 CFR 438.4, according to the following criteria:

- The capitation rates have been developed in accordance with generally accepted actuarial principles and practices.
- The capitation rates are appropriate for the populations to be covered, and services to be furnished under the contract.
- The capitation rates meet the requirements of 42 CFR §§42 CFR.438.3(c), 438.3(e), 438.4, 438.5, 438.6 and 438.7.

For the purposes of this certification "actuarial soundness" is defined as follows:

Medicaid benefit plan 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 premiums – including expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income – provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government-mandated assessments, fees, and taxes, and the cost of capital.

The assumptions used in the development of the actuarially sound capitation rates have been documented in our correspondences with the Oklahoma Health Care Authority. This certification documents the assumptions used to create the actuarially sound capitation rates for the contract period April 1, 2024 through June 30, 2025. The assumptions used to develop the projected benefit and non-benefit costs for covered populations were based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.

The actuarially sound capitation rates are based on a projection of future events. It may be expected that actual experience will vary from the experience assumed in the rates. In developing the actuarially sound capitation rates, we have relied upon data and information provided by the Oklahoma Health Care Authority. Detailed data has been validated to financial records provided by the Oklahoma Health Care Authority. We did not audit the data, but we reviewed the data for reasonableness and consistency in addition to financial record validation.

The CEs should evaluate the capitation rates in the context of their own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with Oklahoma Health Care Authority. Individual CEs may require capitation rates above, equal to, or below the actuarially sound capitation rates associated with this certification.

