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# **Medicaid Managed Care Rate Setting and Program Administration**

*CRFP No. 0511 BMS2700000001*

**Technical Proposal**

September 9, 2026





## I. TRANSMITTAL LETTER

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September 9, 2026

Crystal Hustead, Senior Buyer  
West Virginia Department of Administration, Purchasing Division  
2019 Washington St., East  
Charleston, WV 25305

Dear Members of the Evaluation Committee:

Myers & Stauffer is pleased to provide our Technical Bid in response to Request for Proposal (RFP) No. 0511 BMS2700000001 *Medicaid Managed Care Rate Setting and Program Administration* for the West Virginia Department of Human Services, Bureau for Medical Services (BMS or the Bureau). We acknowledge receipt of all RFP documents and addenda.

As the incumbent performing this work for more than four years, we have had the pleasure of supporting BMS with its advancement of the West Virginia Medicaid managed care program, and we look forward to the opportunity to continue this success. We are confident that our demonstrated performance delivering successful outcomes for BMS's complex initiatives, combined with our industry-leading expertise and deep understanding of your organization's priorities, positions us to continue as a trusted partner in achieving the Bureau's goals. Our team is committed to delivering practical, high-quality solutions that reflect your unique operational environment, regulatory requirements, and strategic objectives. We appreciate the opportunity to partner with BMS and look forward to putting our experience, collaborative approach, and unwavering commitment to excellence to work on your behalf.

If you require additional information or would like a presentation of our capabilities, please contact me at JDubberly@mslc.com or 404-524-9519. We look forward to working with the Bureau to support the future success of the West Virginia Medicaid program.

Sincerely,

A handwritten signature in blue ink, reading "Jerry Dubberly".

Jerry Dubberly, PharmD, MBA  
Principal

1349 W Peachtree Street, NE, Suite 1600  
Atlanta, Georgia 30309  
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866-758-3586  
[myersandstauffer.com](http://myersandstauffer.com)

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**II. TITLE PAGE (RFP SECTION 5.3.2)****II. TITLE PAGE (RFP Section 5.3.2)**

| <b>No. 0511 BMS2700000001<br/>Medicaid Managed Care Rate Setting and Program Administration</b> |                                                                                                         |
|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <b>RFP Subject</b>                                                                              | Medicaid Managed Care Rate Setting and Program Administration                                           |
| <b>RFP Number</b>                                                                               | 0511 BMS2700000001                                                                                      |
| <b>Vendor Name/<br/>Business Address</b>                                                        | Myers and Stauffer LC<br>1349 W. Peachtree St. NE, Ste. 1600<br>Atlanta, GA 30309                       |
| <b>Contact Person Name</b><br><b>Telephone</b><br><b>Fax</b><br><b>Email</b>                    | Jerry Dubberly, PharmD, MBA - Principal (Partner)<br>404-524-9519<br>404-524-0782<br>jdubberly@mslc.com |
| <b>Vendor Signature</b>                                                                         |                        |
| <b>Date</b>                                                                                     | September 9, 2026                                                                                       |

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Myers & Stauffer is a national certified public accounting (CPA) firm, specializing in accounting, auditing, consulting, program integrity, and operational support services to public healthcare and social service agencies. We are a limited liability company organized in the state of Kansas. Myers & Stauffer is wholly owned and managed by its partners and does not have parent or subsidiary companies.

We have elected to operate our CPA firm under an alternative practice structure, as defined by the American Institute of Certified Public Accountants (AICPA). Under this structure our staffing resources are obtained through a contract with the publicly traded company CBIZ, Inc. All staff we obtain through this relationship work exclusively for Myers & Stauffer. Specifically, in 1998, we entered into a transaction with CBIZ, which resulted in the creation of CBIZ M&S Consulting Services, LLC. CBIZ M&S Consulting Services, LLC is wholly owned by CBIZ. As part of this business model, Myers & Stauffer acquires office space, personnel, and other business resources from CBIZ M&S Consulting Services, LLC. These resources, including personnel and consultants, are assigned exclusively to serve the clients of Myers & Stauffer. AICPA professional standards provide specific guidance regarding independence within alternative practice structure firms. These professional standards are published in the Independence, Integrity, and Objectivity section of the AICPA Code of Professional Conduct at ET Section. 1.220.020. We fully comply with this and all other professional standards.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****IV. RESPONSE REFERENCE** (RFP Section 5.3.4/Section 4: Project Specifications)**Project Goals and Mandatory Requirements** (RFP Section 4.2)

Myers & Stauffer understands the West Virginia Department of Human Services, Bureau for Medical Services (BMS or the Bureau) is seeking actuarial services, program oversight, financial services, and rate setting services for the State's Medicaid managed care programs, including Mountain Health Trust (MHT), which includes West Virginia Children's Health Insurance Program (WVCHIP), Mountain Health Promise (MHP), and other programs upon request. As the incumbent vendor and longstanding partner to the state of West Virginia, we are the most qualified vendor and eager to continue supporting BMS and the impactful work we have been doing together for the last four years.


**Myers & Stauffer** At A Glance


National certified public accounting (CPA) firm specializing in public health and human services for nearly **50 years.**



More than **1,000 professional staff** who work full time with our government clients.



**More than 20 years** supporting the state of **West Virginia.**



Hands-on experience protecting the financial interests of government agencies in **all 50 states.**



Dedicated to serving only government agencies, Myers & Stauffer has **no conflicts of interest (COIs).**

Combining our client-first approach with deep subject matter insight into healthcare programs across the country, practical solutions, and a commitment to service, we help our clients strengthen programs, improve performance, and maximize the impact of public resources. Together, we advance missions that improve lives, strengthen communities, and create lasting public value. Myers & Stauffer's Medicaid, CHIP, and other human services agency clients, including agencies in West Virginia, have spanned all 50 states, Washington D.C., the U.S. territories, and the federal government. With more than 20 years of experience providing managed care program administration and consulting services for 29 state Medicaid agencies and for the Centers for Medicare & Medicaid Services (CMS), we far exceed the minimum experience required in the Request for Proposal (RFP). These services include managed care consulting, policy development, program design, procurement and contract development, readiness reviews, implementation, oversight and monitoring, financial services, rate setting, and



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

ongoing consulting services by our team of subject matter experts (SMEs). In fact, we have provided all of these services to BMS over the course of our current contract.

Our proposed solution includes Milliman, Inc. (Milliman) as our subcontractor for the provision of actuarial services. Milliman is nationally recognized for its actuarial and evaluation capabilities. They consult with state Medicaid agencies and have more than 30 years of experience and more than 150 fully credentialed actuaries focused on Medicaid. Milliman is the current certifying actuary for Medicaid agencies in 18 states and one U.S. territory, representing nearly four times the experience specified in the RFP. Each of these relationships include being the primary actuary certifying actuarially sound managed care capitation rates. Milliman has served many of its current Medicaid agency clients for more than 20 years and has been setting managed care rates for more than 30 years. This level of consistency speaks volumes to the quality and value they continue to bring to their state Medicaid agency partners.

For more than four years, BMS has come to know Myers & Stauffer and Milliman (collectively referred to as “the Myers & Stauffer Team” or “the Team”) as a trusted partner based on our:

- Experience.
- Knowledge and expertise.
- Quality service delivery.
- Responsiveness.
- Engagement and ability to solve complex problems.

The Myers & Stauffer Team offers an exceptionally qualified and experienced consulting team that combines West Virginia-specific experience with nearly 70 combined years of organizational experience supporting federal, state, and local health and public health agencies. We take our responsibilities seriously when it comes to serving the needs of the Bureau and its programs, and as the incumbent, we have provided value and consistently delivered high-quality services. Our West Virginia-specific



## Targeted Experience

Our collaborative, cross-functional teams deliver targeted, expertise-driven solutions that transform challenges into opportunities for greater impact. We partner with federal, state, and local agencies to strengthen programs, navigate complex regulatory requirements, and address evolving community needs.

The services in this contract represent core services for the Myers & Stauffer Team. In addition to our long tenure with BMS, our Team is proud to support Medicaid agencies across the nation with the following services:

### ***Managed Care Capitation Rates:***

- More than 30 years of experience.
- Greater than 20 years of Medicaid experience.
- Current certifying actuary for Medicaid agencies in 18 states and one U.S. territory.

### ***Managed Care Contract and Policy Development and Oversight:***

- More than 20 years of experience.
- Contractor for managed care program administration and consulting services for 29 state Medicaid agencies and CMS.

## Exceeding Minimum Requirements

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

experience and demonstrated performance as the incumbent vendor, coupled with our extensive national expertise in Medicaid and CHIP uniquely positions us as the ideal partner to continue to serve BMS.

We have read, understand, and will comply with all RFP requirements, including Section 1: General Information and Instructions, Section 2: Instructions to Vendors Submitting Bids, Section 3: General Terms and Conditions, Section 4: Project Specifications, Section 5: Vendor Proposal, Section 6: Evaluation and Award, and Certification and Signature Page.

## **Approach and Methodology to Goals/Objectives (4.2.1)**

### **Managed Care Program Administration (4.2.1.1)**

Effective oversight and management of BMS's managed care programs are critical to ensure the delivery of high-quality, accessible, efficient, and cost-effective care for the populations it serves. In the following, we describe our approach to provide the managed care program administration, oversight, and other strategic consulting services requested by BMS.

Throughout *Approach and Methodology to Goals/Objectives (4.2.1)*, we include *Demonstrated Experience* highlights to showcase specific, relevant client examples and to illustrate the "real world" success of our methodologies.

We have read, understand, and will comply with all RFP requirements.

### **Operations Plan (4.2.1.1.1)**

The vendor should describe their plan to 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. The vendor should describe their plan to submit within thirty (30) calendar days of award a vendor work plan with a timeline, to be approved by the Agency reflecting all specifications listed in the Managed Care Oversight section of the RFP, 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).

## **Approach and Methodology**

### **Operations Plan and Project Work Plan Development**

Within 30 calendar days of contract award, Myers & Stauffer will develop and submit a comprehensive Operations Plan as well as a Project Work Plan for BMS's review and approval. The Operations Plan will describe how we will conduct our work while the Project Work Plan will include detailed tasks, milestones, deliverables, timelines, and resources to accomplish the work.

As the incumbent, we bring more than four years of experience supporting BMS. Unlike our competitors, we understand your expectations for quality, responsiveness, communication, and project execution, allowing us to seamlessly continue services with minimal transition risk. Rather than investing time in establishing working relationships and learning agency processes, we can immediately focus on delivering results. The Operations Plan serves as the governing document for our service delivery and day-to-day operations. At a minimum, the Operations Plan addresses:

- Project governance and organizational structure, including roles, responsibilities, and lines of authority.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

- Staffing plan, including key personnel, reporting relationships, and procedures for maintaining adequate staffing levels.
- Compliance management processes to ensure adherence to all applicable federal requirements and CMS submissions, program policies, confidentiality standards, security requirements, and contractual obligations.
- Quality management and quality assurance procedures, including internal reviews, corrective action processes, and continuous improvement activities.
- Communication protocols, including routine status meetings, executive briefings, issue escalation procedures, and reporting requirements.
- Risk management methodology to identify, assess, mitigate, and monitor project risks.
- Document management and version control procedures.
- Performance monitoring processes, including methods for tracking project progress, timelines, deliverables, and contract performance metrics.

Myers & Stauffer will collaborate with BMS throughout the development of the Operations Plan to ensure it aligns with BMS's priorities, operational expectations, and desired content. We will customize the content, as requested by BMS. Following BMS's review and approval, we will incorporate all approved revisions and submit a final Operations Plan for formal BMS acceptance.

**Project Work Plan Development**

As part of the Operations Plan, Myers & Stauffer will develop a detailed Project Work Plan that provides a comprehensive roadmap for successful project execution. The Project Work Plan translates contractual requirements into a structured sequence of project activities and establishes the schedule, timeline, responsibilities, and dependencies necessary to successfully complete all work.

We will develop the Project Work Plan using industry-standard project management practices customized to meet BMS's preferences and will submit a draft to BMS for review and approval. We will work collaboratively with BMS leadership to validate project assumptions, confirm priorities, identify critical dependencies, and establish realistic timelines before finalizing the Project Work Plan.

At a minimum, the Project Work Plan will include:

- **Project Activities.** A detailed description of all major project phases, tasks and work activities, and timelines required to complete the scope of work, including all operational and project management activities. The Project Work Plan will include all activities required in the RFP, including but not limited to options for performance targets, incentives and penalties, modifications to program requirements, and implementation and oversight of a managed care medical loss ratio (MLR).
- **Dependencies.** Identification of internal and external dependencies affecting project execution, including required BMS and CMS reviews and approvals, policy decisions, data availability,

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

stakeholder participation, meetings, system access, deliverable acceptance, and other events that must occur before subsequent activities may begin.

- **Milestones.** Key project events that measure project progress, including phase completions, major implementation activities, deliverable submission dates, review periods, approval milestones, implementation dates, and contract and federal reporting deadlines. Milestones will include all key dates for CMS submissions among other milestones.
- **Deliverables.** A complete inventory of all required contract deliverables, including reports, analyses, operational documents, meeting materials, implementation products, and other work products to be submitted to BMS. Each deliverable will identify the responsible party, activities and related timelines for completion, planned submission date, applicable review period, and required approval or acceptance process.
- **Decision Points.** Identification of project activities requiring BMS's review, approval, acceptance, policy direction, or other decisions before dependent work may proceed. Decision points will be clearly incorporated into the project timeline to facilitate timely project execution and minimize delays.



## Focused on Public Healthcare

Providing timely and effective solutions to the complex issues facing government-sponsored healthcare programs is not a business unit or a division of Myers & Stauffer — it is all we do.

As such, West Virginia will have access to our full resources to ensure the successful completion of the engagement.

**Purpose Driven. Government Programs. Exclusive Focus.**

The Project Work Plan will identify personnel responsible for each activity, anticipated durations, sequencing of work, and estimated completion dates to provide complete visibility into project progress and accountability.

### Project Work Plan Monitoring and Maintenance

The Myers & Stauffer Team recognizes that successful project management requires continuous monitoring and proactive adjustment throughout the contract period. Accordingly, the Project Work Plan will function as a living management document that is routinely reviewed and updated to reflect approved project changes. With the extensive number of separate projects and potentially with separate business owners, we are open to maintaining one comprehensive work plan or developing separate, project-specific work plans, as needed.

We will review project status on an ongoing basis through regular project management meetings, milestone assessments, and progress reporting. Proposed revisions and additions to the Project Work Plan may result from approved ad hoc scope of work additions, BMS-directed changes, new CMS



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requirements and timelines, changes in BMS priorities, identified risks, revised implementation schedules, or other project circumstances.

Any proposed revisions to the Operations Plan or Project Work Plan will be documented through established change management procedures and submitted to BMS for review and approval prior to implementation. Following approval, we will update the Operations Plan or Work Plan and distribute the updated versions to BMS using established document control procedures to ensure all parties are working from the current approved version.

Throughout the contract, our Team will use the Work Plan as the primary project management tool to monitor progress, identify schedule variances, manage risks, support decision-making, and communicate project status. This disciplined approach will provide transparency, facilitate timely issue resolution, and help ensure all contractual obligations are completed on schedule, within scope, and in full compliance with program and federal requirements.

### MCO Contracts (4.2.1.1.2)

The vendor should describe their approach and methodology to develop and maintain the MCO contracts associated with both MHT and MHP in compliance with CMS. The vendor should describe their plan to seek contract updates from the MCOs and the Agency 120 calendar days prior to contract implementation date.

### Approach and Methodology

Myers & Stauffer will support the activities required to facilitate the development and maintenance of the MHT and MHP contracts in support of the State's goals, new federal or state legislative and regulatory requirements, programmatic transitions and opportunities for improvement, new initiatives, and assurance of compliance with federal regulations.

Since the start of our current engagement with BMS, we have managed and streamlined the managed care organization (MCO) contract maintenance and amendment process. This includes having established a tightly managed tracking process to formalize the intake of these requests from State staff and the MCOs and developing a consistent process for the review and determining whether updates to the contracts should be made. As shown in *Figure 1*, Myers & Stauffer will continue to administer the following activities in the development and maintenance of the MCO contracts.

Figure 1. MCO Contract Maintenance



- **Planning.** We will develop a work plan for each contract amendment cycle that includes collection of stakeholder input, drafting associated contract amendments, review by BMS

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leadership and BMS legal representation, and finalizing materials for submission to CMS. Given our understanding of current BMS approval processes and timelines, we will manage the work plan to begin within six months before but no later than 120 calendar days prior to the contract implementation date and submission to CMS, ensuring ample time for review and approval. The work plan is a living document that will be adjusted, as requested by BMS, to address unforeseen circumstances, and we will identify risks and potential mitigation strategies when timeline changes occur. We will provide continual communication and feedback to BMS throughout the process.

- **Stakeholder Engagement.** With BMS approval, we will proactively solicit proposed amendments from stakeholders as applicable for each managed care program, including BMS SMEs, sister agencies, and the state's four MCOs in accordance with the timeline approved by BMS. We will draft transmittal emails to request amendments from stakeholders and provide a template for use in documenting requested amendments, impacted sections of the contract, and the stakeholder's rationale for the request. Upon review of these requests, we work with the stakeholder to gain additional context and clarity if the request or the rationale is unclear.

Myers & Stauffer will also proactively recommend necessary amendments based on our understanding of new state or federal regulations, as well as programmatic changes and new initiatives that BMS is implementing for the MHT and/or MHP programs.

- **Amend Contracts and BMS Review.** To support amending the contracts and BMS's review of proposed modifications, we will:
  - **Maintain an Inventory of Amendments and BMS Decisions.** For each contract and throughout the year, we will maintain an inventory of proposed contract amendments that BMS and Myers & Stauffer identify, as well as any proposed amendments received from stakeholders. We will use the inventory of all proposed amendments for review with BMS to determine which are approved for incorporation into the contract, and we will document decisions and rationale for approval or denial.
  - **Assess Proposed Amendments.** We will thoroughly review each proposed amendment to assess potential impacts, make recommendations to BMS for accepting or rejecting each proposed amendment, and provide our rationale for our recommendations. During this process, we draw broadly on the Myers & Stauffer Team's operations, reporting, and technical expertise, as well as our understanding of West Virginia's Medicaid program and BMS's goals and objectives to assess proposed amendments and assist the Bureau in making informed decisions.

We assess requests from an operational and fiscal perspective with the fiscal assessment being closely coordinated across Myers & Stauffer and Milliman to include actuarial input and identification of any impact to rate development. Where there is an impact, we will provide the estimated fiscal impact of the requested change.

Our intensive research of these requests extends to a review of how other states address similar MCO contractual issues. When appropriate, we will prepare a comparative analysis



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of identified peer states, and this analysis becomes part of our review and rationale for our final recommendations to BMS. We will document our research and analysis and make an informed recommendation to BMS that may include acceptance, rejection, or some modified version of the request.

- **Amend Contracts.** Once BMS's senior leadership has provided approval of which proposed amendments to address in the contracts, we will draft the amendments to be consistent with industry standards and compliant with state and federal regulations. These drafts are provided to BMS for review and feedback.
- **Facilitate Draft Amendment Review Process and Finalize Amendments.** Next, we will incorporate BMS-required changes to finalize draft amendments for leadership and legal review and for submission to the MCOs for review and feedback. We will provide the amendment inventory and draft contracts to all reviewers with required timelines for providing feedback. We offer to provide a walkthrough of contract amendments with BMS leadership and legal counsel to facilitate the review process. We also maintain an email inbox to receive and respond to BMS reviewer and MCO questions as they conduct reviews. We will assess all feedback received and provide recommendations to BMS for approval or rejection. We will incorporate decisions in the amendment inventory and finalize the contract amendments. Of note, while Myers & Stauffer will provide recommendations for contract language, these recommendations do not constitute legal advice and are not a replacement for BMS's legal review process.
- **CMS Review.** We will assist BMS with the MCO contract submission process, which involves CMS' new MC-Review state portal web-based system. Prior to the actual submission, we help BMS communicate expectations about the timeline for review and set expectations regarding when CMS will receive the updated contracts and requested timeline for review and approval. For the submission of both the MHT and MHP contracts to CMS, we will provide tracked changes and final versions of the contracts along with a program-specific cover memo inclusive of a high-level summary of changes. We will also coordinate contract submission with our Team's actuarial work for the rate certification and submission of the appropriate directed payment program (DPP) preprint(s), as needed. Through this process, we will also support BMS by responding to any inquiries from CMS regarding contract modifications or capitation rates.
- **Contact Execution.** We will support BMS with communication of the final version of the CMS-approved contracts and associated documents, including any required changes, to the MCOs. We will use these executed contracts as one of the guiding documents to align contract compliance tools, reporting templates, and checklists used in our oversight activities with the amended contracts.

Lastly, while BMS has historically pursued a cycle of midyear amendments, we understand BMS would prefer to move to an annual amendment process. We will continually work with BMS to assess opportunities to minimize the need for a midyear amendment, increase efficiency in the process, and

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reduce administrative burden. For example, we will assess proposed amendments received off cycle and recommend which can wait until the annual amendment period.



## West Virginia BMS

### **Demonstrated Experience: Managed Care Contracts**

Myers & Stauffer comes to this engagement with intimate knowledge and understanding of the MHT and MHP contracts. Unlike other consultants, BMS will not have to invest time explaining the evolution of contract language, why the existing language is important, and the reasons for the existing safeguards. We have drafted amendments to the managed care contracts on a semiannual basis since 2023. These amendments have proven vital in reflecting policy changes, updates to federal regulations, State requirements, improving the clarity of the contracts, and facilitating BMS's oversight of the MCOs. For example, we updated MCO contracts to account for programmatic changes, such as Senate Bill (SB) 820, which required day-one eligibility and connected individuals with substance use disorder (SUD) and serious mental illness (SMI) with care and services sooner. We also included SB 820 requirements to develop a quality withhold program in the contracts to improve the MCOs' accountability for improving quality and health outcomes.

## Other State Medicaid Experience

For Kentucky, Myers & Stauffer has supported a rigorous MCO contract amendment process since 2019. We have provided Medicaid managed care strategic planning, extensive stakeholder engagement, research, and a comparative analysis of managed care contracts in other states. Through our work, we:

- Made recommendations for the next generation of managed care in Kentucky, drafted the Medicaid MCO procurement documents and procurement evaluation tools, and supported the resulting contracts' implementation.
- Conducted a review of the Commonwealth's managed care quality and oversight team skill sets, training needs, and organizational structure.
- Assisted with strategic planning and development of the Supporting Kentucky Youth (SKY) Program for children and youth in out-of-home care, children receiving adoption assistance, youth who are dually involved, former foster care youth, and Medicaid-eligible youth in the juvenile justice system.
- Worked with DMS, the Department for Community Based Services (DCBS), the Department of Juvenile Justice, and the Department for Behavioral Health, Developmental and Intellectual Disabilities to develop and design the Kentucky SKY Program and resulting contract materials.
- Facilitated cross-agency collaboration for implementation of the SKY Program and supported DCBS planning to prepare for implementation and administration of the program.

Our efforts resulted in Kentucky MCO contracts that were aligned with updated federal requirements, had clearer requirements, increased MCO accountability, stronger performance guarantees, and established a framework for the future introduction of value-based payments.



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### What This Means for BMS

Our historical and current work for West Virginia demonstrates our deep understanding of your specific health care environment, including its challenges and opportunities. Through our collaborative work with BMS and other agencies, we have learned invaluable lessons that can be applied to this engagement. Additionally, our similar work in other states means the Myers & Stauffer Team is at the forefront of innovative solutions and best practices across the country. We will bring this knowledge and expertise to BMS and discuss their applicability and customization to the West Virginia program.

### Annual Network Adequacy Assessments (4.2.1.1.3)

The vendor should describe their approach and methodology to 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 should describe their plan to host a network adequacy kickoff meeting thirty (30) calendar days prior to implementation of the network adequacy assessment. The vendor must submit a preliminary timeline based on key milestones, designed to be adaptable to external factors, sixty (60) calendar days prior to implementation of the network adequacy assessment. The timeline should clearly describe the expected steps required to complete the assessment.

### Approach and Methodology

Myers & Stauffer customizes our provider network adequacy (PNA) assessments to meet the specific needs and characteristics of each state and of each managed care program. We continuously monitor evolving state and federal legislative updates and contractual changes to refine our PNA assessment approach where required or appropriate.

We will start the PNA assessment with a thorough understanding of the federal requirements for MCO access to care, including 42 Code of Federal Regulations (CFR) § 438.68 and related sections. We will also proactively have discussions with BMS regarding upcoming network adequacy requirements that will take effect during the contract renewal period as a result of 2024 Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F). These changes include appointment wait times, independent secret shopper surveys, enhanced provider director requirements, telehealth limitations, and other requirements. We will discuss strategies to ensure BMS is in compliance with these requirements.

Given the CFR requires states to establish network adequacy standards for specific provider types, maximum travel times, the availability of providers to ensure access, and access to culturally competent providers, we will review BMS's MHT and MHP MCO contracts to identify the state-established standards and ask any clarifying questions, where needed. We will use this information to develop a proposed preliminary timeline at least 60 calendar days prior to implementation of the annual PNA assessments for BMS review and approval. The timeline will be the same for both the MHT and MHP PNA assessments and include a list of major milestones along with delivery dates, and the plan will be designed to be adaptable to external factors. For example, if we experience delays in receiving geographic or demographic information about providers or members, we may use publicly available datasets where appropriate and utilize that data, along with reasonable assumptions, as part of our analyses. However, we believe the best solution is to control potential external factors where possible.

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This may include activities such as clearly establishing data expectations and timelines for submission, establishing clear communication protocols with the plans about missing or inaccurate data, comparing multiple data sources when those are accessible to validate data, and monitoring potential CMS changes that could impact the assessment.

We will meet with BMS to present our approach and walk through major milestones that we propose for performing the assessments. Any differences in our approach or intended focus, such as an enhanced focus on behavioral health services for MHP, will be presented as well. During this meeting, we will also discuss the proposed content and format of the PNA reports. We have found that understanding how our clients will actually use a report and discussing the content and format on the front end is helpful to both our clients and to our efficient preparation of the report. We incorporate feedback from BMS into the plan and the proposed PNA reports, and we will receive BMS's written approval of the approach prior to beginning work.

At least 30 calendar days prior to implementation of the annual PNA assessment, we will conduct a PNA assessment kickoff meeting with the MCOs during which we discuss both the MHT and MHP assessment. During this meeting, we explain the process, data needs, timeline, and expectations during the PNA review period. We take questions and receive feedback from the MCOs. If the MCOs make requests for modifications to the process or data request that improve the efficiency of the PNA assessment process and that do not compromise the quality, completeness, timeliness, or integrity of our assessments, we discuss the requests with BMS and make any mutually agreed-upon changes.

With the PNA assessment approach approved by BMS, we request the MCO's provider directory report. Each MCO must make annual submissions of its provider directory for each program in which it participates. This point-in-time data will be provided based on the MCO's network as of October 1 of each year, and each plan must attest to the validity, completeness, and accuracy of the submission. Once each MCO submits an initial provider directory, we perform an initial review to confirm that the providers in the directory can be externally validated. For example, we use information from BMS's Medicaid Management Information System (MMIS) to validate that the provider delivers the types of services identified in the MCO's submission. We will also identify encounters submitted by providers who are not in the directory. Where discrepancies are identified, we request MCOs' to review and make necessary corrections.

Once the MCOs have provided their feedback, we will incorporate any updates to MCO provider network submissions and compare the directory of providers against the member population enrolled as of October 1. We compare the provider directory with enrolled member files to identify the provider and provider type located closest to each member. We then compare these results against the contractual standard. For ratios, the number of members will be compared against the number of providers in each geographical region, and the applicable standard is calculated. We use industry standard Geographic Information System (GIS) tools to calculate travel distances.

Our technical staff are proficient in a variety of GIS applications; however, we most frequently use *ArcGIS*, which integrates and connects data through the context of geography and provides world-



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leading capabilities for creating, managing, analyzing, mapping, and sharing all types of data. Utilizing large beneficiary and provider databases received from state Medicaid Management Information System (MMIS) vendors and health plans, we provide a variety of geo-mapping analyses to support our state Medicaid managed care clients in evaluating the access and availability of needed healthcare services within their programs.

We will also provide an opportunity for the MCOs to document any requests made to BMS to allow an exception to a network standard. This documentation serves as the MCOs' representation that BMS has issued an exception to the network adequacy requirements, which may be for a variety of reasons, such as no providers of a specific provider type are practicing within the geographic area. We work with BMS to review, validate, and document approved exceptions. Our analysis will incorporate these BMS-approved exceptions, and they will be documented in our PNA reports.

We will develop and review a draft PNA report for each program with BMS and request approval to send reports to MCOs for review. Upon receiving BMS's permission, each MCO will be given an opportunity to review and provide feedback. We review their comments and incorporate relevant feedback prior to delivering a final draft for BMS review. We review the final draft with BMS and discuss any final changes. During this final review, we include a discussion regarding the strategic opportunities for network access improvement along with actionable recommendations that will help BMS bridge network gaps and issues. With BMS's approval, we will deliver the final report on/by the October 1 deadline.



### West Virginia BMS

## Demonstrated Experience: Network Adequacy

Myers & Stauffer developed a more stringent PNA assessment methodology that has improved opportunities for BMS to identify and act upon gaps in access to services. Year-over-year, we have improved visibility into the MCO's compliance with network adequacy requirements, assessed access to care, strengthened or clarified contractual standards, and held the MCOs accountable for providing timely access to services. These advancements include designing time and distance standards for new provider types, improving data reporting, and increasing consistency in the process for the review and consistent disposition of network exception requests. Additionally, through collaboration with BMS's external quality review organization (EQRO) vendor, we have enhanced data and policy update sharing, analysis, and how provider network data are used in the EQRO Annual Technical Report.

### Other State Medicaid Experience

Myers & Stauffer has developed network adequacy methodologies, performed External Quality Review (EQR) Protocol 4 procedures, and conducted secret shopper services to ensure access to dental, primary care, and behavioral health services. We performed these activities in Arizona, Florida, Georgia, Indiana, Kentucky, Wisconsin, and Virginia, including verification of physical practice addresses and ability to obtain appointments.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Annual MCO Performance and Compliance Report (4.2.1.1.4)**

The vendor should describe their plan to 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 should 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.

**Approach and Methodology**

Myers & Stauffer will develop separate annual reports for the MHT and MHP programs. Each report will provide an overview of BMS-contracted MCOs' performance and compliance with contractual obligations, as well as BMS's accomplishments in serving its managed care populations. Ultimately, the reports will reflect BMS's commitment to improving healthcare quality and accessibility for West Virginians.

The annual reports will be a thorough representation of the two programs and their performance yet written to be appropriate for public consumption without overuse of Medicaid jargon. Key sections of the reports and their respective content that we recommend for inclusion are outlined below. However, prior to drafting these reports, we will meet with BMS and receive the Bureau's feedback regarding these recommendations and adjust our approach accordingly. Our recommended content will start with the following:

- **Comments from the Bureau.** In this section, we will capture highlights of BMS's accomplishments during the reporting period. We will provide a draft of these achievements for BMS leadership's review and editing.
- **Overview of the Bureau, Medicaid, and the Program.** This section will orient the reviewer to West Virginia Medicaid, how the program is administered and managed, program goals, enrollment and demographics, services available, and program expenditures and financial performance. This section will also include information to address areas, such as the MCOs' MLRs, the state directed payment (SDP) program, and any cost savings information.
- **MCO Profiles.** The BMS-contracted MCOs will be introduced, and their membership/enrollment will be provided for the reader.
- **Quality.** BMS's diligence in ensuring quality and improvements to health outcomes will be represented in this section. Our goal in drafting this section will be to help the reader understand the program's performance and areas identified for improvement. This section will include information, such as key findings from BMS's annual EQR Technical Report, each MCO's accreditation status, health outcomes measured, measurements of the patients' experience with healthcare services provided through the program, and BMS's performance with the CMS-required Quality Strategy.
- **Program Initiatives.** We will highlight specific program initiatives undertaken by the MCOs, including those required by CMS and BMS, legislated by the West Virginia Legislature, and implemented independently by the MCOs to address the state's unique healthcare needs. We will include information about the success of each initiative.



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- **Program Integrity.** The commitment of BMS's Office of Program Integrity (OPI) to identify, prevent, and mitigate fraud, waste, and abuse (FWA) within the West Virginia Medicaid and WVCHIP programs will be the focus of this section. Here, we will highlight OPI and MCO initiatives to ensure that Medicaid services are billed and administered in accordance with all applicable standards, while safeguarding public healthcare funds through strategic partnerships with MCOs, as well as state and federal law enforcement agencies, including the Medicaid Fraud Control Unit (MFCU).

We will meet with BMS each year prior to starting work on the MHT and MHP annual reports to discuss content and ensure alignment with BMS's expectations. Our Work Plan will be constructed to deliver the annual reports within 90 calendar days of the end of the reporting period and include time for BMS's review, our edits based on feedback, and BMS's final approval.



### West Virginia BMS

## Demonstrated Experience: MCO Reporting

In a collaborative process with BMS, we have produced informative public-facing annual reports for the MHT and MHP programs since calendar year (CY) 2023. The annual reports provide education and public transparency regarding the operations and performance of the West Virginia Medicaid/ CHIP programs and include the following:

- Program overviews, member demographics and enrollment, MCO profiles, quality performance, program expenditures, and program integrity metrics.
- Community reinvestments and supports undertaken by the MCOs (e.g., food is medicine).
- Encounter data reconciliation and validation report results.
- Updates regarding legislative actions impacting the program, such as the implementation of SB 820 from the 2025 legislative session.

These reports provide education and public transparency regarding the operations and performance of the West Virginia Medicaid managed care programs.

### Other State Medicaid Experience

We produce recurring fiscal analysis reports in multiple states, including Colorado, Georgia, Hawai'i, Idaho, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, Nebraska, New Mexico, Ohio, Tennessee, Texas, Utah, Virginia, West Virginia, and Wisconsin. Similar to the MHT and MHP annual reports, these reports provide transparency into the MCO financial performance.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Analysis Dashboard (4.2.1.1.5)**

The vendor should describe its approach for providing an analysis dashboard with simultaneous access for up to ten (10) State users. The Vendor-hosted tool should be compatible with Agency systems, including Microsoft Windows 11 or equivalent, Microsoft 365 or equivalent, and Google Workspace or equivalent and include configurable settings to meet Agency needs. The dashboard allows the Agency to identify medical service utilization patterns by category of service, as well as medical and administrative cost profiles for all Managed Care cohorts, major lines of business, and individual Managed Care members, to support quality improvement and outreach efforts. The tool functions as a program compliance dashboard and at a minimum, be subject to refinement by the Agency. The tool allows tracking of:

- 4.2.1.1.5.1. All deliverables submitted by the MCOs under the Managed Care contract.
- 4.2.1.1.5.2. MCO policies and procedures.
- 4.2.1.1.5.3. Contract and amendment language, including version history.
- 4.2.1.1.5.4. MCO quality metrics and report card information.
- 4.2.1.1.5.5. Network adequacy documents and readiness review materials.
- 4.2.1.1.5.6. Grievances and appeal

**Approach and Methodology**

We understand the importance of having reliable and continuous access to accurate, complete, timely, and actionable information for monitoring performance and enforcing compliance with contractual requirements. Further, we recognize BMS's need to have the data organized and presented in a meaningful and user-friendly way to support program administration. We will deliver a technical solution with configurable settings that is compliant with all technical requirements stated in the RFP.

See additional details in *MCO-Specific Reports and Maps (4.2.1.1.18)* and examples of our dashboard in *Figure 6. MC-Ops Samples*.

Under our current contract, Myers & Stauffer has deployed our Managed Care Operations (MC-Ops) dashboard to support the Bureau's oversight and monitoring of the MHT and MHP MCOs. The West Virginia MC-Ops dashboards cover numerous functional areas, including member enrollment, call center operations, financial performance, MLR reporting, claims adjudication and denials, MCO reporting oversight, healthcare service utilization, and population health. These dashboards facilitate the State's oversight and monitoring of its MCOs and features support performance comparisons, identification of outliers, and trend analysis.

We will continue to provide and enhance these interactive dashboards, leveraging visual analytics, providing BMS insights into the performance of managed care plans. For instance, we will enhance the current dashboard site with contract version history comparisons along with appeals and grievance reporting from the MCOs as well as comparison data from the Managed Care Plan Annual Report (MCPAR) data. Our system will also house MCO documentation and submissions, such as policies and procedures, contract and amendment requirements, quality metrics and report card information, network adequacy documents, readiness review materials, grievances and appeals, and other documents as mutually agreed upon.

Our proposed approach leverages secure web portals, compliance report tracking tools, customizable proprietary tools developed by Myers & Stauffer, and embedded Microsoft Power BI dashboards hosted on the Government Community Cloud High platform. This integrated solution not only ensures secure



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data handling but also facilitates proactive communication, follow-up, and technical support for timely and specification-conforming reporting.

The delivery of a technical solution is the first step. We understand the usefulness of the system will depend, in part, on supporting users with training and understanding of the system; keeping data updated, ensuring only authorized individuals have access to the system based on their respective roles; maintaining the information technology (IT) components; and continually evolving the dashboard to meet the ever-changing needs of BMS. We highlight this support we will provide to BMS in *Figure 2* and provide additional detail below.

Figure 2. MC-Ops Support



- User Support and Training.** Our business analysts maintain detailed user manuals for our dashboard platforms. These manuals describe dashboard navigation and demonstrate the basic functions for interacting with the dashboards. The manuals also provide information on account management, including how to reset passwords, and how to communicate questions or potential issues. All new users receive a copy. The user manual is also available for download from the portal. We have organized training demonstrations with our clients and stakeholders to walk through the use and functionality of the web portals and dashboard reports. These demonstrations are an effective way to introduce new users to the dashboards, build rapport, and encourage open communication between users and our staff.
- Data Updates.** Our team manages dashboard data updates through an automated process that ensures data are consistently accurate and up to date. We have developed data processing procedures to pull information from various sources at regular intervals to refresh the dashboards. This process is carefully monitored to ensure seamless integration and minimal disruption. Our team continuously verifies data integrity, troubleshooting any discrepancies that may arise, ensuring the dashboards reflect the most current and reliable information. We manage data integration from numerous customized Excel reporting templates populated by the MCOs. Reporting errors are common with these data sources and our team works with the State and MCOs to remediate errors and update the impacted dashboards in a timely manner.

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- **User Management.** User management involves controlling and monitoring access to the dashboard platform, ensuring that the right individuals have the appropriate permissions to view data. This process includes creating and managing user accounts, defining user roles, and setting specific access levels based on the type of user and contract requirements. We recognize the value of defining user roles early in the development process and collaborate closely with clients and stakeholders to identify the responsibilities and access needs of various user groups. Establishing well-defined user roles enhances data security by restricting access to protected information and contributes to more efficient platform maintenance and scalability. Clearly defined user roles can also inform the dashboard design process by enabling customization for specific user groups. We will provide access to the dashboard for up to 10 State users.
- **IT Maintenance.** Our IT staff perform regular monitoring and updates to the various IT components that support the dashboard reporting platform. These components include, but are not limited to the web portal infrastructure, user management system, analytics platform, SQL Server data warehouse, file network system, and Microsoft Power BI cloud infrastructure. Regular maintenance is critical to ensure efficient operation of the web portal and dashboards, and ensure our systems have the most up-to-date security patches. We complete many IT maintenance activities without directly impacting user access and performance of the dashboards. We plan updates to occur during low traffic periods outside of normal business hours and send notification emails to users to communicate the scheduled impact. Additionally, usage logs allow us to proactively address any performance issues or system errors that might arise, ensuring the platform runs smoothly. By continually analyzing usage data, we can make informed decisions about where to focus resources for ongoing improvements, ultimately enhancing user experience and ensuring the dashboard remains responsive and efficient.
- **Dashboard Management.** We work with clients to define and implement enhancements to dashboard reporting, as requested. We also suggest enhancements, where applicable, outline the expectations and timeline for any updates, and only pursue work as approved by the client. We gain valuable insights into how users interact with the platform by tracking metrics, such as frequency of use, which features are accessed most often, and how long users spend on specific sections. Monitoring these functions allows us to discover patterns and potential bottlenecks and identify areas of the dashboard that may need optimization, whether to improve load times, enhance functionality, or simplify navigation.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****West Virginia BMS****Demonstrated Experience: Analysis Dashboard**

Myers & Stauffer developed a customized, interactive dashboard for BMS and has made enhancements over time to incorporate additional information to support the oversight and monitoring of the managed care program. We are currently working to include quality and performance metrics and components of the EQRO Annual Technical Report. These enhancements have supported BMS's analysis of managed care utilization trends and metrics by services, demographics, and financial requirements. This includes performance analysis in areas, such as:

- Enrollment.
- MCO financial performance.
- Network adequacy.
- Quality and performance metrics.
- Program integrity.
- Utilization trends.
- Contractual performance.

**Other State  
Medicaid  
Experience**

We have also deployed dashboards, analytic tools, and supporting systems for other states, such as Colorado, Georgia, Illinois, and Mississippi. In addition to oversight of MCOs, these tools facilitate data collection and allow users to upload/download documentation, host forums, build electronic surveys, offer electronic project management tools and resources, store project and training documents and FAQs, monitor progress, and retrieve reports.

**MCO-Related Training/Training Manual (4.2.1.1.6)**

The vendor should describe their plan to provide MCO-related training to Agency staff and maintain a training manual for reference.

**Approach and Methodology**

Based on the needs of BMS, we will develop a managed care training curriculum, including sessions and related resource materials subject to BMS's review and approval. These materials will be included in a training manual that will be maintained and updated as new trainings are conducted or as programs or processes evolve. We have provided training to BMS covering topics, such as:

- **MC-Ops Training:** Myers & Stauffer conducts training for BMS staff, including refresher training, as needed. When MC-Ops upgrades are implemented, Myers & Stauffer conducts training sessions and provides written training materials (*Figure 3*).
- **MCO Reporting:** MCO contract provisions require the MCOs to collect, validate, and report required program data to BMS in an accurate and timely manner and attest to the accuracy and completeness of all submitted data and reports. Myers & Stauffer has developed an MCO reporting training module and manual for BMS staff to ensure accuracy in submission, data integrity, and compliance with individual MCO reporting templates.
- **MCO Materials:** Myers & Stauffer has developed a modular training program with a training manual for BMS staff on standard MCO materials, including standard operating procedures (SOPs) for the review of MCO marketing material submissions and SOPs for the review of

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annual/ad hoc MCO material submissions (e.g., member handbooks, provider directories, etc.).

A detailed checklist for reviewing marketing material submissions is available for BMS staff.

Our staff with managed care expertise will meet with BMS to understand the need for training, intended audience, and gaps the training will be designed to fill. Content will be tailored specifically for the identified audience, and we will consider the audience's level of knowledge and understanding coming into the training. We envision most training sessions will be in the form of virtual webinars with sufficient time for questions and answers throughout the training. Where an on-site presence would enhance the effectiveness of the training, our team will conduct trainings in the BMS offices as mutually agreed upon. Our trainers will have the appropriate expertise in the area being discussed and prepare ancillary training materials and resources to support the learning experience. If the training is conducted virtually via webinar, the training will be recorded for future use by new employees or as a refresher for individuals previously trained. Our training manuals will also support the learning experience and serve as a valuable resource after the training.

To ensure the effectiveness of our training and to support our continuous quality improvement processes, we will solicit feedback, typically in the form of an electronic survey, evaluating the helpfulness of the material presented and the effectiveness of our trainers. This feedback will be applied to future trainings as part of our continuous improvement efforts.

Figure 3. Sample BMS Training Manual





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### What This Means for BMS

BMS can not only rely on us as a dependable training resource with detailed knowledge of West Virginia Medicaid history, but also as a frontline resource for insight on regulatory and compliance changes as they arise.

The Myers & Stauffer Team invests in staying current on best practices, trends, and opportunities for the benefit of improved patient outcomes, as well as positive impacts on health spending. We assist our clients by making them aware of potential improvements/updates to their programs. We use our industry experience and noted best practices from other states as a backdrop for our work. We are aware of what works, what does not, and why. Our experience and professionals, through their research, education, and relationships, are front and center when it comes to innovative ideas in health care and human services

### MLR Audits, IBNR, and Risk Adjustment Activities (4.2.1.1.7)

The vendor should describe its approach for providing support for MLR audits, IBNR, and risk adjustment activities. Additionally, the vendor should describe their plan to host a kickoff meeting with the MCOs prior to implementation to communicate expectations for these activities. The vendor should describe their approach and methodology to 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.

The Myers & Stauffer Team will ensure oversight of all current and new programs developed and operating under the BMS MHT and MHP managed care waivers and deploy communication plans encompassing all affected stakeholders. In addition to existing waivers, we will also support new waivers that may be developed and implemented.

As part of this process, MLR, incurred but not reported (IBNR) expenses, and risk adjustment are fundamental indicators that will be used during the oversight of BMS's MCOs. Collectively, these indicators provide insight into financial performance, actuarial soundness, and the appropriate use of Medicaid funds. The following sections describe the Myers & Stauffer Team's approach to addressing MLR audits, IBNR calculations, and risk adjustment procedures.

### MLR Audits

#### Approach and Methodology

Our Team has been in the forefront of assisting states with the monitoring and oversight of their managed care contractors. We have audited large (revenues in excess of \$100 billion), complex MCOs in several states, and on behalf of CMS. We bring expert knowledge of industry practices related to the administration of Medicaid and CHIP, and of MCOs, including understanding the complex organizational and operating structures employed by the large, affiliated group corporations that are typical to the industry; industry practices in applying administrative overhead rates; and reporting of affiliate and related-party transactions. We understand the challenges that complex contractual relationships can pose for our state and federal clients. As a

The MLR procedures are outlined in our response to *Financial Services (4.2.1.2.1)*.

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result, we approach each audit with a proven framework that allows us to gain a full understanding of performance, compliance, and financial reporting aspects of each contract. This proven framework has led us to identify material areas of contractor noncompliance, which has resulted in millions of dollars contractors have had to remit to the client, as well as the assessment of liquidated damages against the contractors. We will bring this direct experience to perform annual MLR audits of MCOs for BMS.



### What This Means for BMS

Our direct experience with managed care in West Virginia and across numerous other states, coupled with our national contacts gives us the deep knowledge base to create customized solutions for BMS. We offer BMS a selection of knowledgeable professionals with access to a large contingent of staff who understand the varying aspects of managed care. This allows us to offer comprehensive advice, consulting, and audit services on all aspects of managed care. Our deep knowledge base provides BMS with a resource that is unmatched by a single competitor.

*The MLR Monitoring, Reporting, and Oversight: A Toolkit for States to Ensure Complete and Accurate MLR Reporting (CMS MLR Toolkit)*, released by CMS in September 2024, requires that all states, as part of their managed care financial data oversight responsibilities, conduct or contract for an independent, periodic audit. This audit will evaluate the accuracy, truthfulness, and completeness of the encounter and financial data, including MLR financial information, submitted by MCOs as mandated under 42 CFR § 438.602(e). The CMS MLR Toolkit emphasizes that these audits are typically conducted by certified public accountants.

Our experience working with states, including West Virginia, to meet the federal requirements for financial audits has led us to conduct the attest work associated with the MLRs as examinations under attest standards established by AICPA. Those standards require that we examine, on a test basis, evidence about the MCO compliance with the MLR requirement and perform procedures we consider necessary in each circumstance. The procedures selected depend on the examiner's judgement, including the assessment of the risks of material misstatement of the MLR reporting, whether due to fraud or error. Because of the inherent limitations of an examination and internal control, an unavoidable risk that some material misstatements may not be detected exists even though the examination is properly planned and performed in accordance with AICPA attestation standards.

We currently work with BMS to conduct the MLR examinations of the MHT, MHP, and WVCHIP programs. As a result, we have extensive experience with West Virginia's MCOs, including their MLR instructions, MCO contracts, and the unique expenses and reporting methodologies of each MCO. Additionally, we are currently the auditor of choice for more than one-third of the states' Medicaid programs performing MLR examinations. We have extensive experience addressing typical and unique issues that vary by each type of health plan.

Currently, this engagement is being performed as an examination and is conducted in accordance with AICPA attestation standards, including all relevant professional and ethical requirements. An



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examination is designed to obtain reasonable assurance about whether the MLR are in accordance with the criteria set forth in CFR 42 § 438.8 and other applicable federal and state guidance (criteria) in all material aspects. The goal of the examination is to express an opinion on whether the MLR are presented in accordance with the criteria in all material respects and whether the health plan achieves the minimum MLR requirement (85%).

To bring consistency and standardization across all health insurance markets and to promote fiscal stewardship, administrative efficiency, and comparability across states and markets, 42 CFR § 438.8 requires that an MLR for MCOs be calculated, reported, and used in the development of actuarially sound rates. Capitation rates must be set so MCOs would achieve an MLR of at least 85% using the projected revenues and costs for the rate year but not exceed a reasonable maximum threshold that would account for administrative costs. Key components in the rule specific to MLR include:

- Actuarially sound rates developed using projected revenues and costs must be set to achieve an MLR of at least 85% (industry standard). States may choose to implement a higher percentage but must allow for reasonable administrative costs. This is so there is not a degradation to beneficiaries' access to services, quality of care, provider participation, and continued viability of the Medicaid managed care plans in that market. When establishing a maximum threshold, states may also consider the type of services provided and the maturity of the program.
- States must use past MLR calculations and reporting as part of developing future years' rates so an entity would reasonably achieve a minimum 85% MLR in future contract years.
- The State must ensure, through its contracts starting on or after July 1, 2017, that each MCO calculates and reports an MLR in accordance with 42 CFR § 438.8. The MLR period must be consistent with a rating period selected by the State.
- The MLR report must also include methodology for allocation of expenditures and any credibility adjustment applied, as well as a comparison with the audited financial statements.
- The MLR reports must be submitted within 12 months of the end of the MLR reporting year.
- The MCO must provide an attestation with the MLR report submission that the MLR was calculated in accordance with the standards included in this rule.
- The State must annually provide CMS with a summary description of the reports received from each of the MCOs along with the actuarial rate certifications. At a minimum, this description must contain the amount of the numerator, denominator, MLR experienced, the number of member months, and any remittances owed by each of the entities for that MLR reporting year.
- If the State's contract requires remittances to the State for not meeting the minimum MLR requirements, then the State must repay the federal share for these remittances, taking into account the appropriate federal financial participation rates. In addition, a report describing the methodology used to determine the applicable state and federal shares of the remittances must be submitted.

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The objective of the MLR examination procedures is to align reporting to Medicaid MLR requirements as outlined in 42 CFR § 438.8, ensure compliance with 42 CFR § 438.602(e) to determine whether the minimum contractually required MLR percentages have been achieved, and if applicable, determine if a partial return of the capitated premium amounts is due from the MCO as a result of their noncompliance.

We begin each engagement with a kickoff meeting with representatives from the MCOs. The kickoff meeting clearly outlines expectations, timelines, and documentation needs. Based on our experience, establishing clear expectations and lines of communication at the beginning of the engagement allows for successful completion of the project. As a component of the initial documentation request, a questionnaire is sent to the MCOs to gain an understanding of their organizational structure and unique characteristics so we can assess audit risks. Additionally, as part of the process, we request general items from BMS and MCOs that include the following:

- **BMS Requests:**
  - MCO contact information.
  - MLR template submitted to the State, including the attestation/certification statements, comparison to audited financial statements, and description of the aggregation method.
  - Instructions for completing the MLR template.
  - Signed contracts between BMS and the MCOs.
  - State data detailing payments to MCOs.
  - Member months State data.
  - Confirmation of rating period aligning with the MLR reporting period.
  - Confirmation of any value-added services.
  - Detail summary of any sanctioned fees, fines, or penalties for each MCO, if applicable.
  - Completed data questionnaire.
  - Rate certifications.
- **MCO Requests:** The appropriate tabs within the MLR template that are central to the entire process will be checked for mathematical accuracy and completeness. The reported elements will be traced to supporting **detailed** documents included in the initial request. This will include, but not be limited to the following:
  - Audited financial statements.
  - Board meeting minutes.
  - Complete working trial balance (WTB) for the reporting period.



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- Complete general ledger detail for the reporting period.
- Crosswalk of WTB to claimed expenses and revenues.
- MCO supporting documentation for all as-filed values for the reporting period.
- Allocation schedules utilized to support reported expenses.
- Listing of all external (third party and related party) contracted entities and support for claims paid or expenses claimed.
- Claim lag reports and sampled claims data detail.
- Contract agreements with parent companies, vendors, and providers.

Myers & Stauffer's approach begins with a thorough assessment of the risk associated with each MCO's reported expenses and revenues. Our procedures are designed to mitigate risk and test the accuracy of financial data submitted by each MCO. This process will include a review of each MCO's procedures over their reporting processes to ensure consistency and compliance with federal definitions and regulations. Our approach will also contain procedures to review any cost allocations to the MCO and program from both the MCO and any corporate entity to ensure the allocation method used yields the most accurate results and that the expenses are apportioned properly amongst the entities and programs incurring the expenses. Myers & Stauffer has many years of experience working with MCOs, parent companies, related parties, third parties, and claims/encounter data, which all factor into the financial reporting. This knowledge helps with assessing risk of potential misstatements and targeting any specific data elements for testing.

Our examination program can be modified in coordination with BMS to incorporate any specific areas of concern or granularity required. Included within the program are narrative comments that explain the purpose of each step. The program also provides a reference guide for resolving issues in accordance with state and federal guidance and ensuring consistent treatment of issues when the scope of work is performed on multiple MCOs. The references include items, such as:

- Relevant regulatory citations and guidance (e.g., MCO contract references, MLR and administrative instructions, specific CFR sections, CMS Informational Bulletins issued by the Center for Medicaid and CHIP Services or Center for Consumer Information and Insurance Oversight applicable to MLRs, and any other relevant federal guidance or publications).
- CMS MLR Toolkit.
- Clarifications or directives from BMS regarding any state-specific guidance.
- AICPA attest engagement standards.

In addition to providing MLR examination reports, our process also includes developing a letter to management outlining recommendations and suggestions identified throughout the duration of the engagement related to federal and state regulations, reporting changes, instruction revisions, and

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

overall process considerations that will improve the delivery of services, yield more robust programs, and proactively identify opportunities to align and maximize project resources.

We are committed to monitoring regulatory revisions affecting the MLR or other MCO financial data, ensuring our clients are aware of changes as they are implemented or are proposed. We work with CMS when areas within the regulations may need clarification.

Additional support will include:

- Delivering status updates with both BMS and the MCOs.
- Providing guidance to BMS on the impact of new or updated CMS regulations and guidance.
- Attending virtual or in-person meetings with BMS and MCOs, as needed.
- Performing annual MLR template review and updates to incorporate changes and align with any updated CMS regulations and guidance.
- Tracking MLR reporting submissions.
- Performing a high-level review of the submitted MLR reports for any obvious errors prior to submission to BMS. If errors are identified, we will work with the MCOs on updates and resubmission.
- Submitting the accepted MLR MCO reports to BMS.
- Assisting with CMS MLR report submissions.
- As needed, identify the need for draft amendments to MCO contract requirements to ensure alignment with CMS MLR regulations and BMS policies, report MLRs publicly, and support responding to questions from the legislature or other stakeholders.

### **Demonstrated Experience: MLR**

#### **West Virginia BMS**

Myers & Stauffer has supported BMS's progress from an environment where MCOs self-reported their MLRs to one where MLRs are calculated consistently and audited under AICPA standards. We implemented annual MLR audits, allowing BMS to identify and address issues timelier and report MLR performance publicly and to the West Virginia Legislature. The diligence invested in this effort has provided BMS with accurate, consistent, and audited MLRs in full compliance with CMS requirements. These audited MLRs are used with confidence in capitation rate setting and fiscal oversight of the MCOs.

#### **Other State Medicaid Experience**

Myers & Stauffer has extensive experience developing MLR templates, creating MCO communications, managing the MLR process, and conducting audits under AICPA guidelines in Colorado, Georgia, Hawai'i, Idaho, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, Nebraska, New Mexico, Ohio, Tennessee, Texas, Utah, Virginia, and Wisconsin.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****IBNR Estimates****Approach and Methodology**

IBNR estimates support more than rate development. Reliable IBNR estimates strengthen BMS' understanding of emerging trends, evaluate MCO financial performance, and make informed budgeting and oversight decisions for MHT, MHP, and WVCHIP. Milliman has extensive experience developing IBNR estimates for Medicaid populations and beyond. Milliman develops IBNR estimates by MCO and major category of service to inform the development of actuarially sound capitation rates, as well as assisting states to develop IBNR estimates for their fee-for-service (FFS) services and populations. Milliman currently assists WVCHIP with FFS IBNR projections.

Milliman's actuaries use an internal Excel-based model, Milliman's Claim Reserve Estimation Workbook (CREW™), to stage historical payments over time and inform IBNR assumptions. CREW allows for raw claims data to be entered in aggregate or with stratifications for each covered population and service type grouping. Unlike simpler models, CREW accommodates unusual claim payment patterns, as well as changing enrollments, benefits, unit costs, and other key factors. By reflecting real-world changes that many traditional reserving approaches do not capture, CREW produces highly reliable IBNR estimates.

CREW also offers reporting features that make it an exceptional reporting tool. Our Team can share output from these reporting features to help understand the development of the IBNR estimates. Our Team will support BMS by using CREW to:

- Summarize claims and calculate loss ratios by incurred month, quarter, and CY so that BMS can understand cost and utilization patterns over time, monitor financial performance, and identify emerging trends earlier.
- Analyze incurred claim trend and reflect seasonal patterns including working day adjustments by service category so that reserve estimates more accurately reflect expected claim activity and are not distorted by temporary or seasonal fluctuations.
- Calculate restated reserve levels using claim run-out data so that reserve assumptions can be validated against actual experience and refined over time to improve confidence in future estimates.
- Sensitivity-test best estimates against alternative assumptions so that decision-makers can understand the range of possible outcomes, quantify uncertainty, and assess financial risk under different scenarios.
- Graph results to better display estimates so that complex actuarial results can be communicated clearly to leadership, finance teams, and other stakeholders.
- Summarize results several ways to identify patterns and outliers so that unusual claim developments, emerging risks, and potential data quality issues can be detected and investigated quickly.

CREW uses a dual approach by developing incurred claim estimates based on both claims lag patterns and projections of historical costs on a unit cost basis. The tool is designed so that the user can easily

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

test and document the sensitivity of different assumptions on the resulting IBNR estimate. This feature is critical because reserve estimates can vary substantially based on the assumptions used. By evaluating alternative scenarios, CREW helps quantify uncertainty and validate the reasonableness of key assumptions. Milliman will use this model and actuarial judgment to develop FFS and managed care IBNR assumptions, as requested, and can create customized approaches as needed.

To implement the IBNR methodologies in the current programs, Milliman uses the following approach:

- A kick-off meeting at the start of rate setting to discuss the IBNR and other proposed rate setting methodologies.
- A data collection period whereby MCOs are requested to provide their own IBNR estimates for comparison.
- A question and answer period with the MCOs whereby MCOs answer questions regarding their own specific data based on Milliman observations.
- A draft rate process where IBNR factors in aggregate are shared with the MCOs.
- A final rate process where IBNR factors are documented in the final capitation rate certification along with the approach and assumptions.

This process allows for transparent, collaborative results and is utilized for the MHT and MHP programs currently. Milliman will adapt this process as necessary to ensure oversight of current and new programs developed and operating under existing managed care waivers, new waivers, or waiver renewals.

### Demonstrated Experience: IBNR

#### West Virginia BMS

Milliman has supported BMS with IBNR calculations through its FFS quarterly reporting process since 2023 and through the MCO MHT and MHP capitation rates since 2022. Since 2022, the MCO IBNR accuracy has improved through Myer and Stauffer's data validation and reconciliation process and Milliman's projection models. In the SFY 2023 MHT capitation rates, the IBNR – including data missing from the State's data warehouse – represented approximately 3 to 5% of expenditures for most medical services depending on the MCO. In the SFY 2027 capitation rates, the completion adjustment has been reduced to 1-3% depending on the MCO based on the Myers & Stauffer Team working with MCOs to improve their data accuracy. IBNR assumptions can now be used with confidence in capitation rate setting and fiscal oversight of the MCOs.

#### Other State Medicaid Experience

We have extensive experience developing IBNR estimates for FFS and MCOs. Milliman develops IBNR assumptions in each of the 18 states it certifies capitation rates. These assumptions are a crucial part of capitation rate setting and fiscal management.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

## Risk Adjustment

### Approach and Methodology

We view risk adjustment as more than a technical exercise; it is a powerful tool for understanding the factors driving healthcare costs and utilization. By converting claims, pharmacy, and eligibility data into measures of member acuity, risk adjustment helps the State make fair comparisons across MCOs and populations, distinguish changes in health status from changes in program performance, improve the accuracy of financial analyses, and support informed policy and operational decisions. Milliman applies and customizes risk adjustment methodologies for Medicaid programs across the country, adapting our approach to each state's unique populations, program design, and analytical objectives. This includes use and modification of the diagnosis- and pharmacy-based tool Chronic Illness and Disability Payment System (CDPS+Rx), as well as long-term services and supports (LTSS) risk adjustment tools, and mental health risk adjustment methodologies. We have significant experience using the CDPS+Rx risk adjustment model, applying it to healthcare claims data for 16 Medicaid clients, including analyses on behalf of our Medicaid state agency clients. Risk adjustment models and the risk scores and insight derived from them can improve the State's ability to manage costs, make fair comparisons across populations, and support more informed policy and program decisions. For West Virginia, we currently use risk adjustment to normalize risk scores across MCOs in the MHT program and for monitoring of MHT acuity over time.

Below are the standard considerations that our Team's actuaries use during the risk adjustment process.

### *Compiling Eligibility and Claims Information for CDPS*

The first step to any of our work will include the collection of detailed historical enrollment, FFS claims, and MCO encounter data. Once data is validated, we will use the enrollment data, FFS claims data, and managed care encounter data to calculate risk scores. We use both claims and encounter datasets to capture 100% of the members' diagnosis and pharmacy profile. We apply claims data, including diagnosis codes, pharmacy National Drug Codes (NDCs), and enrollment/eligibility information, which are necessary to establish acuity factors specific to each individual.

The risk adjustment model contains algorithms that develop these individual acuity factors. The inputs for the model are:

- A list of enrolled members. Our actuaries will compile a unique list of MCO-enrolled members and their demographic information (age, gender, region) for each MCO.
- All medical claims related to the members identified in the list above, including collecting all FFS and encounter claims for the identified members. Depending on the methodology, certain types of claims may be excluded from the diagnosis extraction because of their potential to mislead the risk scoring algorithm. For example, if a person is tested for diabetes and has a laboratory test with a diabetes diagnosis, they may come back either positive or negative for the disease. Our Team does not want to assign additional risk to individuals who test negative, so laboratory diagnoses are excluded from the analysis.
- The set of NDCs for all pharmacy claims related to the members identified in the list above. This includes collecting all FFS and encounter pharmacy claims for the identified members to ensure

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

a complete understanding of a member's conditions. With outpatient pharmacy services carved out of the MCO program, using these FFS claims as well as the MCO physician-administered and outpatient hospital pharmacy claims will improve the accuracy of our risk adjustment determination.

- The individual acuity factors produced by any risk model are only as accurate as the data fed into the algorithm. Our actuaries will work with BMS to ensure the enrollment, claims, and encounter data are as accurate as possible. In addition to validating the data, consideration should be given to the subset of data that will be used by the risk algorithm.

Considerations involving the creation of the risk adjustment input dataset and member risk scores include, but are not limited to the following:

- The weights that should be utilized for developing individual member risk scores. For example, while pharmacy data is utilized in understanding a member's risk profile, pharmacy costs should not be considered in the weights used to assign individual member risk scores in MHT. This is due to the point-of-sale pharmacy expenditures being carved out of the MHT capitation rates.
- The number of member months required for an individual to be assigned an individual acuity score. Milliman generally recommends that a member have a minimum of six months of eligibility in the analysis period prior to including a Medicaid-eligible member in the risk score process so that a complete condition profile may be captured. For MHT, our actuaries have also created MHT-specific adjustment factors that augment the acuity factor calculated by CDPS+Rx for members who have 6-11 months of experience in the period. This allows for distinction between risk scores that are truly complete and risk scores that may become more accurate if a member had more time in the program.
- Acuity factors for members who have not been enrolled for six months.
- Whether to exclude diagnoses that are coded with certain services that are diagnostic in nature (e.g., lab and x-ray services), as these claims may falsely identify a person as having a certain condition.
- Whether to use a diagnosis validation method to confirm an individual has a certain condition (i.e., only using diagnoses that appear two or more times for an individual).
- Determination of whether to apply risk adjustment prospectively or retrospectively.
- Criteria used to assign individuals to an MCO (e.g., most recent month of known enrollment, MCO with the most member months in the experience period, etc.).
- Which populations to include in risk adjustment (e.g., excluding newborns if prospective risk adjustment is used).
- The specific risk adjustment model to use and any additional modifications of that model.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)***Assign Individual Acuity Factors Using the CDPS*

The model uses the inputs described above to calculate individual acuity factors for each enrolled member.

*Summarize and Review MCO Case Mixes*

Individual risk scores can be combined to show the average health risk, or case mix, of each MCO's enrolled population by region and rate cell. Because some MCOs may enroll members with higher or lower expected healthcare needs than the program average, risk adjustment helps make capitation payments more equitable across plans. The process redistributes capitation revenue among MCOs based on the relative risk of the members they serve, while keeping total program spending budget neutral for the State. To do this, our actuaries compare each MCO's average risk score to the overall average for the same region and rate cell, which is set to 1.00. Scores above or below 1.00 show whether an MCO's members are expected to be higher or lower cost than average, helping BMS understand differences in plan risk while maintaining actuarially sound rates.