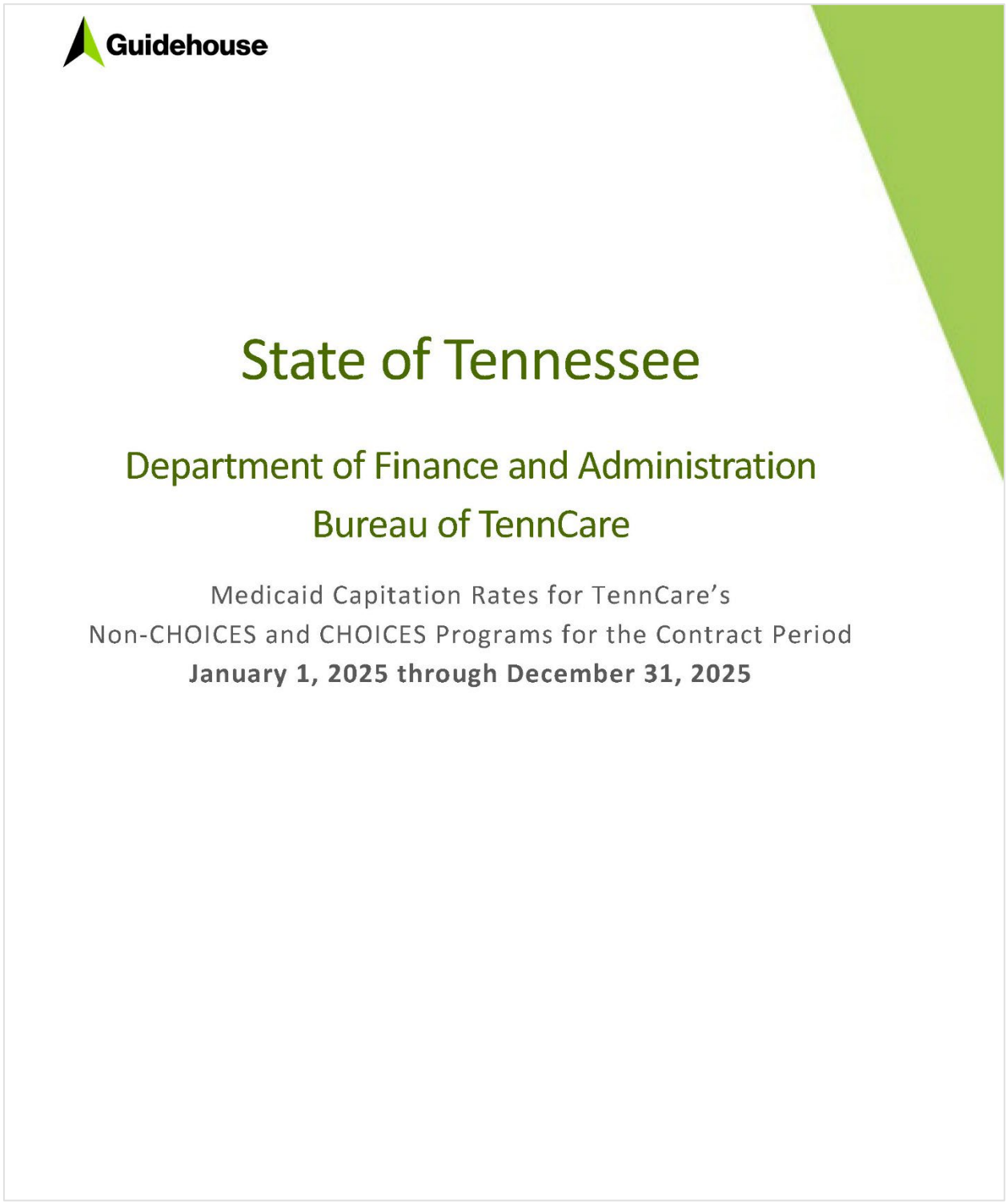
Guidehouse

Sincerely,

Khisamiddin Bobomurodov, FSA, MAAA
November 1, 2023

Melanie Bell, ASA, MAAA
November 1, 2023

Exhibit 2 – State of Tennessee, Medicaid Capitation Rates for TennCare (January 1, 2025 – December 31, 2025)



Guidehouse

September 30, 2024

Mr. Zane Seals
TennCare Chief Financial Officer
Finance & Administration
310 Great Circle Road
Nashville, TN 37243

Subject: Actuarially Sound Medicaid Managed Care Capitation Rates for Tennessee Managed Care Organizations for the period January 1, 2025, through December 31, 2025 (Non-CHOICES and CHOICES programs)

Dear Mr. Seals:

We have calculated and are certifying the actuarially sound rates for the Managed Care Organizations (MCOs) participating in the State's Managed Medicaid Program for Non-CHOICES and CHOICES members for the contract period January 1, 2025, through December 31, 2025.

For the purposes of this report, TennCare's State-directed payments have been categorized as follows:

1. **'Built-in' directed payment** arrangements that refer to fee schedule or rate increases in the base data. These increases are included in the traditional rate development process as part of the 'core' capitation rates, which we define as capitation rates prior to the 'add-on' directed payments.
2. **'Add-on' directed payment** arrangements refer to budgeted increases that are applied after the development of the 'core' capitation rates to produce the final capitation rates paid to the MCOs.
3. **'Separate payment term' directed payment** arrangements refer to increases paid outside of the capitation rates, as defined and approved by CMS.

Appropriate documentation for all directed payments applicable and approved during the CY25 rating period are contained herein. For transparency, this report shows the regional impacts by rate cell of adding the MCO-specific directed payment amounts but avoids showing the MCO-specific capitation rates themselves. For comparison against capitation rates from prior rate setting periods, we include comparisons not only to the final rates with the directed payment application, but comparisons between the 'core' capitation rates, or the baseline rates calculated using aggregate MCO data upon which the directed payment amounts are added.

The following report describes the methods used for calculating these rates. Please let us know if you have any questions regarding these capitation rates or the methods that were used in the calculation.

Sincerely,

Sterling Felsted, F.S.A, M.A.A.A.
September 30, 2024

Alysia Overdorf, F.S.A, M.A.A.A.
September 30, 2024

Guidehouse

Actuarial Certification

We, Sterling Felsted and Alysia Overdorf, are employed with the firm Guidehouse Consulting. We are members of the American Academy of Actuaries and the Society of Actuaries. We meet the requirements for an actuary as set forth in 42 C.F.R. § 438.2 and the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board. We have been contracted on behalf of the Bureau of TennCare and are generally familiar with the program, eligibility rules, and benefit provisions.

The capitation rates provided with this certification are considered actuarially sound for purposes of 42 C.F.R. 438.4, according to the following criteria:

- The capitation rates have been developed in accordance with generally accepted actuarial principles and practices
- The capitation rates are appropriate for the populations to be covered, and services to be furnished under the contract
- The capitation rates meet the requirements of 42 C.F.R. §§ 438.3(c), 438.3(e), 438.4, 438.5, 438.6 and 438.7

For the purposes of this certification "actuarial soundness" is defined as follows:

> "Medicaid benefit plan 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 premiums – including expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income – provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government-mandated assessments, fees, and taxes, and the cost of capital."

The assumptions used in the development of the actuarially sound capitation rates have been documented in our correspondences with the Bureau of TennCare. This certification documents the assumptions used to create the actuarially sound capitation rates for the contract period January 1, 2025, through December 31, 2025. The assumptions used to develop the projected benefit and non-benefit costs for covered populations were based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.

The actuarially sound capitation rates are based on a projection of future events. It may be expected that actual experience will vary from the experience assumed in the rates.