Our actuaries review the resulting MCO case mix scores to ensure each MCO's risk-adjusted capitation rate is actuarially sound and unbiased. The following list outlines important considerations when reviewing these case mix scores:

- **The Size of the Deviation between MCO Case Mix Scores.** Differences may be created by deficiencies in the reporting of diagnosis information in encounter data by some MCOs. Our actuaries will perform an analysis to determine if any MCOs have data quality issues in their diagnosis coding, which would warrant a modification to the risk adjustment process. Our actuaries will work with the State and the MCOs to improve the reporting of diagnosis or pharmacy information while adjusting risk scoring data to keep all MCOs on a reasonably consistent scoring basis. For example, if one MCO is missing encounters for three of the 12 months used for the experience period, our actuaries may modify the experience period used to a period where all MCOs have a consistent level of completeness in their coding. Alternatively, where large deviations occur and no coding issues are found, there are examples of states where one MCO in a region has been significantly selected against because of their superior quality provider network relative to others in the region.
- **Case Mix Score Enhancement through Improved Coding Procedures.** Our actuaries have assisted state clients with determining MCO-employed methods that should or should not be allowable. Examples of methods that should be disallowed include the MCO changing the diagnosis codes reported by the medical provider or requiring providers to use diagnosis codes that will knowingly maximize an individual's acuity score when the individual's actual health risk does not match the coding. Certain conditions are more susceptible to provider upcoding than others. Our actuaries will work with West Virginia to determine whether certain conditions should be removed from the individual acuity score calculation to correct for potential gaming.
- **Stability of the Risk Adjusted Capitation Rates.** Our actuaries will review the year-to-year variation in MCO case mixes and discuss with BMS whether it may be appropriate to make adjustments that reduce variation in risk scores among MCOs. Milliman employs actuarial

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

techniques for other state clients that reduce variations among MCOs to further increase stability. This could include cohort credibility adjustments, risk adjustment corridors, or other actuarial adjustments. These techniques are not used without first verifying that variation is not attributed to a disruption in the managed care program that caused increased selection among MCOs. In West Virginia, our actuaries have customized the model for a new MCO entrant to stabilize the program over time and improve accuracy of the model.

- **Prepare an MCO Case Mix and Prevalence Report.** MCOs want to understand the calculated case mix as it will directly affect revenue received by the MCO. Our Team will publish a report for distribution to the MCOs that outlines the data, methodology, assumptions, and results involved with the risk adjustment process. Our Team will also provide individual member-level risk scores to each MCO for their enrolled population to help them understand the final results. This step helps increase transparency with the MCOs, strengthening the relationship between the State and its contractors. The report could serve as a cover letter provided to each MCO along with a prevalence report for each MCO's members. The prevalence report would illustrate the number of members attributed to each condition class, as well as the applicable risk weights associated with each condition. This report can also be a beneficial tool for MCO care management functions.

*Implementation Process*

To implement the risk adjustment methodologies in the MHT program, Milliman uses the following approach:

- A kick-off meeting at the start of rate setting to discuss any proposed changes to risk adjustment and other proposed rate setting methodologies.
- If any changes are proposed to the risk adjustment methodology, Milliman provides a comprehensive proposed methodology document for BMS and MCO review. This document does not include results but instead focuses on the methodology to get buy-in on the approach before any winners or losers from the methodology changes are known.
- Milliman meets with the MCOs again as needed to discuss the methodology changes, including at a draft rate meeting.
- A question and answer period is utilized so that MCOs can ask any question of Milliman and receive transparent answers, before the methodology is finalized.
- The methodology is finalized considering any changes from BMS and MCO feedback.
- A final risk adjustment report is developed documenting the methodology and risk adjustment results.

This process ensures transparent, collaborative results and is utilized for the MHT program currently on a bi-annual basis. Milliman will adapt this process as necessary to ensure oversight of current and new programs developed and operating under existing managed care waivers, new waivers, or waiver renewals.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Demonstrated Experience: Risk Adjustment****West Virginia BMS**

Through risk adjustment, Milliman has improved the State's ability to manage costs and medical conditions. For example, our risk adjustment methodology has provided an objective evaluation of risks across the MHT MCOs, which has allowed an equitable comparison of fiscal impacts, improved the integrity of capitation rate setting, compensated the MCOs more appropriately for members with higher expected costs, and provided additional assurances regarding the sufficiency of the capitation rates and alignment with population acuity levels. In West Virginia and other states, such as Utah, we continuously evolve our risk adjustment model to increase the predictive value of the risk adjustment model.

**Other State  
Medicaid  
Experience**

Based on the specific needs of Utah, we customized a Milliman Advanced Risk Adjustment model that significantly increased the predictive value of the risk adjustment model. Similarly, we customized our risk adjustment model for the Washington Program of All-Inclusive Care for the Elderly (PACE) program to meet the unique needs of that program and their population's characteristics.

**Ongoing Operations of the State's Children with Serious Emotional Disorder (CSED) 1915(c) Waiver (4.2.1.1.8)**

The vendor should describe their plan to assist in overseeing the ongoing operations 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.

**Approach and Methodology**

We understand the Children with Serious Emotional Disorder (CSED) waiver was created to provide intensive, community-based behavioral health services to children and youth, 3-21 years of age, with serious emotional disorders who would otherwise require treatment in a psychiatric residential treatment facility (PRTF) or other institutional setting. The goals of the program are to prevent institutionalization, preserve family stability, deliver person-centered care, improve behavioral health outcomes, and reduce psychiatric hospital admissions and residential treatment through the provision of services not otherwise covered under West Virginia's Medicaid State Plan.

Myers & Stauffer proposes assisting in the oversight and ongoing operations of the CSED waiver by supporting BMS with:

- Compliance with CMS-approved waiver requirements.
- Monitoring MHP MCO adherence to state policies and timelines.
- Financial requirements (e.g., budget neutrality, waiver expenditures, forecasting expenditures, modeling fiscal impact of waiver changes, etc.).
- Waitlist management and associated processes.
- Monitoring the integrity of member eligibility and enrollment in the CSED waiver in collaboration with BMS, Gainwell, and the MHP MCO.
- Coordination of the waiver operations across Medicaid, behavioral health, child welfare, education, and the MHP program.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

- Stakeholder engagement, including BMS, home and community-based services (HCBS) providers, families, members, and the State's project management office (PMO) consultant, BerryDunn.
- Tracking operational risks and developing mitigation strategies.
- Monitoring quality and overall waiver performance.
- Drafting and implementation of waiver amendments and renewals.

Myers & Stauffer is available to support these functions, as well as other mutually agreed-upon activities for the CSED waiver and across other BMS waivers. As we deliver the specific technical and professional services outlined in the RFP, we will work in a collaborative and coordinated manner with BMS's contracted PMO.

### Waiver Applications and Associated Quality Strategies (4.2.1.1.9)

The vendor should describe their approach and methodology to drafting and/or assisting with waiver applications and associated quality strategies.

#### Approach and Methodology

##### Overall Approach

For all waiver types, Myers & Stauffer will customize our support drafting waiver applications and associated quality strategies based on BMS's specific needs. Our proposed approach includes the following:

- **Understanding the Purpose.** We will start by ensuring our understanding of BMS's vision and policy goals for the intended waiver. We will meet with BMS leadership to ensure our understanding and to help BMS refine its strategic objectives for the waiver, if needed. These discussions will include why a waiver is needed versus a State Plan option, what federal authorities need to be waived, and outcomes sought. For renewals of existing waivers, we will research the waiver's historical performance, known barriers and resources, changes in CMS guidance since original approval, and other factors based on the specifics of the waiver.
- **Conducting Research and Analysis.** Our research and analysis will include several components, including:
  - **Assessment of the Current West Virginia Environment and Needs.** This step typically includes analysis of quantitative data that may include information like member counts and demographics, claims and utilization data, provider networks, and population health data. Additionally, we have found great benefit from analysis of qualitative data that may be obtained by conducting stakeholder engagement activities, such as key informant interviews, focus groups, electronic surveys, and other methods. These methods collect qualitative data and help to truly understand the needs of the members and concerns of providers, as well as barriers and resources that should be considered to support the waiver's success.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

- **Analysis of Other States' Waivers.**

Where available and applicable, we will research and analyze waivers from other states with similar policy goals and objectives to BMS's. This review will support our identification of emerging and innovative models, which we will evaluate against the current West Virginia landscape for appropriateness, viability, and alignment with the State's policy goals.



## Legacy Understanding of West Virginia

BMS can count on our legacy understanding and commitment as we have been supporting West Virginia state agencies since the early 2000s. We have established strong working relationships with State staff, allowing us to see the "big picture" when it comes to creating innovative solutions.

Through the years, we have gained an in-depth understanding and appreciation of your unique health care landscape and the nearly half a million West Virginians served by Medicaid.

### Big Picture Perspective, Innovative Solutions

- **Designing and Drafting the Waiver Application.** We will facilitate strategic sessions with BMS to design the waiver. This step will be informed by our research and understanding of the West Virginia landscape, stakeholder feedback, and emerging and demonstrated successes in other states. Waiver design decisions will be documented and approved by BMS before we begin drafting the waiver application. The waiver application will be drafted, including provisions for quality, monitoring, and oversight, and compliant with all CMS requirements and guidance and include quality oversight and management provisions.
- **Conducting Financial Analysis.** Based on the waiver type (1915(b), 1915(c), or 1115), our team will perform cost effectiveness, cost neutrality, or budget neutrality calculations consistent with CMS requirements and BMS expectations. For example, we would proactively assess the impact of new budget neutrality requirements in the interim final rule and proactively conduct activities such as mapping existing services according to the interim final rule categories, collecting more detailed administrative cost information, and assessing the overall impact and risks to the existing waiver.
- **Supporting Transparency Requirements and Communications.** We support all facets of transparency requirements and BMS's communication needs regardless of the waiver type. These activities may include drafting public notices, developing frequently asked question (FAQ) documents, coordinating public hearings, summarizing comments, advising BMS on any modifications to the waiver content and making BMS-approved changes, as well as supporting BMS throughout the CMS-required public comment process for applicable waivers. In addition to supporting written communications with CMS, we will also support the preparation and delivery of communications to external stakeholders. These materials will be effectively tailored for different audiences to ensure understanding of program purpose and visioned impact.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

- **Assisting with CMS Approval Negotiations.** We will support BMS in the role it deems appropriate during the CMS review and approval process. Our involvement has ranged from being front line and participating in the waiver negotiations with CMS to being behind the scenes and supporting the State with the follow-up information, written letters, and other responses requested by CMS. Key to our support will include sharing insights with BMS regarding the latest written guidance and known decisions, with corresponding considerations and options to drive toward a successful negotiation process. During this process, we will conduct additional research, modeling, and impact assessments of any changes CMS may require.
- **Post CMS Approval Support.** After obtaining CMS approval we will support post approval implementation, monitoring, evaluation, and compliance requirements. For example, we are available to help with finalizing the Special Terms and Conditions (STCs) document and implementing assurances to ensure compliance. We are also available to support the development of the implementation plan, monitoring protocol, and the evaluation design which are all due to CMS after the waiver's approval. We are also well-positioned to support the ongoing monitoring reports, budget neutrality assurances, and interim and summative evaluations as well.

**1915(b) Waiver Considerations**

Specific to 1915(b) waivers, Myers & Stauffer currently manages the 1915(b) MHT and MHP waiver amendments and renewal application processes for BMS. We have assisted with two MHP waiver renewal applications, including the most recent in Spring 2026 for an effective date of July 1, 2026. The MHP waiver will not require renewal again until July 2028. Additionally, we assisted with the most recent MHT waiver renewal application, including transition of BMS's "paper submission" to now providing through the CMS Waiver Management System. The next MHT renewal application will require submission in Spring 2027 for an effective date of July 1, 2027.

Of note for upcoming waiver renewals is that CMS has indicated that monitoring results will no longer be required within the waiver application as similar information is now collected and reviewed via other reporting provided by states. For the upcoming MHT waiver renewal, we will confirm if CMS has released a revised application and address this change accordingly.

For waiver periods beginning in state fiscal year (SFY) 2027, we will support BMS in converting management of the waiver submission process through the new MC-Review state portal web-based system. Our works will also ensure that for any programmatic changes being considered for the MHT and MHP programs, we raise to BMS when amendments or updated cost-effectiveness analysis may be required to the waivers. For example, as planning for 5121 Consolidated Appropriations Act (CAA) implementation continues consideration is needed for whether there are impacts to the 1915(b) waiver (e.g., any new eligibility categories). Additionally, we will review to determine if new requirements are included in the MHP RFP that will result in need for waiver amendment. Should amendments be required, we follow a similar process as above for renewal applications.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Quality Strategy**

Myers & Stauffer will support BMS with the development and federal approval of the Managed Care Quality Strategy (QS) required under 42 CFR § 438.340. Our support will include conducting an assessment of current managed care performance, identifying strengths and opportunities for improved performance, engaging stakeholders, identifying quality measures, assessing baseline performance and performance documented in the EQRO report, recommending targeted improvement goals, and establishing reporting methods and frequencies. We will also support BMS with incorporating language in the MCO contracts to drive accountability for advancing the quality strategy.

Our approach to supporting 1915(c) and 1115 waivers is discussed in *Waiver Program Analysis and Recommendations for Improving Effectiveness and Efficiency (4.2.1.1.11)*.

**Quality Assurances**

For 1915(c) waiver applications, we will support BMS, where needed, to ensure it has addressed the required HCBS quality assurances and required improvement systems in RFP Appendix H (*Quality Improvement Strategy*) of the waiver. Where needed, we will ensure BMS has a written quality strategy aligned with HCBS requirements and has identified performance measures to address CMS assurances and HCBS Quality Measure Set, incorporated methods to collect data (e.g., incident reports, participant surveys, claims, assessments, provider monitoring), identified sources of data to measure and monitor quality, and established a process to evaluate performance and address opportunities for improvement.

## **Waiver/Other Managed Care Program-Related Correspondence (4.2.1.1.10)**

The vendor should describe their plan to develop correspondence, including, but not limited to, waiver applications, letters to federal entities, etc. related to waivers or other managed care program needs.

**Approach and Methodology**

We will assist BMS with development of correspondence related to its waivers and other managed care needs. We currently support BMS with such assistance, as described throughout our proposal, and will continue to draft materials for BMS review and approval prior to submission to CMS. We will also attend meetings with BMS and CMS to respond to any questions or comments that CMS may have or to support BMS in seeking guidance from CMS on managed care related initiatives. We have included additional information about correspondence support we will provide below.

- **Waivers.** We will support correspondences described in our response to *Waiver Applications and Associated Quality Strategies (4.2.1.1.9)*. This will include correspondence such as concept papers or waiver overviews to socialize the waiver with key stakeholders, the waiver application itself, documents to support public transparency, CMS negotiations correspondence, and creating waiver post approval documentation.
- **MCO Contracts.** Myers & Stauffer will continue supporting BMS with managing its contract amendment process and submission of the revised contract to CMS for approval in the capacity requested by BMS. Communications that we will develop include a cover memo to CMS

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summarizing the amendments, the draft contract with track changes to highlight the amendments, and a final contract.

- **Special and Ongoing Managed Care Reporting.** Myers & Stauffer will support BMS with development of CMS required reporting, such as MCPAR, Network Adequacy and Access Assurances Report (NAAAR), and MLR reporting. Additionally, we will assist with any special reporting needs that may arise. For example, if supporting BMS with an MCO readiness review, we will draft the managed care readiness review report for submission to CMS. For all reporting, we will be available to meet with BMS and CMS to address any questions and revise reporting, as required.
- **Formal Letters and Other Correspondence.** Given the extensive changes occurring at the federal level, our experience is that state Medicaid agencies have many questions about implementation of programmatic alterations to address those changes (e.g., community engagement requirements, medical frailty definitions, budget neutrality calculations, etc.). We will continually work with BMS to determine areas where additional information may be needed from CMS and to draft formal letters to CMS with detailed information about the request. We will also be available to draft other types of letters or informal emails to CMS, as needed.

### Waiver Program Analysis and Recommendations for Improving Effectiveness and Efficiency (4.2.1.1.11)

The vendor should describe their plan to conduct analyses of waiver programs and develop recommendations for improving effectiveness and efficiency of waiver programs.

#### Approach and Methodology

Myers & Stauffer will assist BMS with ongoing consideration for how the State can more effectively and efficiently operate and improve its Medicaid program. Throughout this engagement, we will raise considerations to BMS for areas where we recommend BMS consider potential programmatic changes, and we will conduct required analyses to support decision-making about whether such changes would benefit the program. We will also be responsive to BMS's requests for analysis of the State's waiver programs. Our experience and expertise, combined with that of Milliman, allow us to provide such analyses across all waiver types, including 1915(b), 1915(c), and 1115 waivers. For example:

- **1915(c) Waiver Programs.** We will support BMS with analyses of 1915(c) waiver programs that include assessing the adequacy and appropriateness of Title XIX rates to qualified vendors and providers, producing historic rate adequacy review reports and reimbursement rate workbooks, conducting provider audits, service and payment data validation, rate development, and post-payment claims review. Of particular consideration, we are supporting other states with developing and implementing a strategy to successfully eliminate 1915(c) waiver waitlists and could similarly assist West Virginia to improve effectiveness and efficiency.
- **1915(b) Waiver Programs.** Given our extensive work across multiple project areas for BMS, we have a comprehensive understanding of the MHT and MHP 1915(b) waiver programs. For our work with BMS, we will continually assess the most efficient and effective ways to operate these programs to minimize burden for BMS, the MCOs, and providers. For example, as BMS



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continues planning for incorporation of justice-involved youth in compliance with Section 5121 of the CAA of 2023, we will continually assess potential impacts to the current waiver program (e.g., any new eligibility categories), necessary analyses, and required updates. Additionally, we will determine if new requirements are included in the MHP RFP that will result in need for waiver amendment.

- **1115 Waiver Programs.** Myers & Stauffer currently supports BMS with budget neutrality calculations for its 1115 Continuum of Care waiver. Given the recently released changes from CMS regarding budget neutrality calculations, the Myers & Stauffer Team will work with BMS to analyze impacts to the existing budget neutrality calculations on the currently approved waiver, recommend necessary changes, and update the calculations. Given our broad experience supporting waivers across the country, we are available to conduct reviews and evaluations of all aspects of BMS's 1115 waiver operations.
- **1915(i) State Plan Option.** While not a waiver, our team has extensive and successful experience leveraging 1915(i) State Plan options to support states' HCBS strategies. We will research and analyze the State Plan authority option in tandem with waiver authorities, present pros and cons of each option, make recommendations, and offer our rationale supporting our recommendations.

Our plan for analyzing a waiver program and providing recommendations for improving effectiveness and efficiency will be adapted depending on the program under review. We provide the general analysis activities that we will conduct below; however, we will tailor the required activities for each analysis and receive approval of those activities from BMS prior to beginning work.

For any waiver program analysis that we conduct, we will first work with BMS to fully define the goals and priorities for the analysis. For example, an analysis to consider current programmatic challenges and gaps and how those may be addressed will vary significantly from consideration of a new programmatic feature, such as implementation of managed care for a new population (e.g., dual eligibles). We will also want to understand issues, such as level of expected support from the Governor's Office, the Legislature, or other key stakeholders. Based on information learned from BMS, we will leverage our professional experience and approach outlined in *Waiver Applications and Associated Quality Strategies (4.2.1.1.9)* to inform our analysis, which may include the following:

- **Qualitative Research.** We routinely perform comprehensive research on a variety of topics leveraging public and private databases (e.g., PubMed, OpenMinds, Westlaw, VitalLaw), peer-reviewed literature and industry publications, state agency and commercial payer websites, third-party analyses, and legislative reports, as well as state and federal guidance.
- **Quantitative Research.** Our researchers and data analysts are accustomed to receiving datasets, both small and large, from multiple sources and preparing those datasets for analysis. We review the datasets for completeness, missing data, inconsistency in data definitions and field content, and other anomalies. Our established data warehouse that contains BMS data and our

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historical understanding of West Virginia's data allows us to prepare data requests that align with how BMS is able to provide the necessary data.

- **Best Practice Evaluation.** We will research other states that have undertaken similar programmatic changes and the effects of those changes to the extent those are available. We continuously track waivers approved throughout the country and, as a result, understand features that the current administration reviews favorably. This information is important as we consider the degree of flexibility permissible and make recommendations to BMS. Our team will analyze the advantages, constraints, and potential impact of incorporating such programmatic changes. We will approach our analysis by looking for opportunities to build on existing strengths of a state's current programs and initiatives while identifying opportunities for efficiency and effectiveness. We will provide a balanced approach to peer state and best practice research by evaluating similarities while also factoring in evidence of waiver programs that have evidence of demonstrable population health outcomes.
- **Stakeholder Engagement.** We will determine the need for internal and/or external stakeholder engagement to receive feedback that is critical to the analysis, our recommendations, and BMS decision-making. Based on the analysis, we will recommend to BMS the forum for collecting input, which may include key informant interviews, focus groups, town halls, electronic surveys, or other methods.
- **Consider Fiscal Impacts.** Where applicable for the specific analysis, Myers & Stauffer will work closely with Milliman to provide insights into financial implications and to develop fiscal projections and cost estimates of policy decisions, taking into account changes to capitation rates, administrative costs, and overall changes in expenditures. We will include information in our findings as to necessary updates to existing financial sections of the waiver program being analyzed (i.e., cost neutrality for 1915(c) waivers, cost-effectiveness for 1915(b) waivers, and budget neutrality for 1115 demonstrations).
- **Review of Operational Impacts.** Our approach also recognizes that implementation of new or modifications to existing waiver programs often requires new administrative activities for the State, its contracted MCOs, and potentially other vendors (e.g., MMIS, PMO, etc.). States must be able to navigate changes in areas, such as attribution modeling, quality measure identification, baseline benchmarking, performance data analytics, and IT strategies and deployment. As part of our analysis, Myers & Stauffer will identify potential operational changes that may be necessary; the need for new policy, procedures, tools, templates, and reporting development; and training needs of staff, MCOs, providers, or other stakeholders.

Upon completion of our information gathering and analysis, we will provide our findings, as well as any considerations and/or recommendations in a format agreed upon in advance with BMS. We will deliver a report that may include sections, such as background and need for the analysis, methodology used, results of the qualitative and quantitative research, fiscal viability, and recommendations. We will also address any impacts to existing waiver approvals, including information about whether an existing approved authority can be modified or a new authority must be requested. This is critical as each



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authority has its own administrative, operational, and financial implications. We will submit the analyses in draft format to allow for BMS feedback and subsequent revisions prior to finalizing.

### West Virginia BMS

## Demonstrated Experience: Waiver Support

When supporting BMS with integration of its WVCHIP managed care requirements into the MHT contract, we also conducted a deep dive analysis of the State's 1915(b) waivers for areas potentially impacted and in need of updates. We investigated each of the waivers and restructured outdated language to align with CMS' requirements for 1915(b) waivers. This was a highly collaborative process with BMS's Office of Managed Care and included close collaboration with our partner, Milliman, to ensure any capitation or cost effectiveness impacts were also addressed.

### Other State Medicaid Experience

For Kentucky, Myers & Stauffer provided waiver support across several waiver types (e.g., 1915(b), 1915(c), and 1115). Specific to our 1115 support, we assisted with the design and implementation of new Medicaid services targeting needs around SMI services, SUD, recuperative care, and reentry services. We provided intensive consulting services, including program design, project management, comprehensive implementation plans, stakeholder collaboration, policy development and alignment, drafting regulations, creating operational protocols, designing KPIs to measure success, and developing data collection protocols, as well as evaluation frameworks and strategies for sustainability and scalability. We also supported Kentucky with the public input processes required for submission of new 1115 applications to CMS. We continue to support implementation and ongoing operations for various components of the Commonwealth's TEAMKY 1115 waiver.

## Activities Related to 1115 Continuum of Care Waiver (4.2.1.1.12)

The vendor should describe their plan to assist the Agency with activities related to its 1115 Continuum of Care waiver, including but not limited to federal reporting requirements and other analyses, as needed, which should be administered under the managed care organizations.

### Approach and Methodology

We understand West Virginia's Section 1115 Continuum of Care waiver (officially titled "Evolving West Virginia Medicaid's Behavioral Health Continuum of Care") targets adults with SUD or SMI diagnoses and is designed to expand access to the full continuum of behavioral health and SUD services to reduce opioid-related morbidity and mortality, improve care coordination, promote evidence-based treatments, reduce unnecessary emergency department (ED) visits and hospitalizations, improve long-term recovery outcomes, and address health-related social needs (HRSN).<sup>1</sup> Myers & Stauffer's proposed approach to assist BMS with operations for this waiver includes the following mutually agreed-upon activities:

- **Federal Compliance.** We will support BMS on an as-needed basis to monitor its compliance with the waiver requirements and its Standard Terms and Conditions. This will include preparing and tracking submission of required reports and analyses, achieving waiver milestones, and maintenance of required documentation and reports.

<sup>1</sup> [West Virginia \(WV\) Bureau for Medical Services \(BMS\) Section 1115 Waiver Renewal Public Notice.](#)

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- **Monitoring of the Waiver Metrics.** This may include tracking enrollment and eligibility trends, utilization of waiver services, operational issues and potential resolution, access to services, financial performance, and other performance indicators required by CMS. We will conduct these and other analyses, as needed, to support BMS.
- **Budget Neutrality.** Our Team will also support the calculation of budget neutrality for the waiver. Our Team, which includes certified actuaries, are well equipped to support BMS with developing and presenting budget neutrality calculations for review and approval by CMS. Our resources will be particularly important given CMS' announced intention to require greater rigor and CMS' Chief Actuary's approval of budget neutrality for new or renewal waiver applications on and after January 1, 2027.
- **Demonstration Renewal and Amendments.** Our Team is available to guide BMS with activities related to the renewal or any amendments related to the waiver. This may include stakeholder engagement, strategic planning, authorities that need to be waived, benefits for inclusion, drafting of the waiver application and public transparency documents, addressing public comments, as well as supporting post-approval documents that may be required by CMS.

As we conduct these activities, we will collaborate with BerryDunn, as needed, on waiver operations, and assist BMS with ensuring proper waiver administration through the MCO contracts. For example, we will ensure services, such as those addressing HRSN, pre-release Medicaid services for incarcerated individuals up to 90 days before release, recovery-related support services, and other services are accessible to MCO members and being provided consistent with the waiver and its provisions. We will also make sure these requirements are accurately and clearly reflected in the MCO contracts and accounted for in the capitation rates. Similarly, we anticipate supporting BMS with downstream reporting and processes and will support the reporting template development, tracking of MCO report submissions, and monitoring of reported information, as needed by BMS.

#### Policy Impact Analyses and Support to the Agency (4.2.1.1.13)

The vendor should describe their plan to 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).

#### **Approach and Methodology**

The Myers & Stauffer Team has conducted a wide variety of policy analyses of various sizes to support West Virginia and other clients' assessment of policy options, federally required changes, and their potential operational and fiscal impacts, including the impact on the MCO program and contracts.

Our approach can be scaled based on the specifics and complexity of the analysis but starts with deploying our experienced team. We make available our highly qualified, multidisciplinary team of professionals (e.g., policy analysts, researchers, healthcare attorneys, academic researchers, reimbursement specialists, financial analysts, clinicians, etc.), across a variety of staffing levels to provide research, policy expertise, and technical support based on specific policy analysis being

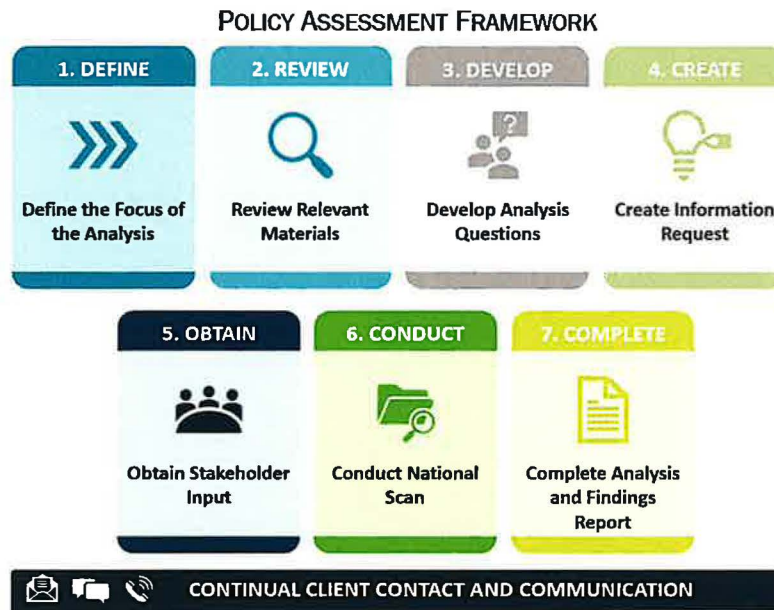


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performed. When necessary, we draw from our deep bench of SMEs with direct experience managing and supporting Medicaid, CHIP, and other social service programs impacted by the policy change.

We will leverage our proven Policy Assessment Framework that is outlined in detail in *Figure 4*. This customizable approach includes various activities that may be conducted; however, we will tailor our approach to meet the specific requirements for each analysis and based on our discussions with BMS.

Figure 4. Policy Assessment Framework



As we implement our Policy Assessment Framework, we will conduct the following activities:

- **Define the Focus of the Policy Impact Analysis.** As policy impact analyses can have multiple aims or purposes, we will meet with BMS to ensure we understand the policy it is considering. Discussions may also include, as relevant, ensuring consensus on interpretation of federal or state regulation or policy that is driving the request for analysis.
- **Review Related Materials.** We review existing materials and request additional data or inputs, where needed, to inform the analysis. For example, if the request is in response to a legislative request or a proposed bill, we will review the proposed bill, existing regulations, and other materials the Bureau may have developed in response to this or similar legislative requests, etc. This is a general review to gain an understanding of the issues at hand to support our drafting of analysis questions and any data requests.
- **Develop Analysis Questions.** Based on the understanding we gain from our review of materials and discussions with BMS, we will identify questions to drive our research and analysis. Questions will be specific to each individual analysis; however, general sample questions might include:
  - What are the expected impacts on quality, cost, access, and outcomes?

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- What are the expected impacts to each eligibility category of members subject to the change?
  - What are the expected impacts to providers serving the populations affected by the change?
  - What are the estimated fiscal impacts, including both benefit expenditures and administrative expenditures?
  - Will there be any systems impacts (e.g., MMIS, enrollment, etc.)?
  - What are the potential staffing needs?
  - Will services need to be procured or existing contracts amended? For example, what are the MCO contract implications, if any?
  - What can we learn from other states' experiences in implementing similar policies that might be applicable in West Virginia?
  - What are the potential unintended consequences of the change?
- **Create Information Request.** Based on the analysis questions, we may need to develop an information request to submit to BMS, MCOs, or other state agencies. However, we will leverage our existing data warehouse, where possible, to avoid the administrative burden of additional data requests to the Bureau. We may access data, such as claims, provider, member, outcomes, quality, financial, or other data. This may include reports that have been completed by BMS or other entities that will inform this analysis and BMS's decisions. As needed, we will work with MMIS staff to ensure we submit data requests in the format required and validate the data received. While we will work to submit a thorough information request, we anticipate that in some studies, additional information may be needed as our analysis progresses, and we will keep BMS apprised of such needs.
  - **Obtain Stakeholder Input.** For more in-depth policy analysis, we may recommend obtaining stakeholder input. Often, how a policy or initiative is implemented is equally important to its success as the soundness of the change itself. Obtaining key stakeholder feedback, including balanced perspectives, may be an essential component of a given analysis to understand perspectives on advantages and disadvantages of the change. Myers & Stauffer is prepared to conduct a variety of stakeholder activities, such as interviews, focus groups, task forces, and surveys. Learning of stakeholder concerns early provides the opportunity to explore refinements or alternative options that will provide the intended results while achieving greater stakeholder acceptance and less provider abrasion.
  - **Conduct a National Scan.** Building on our research, our analysis will include reviewing similar policy impacts in other states. Therefore, we may conduct a national scan to understand best practices, implementation approaches, early successes, and lessons learned. We want to understand experience regarding quality, cost, access, and outcomes. We recognize that one state's experience is one state's experience, so we will always consider applicability of findings in the context of West Virginia's programs.



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- **Complete Analysis and Submit Findings.** We will analyze all the materials, data, and information collected, and present our findings to BMS. Our analysis and documentation to BMS will include a review of policy options, including the advantages and constraints of each, as well as our recommendations and rationale. Our recommendations consider the operational and fiscal impacts to BMS, alignment with state and federal requirements, and importantly, the feasibility of each option.