In developing the actuarially sound capitation rates, we have relied upon data and information provided by the MCOs and the Bureau of TennCare. Detailed data has been validated to financial records provided by the Bureau of TennCare. We did not audit the data, but we reviewed the data for reasonableness and consistency in addition to financial record validation.

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The MCOs should evaluate the capitation rates in the context of their own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the Bureau of TennCare. Individual MCOs may require capitation rates above, equal to, or below the actuarially sound capitation rates associated with this certification.

Sterling Felsted, F.S.A., M.A.A.A.
Member, American Academy of Actuaries
Fellow, Society of Actuaries
September 30, 2024

Alysia Overdorf, F.S.A., M.A.A.A.
Member, American Academy of Actuaries
Fellow, Society of Actuaries
September 30, 2024

Appendix E Reservation of Rights

Submission of this proposal by **GUIDEHOUSE INC.**, a Delaware corporation, or any of its affiliates (the "**Vendor**"), is not an indication of Vendor's willingness to be bound by all of the terms presented in the **WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES, BUREAU FOR MEDICAL SERVICES** (the "**Agency**") Request for Proposals, pertaining to Medicaid Actuarial Services and Manages care Program Administration (the "**RFQ**"). This proposal in response to the Agency's RFQ does not constitute a contract to perform services and cannot be used to award a unilateral agreement. Final acceptance of this engagement by the Vendor is contingent upon successful completion of Vendor's acceptance procedures. Any engagement arising out of this proposal will be subject to negotiation of a mutually satisfactory vendor contract including (i) modifications to certain RFQ terms and conditions and (ii) our standard terms and conditions and fees and billing rates established therein.

Given our past history of successfully negotiating mutually agreeable terms with similar State entities, we do not anticipate any difficulty in reaching a contractual agreement (the "**Agreement**") that will enable us to provide the professional services which you are requesting, while protecting the interests of both parties.

Vendor kindly requests that the Agency consider the following revisions to the General Terms and Conditions:

1. **Section 8 – Insurance**

   Vendor must maintain:

   - Commercial General Liability Insurance in at least an amount of: $1,000,000.00 per occurrence, $2,000,000.00 in the aggregate.
   - Automobile Liability Insurance in at least an amount of: $1,000,000.00 per occurrence.
   - Professional/Malpractice/Errors and Omission Insurance in at least an amount of: $1,000,000.00 per occurrence,$3,000,000.00 in the aggregate. Notwithstanding the forgoing, Vendor's are not required to list the State as an additional insured for this type of policy.
   - Commercial Crime and Third Party Fidelity Insurance in an amount of: $1,000,000.00

     per occurrence.
   - Cyber Liability Insurance in an amount of: $1,000,000.00 per occurrence.

2. **Section 13 – Pricing**

   13. PRICING: The pricing set forth herein is firm for the life of the Contract, unless specified elsewhere within this Solicitation/Contract by the State. A Vendor's inclusion of price adjustment provisions in its bid, without an express authorization from the State in the Solicitation to do so, may result in bid disqualification.

3. **Section 20 – Time**

   20. TIME: The parties shall strictly comply with all time limits established under this Contract.

4. **Section 36 – Indemnification**

36. INDEMNIFICATION: The Vendor agrees to indemnify and defend the State and the Agency, their officers, and employees from and against any third party claims or losses resulting solely and directly from services rendered by Vendor in the performance of this Contract. Such indemnification

shall be conditioned upon the State promptly notifying the Vendor, in writing, of any such claim, permitting the Vendor the authority to settle or defend the claim (including selection of defense counsel) and reasonably cooperating with the Vendor in the defense and settlement thereof. Notwithstanding the foregoing, the Vendor shall not enter into any stipulated judgment or settlement that purports to bind the State without the State's express written authorization, which shall not be unreasonably withheld or delayed.**Vendor kindly requests that the Agency consider the following additions to the General Terms and Conditions:**

1. **Limitation on Liability:** Notwithstanding the terms of any other provision, the total liability of Vendor and its affiliates, directors, officers, employees, subcontractors, agents and representatives for all claims of any kind arising out of the Agreement, whether in contract, tort or otherwise, shall be limited to the total fees paid to Vendor under the applicable statement of work in the preceding twelve (12) months. Neither Vendor nor Agency shall in any event be liable for any indirect, consequential or punitive damages, even if Agency or Vendor have been advised of the possibility of such damages.

2. **Consulting Services Disclaimer:** Vendor will not audit any financial statements or perform any attest procedures in the course of performing the services under the Agreement. Vendor's services are not designed, nor should they be relied upon, to disclose internal weaknesses in internal controls, financial statement errors, irregularities, illegal acts or disclosure deficiencies. Vendor is not a professional accounting firm and does not practice accounting. Vendor's services will not include legal, engineering or architectural advice or services.