We recommend ongoing meetings at a cadence to be determined based on the requested analysis so we can provide updates to BMS about our analysis, methodology, assumptions, and findings and to receive BMS's feedback. We will adjust our assumptions and other inputs based on that feedback and present ongoing findings in an iterative manner. Throughout this process, Myers & Stauffer's recommendations and rationale will be provided to BMS in a collaborative process. We will create reports, presentations, talking points, or other briefs, as agreed upon, for each analysis to support BMS's communication of analysis results to both internal and external stakeholders, as requested. We are also prepared to present findings to BMS leadership or stakeholders, as requested.

Should BMS decide to implement the policy change, we are also prepared to assist the Bureau with planning, implementation, and post-implementation support. Those activities may include overall project management, pursuit of any federal authority, facilitation of meetings, updates to the MCO contract language, assistance with staff trainings, support for procurement of other vendors, readiness reviews, and monitoring and evaluation of results. We will also develop a roadmap for implementation that will include a work plan identifying all tasks, milestones, time frames, and assigned resources necessary to implement the policy change. As part of our ongoing project management activities, we will monitor progress, identify risks, consider dependencies, document decisions, and support strategies for addressing issues. Post-implementation, our monitoring and evaluation services will assess the impact of policies implemented, their effectiveness, and opportunities to refine them. As policies or programs implemented continue to evolve, post-implementation analyses are important to assess success, need for changes, sustainability, or even to determine the continued need for the program or policy.

### Revision of Analyses, MCO Compliance Oversight, and Separate MLRs (4.2.1.1.14)

The vendor should describe their approach and methodology 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. The vendor should describe their plan to oversee MCO reporting in compliance with the code of federal regulations. Separate MLRs for Medicaid and WVCHIP are required. The vendor should describe their plan to also address any additional MLR-related requests from the Agency at no additional cost to the Agency.

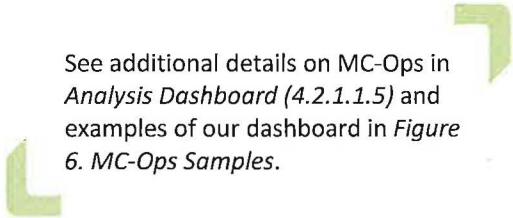
### Approach and Methodology

#### Revisions to Analyses

We understand policy and program development is an iterative process and that Medicaid programs face ongoing changes as new federal rules are implemented and state legislatures are continually implementing new regulations. As discussed throughout our proposal, we continuously monitor

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legislative developments and proposed federal rules through tracking tools, internal diligence, participation in discussions with CMS and all 50 states, and active participation in national conferences and industry groups. This means, along with our adaptive models we develop, we are prepared to revise any analyses based on future releases of requirements or revisions at the state or federal level. Anticipating these revisions, we build our quantitative models, where possible, to be dynamic with input parameters that can be adjusted with those changes flowing throughout our model. For example, we may include easily modifiable assumptions regarding population acuity levels, utilization percentages, provider tax rates, reimbursement increases, etc. to facilitate financial impact analyses and subsequent updates. As new or updated information is gathered, or changes in policy guidance occur, we remain flexible and responsive and revise our analyses. We are also adept at responding to changes to policy design and implementation features that require more qualitative assessment of policy impacts. This may take the form of additional stakeholder forums, follow-up with key informants, publishing electronic survey addendums, or other methods. We work to stay abreast of changes at the federal or state level and monitor other states' implementations of new initiatives or new policies. Therefore, we will also notify BMS when we recommend updates to any prior analyses based on our understanding of ongoing industry changes.



See additional details on MC-Ops in *Analysis Dashboard (4.2.1.1.5)* and examples of our dashboard in *Figure 6. MC-Ops Samples*.

**Plan to Oversee MCO Reporting**

The Myers & Stauffer Team will oversee MCO reporting, monitor MCO compliance, and provide our observations and assessment to BMS along with our recommendations. Our recommendations may include meeting with the MCOs to discuss performance, the issuance of corrective action plans, updates to MCO contract language, or potentially clarification of reporting requirements. Our oversight of MCO reporting starts with a set of standardized report templates that we continuously review to ensure they meet the oversight and monitoring needs. As new programs, program requirements, contract amendments, or federal changes are implemented, we will update these templates and the reporting calendar, if needed, to ensure access to the appropriate data elements to assess MCO compliance and performance.

We will utilize our proven technology solution, MC-Ops, to track all MCO report submissions and identify timeliness and completeness of the MCO submission. Over the last four years, this platform has significantly improved BMS's oversight of timely and complete reports from the MCOs which has allowed more time for the analysis of performance and increasing MCO accountability. The MC-Ops platform includes a calendar and inventory of reports required from the MCOs. The MCOs upload these reports using common report naming conventions, and Myers & Stauffer monitors submission compliance. Upon submission, BMS has a single repository of MCO reports with time and date stamps of when the reports were submitted. This removes any back and forth regarding claims of submission or lack of receipt. MC-Ops serves as the source of truth for reporting. Our solution also preserves continuity of monitoring, even during state staffing turnovers. There is no question of whether the



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

reports were received or not and alerts are issued to Myers & Stauffer, BMS, and the plan of noncompliance.

MC-Ops ingests and stores these standardized MCO reports to assess compliance and report on information in customized interactive dashboards that aggregate, display, trend, and analyze health plan information and tracks corrective action plans (CAPs). Another feature of our solution is the ability to set criteria for certain thresholds within a single report, and once exceeded, the system can flag this as an issue for review. For example, this could be of use when the number of days between claims adjudication and provider payment exceeds an established threshold. These issues could be flagged systematically and escalated for review and potential corrective action. Our oversight of MCO reporting will provide regular checkpoint reviews of the data to identify any negative trends or missing data, as well as status updates with BMS stakeholders. Monitoring will also include early insight into results in comparison to previous periods and other markets, where applicable. If requested, we will support BMS with discussions with an MCO about the findings and to allow the MCO the opportunity to further convey any issues driving the identified trends. As needed, we will notify BMS when we recommend requiring an MCO to submit a CAP or when penalties could be assessed in accordance with the MCO contract. Additionally, we leverage the MCO compliance reports, encounter data, and eligibility data to complete the CMS and legislatively required reporting, including CMS-required reports like the MCPAR and the NAAAR. These reports are vital to CMS' comprehensive assessment of BMS's compliance with federal and state reporting and PNA to ensure timely access to covered services.

**MLRs for Medicaid and WVCHIP**

Myers & Stauffer will conduct annual MLR examinations inclusive of distinct calculations to determine the MLR percentages and any resulting remittance amounts for each MCO for the Medicaid and WVCHIP populations, respectively. These calculations will be further segmented and reported for MHT, MHP, and WV CHIP populations.

Further details of our MLR approach can be found in our response to and 4.2.1.1.1, 4.2.1.1.7, 4.2.1.1.14, 4.2.1.2.1, and throughout our proposal.

A consolidated MLR template will be used to report all member population amounts, inclusive of total column amounts for the MHT, WVCHIP, and MHP programs. Additionally, we will accommodate and respond to any MLR-related requests from the Bureau, internal state auditors, the Office of Inspector General (OIG), or other federal agencies on an ad hoc basis at no additional cost. Such requests may involve meetings or discussions to ensure that Myers & Stauffer fully understands the request and associated deliverables, the details of our procedures, meeting with the MCOs, or other activities. We also understand the MLR process is iterative, and we will work collaboratively with the MCOs to explain our process and obtain additional information and clarification from them, as needed. As additional information is received, we will update our calculations, as appropriate, under the CMS requirements and guidance.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

## Federal Regulations/Requirements Monitoring and Program Impact Analyses (4.2.1.1.15)

The vendor should describe their plan to monitor federal regulations and requirements for potential changes and provide analyses on program impact within thirty (30) calendar days of notification.

### Approach and Methodology

We continuously maintain dialogues with state Medicaid officials, CMS executives, and industry leaders across the nation to closely monitor the state and federal healthcare regulatory and legislative environments and provide our clients with guidance and strategic insight.

Our approach to serve BMS with monitoring and impact assessment of federal regulatory and legislative changes will include our constant surveillance of a variety of proprietary databases, public resources (e.g., electronic CFR, United States Government Publishing Office websites, state government websites), and private service resources (e.g., Bill Track 50, Vital Law Legal Research Database, etc.). We have found these tools allow us to be proactive in identifying potential actions that may have an impact on our clients. It also provides an opportunity for Myers & Stauffer to provide our clients with information that may be used during the rule-making or legislative process to refine the rule or statute before it becomes final.

For any program impact analysis that we conduct to support BMS with consideration of federal regulations and requirements, we will give careful consideration to the potential impacts of changes across areas, such as quality, access to care, delivery system structure, administrative burden on providers, population health, IT, healthcare expenditures, program financing, federal authority, impact to BMS workforce, and other factors. Our review and analysis will follow the policy impact analysis process discussed in our response to *Policy Impact Analyses and Support to the Agency (4.2.1.1.13)*.

As we conduct our analysis, we will leverage our firm's vast experience supporting government-sponsored healthcare programs, qualitative and quantitative research methods, stakeholder engagement activities, and drafting legislative analysis reports. Most important to our analysis is that we come to it understanding BMS's program, goals, data, and interest.

We will complete a legislative and regulatory impact assessment and will request a meeting with BMS to provide a walk through and discussion of our findings. Should additional analysis be needed in specific areas, we will update our analysis based on BMS's feedback. We will also provide briefs, speaking points, and other materials to help BMS communicate the impact to both internal and external audiences. We understand the need for timely analysis and will ensure our analysis of new legislation or regulatory requirements is provided to the Bureau within 30 calendar days of notification.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****West Virginia BMS****Demonstrated Experience:  
Regulations/Requirements Monitoring**

As part of our monitoring of federal regulations and requirements, we have invested significant resources to drive BMS's compliance with the Final Rules impacting BMS's managed care programs. For example, we have incorporated the rule's requirements into the MCO contract monitoring and oversight processes, updated MCO contract requirements, and developed new or enhanced existing protocols, such as PNA, to measure compliance with updated federal requirements.

To identify and track the fiscal impact of the various Final Rules promulgated, we have developed a detailed tracking tool. Our tool has served as a living document and includes direct reference to the specific rule and CFR requirements, categories of impacted areas (e.g., access to care, managed care, nursing facility), assumptions and sources used in our analysis, and fiscal impact by SFY. As part of our development and tracking of these items, the Myers & Stauffer Team worked closely with BMS to gain a holistic view of the fiscal impacts for use in BMS budgeting.

**Other State  
Medicaid  
Experience**

Our Medicaid SMEs have supported our clients with analysis, impact assessments, and other consulting services related to federal changes to health care programs. Examples of analyses include review of the following:

- One Big Beautiful Bill Act (OBBBA) (P.L. 119-21).
- Community Engagement Interim Final Rule (CMS-2454-IFC).
- CMS 1115 Budget Neutrality Guidance (SMD #26-003).
- Medicaid and CHIP Managed Care Access, Finance, and Quality (CMS-2439-F). Final Rule, as well as the 2016 Managed Care Final Rule (CMS-2390-F).
- Ensuring Access to Medicaid Services (CMS-2442-F).
- 42 CFR Part II.
- HCBS Settings Final Rule (CMS-2249-F).

**Managed Care Contract Performance Analyses and Monitoring  
(4.2.1.1.16)**

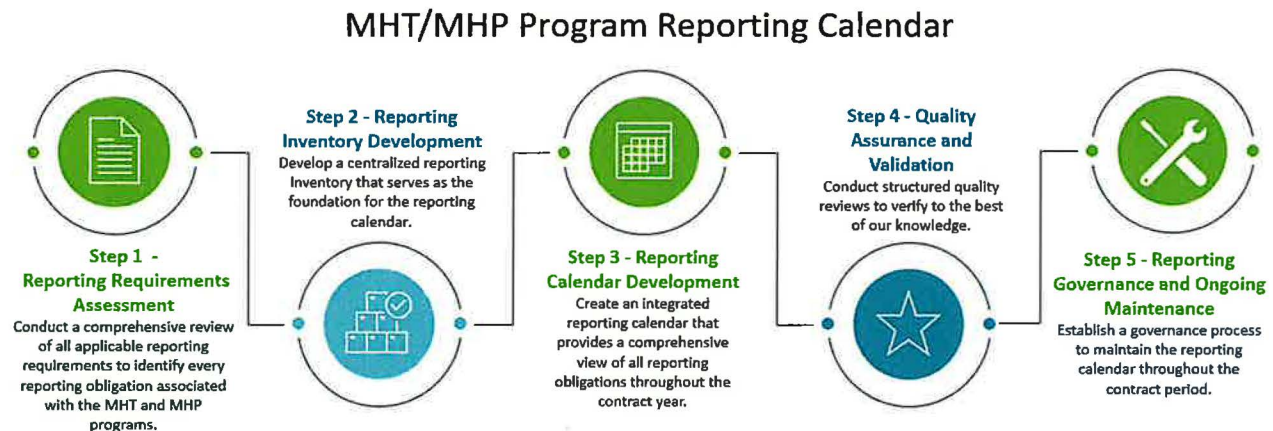
The vendor should describe their approach and methodology to analyze and monitor Managed Care contract performance by conducting program readiness documentation and desk reviews. This includes assessing new entrance initial go-live readiness, reviewing MCO operations, and evaluating new populations added to managed care. Ongoing reviews of the four (4) existing MCOs should 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 should be submitted within 30 calendar days.

**Approach and Methodology  
Contract Performance and Monitoring**

We propose to continue conducting contract performance and monitoring oversight using the process shown in *Figure 5*. Our successful approach includes establishing a shared understanding of expectations and timelines for submission, review and resolution, as well as an environment of accountability.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

Figure 5. MHT/MHP Program Reporting Calendar

*Step 1 - Reporting Requirements Assessment*

Myers & Stauffer will conduct a comprehensive review of all applicable MCO reporting requirements to identify every reporting obligation associated with the MHT and MHP programs. This assessment includes reviewing:

- Current MHT and MHP managed care contracts.
- Federal Medicaid Managed Care Regulations (42 CFR Part 438).
- CMS guidance, reporting FAQ, webinars, etc.
- BMS policies and reporting guidance.
- Existing matrix of required reports.
- Previous report review findings.

We will facilitate interviews and working sessions with BMS to document the reporting processes and workflows, identify business owners for each report, identify opportunities to streamline reports, and identify any unmet reporting needs that BMS may have.

*Step 2 - Reporting Inventory Development*

Following the assessment, Myers & Stauffer will develop a centralized reporting inventory that serves as the foundation for the reporting calendar. Each reporting requirement will be documented with:

- |                         |                                                    |
|-------------------------|----------------------------------------------------|
| • Report title.         | • Submission recipient/method.                     |
| • Program (MHT or MHP). | • Recommended file name.                           |
| • Contractual citation. | • Validation requirements.                         |
| • Reporting frequency.  | • Applicable performance measure.                  |
| • Due date.             | • Risk level.                                      |
| • Business owner.       | • Notes and supporting documentation requirements. |
| • Data source(s).       |                                                    |
| • Required approvals.   |                                                    |



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)***Step 3 - Reporting Calendar Development*

Using the validated inventory, Myers & Stauffer will create an integrated reporting calendar that provides a comprehensive view of all reporting obligations throughout the contract year. The calendar will include:

- Weekly, monthly, quarterly, semiannual, annual, and ad hoc reports.
- CMS reporting submissions and deadlines.
- State reporting deadlines.
- Internal review milestones.
- Leadership approval dates.
- Data validation deadlines.
- Resubmission deadlines.
- Post-submission reconciliation activities.

*Step 4 - Quality Assurance and Validation*

Quality assurance is integrated throughout every phase of the reporting life cycle. Myers & Stauffer will conduct structured quality reviews on an annual basis or more frequently upon request to verify the following:

- Data completeness.
- Accuracy.
- Consistency.
- Regulatory compliance.
- Contract compliance.
- Trend analysis.
- Outlier identification.
- Required approvals.

Any identified issues will be documented, assigned for resolution, and tracked through completion in Smartsheet. Based on the report and the protocols established with BMS, notification will be escalated to the appropriate BMS resource along with the actions Myers & Stauffer is taking to address the issue or deficiency with the MCO.

*Step 5 - Reporting Governance and Ongoing Maintenance*

Recognizing that reporting requirements change over time, Myers & Stauffer will establish a governance process to maintain the reporting calendar throughout the contract period. Governance activities will include:

- Monthly reporting status meetings.
- Quarterly compliance reviews.
- Monitoring CMS regulatory updates for changes in reporting requirements and time frames.
- Monitoring State policy changes.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

- Tracking contract amendments that impact reporting due dates.
- Updating reporting schedules.
- Reviewing reporting ownership assignments.
- Ongoing reporting calendar refresh with an annual re-evaluation.

Our team will also maintain a reporting issue log that documents reporting risks, corrective actions, missed deadlines, and process improvements.

**Readiness Reviews**

Myers & Stauffer has extensive experience performing readiness reviews prior to implementing managed care programs, expanding managed care contracts to include new eligibility groups or additional covered benefits, contracting with new MCOs, and assessing the ongoing performance of existing MCOs. We will complete readiness reviews for any new MCO entering the market within four months required by BMS. Our readiness reviews are consistent with the requirements at 42 CFR § 438.66 and are performed with the highest level of independence and objectivity. Our goal is to ensure an MCO's operational readiness and ability to serve Medicaid and CHIP beneficiaries.

We have developed a readiness review tool that has been implemented in multiple states, including West Virginia. The tool is similar to the CMS readiness review tool but captures additional compliance requirements specific to the individual state's contracts and regulations. Our enhanced readiness review tool will be customized based on the specific issues and environment in West Virginia and will not be constrained by a one-size-fits-all national tool. This provides the State with a higher level of confidence in MCO readiness with a comprehensive analysis of detailed compliance requirements. However, results are readily transferred into the CMS template for their reporting and approval.

To support BMS with readiness reviews, we will proactively update this tool prior to readiness review activities based on updates to the MCO contracts, CMS regulations, industry best practices, and lessons we have learned conducting readiness reviews in other states. Our tool tests readiness in the areas of member services, eligibility file processes and application, PNA, care management, claims administration, technology and systems readiness, staffing, financial readiness, and demonstration of operational readiness, among other areas. We will tailor the tool, as needed, for the individual review and whether it needs to be scaled back to focus on one operational area for a large programmatic change (e.g., new technology and systems requiring new connectivity and testing) or to conduct a comprehensive review of a newly contracted MCO.

We use various techniques to complete readiness reviews, such as desk reviews, staff interviews, observations of processes and systems in action, and in-person/on-site assessments of readiness, when appropriate. We will customize our approach to readiness based on the type of review needed, BMS's feedback, specifics of the contract between BMS and the MCOs, and known risks or concerns. Additionally, if BMS staff participate in the reviews, we will provide training on required processes and documentation needs.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

Our approach includes setting expectations with the MCOs early, being transparent regarding the readiness process, and communicating requests and status frequently. With BMS's permission, we propose holding a readiness review kickoff meeting with the MCOs. During this meeting, we would ask that BMS introduce our role in the readiness review and set the tone for MCO compliance with the process and our requests. We will also explain how the readiness assessment will be performed, how data and information requests will be made and tracked, and ensure the MCOs understand their responsibilities. A single point of contact for each MCO to coordinate requests will be requested, and we will establish escalation procedures should issues be identified. A timeline for the assessment along with key milestones and requirements of the plans will be provided.

We initiate our readiness review activities within a time frame to complete the initial assessment no less than four months of go-live with the written report delivered to BMS within 30 calendar days of completion. During our recurring project status meeting with BMS, we will provide updates on the readiness review, discuss any issues, and provide any early insights into readiness, risks, and recommended corrective actions. We will ensure ongoing, thorough communications so our final report includes no surprises to BMS or the MCO.

Upon completion, we will present readiness findings that have been prepared in the CMS-required template to BMS through a formal Go/No-Go review. We recommend this decision be made no later than 30 days prior to scheduled go live. We will discuss our objective findings, recommendations, and rationale for those recommendations. Our recommendations may include:

- **Go:** All critical readiness criteria have been met.
- **Go with Conditions:** Minor issues remain but do not pose significant risk to members, providers, or program operations, but corrective actions should be tracked.
- **No-Go:** Critical operational, compliance, or system deficiencies create unacceptable risk to members, providers, or the program.

Throughout our readiness review, we will conduct an independent and objective assessment; clearly communicate expectations, timelines, and criteria with the MCOs; work collaboratively with all parties; and document and share observations with the MCOs in a constructive manner to support their understanding and remediation of the risk or issue. We will escalate findings, areas in need of remediation, and other concerns to BMS in a formalized, approved escalation pathway.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**


## **Demonstrated Experience: Managed Care Contract Performance Analyses and Monitoring**

### **West Virginia BMS**

In a highly interactive and engaged process with BMS, the Myers & Stauffer Team has supported a rigorous go-live readiness review process to ensure health plans and their subcontractors are ready to serve BMS beneficiaries. For example, we conducted both desk and on-site reviews for the implementation of a new health plan and its subcontractors. Our detailed review identified issues with policies, staffing, staff training, systems readiness, and other operational components that created a risk of the plan not being ready by the planned implementation date. Throughout this process, we applied the CMS-approved readiness review tools, prepared readiness review reports, delivered recommendations to BMS, and supported management of MCO corrective actions. Based on our detailed review and recommendations, the go-live date was delayed, ensuring readiness to serve West Virginians enrolled in MHT.

### **Other State Medicaid Agencies**

For Kentucky, we performed readiness reviews for two managed care programs, as well as state readiness reviews. Our work included reviews of six MCO contracts, including two newly contracted MCOs, as well as reviews for implementation of a new managed care program, Kentucky SKY. Our work included developing readiness review tools, conducting staff training, facilitating desk reviews, supporting virtual MCO interviews, preparing reports for the Department and for CMS, and monitoring MCO corrective actions. As part of our review for Kentucky SKY, we assessed the readiness of one plan specifically designated to serve children in state custody through the foster care system. To protect this vulnerable population and ensure continuity of care, we developed additional readiness criteria the Medicaid and child-serving agencies needed to ensure were in place. This required intensive cross agency facilitation and working closely with the MCO to ensure their understanding of requirements and readiness.

## **Analyses and Ongoing Monitoring of MCO Provider Networks (4.2.1.1.17)**

The vendor should describe their approach and methodology to perform analyses and conduct ongoing monitoring of MCO provider networks and conduct quarterly analyses of the MCOs' networks against program requirements.

### **Approach and Methodology**

Myers & Stauffer has made great strides with BMS in improving overall PNA monitoring through the annual PNA assessment described in *Annual Network Adequacy Assessments (4.2.1.1.3)*, and monitoring provider networks through quarterly reports that the MCOs are required to submit. These reports contain information that identifies network changes reported by the MCOs at an aggregate level. As these quarterly reports are submitted, our monitoring efforts note, for example, when terminated providers may impact contractual compliance. Our dashboard platform, MC-Ops, contains trending metrics on primary care network growth and contracted providers at a summary level. These efforts currently monitor aggregated metrics self-reported by the MCOs.

Going forward, Myers & Stauffer plans to implement enhancements to the MCOs' quarterly provider network reporting requirements. These enhanced requirements will distinguish our PNA assessment from our competitors, improve the data points available to assess true access to services, and serve as the interim tool for network adequacy monitoring between annual PNA assessments. Our recommended enhancements to the process and reporting include:



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- **Provider Roster Tracking.** We will request that MCOs share information, such as the quarterly provider rosters that they already produce for BMS's EQR vendor. We will validate these provider rosters against provider enrollment files received from BMS's MMIS.
- **Enhanced MCO-reported Metrics.** We will work with BMS to recommend updates to current MCO reporting on provider network changes. These updates will expand on current reported metrics, such as primary care provider (PCP) member panels and provider credentialing. We will also recommend additional quarterly reported metrics, including the total number of services per provider, average cost per visit per provider, and metrics for additional provider types.
- **Ongoing Evaluation Against Contractual Provider Network Standards.** We will incorporate analytical methods that are already deployed for the annual PNA assessment performed by Myers & Stauffer. These methods will incorporate time and distance standards and member-to-provider ratios that can be evaluated on a trending basis. This will strongly enhance oversight, as BMS will be able to monitor adherence to contractual standards throughout the year as opposed to the single point-in-time view of the current annual PNA assessment.
- **Cross-referencing Reconciled Encounter Data.** We will use the bimonthly encounter data validation (EDV) analysis to help identify utilization metrics within the provider network and identify anomalies or changes over time. This will allow us to calculate metrics like average services per member, average cost per visit, and similar utilization factors.

By leveraging data sources that are already prepared, recommending minimal targeted template updates, and referencing our annual PNA analysis methodology, these recommended enhancements will produce better insight into network adequacy on a quarterly basis. Our proposed strategy does not create undue administrative burden on the MCOs. This comprehensive approach will:

- Deepen the understanding of how each MCO's network is performing when compared to peer MCOs.
- Supports validation of MCO-reported provider network metrics.
- Allow filtering within MC-Ops to provide users with options to view statewide, regional, and individual provider metrics and trends regarding both available and utilized services, which cannot be as easily understood by reviewing a single report.
- Facilitate an understanding of how networks are performing over time by allowing BMS to review performance trends for each MCO quarterly instead of at a point in time.

### MCO-Specific Reports and Maps (4.2.1.1.18)

The vendor should describe their plan to develop MCO-specific reports and maps showing providers, clinics, and hospitals by specialty and location. Information should be submitted within ten (10) calendar days of request, unless otherwise noted.

### **Approach and Methodology**

To meet this requirement, Myers & Stauffer will use contractually required MCO reporting combined with encounter information from the MMIS to develop dashboards that map providers, clinics, and hospitals statewide by specialty and location. The primary data for this report will come from quarterly

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

provider rosters that each MCO currently submits to BMS's EQR vendor. We will request these provider rosters and import them into our MC-Ops solution where each location is documented with a point on the map. Leveraging MC-Ops will allow BMS to quickly produce a map for a specific specialty, geographic area, or MCO. We commit to providing the requested information within the required 10 calendar days of the request. This approach also allows BMS to review historical information, quickly comparing providers that were previously on the roster to the updated report each quarterly report.

In addition, Myers & Stauffer will supplement this mapping information with encounter data to get a better understanding of the level of services provided at each location during a given period. We will also incorporate methodologies from our annual PNA assessment to monitor contractual provider network standards ongoing.

We propose the use of provider network key performance indicators (KPIs), such as:

- **Statewide Metrics.**
  - Map pinpointing provider, clinic, and hospital locations.
- **Regional Metrics.**
  - Average number of visits per member per quarter.
  - Average number of members seen per provider.
  - Average cost per visit.
  - Average time/distance to providers.
  - Average provider-to-member ratio.
- **Individual Metrics.**
  - Number of members the provider sees each quarter.
  - How many members use this provider as a PCP.
  - Average number of services provided to Medicaid members by the provider each quarter.
  - Average cost per visit.

We will integrate these metrics and associated maps into our MC-Ops tool, enhancing our existing technology to support our efforts. Because of the flexibility of our tool, one dashboard can present the data in different views, such as statewide or geographic displays, focus on one or many provider types (PCP, obstetrician/gynecologist, pediatrician, etc.), networks by MCOs, programs (e.g., MHT, MHP), and other views. Myers & Stauffer will be able to support different functional areas within the Bureau, including:

- **Managed Care:** perform oversight and quickly identify contractual compliance.
- **Quality:** identify regions where standard of care can be improved.
- **Program Integrity:** identify outlier providers that should be further reviewed.

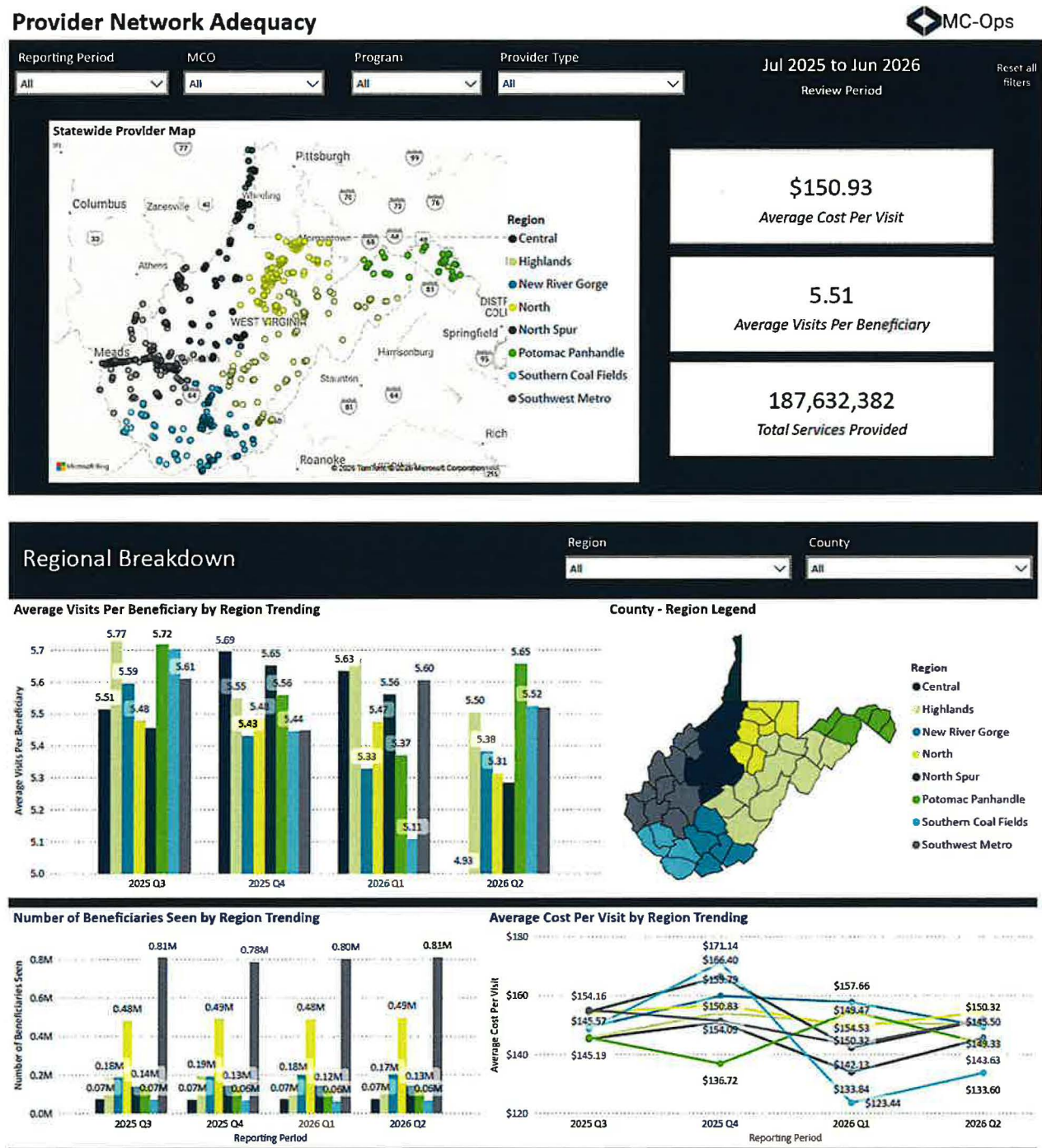


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Our proposed approach will greatly enhance the monitoring and oversight of provider network adequacy and support the bridging of gaps in timely access to services.

Figure 6 provides examples of our PNA dashboards, maps, and reports.

Figure 6. MC-Ops Samples



## PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)

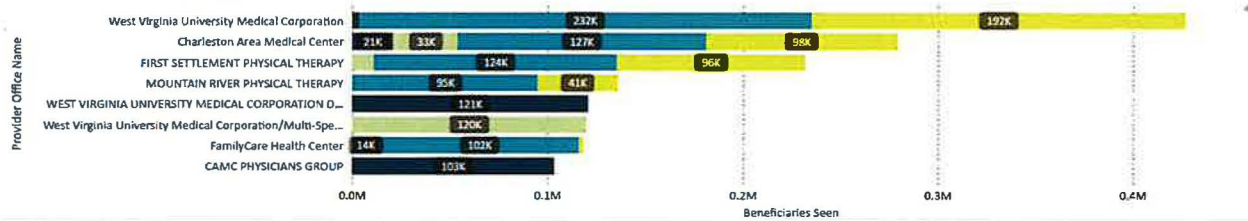
## Provider Detail

Provider Office Name

All

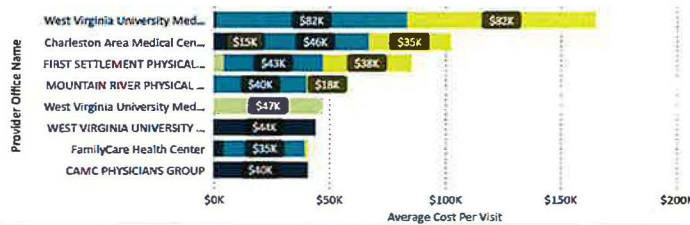
## Total Beneficiaries Seen by Provider and MCO

MCO ● AETNA ● HHOWV ● THP ● WELLPOINT



## Average Cost Per Visit by Provider and MCO

MCO ● AETNA ● HHOWV ● THP ● WELLPOINT



## Providers with Highest PCP Usage

|                                                      |        |
|------------------------------------------------------|--------|
| West Virginia University Medical Corporation         | 63,569 |
| Charleston Area Medical Center                       | 47,629 |
| FamilyCare Health Center                             | 33,746 |
| WEST VIRGINIA UNIVERSITY MEDICAL CORPORATION DBA UHA | 25,806 |

| NPI Number | Provider Office Name                                   | Provider Type         | County  | Region          | Total Services Provided | Beneficiaries Seen | Average Cost Per Visit | Average Visits Per Beneficiary | Beneficiaries Using as PCP |
|------------|--------------------------------------------------------|-----------------------|---------|-----------------|-------------------------|--------------------|------------------------|--------------------------------|----------------------------|
| 1285785451 | A Place To Heal                                        | SPEC_FREQ_PT          | Raleigh | New River Gorge | 31,524                  | 946                | \$611.41               | 26                             |                            |
| 1760143002 | A Set Chance                                           | BH_PROV_UCSW          | Fayette | New River Gorge | 36,529                  | 1823               | \$306.53               | 28                             |                            |
| 1295106854 | A SPECIAL TOUCH IN-HOME CARE                           | SPEC_OTHER_HOMEHEALTH | Kanawha | Southwest Metro | 42,782                  | 2269               | \$345.72               | 23                             |                            |
| 1942967013 | ABELE, REBEKAH R                                       | PCP                   | Kanawha | Southwest Metro | 39,620                  | 2418               | \$859.42               | 34                             | 622                        |
| 1386682540 | Access Health                                          | SPEC_OTHER_DME        | Raleigh | New River Gorge | 40,428                  | 1719               | \$370.59               | 18                             |                            |
| 1164862660 | Access Health Fayette Clinic/FM                        | PCP                   | Raleigh | New River Gorge | 37,266                  | 1347               | \$392.01               | 22                             | 686                        |
| 1851659387 | Access Health Fayette Clinic/FM                        | PCP                   | Fayette | New River Gorge | 43,475                  | 2288               | \$560.97               | 16                             | 672                        |
| 1013995851 | Access Health OB-GYN                                   | OBGYN                 | Raleigh | New River Gorge | 46,586                  | 1367               | \$637.34               | 14                             |                            |
| 1346200599 | Access Health OB-GYN                                   | OBGYN                 | Raleigh | New River Gorge | 37,134                  | 2421               | \$1,246.82             | 24                             |                            |
| 1346200599 | Access Health OB-GYN                                   | PCP                   | Raleigh | New River Gorge | 32,443                  | 1595               | \$511.31               | 27                             | 648                        |
| 1265429831 | AccessHealth                                           | PCP                   | Raleigh | New River Gorge | 50,442                  | 1504               | \$626.64               | 25                             | 538                        |
| 1649584970 | AccessHealth                                           | OBGYN                 | Raleigh | New River Gorge | 54,010                  | 1902               | \$567.78               | 29                             |                            |
| 1700949658 | AccessHealth                                           | PCP                   | Raleigh | New River Gorge | 22,983                  | 1483               | \$366.19               | 23                             | 576                        |
| 1801073218 | AccessHealth                                           | OBGYN                 | Raleigh | New River Gorge | 31,779                  | 469                | \$476.92               | 16                             |                            |
| 1295573509 | ACCESSHEALTH BROOKSHIRE                                | ECP_FQHC_RHC          | Raleigh | New River Gorge | 36,667                  | 2626               | \$277.41               | 14                             |                            |
| 103380135  | ACTIVE FITNESS AND PHYSICAL THERAPY - COFC - EPCO - PT |                       |         |                 | 37,477                  | 1736               | \$1,080.27             | 38                             |                            |
| Total      |                                                        |                       |         |                 | 187,632,382             | 8237007            | \$3,018,630.38         | 110128                         | 1,538,959                  |

## Comprehensive Reporting Calendar for MHT/MHP Programs (4.2.1.1.19)

The vendor should describe their approach and methodology to 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/medicaidand-chip-managed-care-finalrules/index.html#:~:text=On%20January%2017%2C%202017%2C%20CMS%20released%20a%20final,under%20Medicaid%20managed%20care%20contracts%20and%20rate%20certifications.WVStateCodechapter9:https://code.wvlegislature.gov/9/>.

## Approach and Methodology

As the incumbent, Myers & Stauffer has established a reporting calendar for MCOs to submit reports regarding the MHT and MHP program, as well as other contractual requirements. At the start of this contract, we will meet with BMS to review the current calendar, map reports to contractual



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

requirements, and receive feedback from the Bureau regarding any changes it would like implemented. As previously mentioned, we will also include considerations to assess compliance with future requirements from the 2024 Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F). Identifying compliance gaps prior to the rule's effective date will allow us to support BMS with strategies to come into compliance before the effective date. Throughout the contract, we will maintain the comprehensive reporting calendar and make BMS-approved modifications to meet the changing reporting needs of the program. Establishing this calendar, monitoring it, and acting on the content of the reports are critical activities for effective MCO contract compliance monitoring, overall managed care program administration, and ensuring compliance with federal, state, and agency-specific reporting requirements.

Figure 7 and Figure 8 include a sample of the reporting schedule and an MC-Ops dashboard reflecting report submission status.

Figure 7. Reporting Schedule Sample

| MCO |  | Frequency | Reporting Period |  | Report Status |
|-----|--|-----------|------------------|--|---------------|
| All |  | All       | All              |  | All           |

| MCO        | Report Name                                                     | Frequency | Reporting Period | Report Due Date            |
|------------|-----------------------------------------------------------------|-----------|------------------|----------------------------|
| Aetna CHIP | Annual Financial Statements                                     | Annual    | 2025             | Monday, June 01, 2026      |
| Aetna CHIP | Children's Residential and PRTF Services and Demographic Report | Monthly   | 2025, 12         | Thursday, January 15, 2026 |
| Aetna CHIP | Children's Residential and PRTF Services and Demographic Report | Monthly   | 2026, 01         | Sunday, February 15, 2026  |
| Aetna CHIP | Children's Residential and PRTF Services and Demographic Report | Monthly   | 2026, 02         | Sunday, March 15, 2026     |
| Aetna CHIP | Children's Residential and PRTF Services and Demographic Report | Monthly   | 2026, 03         | Wednesday, April 15, 2026  |
| Aetna CHIP | Children's Residential and PRTF Services and Demographic Report | Monthly   | 2026, 04         | Friday, May 15, 2026       |
| Aetna CHIP | Children's Residential and PRTF Services and Demographic Report | Monthly   | 2026, 05         | Monday, June 15, 2026      |
| Aetna CHIP | Claims Aging Report                                             | Monthly   | 2025, 12         | Thursday, January 15, 2026 |
| Aetna CHIP | Claims Aging Report                                             | Monthly   | 2026, 01         | Sunday, February 15, 2026  |
| Aetna CHIP | Claims Aging Report                                             | Monthly   | 2026, 02         | Sunday, March 15, 2026     |
| Aetna CHIP | Claims Aging Report                                             | Monthly   | 2026, 03         | Wednesday, April 15, 2026  |
| Aetna CHIP | Claims Aging Report                                             | Monthly   | 2026, 04         | Friday, May 15, 2026       |
| Aetna CHIP | Claims Aging Report                                             | Monthly   | 2026, 05         | Monday, June 15, 2026      |
| Aetna CHIP | Data Certification Form                                         | Monthly   | 2025, 12         | Thursday, January 15, 2026 |
| Aetna CHIP | Data Certification Form                                         | Monthly   | 2026, 01         | Sunday, February 15, 2026  |
| Aetna CHIP | Data Certification Form                                         | Monthly   | 2026, 02         | Sunday, March 15, 2026     |
| Aetna CHIP | Data Certification Form                                         | Monthly   | 2026, 03         | Wednesday, April 15, 2026  |
| Aetna CHIP | Data Certification Form                                         | Monthly   | 2026, 04         | Friday, May 15, 2026       |
| Aetna CHIP | Data Certification Form                                         | Monthly   | 2026, 05         | Monday, June 15, 2026      |

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

Figure 8. MC-Ops Dashboard - Submission Status



### What This Means for BMS

Myers & Stauffer's structured methodology provides BMS with a centralized, sustainable reporting management framework that improves visibility into reporting obligations, enhances accountability, reduces compliance risk, and strengthens oversight of the MHT and MHP programs. Our approach ensures required reports are submitted timely and are compliant with federal, state, BMS, and managed care contract requirements.

## Identification and Compliance with All Federal/State Medicaid and WVCHIP Laws, Regulations, and Policies (4.2.1.1.20)

The vendor should describe their plan to identify and comply with all federal and state Medicaid and WVCHIP laws, regulations, and policies, as outlined by the CMS and the Agency, which can be accessed at <https://www.medicaid.gov/medicaid/managed-care/index.htmlhttps://dhhr.wv.gov/bms/Members/Managed%20Care/Pages/default.aspx>.

### Approach and Methodology

We will comply with all existing and future applicable regulations, requirements, standards, directives, statutes, policies, and similar rules issued by the Bureau or the state or federal government that take effect during this engagement.

The Myers & Stauffer Team will establish and maintain a comprehensive regulatory compliance process that ensures all project activities, analyses, recommendations, and deliverables are consistent with applicable federal and state Medicaid and CHIP requirements. Our process to identify and comply with these requirements incorporates continuous monitoring of regulatory changes, SME reviews, and quality assurance checkpoints throughout this engagement.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

As part of our plan, we will:

- **Maintain Subject Matter Expertise.** Our approach starts with our team of proven Medicaid and CHIP SMEs (e.g., healthcare policy analysts, data analysts, actuaries, healthcare attorneys, and former Medicaid and CHIP leadership). We recruit and retain experts in these and other areas, providing a diverse group of health and human service resources to BMS. Based on our commitment to excellence, we provide our team members with tools, training, resources, and opportunities for continuous learning and advancement to maintain and advance their expertise.
- **Maintain a Comprehensive Regulatory Baseline.** As the incumbent, we have an established inventory and understanding of the state and federal Medicaid and CHIP regulatory authorities and requirements. This inventory serves as the foundation for our work and ensures that we operate consistently with those state and federal requirements.

We have a deep understanding of the Social Security Act, other federal statutes, as well as CMS regulations and guidance, State Health Official (SHO) letters, State Medicaid Director (SMD) letters, informational bulletins, FAQs, and other sub-regulatory guidance. We also have a deep understanding of the West Virginia approved waiver authorities. Other baseline materials will include BMS's policy manuals, operational procedures, and agency guidance.

- **Monitor State and Federal Changes.** Our professionals will constantly monitor and identify developments and assess their impacts on BMS's programs. We will use tools, such as Bill Track 50, Vital Law Legal Research Database, and other resources to keep abreast of regulatory and statutory changes. We will also monitor CMS publications, guidance, and take advantage of any CMS technical assistance. We have memberships and participate in national Medicaid organizations and professional associations where evolving Medicaid and CHIP requirements are discussed, often well in advance of their effective date. Similarly at the state level, we monitor the legislative activity of the West Virginia Legislature, including both proposed and passed bills. Our support to BMS in drafting legislative briefs in preparation for and during the West Virginia legislative session provides us with an understanding of key Medicaid and CHIP considerations and the legislative environment and processes. Potential impacts will be evaluated promptly and our work and processes updated whenever new requirements affect the contracted services or deliverables.
- **Apply Compliance Reviews to All Work Products.** Every substantive deliverable will undergo a structured quality assurance review prior to submission. This is a part of our firm's pervasive quality culture that includes self-review, peer review, and management review. We will also conduct a compliance review to ensure all content, including our recommendations, is consistent with current federal and state requirements. Our senior Medicaid and CHIP SMEs will perform this final compliance review before deliverables are submitted to BMS. Using their knowledge and expertise and the resources mentioned previously, they will ensure conformity.

Through our structured compliance framework, the Myers & Stauffer Team ensures all project activities and deliverables are developed in accordance with federal Medicaid and CHIP statutes, regulations,

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

waiver authorities, CMS guidance, as well as state statute, rules, and policies. Our approach enables our Team to provide work products that remain accurate, defensible, and aligned with evolving federal and state requirements throughout the contract period.

## EPSDT Service Provisions Analysis and MCO Contract Compliance Tracking (4.2.1.1.21)

The vendor should describe their approach and methodology to analyze Early Periodic Screening, Diagnosis, and Treatment (EPSDT) service provisions and track MCO contract compliance on a quarterly basis. The vendor should describe their plan to prepare federal and state reports on methods to improve efficiency, effectiveness, coordination and quality of those services in West Virginia as needed. The reports should 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.

### Approach and Methodology

Findings from Early Periodic Screening, Diagnosis, and Treatment (EPSDT) oversight, at a minimum, are required as a submission to CMS on an annual basis in the CMS-416 report. However, regular tracking of EPSDT services and related screening trends offers critical insight into member trends by age groups and MCO compliance with screening ratios and member/provider outreach and education. To monitor EPSDT provisions, we capture the following data:

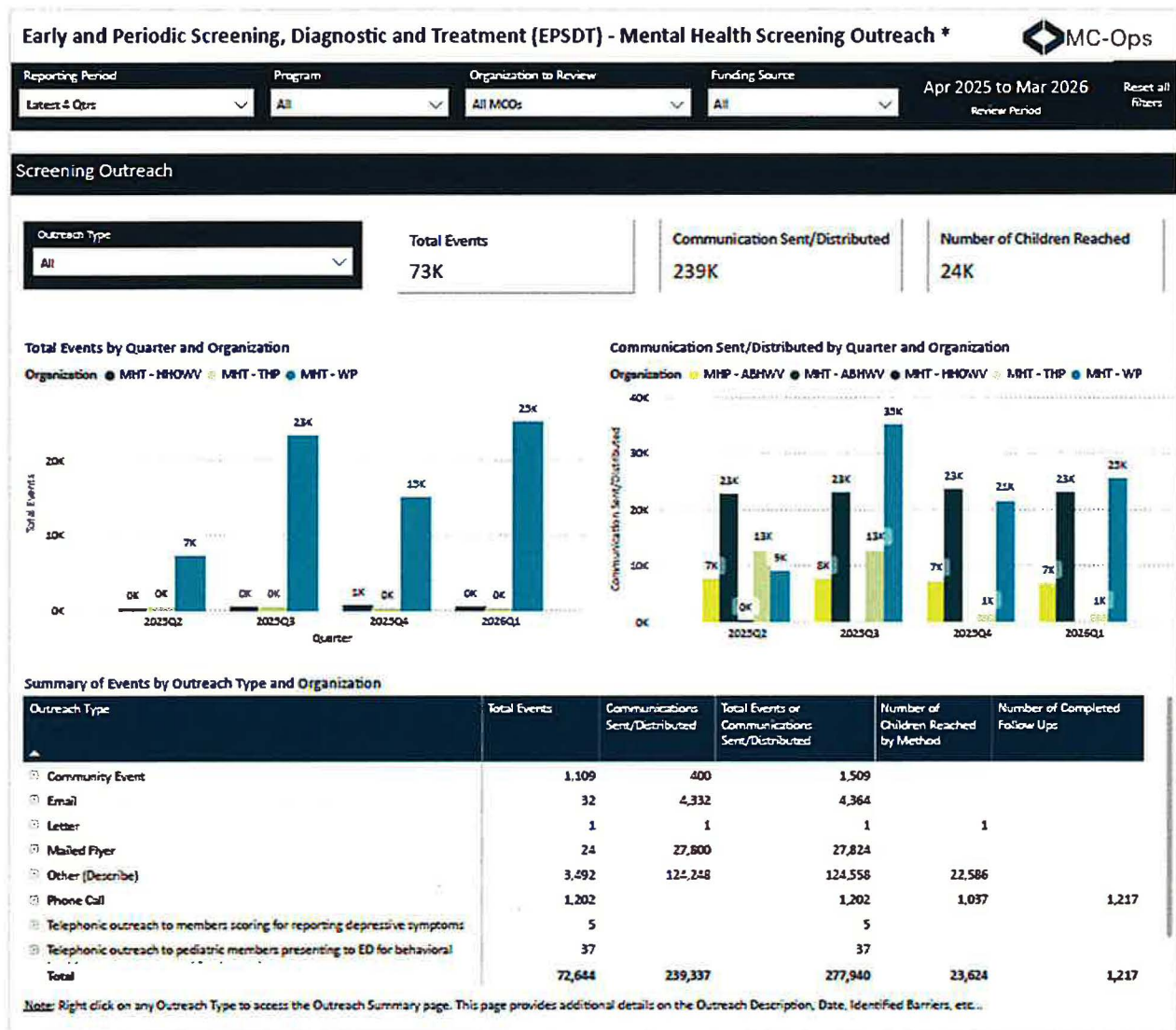
- Quarterly MCO compliance reports with related EPSDT data for a rolling 12-month period:
  - EPSDT eligible enrollment data per month and quarter.
  - EPSDT services within the reporting period.
  - Outreach and education activities.
- MMIS enrollment and encounter data related to EPSDT services.

Myers & Stauffer will continue to perform quarterly analyses of West Virginia's EPSDT service provisions. The basis of the analysis will include reviews of quarterly MCO compliance reports and the State's encounter and enrollment data. We will recalculate EPSDT ratios with the MCO compliance reports and the State's MMIS data based on the CMS-416 reporting requirements to confirm accurate reporting. Since the CMS-416 standards are based on a full year of screenings and eligibility, these calculations will be performed on a rolling 12-month period of data every quarter. We will identify trends in the data and provide BMS with updates regarding each plan's results and if they are making improvements in their ratios well in advance of the next CMS submission. The results of these reports and data will be detailed on the MC-Ops dashboard site for BMS to review (*Figure 9*) and negative trends will be communicated to BMS. Based on these analyses, we will identify opportunities and make recommendations to improve the efficiency, effectiveness, coordination, and quality of EPSDT services.



## PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)

Figure 9. EPSDT Mental Health Screening Dashboard



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## **Demonstrated Experience: EPSDT Service Provisions Analysis/MCO Contract Compliance Tracking**

### **West Virginia BMS**

Myers & Stauffer facilitated improvements in the capture and reporting of EPSDT activities of the MCOs, including capture of the various methods that providers and MCOs interact with parents to encourage EPSDT examinations consistent with the periodicity schedule. Our Team collaborated with the MCOs and the MMIS vendor to identify underreporting, accurately quantify the activities that were being performed, and update data capture and downstream reports. As a result of our efforts, BMS was able to demonstrate a higher level of performance than previous reports had indicated, compliance with EPSDT reporting requirements, and alignment with a related Department of Justice (DOJ) memorandum of understanding. All enhanced EPSDT requirements were clearly defined in the MCO contract, including continuity of care requirements for EPSDT services.

### **Other State Medicaid Experience**

We have supported other states, including Georgia, Hawai'i, and Kentucky with addressing the delivery, tracking, and reporting of EPSDT services. This work has spanned supporting services required under 5121 of the CAA of 2023, comparison of managed care versus FFS EPSDT performance, enhancements to the state's Quality Strategy to improve and measure EPSDT performance, and other services.

### **Ad Hoc Reports (4.2.1.1.22)**

The vendor should describe their approach and methodology to provide ad-hoc reports, at no additional cost, 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 should be based on an approved SOW.

### **Approach and Methodology**

The Myers & Stauffer Team has consistently demonstrated our ability, expertise, and willingness to conduct ad hoc analysis and reporting to support BMS's needs. We will provide ad hoc reports and analyses, upon request, in support of continuous improvement in the efficiency, effectiveness, and quality of the Managed Care program. This may include any number of analyses and reports, including comparative analysis of BMS's managed care program and FFS program. Requests will be logged through our team, assigned to the appropriate analysts, and delivered within the timeline established for each specific request.

Additional details regarding our approach which will be tailored based on the needs of each ad hoc report request can be found in our response to *Data, Program and Regulatory Analyses (4.2.1.1.23)*.

The Myers & Stauffer Team will use a data-driven approach to address opportunities for improvement of the efficiency, effectiveness, and quality of the managed care programs. As part of our approach, we will use transparent processing and communication with the State and other stakeholders throughout the reporting process to ensure that we fully understand the request and associated deliverables. We will clarify scope up front, provide status updates, and follow up to confirm the deliverable is compliant



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

with the requester's needs. Where modifications to the reports or their assumptions are needed, we will make those adjustments and update our analysis.

Our one firm approach provides BMS with resources to quickly respond to ad hoc reporting requests. We are accustomed to doing so, not only for BMS, but for many of our clients. This experience also allows us to leverage research and analyses across states and then customize based on state-specific factors. For example, in other engagements, we have researched managed care trends and best practices in other states, provided guidance on managed care model evolution, contracting best practices, infusion of value-based payment into MCO contracts, prepared fiscal modeling, developed legislative briefs, and conducted numerous other analyses and reports. Our team has demonstrated to BMS our ability to quickly respond to changes and fluctuations in the industry and identify opportunities for improved program performance and oversight.

Additionally, we embrace a "one firm" approach to serving our clients, which means BMS will have access to a diverse pool of subject matter experts (SMEs) across Myers & Stauffer and Milliman. This depth of professional staff allows us to identify, analyze, and recommend national best practice standards and to quickly expand and/or supplement our project team to support an ad hoc analysis request. As BMS has experienced, we routinely introduce insight from individuals throughout our firms and leverage those resources, as needed.



## One Firm Approach

We embrace a "one-firm" approach to serving our state agency clients that is both invaluable and cost-effective. This means that BMS will not only have available the staffing resources and knowledge base from our proposed project team, but also from our pool of professionals located in our 21 offices nationwide. We practice a philosophy of "how can we help?" As we do for all our state engagements, we routinely seek input from our firm-wide pool of experienced professionals who may have met a similar challenge previously. We then tap into those resources, as needed, to supplement our services to West Virginia with solutions and best practices used in other states.

### **"How Can We Help?" Philosophy for West Virginia Medicaid and CHIP**

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****West Virginia BMS****Demonstrated Experience: Ad Hoc Reports**

Milliman supported West Virginia with data-driven tools that improved managed care operations, efficiency, effectiveness, and quality. For example, Myers & Stauffer and Milliman developed ad hoc analyses and reports using our deep experience nationwide, along with Milliman's proprietary data and tools to analyze Day One enrollment pros and cons and operational and fiscal impacts. Milliman also worked with the State to identify analyses that should be performed regularly as part of rate setting and to provide ad hoc analyses and reports to BMS upon request.

**Other State  
Medicaid  
Experience**

In Washington State, Milliman regularly compares the MCOs' relative reimbursement, administrative expenses, ED utilization, and pharmacy expenditures to develop capitation rate adjustments that are designed to remove waste and inefficiencies. Milliman also evaluated the effectiveness and savings associated with the State's decision to integrate its behavioral health program with its full managed care program. Additionally, in Utah, Milliman actuaries performed an analysis that assessed the cost and quality outcomes for Adult Expansion members who were enrolled in managed care versus members who elected to enroll in FFS.

**Data, Program and Regulatory Analyses (4.2.1.1.23)**

The vendor should describe their plan to 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 the Agency.

**Approach and Methodology**

Myers & Stauffer has frequently assisted BMS with the production of data, as well as program and regulatory analyses. We recognize these requests frequently require tight turnarounds, and we have always been responsive to such requests. These analyses are often used as BMS responds to legislative, federal, state, budgetary, provider, advocacy, or other requests. These responses often include data analysis and regulatory analyses, stakeholder outreach, and development of concise and audience-ready materials for BMS use. Our approach to providing these services includes the following:

- **Engage SMEs.** When a request is received from BMS, the first step taken is to assess the content of the request and triage to the relevant SME within Myers & Stauffer. If needed, we schedule either an internal meeting or a meeting with BMS to discuss our capabilities and expertise, propose analyses and formats, and set time frame expectations. We work to reach a mutually agreed-upon schedule and deliver the requested analysis accordingly. Our commitment to the provision of these SMEs is shown by the fact that team members across all seven Myers & Stauffer engagement teams have been engaged to support BMS requests over the course of our current contract. This includes experts in audits, managed care, Medicaid financing, rate setting, pharmacy, program integrity, managed care, and other Medicaid and CHIP consulting services.
- **Collect Data.** Once data needs are established, Myers & Stauffer pulls from internal data or engages stakeholders, such as Milliman, BMS, MMIS, the MCOs, or other sources to compile all necessary source data. During this process, we rely on the accuracy and completeness of this data. Where known issues may exist, we call that out during our analysis and reporting and



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

develop strategies to mitigate any issues.

This may include the use of proxy data (e.g., trends, other state observations, etc.), if appropriate.

- **Data Analysis.** Myers & Stauffer completes necessary analysis of data to provide historical context on factors, such as utilization, expenditures, future cost projections, or trend analyses. Myers & Stauffer collaborates with Milliman to provide quantitative analyses of managed care data. Our Team also performs qualitative data analysis, synthesizing research on regulatory landscapes and providing insights into program requirements and policies.
- **Recommendations and Insights.** After detailed analyses, Myers & Stauffer provides insights to inform recommendations about program development, policy changes, or budgetary actions or the impact of legislative mandates and CMS rules. These will typically be delivered through meetings with BMS and accompanied by a written summary, concise policy briefs, data visualizations, or other agreed-upon resources. Documents are provided in a timely manner according to timelines set by BMS.
- **Provide Continual Support.** When a request requires a greater level of research and support, Myers & Stauffer establishes processes to continually support BMS through tasks, including standing meetings, revision processes, and potential presentation of materials to stakeholders. When necessary, Myers & Stauffer provides data insights proactively on a monthly, quarterly, or annual basis to preempt requests. For example, we may anticipate certain legislation being introduced in the West Virginia Legislature during the upcoming legislative session. We may gather data, conduct analyses, and create briefs or other material to help BMS prepare for discussions regarding the impact of the proposed legislation on the Bureau.



## Timely Responses and Communication

Timelines for program and regulatory analyses are often outside BMS' control. We have been highly responsive and ensured support for timely responses to the Legislature, the Governor's office, CMS, and other needs.

### Assisting BMS with External Issues

## Comprehensive Quality Assessment and Performance Improvement Strategy (4.2.1.1.24)

The vendor should describe their approach and methodology to 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-managedcare-quality/state-quality-strategies/index.html>, CMS standards, and other relevant quality review programs. This strategy should integrate input from enrollees and advocates. Annually, the vendor should provide a plan on how it will update the QISMC in collaboration with Agency Quality and Managed Care staff. Collaborator engagement should include Managed Care Organizations Agency or other collaborators. The 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.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

### Approach and Methodology

Myers & Stauffer understands that the Quality Improvement System for Managed Care (QISMC) program has evolved. QISMC was a comprehensive quality oversight framework developed by what is now CMS during the late 1990s. Although QISMC itself is no longer used as a standalone program, it fundamentally reshaped Medicaid managed care quality oversight. Nearly every major Medicaid managed care quality requirement in effect today traces its origins to QISMC. The QISMC concept continues today in many of the CMS components found in the Quality Strategy and External Quality Review requirements. We are experienced with the changing CMS quality assessment and improvement requirements, including the following managed care oversight activities:

- Creating and updating a Managed Care QS.
- Developing a MCO Quality Assessment and Performance Improvement (QAPI) program.
- Conducting EQR activities.

We will develop a comprehensive strategy that encompasses all required elements to guide the quality assurance and improvement approach for the MHT and MHP programs. Quality assurance is embedded into all aspects of the managed care program oversight activities.

#### Managed Care Quality Strategy

Myers & Stauffer coordinates with appropriate BMS staff to update the QS at least every three years, as required by CMS and more frequently, as needed. Our first step will be to establish broad parameters for the strategy by reviewing MCO performance on reaching the goals of the SFY 2024-2027 QS, considering feedback from the EQRO, determining any new statewide health goals, and collecting guidance from BMS Managed Care and Quality staff on priority areas. Once we have developed a framework, Myers & Stauffer will implement the following methodology:

- Develop and maintain a work plan.
- Establish a regular meeting cadence with the Bureau.
- Review all applicable state and federal updates as published.
- Submit a findings document and QS outline to BMS for review and approval.
- Provide recommendations on goals, objectives, and performance measures.
- Convene a stakeholder work group with MCOs, key Bureau staff, and other stakeholders identified by BMS. Myers & Stauffer will prepare presentation materials for all stakeholder meetings and those that may be needed for other groups, such as the Beneficiary Advisory Committee. Stakeholder feedback will be incorporated throughout the drafting process.
- Prepare a draft copy of the QS for BMS feedback and incorporate feedback to finalize the document.
- Deliver a final copy of the QS for BMS approval that can be posted for public comment.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

- Produce the final QS, in a format(s) preferred by BMS (e.g., Section 508 compliant), that can be submitted to CMS and posted on the BMS website.
- Develop a QS monitoring framework that BMS can use to assess ongoing progress and inform continuous quality improvement initiatives.

We will assess the QS annually for effectiveness and update accordingly to reflect state and federal mandates as significant changes occur, or no less than every three years. As the delivery system landscape continues to evolve, the QS provides a roadmap for BMS to support improved quality for all Medicaid and WVCHIP members.

**Quality Assessment and Performance Improvement**

All MCOs serving Medicaid and CHIP members must implement a QAPI in accordance with the standards established in 42 CFR § 438.330. The QAPI includes four main components: performance measurement, performance improvement projects (PIPs), utilization monitoring, and mechanisms to assess the quality of services provided to members with special healthcare needs or receiving LTSS. Myers & Stauffer will collaborate with BMS, EQRO, and the MCOs to establish comprehensive QAPI standards. The EQRO plays a significant role in the QAPI plan, including recommending and approving PIPs. We will include a thorough description of the QAPI requirements in the MCO contract and make updates, as needed, during regular contract amendment cycles. We will also review the annual QAPI reports submitted by the MCOs to ensure compliance. These reports include a wealth of information on each MCO's quality initiatives. Myers & Stauffer will use this information to inform other managed care quality improvement activities.

**External Quality Review Activities**

While BMS's EQRO vendor is responsible for carrying out EQR activities, Myers & Stauffer will continue to closely coordinate with their efforts. For example, the EQRO provides recommendations for performance measures that we will use in the QS and to create value-based payment (VBP) initiatives, such as the Quality Withhold program. Myers & Stauffer will also review findings from the EQRO on network adequacy and access as we conduct provider network reviews.

Establishing a consistent and comprehensive approach to quality improvement that reaches across all aspects of West Virginia's managed care programs requires collaboration with internal and external stakeholders. Myers & Stauffer will rely on our deep understanding of the MHT and MHP programs along with established relationships to develop a strategic approach to quality assurance and performance improvement. This paired with comprehensive program monitoring, contractual standards, evaluation of performance measures, and other tools, will support BMS in achieving its goals and objectives.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Program Expansion Options (4.2.1.1.25)**

The vendor should describe their approach and methodology for developing and implementing program expansion options, including, but not limited to, preparing documents that outline potential cost savings, policy considerations, risks, issues, coordination requirements, and legal constraints.

**Approach and Methodology**

The Myers & Stauffer Team will develop program expansion options, including preparing documents that outline potential cost savings, policy considerations, risks, issues, coordination requirements, and legal constraints. We will use our deep policy and actuarial expertise, experience specific to West Virginia and nationwide, and analytical knowledge. We combine our expertise to provide BMS with evidence-based insights into options, resources required, impacts to the existing programs, types of federal authorities that may be required, and a realistic work plan to support implementation.

Our work will start with defining the goals for the expansion effort, gaining an understanding of the populations or program BMS is targeting for the expansion, and any constraints such as timelines or budgets. With these factors, we will be able to more precisely focus on the appropriate options. For example, if BMS wishes to implement an expansion effort within a six-month time frame, we will focus our analysis on options that do not require a Section 1115 waiver as obtaining CMS approval would be inconsistent with the implementation timeline.

We will conduct research and analysis that is appropriate to the expansion topic. This may include analyzing existing utilization, creating models to project utilization and expenditures for new populations, estimating potential savings, identifying financing options (e.g., braided or blended funding), estimating number of individuals who may participate in the expansion, and other analyses. Reviews of other states undertaking similar expansion efforts may also be conducted. If so, states most comparable to BMS will be selected, when possible. If appropriate, we may also engage stakeholders to gain a better perspective of the qualitative factors that should be considered as part of the expansion effort.

Based on our research and analysis, we will develop an options analysis. This options analysis will include information, such as a detailed description of each option, any federal authorities that must be obtained to implement, how each option aligns with BMS's goals. It will also highlight any limitation or potential unintended consequences, operational requirements like staffing and budget that would be required to implement and maintain the expansion, along with our objective recommendation of which options are viable and why.

We will present our options analysis to BMS and walk through our findings and recommendations. Feedback from BMS may result in the need for additional research and analysis, which we will perform and provide updated findings to BMS.

If requested, we will develop a realistic work plan with a detailed work breakdown identifying the tasks, milestones, timelines, resources, and other factors to provide BMS with insight into implementation. This work plan will provide BMS with a realistic roadmap for implementation. We will also offer an Operations Plan, depending on the size of the initiative. This Operations Plan will include critical



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

components to guide implementation, such as a governance structure for decision-making, communications strategy, project monitoring structure, and other elements.