3. **Standard of Care and Performance:** Vendor agrees that the services provided for under the Agreement will be performed in a professional manner in accordance with recognized professional consulting standards for similar services and that qualified personnel will be assigned for that purpose. In providing the services, Vendor and its personnel shall exercise reasonable care. Vendor cannot guarantee or assure the achievement of any particular performance objective, nor can Vendor guarantee or assure any particular outcome for the Agency or any other person as a result of the Agreement or the performance of the services contemplated thereunder.

   If, during the performance of the services, or within one (1) year following completion of the Agreement, such services will prove to be faulty or defective by reason of a failure to meet such standards, Vendor agrees that upon prompt written notification from the Agency prior to the expiration of the one-year period following the completion of the Agreement of any such fault or defect, such faulty portion of the services will be redone at no cost to the Agency up to a maximum amount equivalent to the cost of the services rendered under the Agreement. The foregoing will constitute Vendor's sole warranty with respect to the accuracy or completeness of the services and the activities involved in its preparation, and is made in lieu of all other warranties and representations, express or implied, including any implied warranties of merchantability or fitness for a particular purpose.

4. **Intellectual Property:** Upon full payment of all amounts due Vendor in connection with the Agreement, all rights, title and interest in any information and items, including summaries, documents, reports and portions thereof Vendor provides to the Agency (collectively, the "**Vendor Deliverables**") will become the Agency's sole and exclusive property for its internal business purposes and uses pursuant to the scope set forth in the applicable statement of work, subject to the exceptions set forth hereafter. Vendor shall retain sole and exclusive ownership of all rights, title and interest in its work papers, proprietary information, processes, methodologies, know-how and software, including such information as existed

prior to the delivery of the services and, to the extent such information is of general application, anything that it may discover, create or develop during provision of the services (collectively, the "**Vendor Property**"). To the extent the Vendor Deliverables contain any Vendor Property; the Agency shall be granted a non-exclusive, non-assignable, royalty-free license to use such Vendor Property solely in connection with the subject of the Agreement.

5. **Acceptance**: Receipt of a deliverable occurs when the deliverable is provided to the Agency. Receipt of services is deemed to occur when the Agency receives an invoice from Vendor for those services. Absent written notification of non-acceptance from the Agency within five (5) business days of receipt, deliverables and services will be construed as accepted. Any such notice shall specify in reasonable detail the reasons such deliverable or service has been deemed unacceptable. If the notice of non-acceptance is not sufficiently detailed to allow Vendor to determine why such deliverable or service is unacceptable, Vendor may request in writing that the Agency provide additional information. The passage of ten (10) business days from the date of such request without the provision of such additional information shall constitute final acceptance of such deliverable or service by the Agency. Within fifteen (15) days of receipt of the Agency notice, Vendor shall, at its option, either correct the problems in such deliverable or service or present the Agency with a plan to fix such problems within a reasonable period of time under the circumstances. The deliverable or service shall be deemed accepted by the Agency after comments have been incorporated and the deliverable or service re-submitted. Acceptance by the Agency shall not be unreasonably withheld or delayed.

Vendor kindly requests that the Agency consider the following revisions to the HIPAA Business Associate Addendum:

1. **Section 3(l) – Notification of Breach**

   Notification of Breach. During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology within fifteen (15) business days by email or web form upon the discovery of any Breach of unsecured PHI; or of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and, unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or https://apps.wv.gov/ot/ir/Default.aspx.

   The Associate shall promptly upon discovery investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within fifteen (15) business days of the discovery, the Associate shall notify the Agency Procurement Officer, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) Date of discovery; (b) What data elements were involved and the extent of the data involved in the Breach; (c) A description of the unauthorized persons known or reasonably believed to have improperly .used or disclosed PHI or confidential data; (d) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (e) A description of the probable causes of the improper use or disclosure; and (f) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

Vendor kindly requests that the Agency consider the following addition to the HIPAA Business Associate Addendum:

1. **Unsuccessful Attempts**. Both the Agency and Associate agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur would swamp any potential benefit gained from reporting them. Consequently, both Agency and Associate agree that this Agreement shall constitute the documentation, notice and written report of such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the parties consider the following to be illustrative (but not exhaustive) of Unsuccessful Security Incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of EPHI or interference with an information system:
    a. Pings on a party's firewall;
    b. Port scans;
    c. Lost or stolen encrypted hardware, such as laptops;
    d. Attempts to log on to a system or enter a database with an invalid password or username;
    e. Denial-of-service attacks that do not result in a server being taken off-line; and
    f. Malware (e.g., worms, viruses).

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