### MCO Reporting Templates and for Reviewing/Acting on High Complexity Reports (4.2.1.1.26)

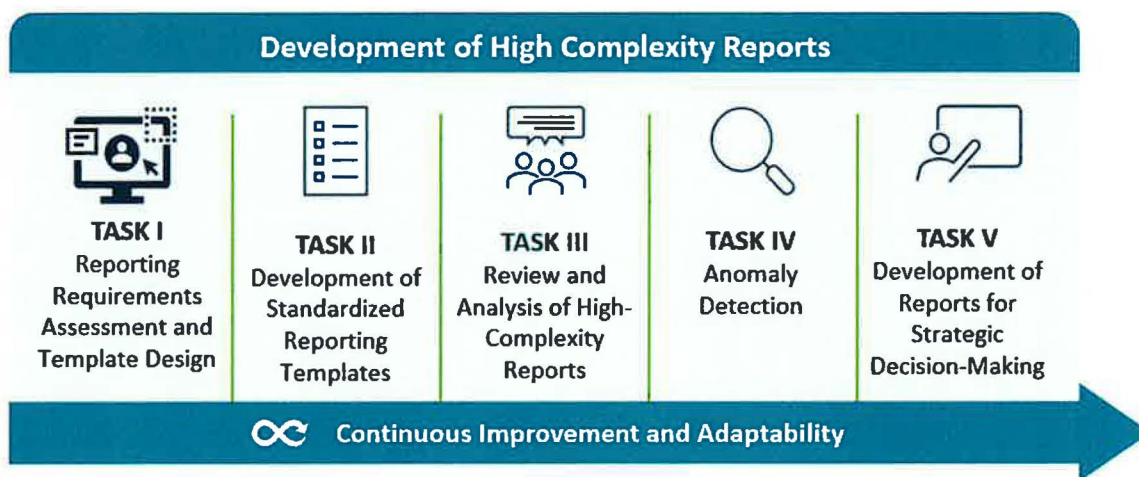
The vendor should describe their approach and methodology for creating all needed MCO reporting templates, and for reviewing and acting on high complexity reports. High complexity reports are those requiring advanced statistical analysis, clinical expertise, or complex financial auditing, as well as reports used for program-wide modeling (those rolled up into comprehensive reports). The vendor's responsibilities should include reviewing reports for clinical or financial anomalies and generating Agency reports for strategic decision-making. The Agency reserves the right to elevate or demote the complexity level of any report based on data trends, legislative changes, or identified risks. Required MCO reports and their due dates are included in Exhibit C. The vendor should conduct an individual MCO meeting once a month, in person or virtual, to review and discuss results from submitted reports including but not limited to a Cash Disbursement Journal, the EPSDT results (see 4.2.2.1.19), and dashboard results. Separate Medicaid & WVCHIP reporting is necessary.

#### Approach and Methodology

Myers & Stauffer will partner with BMS to develop standardized, compliant, and sustainable MCO reporting templates and scale the complexity of those reports and their review based on the specific needs of BMS. We will conduct oversight, compliance monitoring, financial accountability, and quality improvement reviews of all reports, regardless of the level of complexity and provide BMS with meaningful input to support strategic decision-making. Our methodology combines regulatory expertise, advanced data analytics, clinical and financial subject matter expertise, and rigorous quality management processes to ensure reports are accurate, actionable, and delivered on time. We will ensure separate Medicaid and WVCHIP reporting and provide reports support not only federal reporting requirements but meet the business needs of BMS to manage these programs.

Recognizing that reporting requirements and risk priorities evolve, our approach (*Figure 10*) is designed to accommodate changes approved by BMS that may be a result of legislative changes, emerging risks, audit findings, or program tracking needs or performance trends.

Figure 10. Development of Reporting Requirements



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Task 1 - Reporting Requirements Assessment and Template Design**

We will begin by conducting a comprehensive assessment of all reporting requirements applicable to the Medicaid managed care program. Our team will review managed care contracts, federal regulations, state requirements, CMS guidance, existing reporting formats, and BMS business needs to identify the purpose, audience, frequency, required data elements, and intended use of each report.

Working collaboratively with BMS program staff and other contractors, we will facilitate structured requirements sessions to validate reporting expectations, identify opportunities for standardization, and eliminate duplicative reporting. The information collected will be documented in a reporting requirements matrix that serves as the foundation for template development.

During this phase, our Medicaid and CHIP SMEs will independently validate that each reporting requirement is accurately traced to its contractual, regulatory, or operational source. Draft requirements will be reviewed internally before being presented to BMS for validation. We will work closely with BMS program leadership, quality staff, finance staff, data analytics teams, and other designated contractors to ensure templates meet operational and regulatory needs while supporting downstream reporting and oversight activities. This collaborative requirements-gathering process ensures reporting templates are comprehensive, standardized, and aligned with BMS business objectives while reducing duplicate reporting and improving consistency across MCO submissions.

**Task 2 - Development of Standardized Reporting Templates**

Using the validated reporting requirements, Myers & Stauffer will develop standardized reporting templates that promote consistency, improve data quality, and streamline report production. Each template will include standardized definitions, required data fields, calculation methodologies, reporting instructions, validation rules, and submission requirements. Templates will be designed to accommodate future enhancements and evolving reporting requirements without requiring complete redesigns.

Each template will undergo a multilevel review that includes technical validation, regulatory compliance review, usability testing, and editorial review. Pilot testing will be conducted using historical reporting data to verify calculations, formatting, and functionality before production use. Draft templates will be reviewed with BMS and affected stakeholders through structured review sessions. Feedback will be documented, incorporated, and validated before templates are finalized.

Standardized templates will improve reporting consistency, reduce reporting errors, simplify MCO reporting expectations, and decrease the administrative effort required to review submissions.

**Task 3 – Development, Review, and Analysis of High-Complexity Reports**

Myers & Stauffer employs a multidisciplinary team for the development and review process for high-complexity reports requiring advanced statistical analysis, clinical evaluation, financial auditing, or program-wide modeling. Reports will be developed and reviewed by professionals with the appropriate expertise, including clinicians, statisticians, certified public accountants, Medicaid policy specialists, and data analysts to ensure each report is evaluated from the appropriate technical perspective.



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Our review process moves beyond verifying calculations to evaluating the reasonableness of reported results, identifying emerging trends, assessing compliance with contractual requirements, and determining whether reported outcomes warrant further investigation. Every high-complexity report undergoes multiple internal reviews, including:

- Technical review by the assigned SME. For example, we may conduct analyses that include pattern recognition, cluster analysis, standard deviations, outlier indexing, predictive analyses, inferential analyses, regression, or other types of analyses. Likewise, our clinicians may conduct clinical analysis that involve utilization trends, alignment with clinical best practices, or even a review of medical records supporting utilization in certain outlier cases.
- Independent peer review by a second senior consultant.
- Quality review to verify completeness, consistency, and compliance.
- Executive review for reports supporting significant policy decisions or legislative reporting.

Review comments and resolutions are documented to maintain a complete audit trail and ensure consistency across reporting cycles.

When anomalies or unusual trends are identified, Myers & Stauffer will collaborate with BMS, MCOs, and other contractors to validate findings, determine root causes, and identify corrective actions before finalizing reports.

Our layered review process provides BMS with reliable, well-supported analyses that improve confidence in reported information and enable informed operational and policy decisions.

**Task 4 - Anomaly Detection**

Myers & Stauffer applies a risk-based analytical approach to identify anomalies that may indicate data quality issues, emerging program risks, inappropriate utilization, FWA, or noncompliance with managed care contract requirements.

Rather than evaluating individual measures in isolation, we analyze longitudinal trends, compare performance across MCOs, benchmark results against historical experience, and assess relationships among multiple performance indicators to identify meaningful patterns requiring additional review.

Potential anomalies are independently validated using multiple data sources before findings are reported to BMS. Significant findings are discussed internally among clinical, financial, and analytical experts to ensure conclusions are evidence-based and appropriately supported.

We will discuss significant anomalies with BMS before finalizing recommendations and coordinate with MCOs or other contractors, when directed by BMS, to obtain clarification or supporting documentation.

Early identification of emerging risks will enable BMS to proactively address operational, financial, and clinical issues before they adversely affect program performance or compliance.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Task 5 - Development Reports for Strategic Decision-Making**

Myers & Stauffer will transform complex analytical findings into reports that support strategic planning and decision-making. Reports will synthesize information from multiple data sources, identify key trends and risks, evaluate MCO performance, and present actionable recommendations.

All Bureau reports will undergo technical, editorial, and executive review to verify analytical accuracy, consistency of messaging, completeness, and readability before submission. Each report will be tailored to its intended audience and include concise narratives, performance dashboards, visualizations, and executive summaries that facilitate timely decision-making.

We will present preliminary findings to BMS leadership, incorporate feedback, and refine reports to ensure the final deliverables address operational priorities and strategic objectives. Our reporting enables BMS leadership to quickly understand program performance, prioritize resources, evaluate policy options, and make data-informed decisions that strengthen oversight of the Medicaid managed care program.

**Joint and Individual MCO Monthly Meetings**

The Myers & Stauffer Team currently schedules and facilitates a monthly call with BMS and the MCOs. This joint meeting is held to discuss common topics impacting all MCOs and provides the opportunity for all MCOs to hear the same message from BMS and the Myers & Stauffer Team. Typical agendas have included topics like contract management, upcoming changes to CMS requirements, MCO report submissions, MLR examination processes and updates, EPSDT performance, electronic data validation measurement, PNA data requests and findings, BMS grants (e.g., Transforming Maternal Health), day one enrollment, quality withhold program, general capitation rate setting topics, as well as open discussions regarding questions and technical assistance needs that are common across all of the MCOs.

In addition to the monthly all-MCO meeting, we will formalize our current ad hoc individual MCO meetings and establish standing monthly meetings with each MCO. We will establish this monthly cadence to give each MCO an opportunity to discuss topics that are specific to their operations and performance. We will keep meeting summaries to document topics discussed and their respective resolutions and make those records available to BMS as part of our project management artifacts.

**Continuous Improvement and Adaptability**

We recognize that BMS may elevate or reduce the complexity of reports as reporting priorities evolve. To support this flexibility, we will maintain a formal change management process that documents changes to report classifications, templates, and processes. These changes will be documented, communicated, and incorporated through version-controlled updates, ensuring reporting processes remain responsive without disrupting ongoing operations.

Our structured methodology provides BMS with standardized reporting tools, rigorous analytical review, and executive-level reporting that strengthen oversight of the Medicaid managed care program. Through collaborative planning, multidisciplinary expertise, advanced analytics, and comprehensive quality assurance, we will deliver accurate, timely, and actionable reporting products that reduce



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compliance risk, improve data reliability, support strategic decision-making, and adapt to the evolving needs of the program.

### **MCO Compliance Plan Implementation (4.2.1.1.27)**

The vendor should describe the approach and methodology for monitoring MCO compliance plan implementation to support collaboration between the West Virginia Office of Program Integrity and the MCOs. This includes, but is not limited to, coordination activities, strategic planning, and oversight.

#### **Approach and Methodology**

Myers & Stauffer will provide comprehensive support to BMS, including strategic planning of MCO program integrity activities and ensuring compliance and oversight for the managed care programs. Our procedures will align with the program integrity requirements set forth in the MCO contract and include the following:

1. **Strategic Planning.** Myers & Stauffer will meet with the BMS program integrity leadership and support the development of a strategic plan to guide the direction, oversight, monitoring, and coordination of program integrity activities across the MCOs. This plan, along with the MCO contract language, will lay the foundation for a coordinated and unified program integrity governance, accountability, reporting, and enforcement approach.
2. **Review MCO Contract Requirements.** Myers & Stauffer will review the Internal Compliance Plan section of the MCO contract to ensure a thorough understanding of all program integrity requirements, including policy management and reporting.
3. **Review of Policies and Procedures.** We will conduct a thorough review of these policies and procedures submitted by the MCOs to ensure alignment with the contractual obligations specified by BMS. The evaluation includes:
  - **Policy Comprehensiveness:** Assessing whether each MCO's program integrity policies and procedures explicitly address the core components of FWA prevention, detection, investigation, reporting, corrective action, and recovery.
  - **Contractual Crosswalk Analysis:** Developing a crosswalk to compare specific contractual obligations with the content of the MCO's program integrity policies. This allows us to identify any gaps or inconsistencies in meeting the requirements.
  - **Implementation Evidence:** Evaluating how the program integrity policies and procedures are implemented in practice, including their application across the organization and alignment with BMS's guidance.
  - **Timeliness and Updates:** Confirming that submitted program integrity policies and procedures are current and updated regularly to reflect changes in federal and state regulations.
4. **Interviews with MCOs.** To ensure MCO compliance and operationalization of policies, we will engage directly with key MCO staff involved in program integrity efforts. The interviews are designed to:

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- **Validate Policies:** Confirm that staff members are aware of and adhering to the approved policies and procedures.
  - **Assess Training Effectiveness:** Determine the extent to which staff are adequately trained in detecting, investigating, and addressing FWA cases.
  - **Evaluate Knowledge and Oversight:** Identify the roles and responsibilities of staff overseeing program integrity efforts at the local and corporate levels to ensure they align with MCO contract expectations.
  - **Identify Gaps and Risks:** Gather insights into potential operational, training, or resource gaps that could hinder the implementation of a robust and collaborative program integrity environment.
5. **Evaluation of Program Integrity Measures.** We will examine the MCOs' program integrity measures in place to ensure a proactive and comprehensive approach to addressing FWA. Specific tasks include:
- **Documentation Review:** Verifying whether each MCO's program integrity compliance plan includes documented processes for FWA detection, prevention, investigation, reporting, and corrective actions.
  - **Operational Assessment:** Confirming that fraud detection tools and technology are effectively utilized and determining whether the MCO leverages data analytics to identify anomalies or trends indicative of FWA.
  - **Case Handling Protocols:** Reviewing documentation related to the investigation of FWA cases and ensuring cases are escalated appropriately and resolved according to contractual and legal requirements.
6. **Monitoring and Resolution Systems.** A critical aspect of program integrity is the MCOs' ability to monitor and address FWA cases. We will evaluate the adequacy of the monitoring systems through the following procedures:
- **System Analysis:** Reviewing the functionality of systems and processes implemented to monitor program integrity cases. This includes checking automated and manual processes for identifying, flagging, and prioritizing suspected cases.
  - **Reporting and Tracking:** Assessing whether the MCO maintains accurate, detailed, and up-to-date logs for tracking FWA cases, and verifying that tracking aligns with CMS and BMS reporting requirements.
  - **Escalation:** Evaluating each MCO's escalation protocols to ensure cases are escalated within the MCO and to BMS, where appropriate.
  - **Corrective Action:** Confirming that resolutions are well-documented, timely, and include appropriate corrective actions to prevent recurrence of issues.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

7. **Training Programs.** Training is integral to ensuring awareness and preparedness among each MCO's staff. To evaluate the adequacy of FWA training programs, we will implement the following procedures:

- **Content Review:** Analyze the curriculum of each MCO's training programs to ensure they include comprehensive content on FWA detection, prevention, and reporting.
- **Frequency and Accessibility:** Confirm that training is provided regularly to all relevant staff and is accessible in various formats (e.g., in-person sessions, e-learning modules).
- **Participation Records:** Review attendance and completion records to ensure all required staff members have participated in training sessions.
- **Evaluation of Effectiveness:** Assess feedback mechanisms or post-training evaluations to determine the effectiveness of the training programs in increasing staff competency regarding program integrity.



### Combatting Fraud, Waste, and Abuse

Myers & Stauffer will focus on the ultimate goal of holding the MCOs accountable for developing and implementing mechanisms to identify and address fraud, waste, and abuse.

### Accountability for the MCOs

8. **Oversight Activity Evidence.** To evaluate the effectiveness of each MCO's program integrity oversight, we will review reports and other documentation that demonstrate ongoing monitoring and compliance efforts. This involves:
- **Audits and Investigations:** Reviewing audit reports, investigation logs, and summaries to ensure the MCO is actively identifying and addressing potential FWA cases.
  - **Performance Metrics:** Verifying whether the MCO tracks KPIs related to program integrity, such as the number of identified FWA cases, resolutions, and timeliness of reporting.
  - **Follow-Up Actions:** Ensuring the MCO takes appropriate and timely corrective actions based on findings from program integrity activities.
9. **Review of Organizational Structure.** A well-defined and adequately staffed organizational structure is critical to effective program integrity oversight. To assess this, we will implement the following procedures:
- **Organizational Charts:** Review organizational charts to determine how program integrity functions are integrated at both local and corporate levels, if applicable.
  - **Role Clarity:** Assess whether the roles and responsibilities of staff assigned to program integrity are clearly defined and documented.
  - **Resource Allocation:** Evaluate whether the MCO has sufficient personnel, resources, and expertise to effectively manage and oversee program integrity activities.

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Myers & Stauffer will assess the MCOs' compliance with program integrity contractual requirements and support BMS's effort to increase MCO accountability for preventing, detecting, investigating, reporting, and addressing FWA within the plans. By conducting these detailed procedures, we will provide BMS with a comprehensive view of program integrity activities across the plans and lay the foundation for more coordinated FWA activities and escalations to BMS. Ultimately, our work will support BMS with holding the MCOs accountable for protecting the integrity of the BMS managed care programs.

## Financial Services (4.2.1.2)

### Financial Services (4.2.1.2.1)

The vendor should describe their approach and methodology to provide financial services which should 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.

#### Approach and Methodology

Our Medicaid and CHIP financial services are centered on ensuring fiscal integrity, regulatory compliance, accurate provider reimbursement, and sound financial management.

Our work in all 50 state Medicaid agencies provides us with a broad range of financial and reimbursement expertise. Our services span every aspect of Medicaid and CHIP financing, such as financial audits, MLR examinations, administrative expenses reviews, cost reports, provider rate setting, upper payment limit (UPL) calculations, disproportionate share hospital (DSH) program, provider taxes, DPPs, proper claiming of federal funds, waiver support, IBNR calculations, legislative support, or other services. Not only have we helped design these programs, but we have also supported their implementation and ongoing operations.

As with all our work, our strength is our people. As a CPA firm and with our actuarial partner, Milliman, we have a breadth of health and human service finance expertise that will be available to BMS. Our accountants, actuaries, data analysts, policy experts, clinicians, and other experts work collaboratively to understand not only the financing rules, regulations, and best practices but also the impact of financial options and decisions on the operations of Medicaid program and CHIP.

Our scope of comprehensive services helps ensure MCOs are on track to achieve intended performance goals. Often, issues currently being addressed in one state have previously been addressed in another state, allowing us to leverage our experience for efficient solutions. We prioritize careful attention to detail in the early planning stages of developing financial reporting templates to avoid unnecessary revisions and multiple submissions from MCOs due to poor communication or lack of QA procedures. Additionally, we suggest training and education for MCOs to ensure accurate and consistent reporting. Our in-depth knowledge of industry practices related to the administration of Medicaid and CHIP, as well as the complex organizational and operating structures of MCOs, positions us to navigate the challenges posed by intricate contractual relationships. Our proven audit framework enables us to fully understand and assess performance, compliance, and financial reporting aspects of each contract.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

Developing, implementing, and periodically evaluating an effective financial monitoring program can provide BMS with timely information to make well-informed program management decisions, make programmatic adjustments that target inefficiencies, leading to cost savings, and provide opportunities to redirect resources towards initiatives that align with the State's overall healthcare objectives. A well-designed financial monitoring program can also serve as the basis for many other projects. All such financial monitoring programs start with requiring the MCOs to submit comprehensive financial information on a periodic basis (typically at a quarterly and cumulative annual basis). This information is then analyzed and used to generate a variety of management reports and data dashboards that can be effectively used to synthesize very large amounts of data and quickly produce the metrics of greatest importance to BMS. Reported data needs to be consistent across the MCOs to ensure analytical results are accurate and appropriate.

The approach and methodology we will apply will depend on the financial services requested. In the following section, we provide our approach to MLR examinations. The approach to the other financial services in the RFP requirement are summarized in *Table 3*.

**Medical Loss Ratio**

The Myers & Stauffer Team will provide professional services to ensure that each MHT, WVCHIP, and MHP MCO MLR report fully complies with the most recent MLR guidance published by CMS and the MCO contract requirements. Our approach to the MLR examination and issuance of MCO-specific MLR examination reports involves the methodology outlined in *Table 1*.

Table 1. MLR Examination Procedures

| <b>MLR Examination Procedures</b>                                                     |                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1. Send notification letters and conduct kickoff meeting.</b>                      | Our MLR Lead will conduct a kickoff meeting with BMS at the start of the engagement for review and approval of our proposed approach and timeline. Upon BMS approval, a notification letter will be sent to the MCOs, and an MLR kickoff meeting will be scheduled with the MCOs to communicate expectations for the MLR examination.                                                           |
| <b>2. Review supporting MCO documentation and reconcile to the MLR.</b>               | Assigned staff accountants will use the MCO-submitted trial balance, general ledger, and other supporting documents to reconcile the MLR reported values. The MCOs will be notified of any inconsistencies found that require additional explanation or supporting documentation.                                                                                                               |
| <b>3. Perform preliminary procedures.</b>                                             | Assigned staff accountants will begin procedures to review materiality, risk assessment, contracts, audited financial statements, and policies and procedures. Any pertinent items found will be documented for testing.                                                                                                                                                                        |
| <b>4. Review the MCO revenues compared to the State's revenue data.</b>               | Assigned staff accountants will compare the State's revenue data, including capitation and other applicable payments outside of the capitation factored in the MLR calculation. The MCOs will be notified of any discrepancies and will be asked to provide an explanation. If the information provided is not appropriate, the State's data will be used to propose any necessary adjustments. |
| <b>5. Review the revenue deductions compared to the MCO supporting documentation.</b> | Assigned staff accountants will compare the MCO supporting documentation for any revenue deductions reported on the MLR. The amounts claimed on the MLR will be reconciled to the documentation. If discrepancies are identified, the MCO will be notified and asked to provide an explanation. If an appropriate                                                                               |

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| <b>MLR Examination Procedures</b>                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                   | justification cannot be given, any necessary adjustments will be proposed based on the MCO documentation provided.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>6. Identify medical sample requests and send to MCOs. Perform testing procedures.</b>                                          | Assigned staff accountants will review submitted paid claims data provided by the MCO to determine the appropriate sampling methodology. Claim samples will be selected from the MCO's paid lag triangle. Upon review of the sample documentation, proof of payment samples will be selected for claim-level testing to ensure medical expenses are appropriate.                                                                                                                                                                                                                               |
| <b>7. Perform other medical expenses testing for amounts reported within incurred claims.</b>                                     | Assigned staff accountants will review the MCO-submitted other medical expenses data to determine the appropriate testing procedures. This may include various methods, such as sampling, data comparison, contract review, and allocation testing.                                                                                                                                                                                                                                                                                                                                            |
| <b>8. Perform provider incentive testing procedures, if applicable, select samples, and send to the MCOs.</b>                     | Assigned staff accountants will review the submitted provider incentive data and applicable contracts to determine the appropriate sampling methodology. Samples will be determined based on types of incentive programs claimed in the MLR calculation. Upon determination, various types of samples will be selected for testing and sent to the MCOs. Testing procedures will be performed on the requested samples for accuracy and allowability when compared to the listings and contracts submitted.                                                                                    |
| <b>9. Perform healthcare quality improvement (HCQI), health IT, and EQR testing procedures, select samples, and send to MCOs.</b> | Assigned staff accountants will review submitted HCQI/health IT/EQR data to determine the appropriate sampling methodology. Sample types will be determined based on the type of cost claimed in the MLR calculation. Upon determination, various types of samples will be selected for testing and sent to the MCO. Testing procedures will be performed on the requested samples for accuracy, classification, and allowability.                                                                                                                                                             |
| <b>10. Perform related-party and third-party vendor relationship testing procedures and sample, as necessary.</b>                 | Assigned staff accountants will review submitted third-party and related-party data to determine the appropriate testing procedures necessary. Upon review of the relationship, samples will be selected on an as-needed basis. If sampling is not necessary, alternative testing procedures will be conducted to ensure the cost reported in the MLR is appropriate. If the vendor is a third party, testing will be conducted to ensure administrative costs are removed. If the vendor is a related party, testing will be conducted to ensure profit and administrative costs are removed. |
| <b>11. Perform IBNR testing procedures.</b>                                                                                       | Assigned staff accountants will review the submitted IBNR data and reconcile the amounts to the MLR. Analysis will be completed on the supporting documentation to determine if the IBNR calculation is appropriate. The methodology reported by the MCO will be reviewed to ensure consistency in reporting.                                                                                                                                                                                                                                                                                  |
| <b>12. Review for credibility adjustment based on membership.</b>                                                                 | Assigned staff accountants will review member months based on MCO documentation and State data. If the membership is within the cited regulation threshold, a credibility adjustment will be calculated and included in the MLR.                                                                                                                                                                                                                                                                                                                                                               |
| <b>13. Calculate the appropriate MLR and remittance due to the State.</b>                                                         | The MLR and remittance will be recalculated based on the MCO contractual requirements, incorporating the proposed adjustments resulting from our examination procedures above. The amount due to or from the State will be reflected within the final MLR examination report deliverable.                                                                                                                                                                                                                                                                                                      |
| <b>14. Communicate proposed adjustments to the MCOs.</b>                                                                          | A summary of adjustments will be provided to the MCOs that will include supporting documentation for the adjustments along with the impact to the MLR percentages and remittance amount. The MCOs will be offered an exit conference, given time to review the documentation, and allowed to provide                                                                                                                                                                                                                                                                                           |



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

| <b>MLR Examination Procedures</b>                 |                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                   | additional documentation or explanations for consideration. This cycle will be repeated until no new documentation or explanations are provided.                                                                                                                                                                                                                                  |
| <b>15. Submit draft and final reports.</b>        | Draft reports will be provided to BMS for review and approval prior to release to the MCOs. The MCOs will be given time to review the draft report and to provide a representation letter. Once the representation letter is received, and a State representation letter signed as well, the final reports will be prepared and submitted to BMS and copies provided to the MCOs. |
| <b>16. MLR template and instructions updates.</b> | The MLR template and instructions will be reviewed on an annual basis for potential updates. The template and instructions will be submitted to MCOs for review prior to the annual submission. Additional updates will be considered based on MCO feedback.                                                                                                                      |

Through each step of our procedures, Myers & Stauffer will collaborate with BMS and the MCOs to ensure transparency into the MLR examination process and ensure the review progresses according to schedule. If any issues arise during the process, these are shared with BMS during recurring project status meetings.

*MLR Audit Key Issues*

The procedures are developed to meet the engagement objectives and are designed to obtain sufficient evidence to support our findings. Each year, our procedures are further refined to target specific risk areas based on previous findings and to adapt to changes in regulations and contract terms. Our experience auditing national MCOs in multiple states, including West Virginia, has allowed us to develop a base of knowledge regarding key issues that may impact this scope of work in West Virginia, and additionally, our gained knowledge specific to local MCOs. Our ability to identify and defend key issues has been strengthened through years of research, combined with our relentless quest to stay abreast of the changing environment the MCOs operate in. The risk-based approach requires that we have a thorough understanding of the “big picture” of the MCOs’ environment. An understanding from a more global perspective helps assess risk. *Table 2* highlights some of the key issues we have identified during our MLR engagements.

Table 2. MLR Audit Key Issues

| <b>MLR Key Issues</b>              |                                                                                                                                                                                                                                                                                                                                                                                                 |
|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Revenue</b>                     | MCOs’ reported revenues may exclude retroactive activity, additional payments related to the Medicaid managed care program outside of capitation, as well as directed payments and risk corridor adjustments. All amounts should be included to appropriately reflect revenues on the MLR as part of the denominator.                                                                           |
| <b>Taxes</b>                       | Taxes reported by the MCOs may have various issues, including unallowable taxes, improper allocations to the Medicaid line of business, improper reporting due to exclusion of change in deferred tax assets, or inclusion of taxes on investments.                                                                                                                                             |
| <b>Provider Incentive Payments</b> | Provider incentive payments often include estimates of anticipated payments based on required outcomes or metrics. During the reconciliation period, it is common for providers to fail to meet all required metrics, resulting in reduced payments or no payments for the reporting period. Additionally, some arrangements are not based on metrics at all, both overstating incurred claims. |

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

| <b>MLR Key Issues</b>                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                          | Furthermore, incentives related to performing HCQI activities may inflate incurred claims expenses instead of being reported as HCQI.                                                                                                                                                                                                                                                                                                                                     |
| <b>Pharmacy Benefit Manager (PBM) Arrangements</b>                                                       | MCOs contract with PBMs to perform various pharmacy services, including reimbursement for covered drugs. These arrangements often leave MCOs unaware of additional profit mechanisms employed by PBMs. This lack of transparency hinders accurate reporting of pharmacy expenditures as additional fees or guarantees assessed by PBMs to pharmacies are not reported as reductions to incurred claims, leading to an overstatement of incurred claims.                   |
| <b>Recoveries and Overpayments Related to Incurred Claims</b>                                            | Incurred claims should be reduced by any recovery or overpayment related to the reporting period, but MCOs are not always properly reporting these amounts. Often, there is a delay between when recoveries are determined and processed compared to the original claim payment. This creates a risk of overstating incurred claims as many MCOs are not properly accruing and reporting anticipated recoveries and overpayments to be processed after the runout period. |
| <b>Unallowable HCQI/Health IT/EQR</b>                                                                    | HCQI reporting captures various types of expenses, including salaries and benefits, vendor expenses, health IT expenses to support the employees, etc. MCOs tend to include a large portion of expenses for personnel and non-personnel that do not qualify based on the Medicaid MLR HCQI/health IT/EQR guidance. This reporting component can often be misinterpreted by the MCOs when reporting these expenses.                                                        |
| <b>Adjust Vendors' Expense Reported on a Per Member Per Month (PMPM) Basis to Actual Claims Incurred</b> | Vendor expense arrangements on a PMPM basis are common among MCOs. This arrangement allows for the inappropriate inclusion of administrative expense and profit to be reported as a medical expenditure since it is not allowable as part of the incurred claims costs. MCOs should be reporting vendors at actual cost incurred for the services provided. Any additional amounts paid as a result of the contractual arrangement should be reported as nonclaims cost.  |
| <b>Various Ownership Types</b>                                                                           | MCOs can be owned by individuals, corporations, counties, health systems, or religious orders. Health system-owned MCOs typically incur related-party issues as the amounts are not reported at the cost of the related party providing the service.                                                                                                                                                                                                                      |
| <b>Related Organizations</b>                                                                             | All transactions with related organizations must be reported at the cost of the related party, assuming the related-party exceptions are not met.                                                                                                                                                                                                                                                                                                                         |
| <b>Documentation Issues</b>                                                                              | Adequate documentation must be provided at the time of audit. Failure to provide documentation could lead to the removal of amounts included on the financial reporting.                                                                                                                                                                                                                                                                                                  |
| <b>Changes in Reporting Methodologies</b>                                                                | MCOs change reporting methodologies for various reasons, but significant shifts in how costs are categorized or allocated in the financial reporting can be a red flag and will require a more detailed review.                                                                                                                                                                                                                                                           |

The results of the work performed are provided to the Department at the completion of the engagement in the form of an Independent Accountant's Report (the Report). The Report includes a narrative of our adjustments and the adjusted MLR percentages. Use of the draft and final reports are restricted to BMS, MCO, and actuary if specified by BMS.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Other Financial Services Support**

We will also support BMS with 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, DPP calculations and support, provider payment reviews, MCO tax settlement calculations, waiver support, and audit support, including IBNR calculations. *Table 3* provides an overview of our approach, including a cross-reference to our detailed approach, when applicable.

Table 3. Other Financial Services Support

| Financial Service                             | Overview of Approach                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Rate Studies and Reimbursement Support</b> | Our detailed approach to supporting provider rate studies and reimbursement support services is found in <i>Compliant Provider Rate Setting Services (4.2.1.5.1)</i> . Our general approach, however, starts with understanding the scope and objectives of the rate study, gathering data and potentially provider input, ensuring data accuracy and completeness and conducting preliminary analyses, calculating model rates, determining the fiscal impact, helping the State assess implementation feasibility, and communicating our final work product to the State. We also support implementation, including communication strategies with stakeholders.                                                                                                                                                                                       |
| <b>Legislative Planning</b>                   | For upcoming legislative sessions or legislative forums, we will conduct a fiscal analysis of bills, as requested, taking into full account the fiscal and operational impact. Our approach will go beyond simply benefit costs and also include operational/ administrative costs. This may include review of the need for additional staffing, overhead costs, modifications to existing contracts, and other costs. We will provide detailed analysis and summarize our findings into digestible briefs that BMS can use during legislative testimony or as leave behinds for legislators. Multiple versions of each brief will be developed, as needed, based on the end user or target audience. For example, the BMS Chief Financial Officer (CFO) may require a detailed brief and a much higher-level brief would be required for a legislator. |
| <b>Budget Support</b>                         | Our policy and financial experts will collaborate to support BMS with budget inquiries, preparing for upcoming budget cycles, ideating on potential strategies to address budget shortfalls, and other activities, as requested by the CFO. We will support modeling of budget impacts with variables that can be modified based on assumptions, where appropriate. Further, we will develop materials and presentations, as needed, to support BMS Finance.                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Financial Projections and Analysis</b>     | Similar to budget support, we will conduct analyses and projections to support BMS as it assesses the fiscal impact of various events, new initiatives, benefit changes, or policy changes. We will use our existing data warehouse to the extent possible and request additional data only when needed to minimize the administrative burden on BMS and its other vendors. We will present our projections along with inputs, assumptions, and other relevant factors to BMS and make updates, as requested. As applicable, we will incorporate our financial analysis into our legislative briefs which address fiscal, operational, policy, and other programmatic components.                                                                                                                                                                       |
| <b>Federal and State Reporting</b>            | We will support BMS with ensuring the accuracy, completeness, and timeliness of state and federal reporting. For example, if requested, we will support BMS with reviewing its CMS-64 and other federal claiming reports to ensure their accuracy and appropriate draw down of federal funds. We understand there are a number of existing federal and state reports and a need for ad hoc reports and we are prepared to support BMS with their production.                                                                                                                                                                                                                                                                                                                                                                                            |

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

| Financial Service                           | Overview of Approach                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Federal and State Rules and Projects</b> | As proposed rules are developed and made public, we review them from a multidisciplinary perspective to ensure a complete and detailed understanding of their impact or potential impact. We start our analysis early with proposed rules and adjust our financial analyses based on the Final Rule. Our early and interim analysis supports our state clients with understanding the potential impact, making budget requests, and contributing comments during the public comment period to attempt to influence the Final Rule.                                                                                                                                                                                                                                                                                                                                                                             |
| <b>DPPs</b>                                 | Our approach for supporting financial services associated with DPPs is described in <i>Directed Payment Program Amounts/Other Supplemental Payments (4.2.1.3.13)</i> . Our services, however, include the design of the DPP, completion of the CMS preprint, quality measures and VBP structures, calculation of DPP budgets and payments earned by providers, and evaluation of the effectiveness of the DPP given its stated purpose.                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Provider Payment Reviews</b>             | We conduct a number of provider payment reviews for a variety of purposes. For example, we use encounter data payments to compare provider payments against MCO contract rates to measure the MCO's fidelity to their contractual obligations to the provider. We also conduct provider payment review to assess the accuracy of the State's MMIS and the application of reimbursement methodologies consistent with the approved State Plan. We also perform other provider payment reviews as part of our program integrity support where we review medical records and other documentation to ensure that billed services were actually rendered to the Medicaid or CHIP member.                                                                                                                                                                                                                            |
| <b>MCO Tax Settlement Calculations</b>      | Our approach includes supporting the calculations, consistent with the approved tax. To do so, we obtain and validate data inputs, such as enrollment, capitation payments, premium revenue, encounter data, and other financial data. Then, we calculate the tax liability for each MCO and reconcile estimated tax payments with actual tax liabilities. We also support financial modeling and scenario analysis to evaluate the fiscal impact of proposed tax rate changes.                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Waivers</b>                              | Our approaches for supporting the financial services associated with waivers, including cost effectiveness, cost neutrality, and budget neutrality calculations is described in detail in <i>Waiver Program Ongoing Implementation, Support, Federal/State Reporting, and Financial Projections (4.2.1.2.3)</i> . We prepare each of these calculations consistent with CMS guidance and the approved waiver. We also support projections of expected waiver expenditures, the impact of added benefits, and for the opening of additional waiver slots or expanded eligibility.                                                                                                                                                                                                                                                                                                                               |
| <b>IBNR Calculations</b>                    | We are well-equipped to conduct IBNR calculations. Our approach for supporting financial services associated with IBNR calculations is described in detail in <i>MLR Audits, IBNR, and Risk Adjustment Activities (4.2.1.1.7)</i> . However, our Team's general approach begins with having high quality claims data. Data quality is ensured by our rigorous EDV processes or using Milliman's CREW™, which is an Excel-based model that Milliman actuaries use internally to stage historical payments over time and inform IBNR assumptions. CREW allows for raw claims data to be entered in aggregate or with stratifications for each covered population and service type grouping. CREW's primary asset is its ability to accommodate unusual claim payment patterns, as well as changing enrollments, benefits, unit costs, and other key factors. The result is a far more accurate estimate of IBNR. |
| <b>Financial Audits</b>                     | As a CPA firm with a large practice area staffed with CPAs, certified fraud examiners (CFEs), and auditors, we conduct a large volume of audits and financial review, including those consistent with AICPA standards. We approach these audits with the purpose of ensuring the payments are accurate and consistent with contracts and regulations, to help identify improper payments, and identify any fraud and abuse. We invest time ensuring we understand the rules, regulations, provider manuals, etc. and develop audit procedures. We identify and obtain necessary data elements and apply                                                                                                                                                                                                                                                                                                        |



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

| Financial Service | Overview of Approach                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                   | <p>the audit procedures. We investigate anomalies and present findings along with recommendations to the State and receive their feedback before finalizing our report. Our report is more than a findings report, it includes recommendations, suggested corrective action, and actionable next steps.</p> <p>Myers &amp; Stauffer and Milliman support BMS Finance with data analysis and research for the BMS Single State Audit. The support involves refreshing previous analytics, conducting new data reviews, and reviewing and responding to audit findings, as needed.</p> |

**Demonstrated Experience: Analysis Dashboard****West Virginia BMS**

The Myers & Stauffer Team provided a detailed fiscal analysis regarding the impact of changes under H.R. 1 (OBBA) on the State's current MCO tax. Using our deep understanding of Medicaid taxes and financing, we identified the opportunity to transition the current tiered MCO tax to a percent of premium tax structure to comply with the new federal requirements. Included in our review was the impact on other related programs, such as the State's DPP. Based on our review and recommendations, this transition would not only be a move to compliance, but it could also potentially generate nearly \$35 million in additional revenue for the state.

**Other State  
Medicaid  
Experience**

Myers & Stauffer has performed MLR audits to support the fiscal integrity and oversight of managed care programs for numerous Medicaid clients, including, West Virginia, Georgia, Hawai'i, Idaho, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Mississippi, New Hampshire, New Mexico, North Carolina, Tennessee, Utah, Virginia, Washington D.C., and Wisconsin.

**Analysis of Payment and Reimbursement Accuracy (4.2.1.2.2)**

The vendor should describe their plan to analyze the accuracy of payments and reimbursements related to changes under the Affordable Care Act (ACA) or other federal or state healthcare and/or payment provision rules, regulations, laws, or codes.

**Approach and Methodology**

The Myers & Stauffer team has supported BMS through state legislative as well as federal payment and financing regulatory changes issued over the past several years. We monitor bills introduced into the West Virginia legislature as well as congress and track their progress on a daily basis, anticipating BMS's policy and fiscal needs to address inquiries it may receive. For each bill or regulatory action, we evaluate applicability to West Virginia's programs and provider types, quantify the financial impact on the Medicaid program and providers, identify constraints on program design and payment levels, evaluate available regulatory flexibilities, and support implementation and compliance. Reimbursement accuracy in the current federal regulatory environment is multifaceted and involves ensuring rates are calculated correctly under an approved methodology, the methodology itself remains compliant, the associated federal claiming is correct, and the resulting payment level is financially sustainable for the State.

Under the provisions of the Affordable Care Act (ACA), West Virginia expanded Medicaid effective January 1, 2014. Expenditures for this expanded population are eligible for enhanced federal match rather than the State's regular Federal Medical Assistance Percentage (FMAP). This two-tier match structure has direct payment accuracy consequences. Eligibility group attribution determines the federal

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

share of claim and capitation payment, so correct attribution between the expansion group and other eligibility categories is necessary to produce accurate federal claiming on the CMS-64. We analyze rate and payment structures with this distinction in mind so that the financial impact of any rate change is understood in both total computable and State-share terms. We will analyze and ensure accuracy of payments and reimbursements associated with ACA provisions, including any updates or modifications made through federal or state law, and we will comply with all applicable ACA requirements and any subsequent changes enacted at either the federal or state level.

The Myers & Stauffer Team's rate work supports this process by establishing rates that serve as the payment floor and the pricing reference against which network reimbursement and encounter data are evaluated. We, therefore, analyze the effect of each regulatory change on the FFS rate structure and communicate the results across our teams for appropriate rate benchmarking.

Several ACA provisions beyond expansion financing remain pertinent to Medicaid programs, including managed care MLR standards at 42 CFR § 438.8, and the ACA-directed Medicaid DSH allotment reductions.

There are a number of recent and pending federal provisions affecting Medicaid payment and reimbursement that we will consider during rate setting work for BMS. These include:

- **Public Law 119-21** (enacted July 4, 2025), referred to by CMS as the Working Families Tax Cut (WFTC) legislation. Section 71115 establishes new indirect hold harmless thresholds for healthcare-related taxes, section 71116 limits total payment rates for SDPs, and section 71111 bars implementation of the long-term care (LTC) minimum staffing standards until after September 30, 2034. The law also establishes community engagement requirements effective January 1, 2027, six-month redeterminations for the expansion adult group, expanded cost sharing, and limits on retroactive coverage.
- **CMS-2439-F**, *Medicaid and CHIP Managed Care Access, Finance, and Quality*, 89 FR 41002 (May 10, 2024). This Final Rule revised SDP standards, required incorporation of SDPs into capitation rates, established appointment wait time and secret shopper standards, revised MLR requirements, and established the managed care quality rating system.
- **CMS-2442-F**, *Ensuring Access to Medicaid Services*, 89 FR 40542 (May 10, 2024). This Final Rule rescinded access monitoring review plans and replaced them with FFS payment rate transparency, comparative payment rate analysis, and payment rate disclosure requirements at 42 CFR § 447.203(b), with initial publication due July 1, 2026; established the interested parties advisory group, HCBS payment adequacy standards, and rate reduction and restructuring State Plan Amendment (SPA) procedures.
- **CMS-3442-F**, *Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting*, 89 FR 40876 (May 10, 2024). The staffing standards were subsequently subject to litigation and to the statutory moratorium under section 71111 of the WFTC legislation, and CMS issued an interim Final Rule removing them at 90 FR 55687 (December 3, 2025). The companion institutional payment transparency reporting



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provisions at 42 CFR § 442.43 and 438.72(a) that require facility-level reporting of the percentage of Medicaid payments spent on direct care worker and support staff compensation remain in federal regulations and continue to impact nursing facility and intermediate care facility for individuals with intellectual disabilities (ICF/IID) payment analysis.

- **CMS-2448-F**, *Preserving Medicaid Funding for Vulnerable Populations — Closing a Healthcare-Related Tax Loophole*, 91 FR 4794 (February 2, 2026). This Final Rule tightened the generally redistributive standard for nonuniform and non-broad-based healthcare-related taxes, with transition timelines for taxes on MCO services.
- **CMS-2449-P**, *Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments*, 91 FR 30400 (May 22, 2026). This proposed rule would implement section 71116 of the WFTC legislation by replacing the average commercial rate (ACR) ceiling with a Medicare-based payment limit — 100% of the published Medicare rate in expansion states, such as West Virginia — establish grandfathering criteria and a subsequent annual phasedown, and create a new FFS targeted payment ceiling. If finalized as proposed, the annual Medicare payment rules (skilled nursing facility [SNF] prospective payment system [PPS], inpatient PPS (IPPS), outpatient PPS (OPPS), and the physician fee schedule) now function as ceilings on certain Medicaid payment levels.
- **CMS-2452-P**, *Amending the Indirect Hold Harmless Threshold of Healthcare-Related Taxes*, 91 FR 46562 (July 23, 2026). This proposed rule would implement section 71115 of the WFTC legislation by replacing the 6% indirect hold harmless threshold with state-specific thresholds derived from taxes enacted and imposed as of July 4, 2025, eliminate the 75/75 test, add services of health insurers as a permissible class, and for expansion states, phasedown the applicable threshold to 3.5%, with nursing facility and ICF/IID tax classes treated differently from other classes.
- **Center for Medicaid and CHIP Services sub-regulatory guidance**, including the February 2, 2026, “Dear Colleague Letter” providing preliminary guidance on section 71116 of the WFTC legislation and the September 10, 2025 informational bulletin addressing SDP practices.

### Our Approach

For each federal rule and regulation issued, we will perform a review of applicability against West Virginia’s payment methodologies, Medicaid State Plan provisions, waivers, and provider types. As applicable, and if requested by BMS, we then quantify the impact using available data. Impact quantification can be performed at three levels: the effect on individual provider payment, the effect on aggregate program expenditures, and the effect on the State’s financing structure, including the interaction between provider taxes, payment ceilings, and the nonfederal share available to support current rate levels.

Analysis is only useful if it produces actionable options. For each requirement, we identify the flexibilities available to BMS and the trade-offs among them. These resulting provisions from the listing of new final and proposed federal regulations carry varying implementation time frames, and part of our role is sequencing the Bureau’s decisions so that elections are made while they remain available.

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We then support implementation and compliance. For example, Myers & Stauffer assisted BMS with the initial implementation of the FFS payment rate transparency requirements at 42 CFR § 447.203(b) for the July 1, 2026, deadline, including compilation and validation of published rate information and establishment of the update process required as rates change. We will provide the same support across other requirements as they take effect.

**Ongoing Monitoring**

Myers & Stauffer tracks Federal Register publications, CMS sub-regulatory guidance, and proposed rulemaking across our state Medicaid client base. As needed, we issue written client alerts summarizing new requirements and their operational and financial implications. BMS receives these alerts along with West Virginia-specific analysis of what each issuance means for the State's programs and providers. We also work with the Bureau to review state legislation affecting Medicaid reimbursement, model the effect of proposed and enacted state provisions on provider rates, and support implementation and compliance as those provisions take effect.

**Waiver Program Ongoing Implementation, Support, Federal/State Reporting, and Financial Projections (4.2.1.2.3)**

The vendor should describe their plan to assist in overseeing the ongoing implementation, support, federal and state reporting, and financial projections of all relevant waiver programs.

**Approach and Methodology**

Myers & Stauffer currently supports BMS with ongoing implementation, federal and state reporting, and financial projections for the MHT and MHP 1915(b) waiver programs. We also provide similar support to other states with 1915(c) and 1115 waiver programs. We provide an experienced team of SMEs to support cost-effectiveness (1915(b) waivers), cost neutrality (1915(c) waivers), or budget neutrality (1115 waivers) calculations that comply with CMS requirements and accurately reflect the fiscal performance of the new or modified authority. Historically, we have supported clients by leading these activities or by engaging with the State's financial team and/or actuarial vendor.

While such support may vary based on the waiver program, below we have highlighted general financial support we will provide to BMS and we will tailor this support based on the given request.

- **1915(b) Waiver Cost-Effectiveness Analyses.** We will work closely with BMS and its vendors to develop cost effectiveness projections for the MHT and MHP programs and provide meaningful context to the waiver's financial data, including proactively drafting responses to potential CMS questions and recommending changes to CMS-64 quarterly reporting to better separate and identify costs by waiver renewal period and Medicaid eligibility group (MEG).

As part of our waiver cost effectiveness analysis, we have and will continue to compare waiver cost information from the State's CMS-64 reports, quarterly waiver member month reports to CMS, and claims and capitation payment data extracts from the State's fiscal agent contractor to identify any significant variances in reporting and engage with BMS to explain or resolve issues.

- **1915(c) Waiver Cost Neutrality.** Similar to our experience with the 1915(b) cost-effectiveness waiver, we have the knowledge and experience to support BMS in developing 1915(c) cost



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neutrality submissions. For existing 1915(c) renewals, we will evaluate historical data, including person-level enrollment, utilization, and expenditure data to support the 1915(c) cost neutrality development. This includes using information directly from historical data to develop all components for 1915(c) cost neutrality. After preparation and submission by BMS, we will support BMS's response to any questions CMS may have related to the cost neutrality development.

- **1115 Waiver Demonstration Budget Neutrality Support.** When assessing budget neutrality, we will follow CMS guidance related to cost and trending estimates. Our resources will be particularly focused on compliance with CMS' announced intention to require greater rigor and CMS' Chief Actuary's approval of budget neutrality for new or renewal waiver applications on and after January 1, 2027. Following are general strategy steps we will take to complete budget neutrality adjustments, which we may modify depending on the waiver program at hand.
  - **Gain Understanding of Waiver Services.** We will meet with BMS to gain an understanding of the waiver goals and services being requested either within a new or renewed waiver. For a waiver renewal, we will research the existing budget neutrality estimates to gain an understanding of the prior approved calculations, and work to understand any programmatic changes that will impact the new calculations.
  - **Collect Data.** Where possible, we will use our existing data warehouse for West Virginia data. Where there are gaps in data, we will submit a data request to BMS for the appropriate data, inclusive of but not limited to multiple years of historical costs (typically five years), information needed to estimate cost of the waiver services, enrollment data, data related to hypothetical expenditures, trend rates (BMS trends and Presidential Budget limit trends), MEGs, and savings from prior years within the same renewal period, if applicable. Where data is not readily available, we will meet with BMS and any BMS contractors to research methods to find suitable alternatives or estimates to complete the neutrality calculations.
  - **Prepare Calculations.** Using the data collected, we will prepare a budget neutrality model that will meet CMS requirements. We will assess estimates for hypothetical costs (costs that could have been incurred under the State Plan), and potential waiver cost savings to be offset, and will apply the appropriate trend analysis. We will present the information for each MEG, as applicable, and will show a summary of the budget estimates with and without the waiver services. We will provide source data and document the calculations for transparency and ease of use.
  - **Assure Quality.** Once calculations are complete, we will conduct an internal quality review, followed by a meeting with BMS and any BMS contractors as it may be necessary to discuss the reasonableness of estimates and ensure the outputs meet expectations. We will make any needed updates or changes necessary to ready the calculations for CMS submission.

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- **Assist With CMS Negotiations, as Needed.** Typically, CMS will review the budget neutrality estimates with states and negotiate terms, data sources, trends, etc. We are available to assist with questions and make any necessary updates to the model.

Myers & Stauffer will utilize our experienced team, including Milliman, to propose a budget neutrality strategy for BMS's consideration. The proposed strategy will comply with the updated CMS requirements and accurately reflect the fiscal performance of the new or renewed waiver. Where we identify issues, we will work closely with BMS to explore alternative options for consideration and their respective impact on the neutrality calculations.

**Post-Waiver Approval Support**

In addition, Myers & Stauffer will support BMS with developing and drafting post-approval reporting and other materials, as required by CMS. While specific to a given authority, these materials often include implementation plans, evaluation design documents, interim and summative evaluation plans, financial claiming protocols, protocols for assessing member eligibility and needs, infrastructure planning documents, and monitoring protocols and/or reports. For 1115 waiver implementation, for example, we have supported states with post-award public forums, as required by 42 CFR § 431.420(c). CMS requires states to hold the first of these forums within six months after the implementation date of the demonstration. We have prepared materials for these forums, captured feedback regarding the progress of the demonstration, and prepared summary reports suitable for inclusion in reports to CMS. In addition to these post-award activities, we frequently develop and disseminate direct stakeholder communications materials designed to reinforce a client's strategic vision and goals regarding a particular SPA or waiver; deliver clear, accurate, and timely messages; provide instructive guidance; and promote buy-in. Materials have included emails, newsletters, provider bulletins, and FAQ documents.

**Actuarial Services (4.2.1.3)****Managed Care Program Rate Development, Setting, Certification, and/or Review (4.2.1.3.1)**

The vendor should describe their approach and methodology to complete the development, setting, certification, and/or review of rates for the State's Managed Care programs. Capitation rates for Managed Care should be developed based on readily available State data and set by cohorts, including, but not limited to, age, gender, eligibility category, geographic location, and population risk factors. The vendor should describe its plan to host a MCO rate setting kick off meeting prior to implementation of activities to outline the process of rate development with the MCOs and conduct meetings throughout the rate setting process with the MCOs.

**Approach and Methodology**

Milliman's rate setting process follows federal regulations (as promulgated under the Medicaid and CHIP Managed Care Rule (Final Rule) and actuarial standards of practice (ASOPs), specifically, the rate development standards under 42 CFR 438.5 and the definition of actuarially sound capitation rates as defined under 42 CFR 438.4 and ASOP 49. Based on our experience working with state Medicaid agencies across the country, we have observed that the level of scrutiny being applied to risk-based managed care rates by CMS and the level of required documentation continues to increase from prior levels. With consideration for potential updates to federal regulations and a continually expanding Medicaid Managed Care Rate Development Guide, actuaries are required to provide much greater

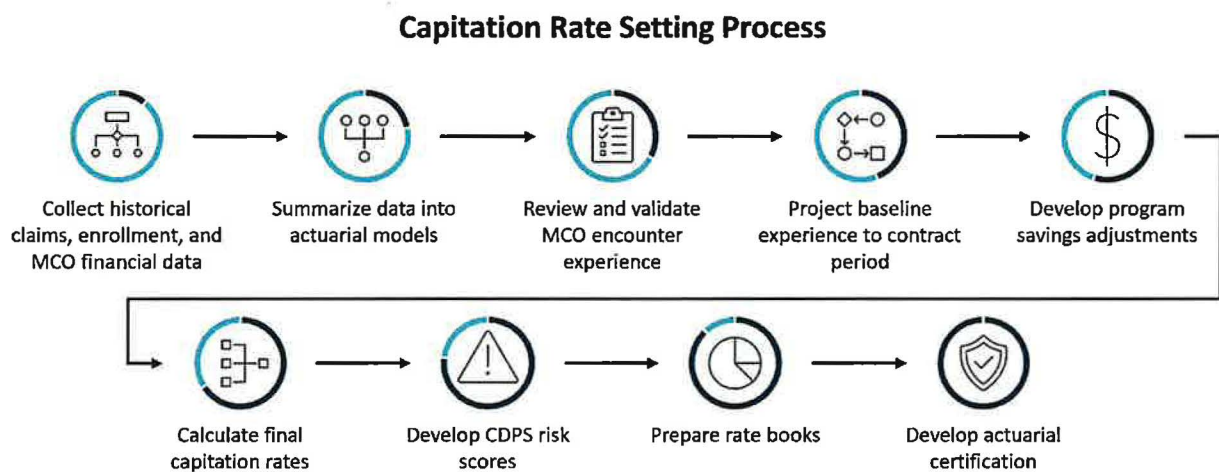


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demonstration of the “why” and “how” in the rate setting process, versus merely documenting the final values of the assumption or action. That is why the Milliman Team assisting West Virginia focuses on using clear, transparent methodologies and communications with both BMS and the MCOs to develop Medicaid managed care capitation rates. It is not the process in the rates itself but the ability to clearly articulate and defend Medicaid managed care rate setting assumptions that sets Milliman apart. The Milliman Team will continue to provide data to BMS and the MCOs to help build consensus in its rate setting assumptions and use kickoff meetings, data requests, and regular meetings with the MCOs more broadly to emphasize the need for sustainable and sound actuarial capitation rates.

Milliman will follow the process for developing capitation rates shown in *Figure 11*.

Figure 11. Capitation Rate Process



### Step 1. Collect Historical Claims, Enrollment, and MCO Financial Data

The first step for capitation rate setting is to collect historical claims, eligibility, and MCO financial data from the State and MCOs. The claims data typically include MCO encounter and are supported by FFS data to help inform day one enrollment assumptions and to understand costs, such as medication-assisted treatment and pharmacy services that are paid for by the State on an FFS basis. Reviewing all data gives us a better view of the program more holistically. Milliman cleans the detailed datasets to eliminate duplicate claims, claims from noneligible participants, and services not covered by specific capitation rates. Eligibility data include capitation records and FFS eligibility records, as needed, to support program changes.

MCOs are also asked to provide financial data in a template provided by Milliman. It is important for all MCOs to report financial data consistently using a State-prescribed reporting template to collect historical Medicaid revenue, claims, and administrative expenses. Milliman continually reviews the current template and suggests modifications based on discussion with the client and comparison to other states. Milliman has worked with many states to implement or enhance an existing financial reporting template, ensuring compliance with CMS reporting standards. In West Virginia in particular, Myers & Stauffer and Milliman have used the financial reporting template and encounter data validation

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(EDV) to drive significant improvements in managed care encounter data. This has improved the accuracy and reliability of the data for rate setting.

**Step 2. Summarize Data Into Actuarial Models**

The next step is to summarize the encounter claims data into actuarial models. An actuarial model illustrates the claims experience in a format that allows analysis by specific categories of service. The actuarial model develops utilization rates per 1,000, cost per unit of service, and per member per month claim costs.

Based on decades of experience analyzing claims data, Milliman developed analytical methodologies to group healthcare claims experience in categories of service that create meaningful, homogeneous groupings of services. These groupings, or categories of service, allow for a consistent comparison of utilization rates within each category of service and are customized to best report on services or providers frequently used by the MHT and MHP programs. For example, by expanding a generally classified “physician” or “physician – primary care” category into additional category of services, we are able to analyze office visits, hospital visits, well baby examinations, surgical services, ED services, and other categories of service by meaningful utilization and cost statistics. In West Virginia, Milliman has customized the claim identification logic to separately identify certified community behavioral health center (CCBHC), federally qualified health center (FQHC)/rural health clinic (RHC), and CSED service utilization to allow for more transparent data summaries and to allow for easier comparison of values across each MCO and review changes in the programs and trends over time.

**Step 3. Review and Validate MCO Encounter Experience**

Following actuarial modeling, Milliman reviews the encounter experience to determine the completeness of the data on an annual basis. The Team validates encounter data and other MCO-submitted data using audited financial reports. Additionally, Milliman compares this data to Medicaid benchmarks to determine if the MCO encounter experience is appropriate to use in the rate setting process. Milliman’s actuarial modeling techniques allow for a detailed service category review of the encounter experience reported by the MCOs. Milliman also provides the detailed data that will be used in the capitation rate development process back to each MCO so each MCO can review the quality of its own data and benchmark itself to the statewide data. This promotes both transparency in the rate setting process and provides the MCOs with rich data that they can use to drive efficiencies in the program.

Detailed comparisons of the MCO encounter and financial data can identify issues that impact rate setting. For example, the encounter data may include value-added services provided by MCOs that should not be included in the base data used for rate setting. These comparisons can also provide insight into the appropriate cost to use for sub-capitated services since encounter data are often valued on a per-service basis while financial data reflect the actual MCO payments to sub-capitated providers. This review also provides additional insight into how the MCOs report related-party arrangements. In one state, our detailed review of encounter claims and MCO financial data revealed payments to related parties far exceeding actual provider payments. Without this review, there is the possibility of overstating capitation rates.



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In certain cases, MCO encounter data may require adjustments to address missing encounters. Encounter data that are not considered credible will be eliminated from the base experience data used to develop the capitation rates.

**Step 4. Project Baseline Experience to Contract Period**

Milliman projects the summarized baseline data for each rating category to the contract period by developing adjustments for the following items: claims completion, encounter underreporting (if appropriate), healthcare trend, carve out of services not included under the capitation rates during the contract period, inclusion of FFS data not covered under managed care in the base period but expected to be covered by capitated MCOs in the contract period, policy and program changes, smoothing of outlier data, acuity changes, and other actuarial adjustments. The rating categories and assumptions for each of these adjustments vary by program eligibility category and rate cell (including age, sex, and region).

For newly covered populations that do not have historical data available, Medicaid or commercial claims experience will need to be adjusted appropriately. Capitation rates in these situations should reflect estimated acuity, provider reimbursement, pent-up demand, potential adverse selection, and utilization mix differences with existing Medicaid populations.

Milliman pays particular attention to, and provides full transparency into, the adjustments made for program changes including provider reimbursement and impacts from fiscal notes. Milliman has experience with Medicaid programs nationwide to assist with quantifying the potential fiscal impact associated with issues, such as:

- Facility and physician reimbursement changes.
- Newly covered benefits.
- Changes in the limits applied to covered benefits.
- Changes in co-pays or other cost sharing mechanisms.
- Newly eligible populations.

Milliman communicates these impacts in a variety of methods. For formal rate reports, we clearly outline the data, assumptions, and methodology underlying the results applied for each program change. This communication often includes mentioning program changes that have no material impact on projected costs in the interest of full transparency.

As an example, when West Virginia implemented its CCBHC program, the Myers & Stauffer team was able to leverage their experiences supporting other states with CCBHC programs to reasonably estimate the expected expenditures and ramp up in expenditures of the CCBHC program. In the first nine months of the program, Milliman transparently shared its rate setting assumptions with the MCOs to increase their comfort level with the assumptions. While the MCOs expressed concerns that there were many unknowns associated with the CCBHC program that would be difficult to estimate for rates, the Milliman

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estimates were very reasonable in relation to the actual expenditures that occurred during the rating period.

Potential impacts of program changes need to be compiled for fiscal notes, especially during a legislative session. We follow the same process for developing and communicating those fiscal impacts, including transparency into the assumptions and data underlying those results. However, we understand that the precision needed and time available to perform such analyses can vary significantly for different program changes. As such, we always discuss those needs with our state partners and take that into consideration in developing work plans while still ensuring superior quality and clarity of the work.

**Step 5. Develop Program Savings Adjustments**

The next step is to adjust the projected utilization and cost per unit data to reflect anticipated levels of managed care efficiency between the base period and the contract period. If the base experience reflects FFS data, the managed care adjustments represent the anticipated impact of managed care on projected experience. If the base experience reflects managed care data, the managed care adjustments calibrate the experience data to reflect anticipated improvements in managed care efficiency between the experience and contract periods. Milliman will not necessarily assume the MCOs operating during the historical experience period are operating at optimal efficiency.

For acute care services, managed care savings are typically assumed to result from reductions in unnecessary or duplicative services and increases in preventive care due to care coordination provided by the MCOs. We will assess MCO performance and develop managed care adjustments, as needed, based on Milliman's proprietary databases and publicly available MCO performance and quality measures. For example, the following rate adjustments may be recommended based on the analysis:

- Lowering ED visit utilization for MCOs with a high degree of unnecessary ED visits in the base period, with corresponding utilization shifts to professional office visits.
- Lowering inpatient admissions for MCOs with a high percentage of avoidable admissions in the base period, with corresponding utilization shifts to outpatient and/or professional preventive services.

For acute care services, the Milliman Team has extensive experience developing adjustments for projected improvement in managed care efficiencies. One example of this experience is with 3M's potentially preventable events tool. Using this tool allows for a clinically supportable and transparent method to include savings opportunities in the capitation rate development. Milliman will also consider BMS's requirements in the MCO contracts that provider reimbursement over 102.5% of the Medicaid FFS fee schedules not be included in the Medicaid capitation rates.

The Myers & Stauffer Team understands that West Virginia may consider adding LTSS for its managed care program. For LTSS, managed care savings are typically assumed to result from an increased proportion of beneficiaries receiving care in the community rather than in an institutional setting. To identify an appropriate amount of savings, we review the historical and current distribution of beneficiaries among residential settings, consider demographic mix and clinical opportunities, and ensure consistency with contractual requirements.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Step 6. Calculate Final Capitation Rates**

The final capitation rates may include adjustments for age, sex, category of aid, and region area.

Milliman regularly reviews the effectiveness of its prior capitation rates to understand where accuracy could be improved. For example, in the West Virginia MHT program, Milliman suggested consolidating rate cells for pregnant women, for specific ages within Expansion, and others to improve the accuracy and credibility of rate development. Milliman also adjusts capitation rates for MCO taxes, administrative costs, quality expenses, premium taxes, and directed payments.

Milliman develops appropriate administration allowance and quality expense assumptions based on the contractual obligations of the MCOs and reported administrative cost experience from MCO-submitted financial data. Adjustments are made, as needed, based on changes in administrative service requirements, inflation factors, and other changes between the base period and the contract period. Milliman will also compare base period and contract period administrative costs to its annual MCO benchmarking report that reviews publicly available data and analyzes the financial performance of MCOs nationwide. This Milliman report is widely used by state partners, Medicaid MCOs, federal agencies, and other stakeholders.

Milliman's methodology and rate certification language and documentation are continually updated to reflect emerging regulations and guidance. Milliman is familiar with the requirements in the Medicaid and CHIP Managed Care Final Rule, the CMS Medicaid Managed Care Rate Development Guides, ASOP 49 on Medicaid rate setting, as well as other applicable ASOPs and the CMS rate setting checklist.

**Step 7. Develop CDPS Risk Scores**

Milliman has extensive experience with the CDPS and Medicaid Rx risk adjustment models. They use managed care encounter and FFS claim baseline experience in the calculation of CDPS risk scores and also use managed care encounters in the calibration or selection of risk adjustment weights. Milliman will review whether the inclusion or exclusion of diagnosis codes from specific service categories changes the predictive accuracy of the calculated risk scores. For example, diagnosis codes from radiology and laboratory services are in many cases used for testing purposes and may falsely identify a Medicaid member with a disease state. Milliman also uses its nationwide experience with CDPS+Rx to observe and remove misleading disease assignments. For example, Milliman found that taking muscle relaxants led to misleading disease assignments in other states. Milliman can discuss with BMS whether to exclude these claims or other similar examples to avoid false positive results.

Milliman generally recommends a member have a minimum of six months of eligibility in the analysis period prior to including a Medicaid-eligible member in the risk score process. Milliman will gather all diagnosis and enrollment/eligibility information for the members to calculate individual risk scores.

Milliman will assess whether to develop state-specific diagnosis relative weights rather than using the standard relative weights from CDPS where the data are sufficient. For example, when developing capitation rates for Florida's risk-based managed care program for medical services, it was not appropriate to use the standard relative disease weights from CDPS for medical services capitation rates because of a specialty MCO that primarily enrolled members with SMI. In this case, Milliman developed an alternative set of relative weights for CDPS that included a special category to distinguish these

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members from other non-SMI members. The alternative relative weights were developed through the use of a stepwise linear regression model. Milliman will also consider whether risk scores need to be adjusted for credibility. For example, they assisted West Virginia in developing credibility and duration adjustments for its MHT risk adjustment to improve the effectiveness of risk adjustment when a new MCO entered the program.

Once risk scores are calculated for each individual, we will calculate aggregate risk scores for each MCO based on the projected enrollment for each MCO during the contract period. We normalize the risk scores for each eligibility category and geographic rate region to produce a 1.000 risk score based on historical enrollment. This process ensures a budget neutral risk score adjustment from the State's perspective. Milliman also recommends normalizing risk scores to 1.000 in each age/gender rate cell to avoid double counting the impact of demographic variables, such as age and gender on projected risk scores.

CDPS risk scores have been implemented in a variety of methods in state Medicaid programs. One significant decision relates to the frequency of rebasing the risk scores for the MCOs. The composite risk scores for each MCO can be refreshed on a quarterly, semiannual, or annual basis. The recalculation can vary based on the type of program, voluntary versus mandatory enrollment, as well as the anticipated growth or penetration of the populations into MCOs. For example, as market share is changing, Milliman recommends that rebasing occur more frequently.

West Virginia currently uses actual enrollment paired with historical claims from a prior period to perform risk adjustment. This aligns with CMS' approach for Medicare risk adjustment but is inconsistent with other states. Milliman will continue to evaluate operational and actuarial considerations for continuing or modifying this approach.

**Step 8. Prepare Rate Books**

We prepare rate exhibits showing the step-by-step development of the base capitation rates (before risk adjustment). Milliman is committed to rate transparency so all parties are able to follow the capitation rate calculations and understand all data, methodology, and assumptions used in the process. Milliman presents the rate exhibits to the MCOs, leads MCO meetings to discuss the rates, and works with the State to address any additional questions or comments provided by the MCOs regarding the capitation rate calculation.

**Step 9. Develop Actuarial Certification**

We provide an actuarial certification for each set of capitation rates according to the relevant requirements of federal regulation 42 § CFR 438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7. The actuarial certification is signed by a Milliman actuary who meets the qualification standards required for the certification. Milliman's qualification standards go above and beyond the minimum requirements imposed by the Society of Actuaries (SOA) as they believe signing Medicaid actuarial certifications requires a deep understanding of Medicaid and years of experience in multiple states to truly assess the risk.



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In addition to the actuarial certification, Milliman provides documentation that supports the actuarial certification. The documentation package will include detailed exhibits and narrative summarizing and documenting the base period experience and all rate development assumptions used to calculate the capitation rates. Milliman has significant experience with the actuarial certification process and will provide sufficient documentation to address the requirements in the Final Medicaid Managed Care Regulation, ASOP 49, and the CMS Medicaid Managed Care Rate Setting Guide. Milliman actuaries have extensive experience working with CMS during the rate approval process. They use this experience to proactively address common CMS questions in the rate documentation, facilitating an efficient and cost-effective rate review process.

**Communication and MCO Stakeholder Outreach**

To develop actuarially sound capitation rates requires collaboration between the State, the actuaries, and the MCOs. Milliman currently uses the below approach to engage the MHT and MHP MCOs in the rate development:

- Milliman hosts a kick-off meeting at the start of rate setting to discuss the proposed rate setting methodologies as well as any MCO-specific concerns regarding current rates, trends, or potential program changes.
- Milliman sends a comprehensive data request to the MCOs who are required to complete the data to inform more accurate rate setting.
- A question and answer period is utilized to clarify any information provided by the MCOs and discuss any material differences between Milliman's data observations and the MCO reported data.
- Draft rates, including a detailed rate report document the development and assumptions, are shared with BMS and then the MCOs for their review.
- Rate meetings are scheduled to discuss the draft rates. This typically includes an all-MCO meeting where Milliman presents the key components and results from the rate development process and one-on-one meetings requested by the MCOs to discuss any assumptions or details further.
- Final capitation rates are provided to BMS and the MCOs for review.
- Monthly meetings with the MCOs and ad hoc meetings, as requested, are utilized to keep active communication and address any questions before, during, and after the rates are developed.

We strive to achieve transparency in all communications and provide sufficient information to allow the MCOs to understand the base data, rate calculations, and development of all rate assumptions.

After each year's rate development process is complete, Milliman provides a comparison of expenditures using the current and prior rates, as required by the CMS checklist. Milliman also compares the projected expenditures using the final current year rates to those in the client's budget forecast and works with the client to understand any differences. In addition, Milliman will work with BMS to develop considerations for the following year's rate development process. Milliman will identify and

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communicate potential changes from the current capitation rate development process to the following year's capitation rates and discuss approaches to incorporate any changes.

### West Virginia BMS

## Demonstrated Experience: Actuarial Services

Milliman has provided West Virginia actuarial consulting services for nearly five years. Our managed care rate setting services cover most Temporary Assistance for Needy Families (TANF), CHIP, pregnant women, foster care children, disabled individuals, and Medicaid expansion clients through the MHT and MHP managed care programs. Milliman assists the State with capitation rate setting, risk adjustment, CMS documentation, and various policy analyses. We have assisted with numerous policy analyses and have been an active and involved member of the State's team throughout our tenure. Milliman has assisted in the implementation of a new MCO in the MHT program, MHT integration with WVCHIP, day one enrollment, and a quality withhold program.

### Other State Medicaid Experience

Milliman has provided Medicaid actuarial consulting services, including managed care rate setting, for Washington for the last 28 years.

Washington State covers most TANF, State CHIP, foster care, disabled, and Medicaid expansion clients through managed care. Milliman assists the State with capitation rate setting, risk adjustment, CMS documentation, and various policy analyses. With Milliman's assistance, the program has continued to provide broad access to care while maintaining reasonable cost control. Milliman has assisted in a number of policy analyses, several procurements, and transitions of members from FFS to managed care, as well as Medicaid expansion and a statewide integration of behavioral health and physical health. Over the years, rate setting has included the following programs:

- **Missing or Murdered Indigenous Persons and Washington Medicaid Integration Partnership.** Two fully integrated programs similar to the West Virginia MHT program, but these programs include medical, behavioral health and LTSS services. The dually eligible members are now part of a managed FFS program and other populations are covered under Apple Health, the Washington Medicaid managed care program similar to West Virginia's MHT program.
- **General Assistance Unemployable.** This program ultimately became part of Medicaid expansion. Prior to that change, we set rates and computed shared savings for this program, including many homeless and those with severe behavioral health issues.
- **Medicaid Expansion.** We developed rates and unique risk mitigation strategies for this program, now part of Apple Health.
- **Health Home.** We compute rates for this program, which is key to the managed FFS program for dually eligible members.
- **Foster Care.** Milliman assisted in the procurement and continued support including rate setting for this program.



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### What This Means for BMS

With consideration for potential updates to federal regulations and a continually expanding Medicaid Managed Care Rate Development Guide, actuaries are required to provide much greater demonstration of the “why” and “how” in the rate setting process, versus merely documenting the final values of the assumption or action.

That is why the Milliman team assisting West Virginia focuses on using clear, transparent methodologies and communications with both BMS and the MCOs to develop Medicaid managed care capitation rates. It is not the process in the rates itself but the ability to clearly articulate and defend Medicaid managed care rate setting assumptions that sets Milliman apart.

Milliman will continue to provide data to BMS and the MCOs to help build consensus in its rate setting assumptions and use kickoff meetings, data requests, and regular meetings with the MCOs more broadly to emphasize the need for sustainable and sound actuarial capitation rates.

### High, Mid, and Low Capitation Rate Ranges for Review (4.2.1.3.2)

The vendor should describe their plan to develop high, mid, and low capitation rate ranges for review.

#### Approach and Methodology

If requested by BMS and as approved by CMS, we will develop high, mid, and low capitation rate ranges for review. These approaches are not commonly used currently, and we would also engage in discussions with BMS related to the pros and cons of such a methodology and the limitations under the current Rule.

If BMS were to pursue development of capitation rate ranges, Milliman would follow the steps described in *Managed Care Program Rate Development, Setting, Certification, and/or Review (4.2.1.3.1)*. However, instead of developing sound assumptions for each assumption in Step 4 and Step 6, Milliman would develop a range of assumptions for trends, program changes, and non-benefit costs, where appropriate. These assumptions would be translated into low, mid, and high capitation rates for BMS review.

One challenge with ranges is that the high and low options tend to include a combination of conservative or aggressive assumptions that may not be sound in combination. The best estimate approach leverages assumptions that are appropriate when used together.

### Managed Care Rates at the Individual MCO Level (4.2.1.3.3)

The vendor should describe their plan to develop Managed Care rates at the individual MCO level, if the Agency chooses to develop MCO-specific rates based on risk stratification.

#### Approach and Methodology

The Myers & Stauffer Team currently develops MCO-specific capitation rates by risk adjusting the regional capitation rates using the risk adjustment process described in *Managed Care Program Rate Development, Setting, Certification, and/or Review (4.2.1.3.1)*. We also have worked with BMS to add a

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high-cost drug risk pool that customizes final capitation rates for each MCO by adjusting their revenue for high-cost drugs to align with their proportion of high-cost pharmacy spend. Milliman has broader experience developing MCO-specific rates and can pursue the development if desired by BMS. For example, plan-specific rates may be desired to:

- Recognize MCO-specific administrative considerations.
- Recognize historical costs of each specific MCO.
- Encourage individual MCO initiatives.

For each of these examples or any others requested by BMS, Milliman will follow the methodology described in *Managed Care Program Rate Development, Setting, Certification, and/or Review (4.2.1.3.1)* and will customize individual assumptions, as necessary, to achieve the State's risk stratification goals.

#### Rate Setting Discussion/Meeting/Documentation Support (4.2.1.3.4)

The vendor should describe their plan to 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 documentation, including but not limited to presentations, rate workbooks, spreadsheet files, and rate memos, as requested by Agency staff for meetings.

#### Approach and Methodology

Milliman approaches this type of work from a transparent, collaborative mindset. We engage, listen to, and respond to stakeholders while also providing industry leading knowledge and technical capabilities. We present to all stakeholders, respond to questions, and work to present solutions to concerns. Key presentations and supporting documents are also provided for reference.

We are prepared to provide a complete, detailed explanation of the rate setting methodology for key stakeholders in any format required. We propose one-on-one meetings with the MCOs prior to the rate development to understand issues specific to each plan and during the rate development to present SFY rates. We will also meet with MCOs for any material midyear adjustments and/or risk adjustment results. We complete similar tasks in every state where we serve as certifying actuary.

We also prepare detailed, transparent materials for the State and BMS to better understand rate setting assumptions and for reference during future conversations. These materials include draft rate PowerPoint presentations, detailed Excel workbooks supporting the major underlying rate setting assumptions for the capitation rates, and rate memos in the format requested by CMS. We modify our approach, as needed, based on State feedback, which has been successful in West Virginia.

From our experience, open communication with the State and all stakeholders has produced an efficient model where we are able to submit MCO rates at least 90 days prior to the rating period if all legislative issues are resolved. With other actuaries, the draft capitation rate process may be merely a formality where MCO concerns do not lead to meaningful discussion or changes. However, we believe the rate setting process is meant to be collaborative, as all stakeholders have a unique view and their own information that should be considered in developing actuarially sound capitation rates. While we may not always agree with the MCOs, we believe it is important to be transparent in assumptions and discussions to create more buy-in into the rate setting process. Our approach has meaningfully



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improved the capitation rate setting results and relationships with stakeholders in West Virginia over the past four years.

### Collaboration with Agency Staff to improve Data Accuracy and Efficiency (4.2.1.3.5)

The vendor should describe their plan to 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 should include attending meetings, conference calls, and other requests that the Agency deems necessary. It is the expectation of the Agency that the vendor should provide new and innovative ideas around the rate setting process and efficiencies of such. The Vendor should describe their plan to facilitate direct communication channels between Actuary and the Agency. The frequency should be on an as-requested basis, by Agency leadership. The location of the meetings will be determined by the Agency and whether they will be held in-person or virtually.

### Approach and Methodology

As with all our work, we know clear communication and collaboration with our clients are key to a successful partnership to both accomplish goals and prepare for the future. We strive for a collaborative relationship with our state Medicaid agency clients, where Milliman is viewed as a trusted partner. At the same time, we work towards a professional and positive relationship with the contracted MCOs and provide open lines of communication so issues can be identified and addressed proactively. We have found this type of relationship results in productive, fact-based discussions with MCOs regarding their encounter data, financial data, and questions about the assumptions used in rate development. It also leads to more accurate rates and a more efficient rate setting process. Our Team collaborates to complete detailed reviews of the MCO encounter data. For example, Myers & Stauffer has used EDV reconciliation processes successfully in West Virginia over the past four years to significantly improve the accuracy of the MCO encounter data.

We also appreciate the need for new and innovative ideas to improve data, the rate setting process, and overall efficiency. Our Team will continue to work together 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. We complete this task in every state where we serve as a certifying actuary. Potential additional steps we can take include exploring the use of Milliman's Sentry product on the MCO encounter data to help identify other adjustments that should be made to the rate setting process or benchmarking the West Virginia MCO data to nationwide utilization metrics using Milliman's access to the Transformed Medicaid Statistical Information System (T-MSIS) which is a comprehensive database of nationwide Medicaid utilization. We can discuss these tools, MCO benchmarking, and other analyses to improve the data and rate setting results. We will also discuss approaches to rate setting (such as midyear updates) that could be adjusted to improve efficiency moving forward.

Myers & Stauffer will also facilitate direct communication channels between BMS and Milliman. In addition, Annie Hallum, FSA, MAAA, will serve as a main point of contact for BMS for actuarial matters. Myers & Stauffer and Milliman will attend in-person meetings, virtual meetings, conference calls, and respond to any other BMS requests, as needed, to encourage clear communication, accuracy, efficiency, and collaboration.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Agency-Specified Formats for Reports and Calculations (4.2.1.3.6)**

The vendor should describe their plan to 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.

**Approach and Methodology**

We will provide the Agency with reports, calculations, and supporting data in the format(s) the Agency specifies, ensuring compatibility with existing systems and workflows. Our approach includes:

- **Format Alignment.** We are already familiar with and using formats specified by BMS (e.g., PDF, Excel/CSV, JSON, XML, GIS shapefiles, or database exports) and any applicable data standards. However, we will confirm at the start of the new contract whether there are any required changes and make those updates. We will document these requirements for mutual sign-off.
- **Methodology Transparency.** All calculations will be delivered with accompanying documentation of assumptions and methodology, so the State can independently verify and reproduce results.
- **Databases and Datasets.** Underlying databases and datasets will be provided in the State's preferred structure.
- **On-Demand Requests.** Recognizing that needs may arise outside the standard reporting cycle, we will support ad hoc requests for reports, data extracts, or documentation on an as-needed basis.
- **Version Control and Documentation.** Each deliverable will include version labeling, date stamps, and a change log where updates are made to previously delivered data or reports.

**Rate Uniformity (4.2.1.3.7)**

The vendor should describe their plan to 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 should identify inconsistencies and recommendations to the Agency for improving its rate setting process and helping align areas that are not in uniformity.

**Approach and Methodology**

To identify rate uniformity (where payments can be made consistently across agencies) we will perform a rate study for the State, as requested. Upon request from BMS, our Team will work with the Agency to identify the rates to be reviewed and establish a work group to solicit feedback from key stakeholders involved for better context to the data we analyze from each agency.

The exact rating approach will vary by provider payment type (e.g., diagnosis-related groups [DRGs], community provider, etc.). For provider payments with widely used comparison models (e.g., Medicare payments for Medicare Severity [MS]-DRGs, Medicare payments for the resource-based relative value scale [RBRVS], etc.), we will leverage pre-existing payment models to benchmark the rates and create recommendations for uniformity. For provider payments without widely used comparison models, we will create customized models based on the drivers of costs for the provider services. For example, for community providers, we recommend using an independent rate model (IRM) approach informed by analyses of independent data sources (e.g., Bureau of Labor Statistics wage data), State staff, and



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stakeholder subject matter expertise to develop rate recommendations and compare to existing payment rates. Under an IRM approach, rate assumptions may include the identification of wage levels by type of health professional, employee-related benefits and taxes, supervisor span of control, turnover, training, paid time off, program support costs, administrative costs, transportation, residential facility staffing (if applicable), and facility overhead costs, among others. We will also work with BMS to customize rates, as desired, for geographic differences, incentive payments, quality withholds, and other unique considerations.

The use of a comparison model or IRM approach will allow for identification of inconsistencies and recommendations to the Agency for improving its rate setting process and help align areas that are not in uniformity. We will provide a repeatable, nonproprietary rate methodology to develop payment rates for uniformity. We understand the importance of transparency in these types of analyses and take pride in effectively communicating complex statistical and financial information to nonfinancial staff. We will develop a report that clearly articulates project goals and objectives, key issues, our proposed rate methodology, and the corresponding rate calculations.

### Capitation Rate Updates (4.2.1.3.8)

The vendor should 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.

### Approach and Methodology

Milliman annually performs the rate setting process outlined in *Managed Care Program Rate Development, Setting, Certification, and/or Review (4.2.1.3.1)* to update the capitation rates based on data, pricing trends, changes resulting from federal and/or state requirements, and program changes. Our Team also works collaboratively with the State and MCOs to identify whether program changes or other unanticipated external forces suggest it would be prudent to amend the capitation rates midyear. Our midyear rate amendments follow the same process outlined in *Managed Care Program Rate Development, Setting, Certification, and/or Review (4.2.1.3.1)*, except we only change assumptions, as needed, based on the circumstances leading to the midyear rate amendment. For example, in recent years we have amended MHT and MHP capitation rates every December to address fee schedule changes and program changes. We have also considered adjustments to trend, acuity, or program changes where new information is materially better than the information used in rate setting (such as emerging CCBHC utilization). We will continue to discuss the appropriateness of mid-year rates and work to adapt our approach and methodology to suit the best interests of the State.

In addition to traditional rate setting certification, Milliman has the tools to assess the compliance of the SDPs with new requirements benchmarking to Medicare payment levels and phasing down to these new rate ceilings. The Myers & Stauffer and Milliman partnership provides a seamless process in developing directed payments, assessing compliance and ultimately the actuarial certification that is part of changing federal requirements.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Transition Plan (4.2.1.3.9)**

The vendor should describe their plan to 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 should describe their plan to 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.

**Approach and Methodology**

Both Myers & Stauffer and Milliman are known for our long-term contracts with states, which is a reflection of commitment to our clients and the quality of our services. As the incumbent on this contract, this quality is something BMS has witnessed firsthand. Should we not be selected to continue our work with the State, we will support a seamless and orderly transition of contracted functions. Similarly, at the end of the contract term or upon earlier termination, as directed by the State, we would also transition knowledge, data, resources, and materials to promote the continuity of BMS's operations and the success of the incoming vendor.

When we are the incumbent and must transition out of a project, we work with our clients to support all aspects of the transition, as applicable. Specific to this contract and consistent with the RFP and contractual requirements, we will work with the State to develop a transition plan within 90 calendar days prior to contract expiration, or earlier if requested. The transition plan will address the transfer of data, methodologies, documentation, and ongoing work to the State or a successor contractor. We will work cooperatively with the State and any designated successor to develop the plan. All decision logs, issue trackers, and data from previous deliverables and ongoing projects will be provided to the State at least 60 days prior to the end of the contract. Because our delivery model relies on maintained work plans, deliverable trackers, decision trackers, and documented assumptions throughout the contract, required transition materials are continuously maintained rather than assembled at the end. The result is a transition that is organized and low risk for the State, regardless of whether the hand off goes to a successor contractor or back to BMS.

In addition, our transition process includes the creation and execution of a project transition plan, conducting applicable training of the incoming vendor's team and/or client staff, and meeting all timelines as mutually agreed upon in the client-approved transition plan. Our comprehensive transition plan is designed to:

- Facilitate knowledge transfer.
- Minimize the disruption to State staff.
- Support continuity of operations and ongoing projects.
- Identify roles and responsibilities.
- Establish milestones and metrics to evaluate and assess transition progress.

Our client-centered mission focuses on helping our clients succeed, even if that means transitioning to a new vendor. Our transition plan for this engagement will encompass the following:



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- **Review and Familiarization.** We will facilitate the new vendor's review of our current work product, including reports, methodologies, and other relevant documentation.
- **Collaboration with the New Vendor.** We will engage and collaborate with the new vendor to address any open issues, provide clarifications, and facilitate knowledge transfer in areas, such as rate setting consulting services.
- **Collaboration with BMS.** We will assist the new vendor in collaboration with BMS to ensure the transition aligns with the State's expectations, timelines, and operations requirements.
- **Timeliness.** We understand and acknowledge that all transition work must be completed within BMS's established time frames and will do our part to assist the new vendor in fulfilling these obligations without compromising the quality of work.

We commit to working with BMS and the new vendor to facilitate a smooth transition to ensure operations continue without interruption. With a proactive and transparent approach, we can ensure the turnover process proceeds seamlessly, safeguarding operational integrity and continuity for West Virginia.

### Coordination with State Fiscal Agent for Accurate Encounter Claims (4.2.1.3.10)

The vendor should describe their approach and methodology to coordinate with the State's fiscal agent to ensure accurate encounter claims, and eligibility data is used for rate setting. The vendor should describe their plan to 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.

#### Approach and Methodology

During our work on behalf of states, we routinely work with state fiscal agents and we have established a collaborative and respected working relationship with the biggest vendors across the country. We will leverage our proven approach and these relationships to obtain and improve the accuracy and completeness of encounter data.

Encounter data serves as the base experience in the capitation rate setting process and Myers & Stauffer will invest significant resources to validate the completeness and accuracy of encounter as well as eligibility data. Our Team will utilize validated encounter data, eligibility data, and other data to develop managed care capitation rates, produce MCO risk adjustment analyses, determine MCO DPP calculations, and thoroughly carry out all necessary actions to produce the most comprehensive, compliant, and highest quality services.

To ensure the completeness and accuracy of the MCO encounter data, we request monthly reporting from the MCOs and their subcontractors on their claims-related provider payments in the form of cash disbursement journals (CDJs). These CDJs separately identify the payer (the MCO or subcontractor) and the program associated with the payment: MHT Medicaid, MHT CHIP, and MHP, if applicable. The MCO-reported CDJ totals will be compared to the State's encounter data by program to determine completeness and ensure consistent eligibility determinations between the MCOs and the State. We will

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review the State encounter data to identify potentially duplicate records, missing encounters, or other data issues and work with the MCOs, State, and fiscal agent to resolve the discrepancies.

Similarly, we will apply a rigorous review process to eligibility files and data to assess their completeness and viability for use in rate setting. We will conduct activities to ensure all required records and fields are present and counts reconcile, the file structure conforms to the specifications provided, duplicate or conflicting records are identified and reconciled, anomalies are escalated, and where possible, completeness is verified. Our work in other states has heightened our reviews for common errors such as:

- Missing or invalid eligibility codes.
- Overlapping eligibility periods.
- Incorrect effective or termination dates.
- Inaccurate demographic information.
- Duplicate member records.
- Managed care enrollment outside eligible periods.
- Inconsistent aid category or eligibility group assignments.
- Member-month discrepancies affecting capitation payments.
- Unsupported retroactive eligibility.
- Incomplete documentation supporting eligibility determinations.

Each of these error types can have an impact on the accuracy and integrity of reports, as well as capitation rate setting.

We will report to BMS on the completeness of the encounter data on an agreed-upon basis in the format requested. Our reports to BMS will include the encounter data completeness percentages along with a summary of identified data issues and recommendations for improvements, at minimum. Issues with eligibility files will similarly be escalated to BMS along with the issues identified.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****West Virginia BMS****Demonstrated Experience: Encounter Validation**

Myers & Stauffer has created a collaborative environment where we work closely with BMS, Gainwell, and the MCOs to complete encounter validation procedures. Our work has resulted in improvement in the quality, completeness, and usability of the MCO encounter data; in fact, our work has improved the encounter data accuracy from 95.68% in our 2023 report to 99.99% in our most recent 2026 report, with all MCOs and their subcontractors above 98%. As our process has improved the integrity of this data, we have also recommended and added updates to the MCO contracts, progressing the contractually required accuracy. Our efforts have led to better sight into utilization, expenditures, and quality measurement, as well as providing a significantly improved and trusted base from which capitation rate setting and financial analysis management can occur.

**Other State  
Medicaid  
Experience**

For Mississippi, Myers & Stauffer provides services to ensure compliance with the CMS-required EDV (EQR Protocol 4) of its MCOs. Our analysis includes assessing the MCOs' capabilities, analyzing and testing encounter data, and coordinating the review of medical records with clinical staff to verify the claims submitted. Our EDV process has improved the completeness of data supplied by MCOs to support rate setting and facilitate CMS review and approval of the capitation rates.

**Coordination with Fiscal Agents for Completeness of All Reports  
(4.2.1.3.11)**

The vendor should describe their approach and methodology to work with fiscal agents to ensure completeness of all reports used for state and federal reporting, as requested by the Agency.

**Approach and Methodology**

Our actuaries, data analysts, and policy advisors will work with the fiscal agent (i.e., Gainwell Technologies) to ensure completeness of all reports used for state and federal reporting, as requested by BMS. We have experience working directly with the State, plans, and other third parties to gather and validate data required for all necessary tasks.

We will ensure that any data used to assist with State and federal reporting are complete by comparing to control total files or other reconciling information. We validate any reporting against multiple data sources, as available, and leverage previous reporting to identify any changes. If unexpected changes in the data occur, we will coordinate with the State and fiscal agent to determine the cause and potential remedies.

**Managed Care Encounter and Claims Data and MCO Technical Assistance  
(4.2.1.3.12)**

The vendor should describe their approach and methodology to 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.

**Approach and Methodology**

Our MCO data collection process is customized to fit the populations covered and services provided under each managed care program. As described in *Coordination with Fiscal Agents for Completeness of All Reports (4.2.1.3.11)*, we develop specific data ingestion and validation processes for encounter claims

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submissions, financial data, and additional details pertaining to an MCO's business and carved-out services.

Myers & Stauffer works with the fiscal agent to receive data related to claims, encounters, capitation and other financial data, member eligibility, and provider enrollment on a regular schedule. We also request monthly CDJ data from the MCOs reflecting the MCO and their subcontractors' claims-related payments to providers. By comparing these separate data sources, we are able to validate the managed care encounter data for the State. Our EDV process includes identifying potentially duplicate encounter submissions, missing encounter records, including adjustments and voids, discrepancies in encounter data elements, and potential encounter processing issues.

We will provide technical assistance to the MCOs on any identified data issues by discussing examples, recommending encounter or other data corrections, and working with the fiscal agent to resolve any encounter processing issues.

### Directed Payment Program Amounts/Other Supplemental Payments (4.2.1.3.13)

The vendor should describe their plan to develop methodologies for calculating Directed Payment Program amounts or other supplemental payments, and the associated preprints and quality strategies for such programs.

#### Approach and Methodology

Beginning in 2016, significant federal changes to managed care reimbursement guidelines for states have occurred as they relate to managed care enhanced provider payments, whereby the State provides a lump-sum pool of dollars to the MCO and instructs the MCO to distribute the funds to qualifying providers. CMS contends pass-through payments are contrary to the goals of a managed care delivery system and has continued to address concerns by amending regulatory oversight. Initially, as an alternative to pass-through payments, CMS introduced SDPs as an approved methodology for making enhanced payments to providers under managed care.

BMS officials have worked with various provider stakeholders to use directed payments to enhance provider payment streams. The Myers & Stauffer West Virginia DPP SMEs worked closely with BMS and stakeholders to maximize these programs for hospitals and looks forward to continuing to support West Virginia Medicaid in these endeavors.

Currently in West Virginia, these DPPs include:

- Hospital and academic physicians. "Hospital Directed Payment Program (DPP)": Provides qualifying hospitals and academic medical groups extra funding tied to service utilization.
- Nonacademic physicians working for hospitals. "Physician DPP": Directs augmented payments specifically for nonacademic physicians employed within or contracted by hospital systems.

Federal regulatory shifts continue to impact state Medicaid SDPs by enforcing quality components and evaluation, strict Medicare caps, restricting provider taxes (often used as the nonfederal share funding source), and deferring billions in matching funds. We understand these rules and can help BMS apply



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them to their state program, as well as continuing to assist BMS with understanding and complying with the following changes:

- The 2024 Medicaid managed care rule introduced rigorous constraints on SDP financing mechanisms for MCOs, specifically tightening submission deadlines, expanding reporting mandates, and requiring separate payment terms to be transitioned into capitation rate adjustments.
- The 2025 reconciliation law (H.R. 1/OBBBA) established new limits on SDPs, capping them at 100% of Medicare rates in expansion states. In addition, the law imposes annual reductions to provider tax hold harmless limits, which are used in West Virginia to fund the nonfederal share of SDP.



## Proactive Response to Legislation

We are dedicated to assisting BMS in navigating changes in legislation, as well as making the Medicaid program more efficient and economical. For example, following the passage of West Virginia HB 5157 in 2024, our team supported BMS by preparing payment calculations, rate determinations, and the SFY 2025 preprint. This expansion successfully added critical access, psychiatric, and LTAC hospitals, increasing West Virginia Hospital DPP payments by 278% (\$956 million).

## Dedicated to Client Success

- In May 2026, CMS issued a proposed rule to codify the statutory provisions governing SDPs, incorporating measures that broaden the applicability of newly established limits. Furthermore, the proposal delineates a transition schedule to phasedown existing grandfathered SDPs, targeting Medicare-equivalent caps over a period not to exceed 10 years.
- On July 21, 2026, CMS published a Notice of Proposed Rulemaking to amend the indirect “hold-harmless” threshold of provider taxes as part of the implementation of the OBBBA. Beginning in fiscal year (FY) 2028, the threshold will be reduced by 0.5% annually until the threshold reaches 3.5% in FY 2032.
- Future rule changes as proposed and/or finalized.

Our team has a proven track record of partnering with West Virginia and other state agencies to design, approve, and certify these programs. The vast experience of our professionals lends important context that deepens our understanding of regulatory aspects and both broad and narrow impacts they bring to our clients’ activities. We have previously advised BMS and other state clients on policy, risk assessment, and navigation related to directed payments. We are fully prepared to support BMS through the strategic and technical phases of the upcoming SDP transitions. Our Team tracks federal updates and joins CMS technical assistance sessions on waivers, budget neutrality, managed care, SDPs, and rate reviews, providing you with precise, expert level guidance on complex policies. We provide Medicaid leadership with comprehensive data analyses to support SDP implementation, evaluate pending legislation, and brief stakeholders on risk. We partner with BMS to translate complex data into actionable insights that guide policy decisions. Our accessible methodology ensures that West Virginia legislators and state leaders clearly understand findings, implications, and strategic next steps.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

The Myers & Stauffer Team brings four years of expertise helping West Virginia navigate complex federal and state changes to its SDP programs. Since 2022, BMS has implemented various DPP expansions for West Virginia hospitals. Myers & Stauffer has been actively involved in the approval and implementation of these programs, assisting BMS with leading stakeholder meetings, strategizing on the timing of program activities, and supporting the completion of § 438.6(c) preprint documentation for CMS submissions. Following the passage of West Virginia House Bill (HB) 5157 in 2024, our team supported BMS by preparing payment calculations, rate determinations, and the SFY 2025 preprint. This expansion successfully added critical access, psychiatric, and long-term acute care (LTAC) hospitals, increasing West Virginia Hospital DPP payments by 278% (\$956 million).

Myers & Stauffer partnered with BMS and CMS to secure program expansion approval then led operational rollout by updating payment calculations, establishing new quality metrics, recalibrating compliant tax rates, and managing stakeholder communication and hospital onboarding. We identified and trained the newly eligible hospitals on the West Virginia DPP and tax process and surveyed the new hospitals for needed information. The DPP payment calculation and payment process was modified to incorporate new payment pools. Myers & Stauffer assisted BMS with selecting new quality metrics and targets for the new hospital types. In addition, we calculated the revised tax rate needed for the expanded program, verifying that the tax and waiver complied with federal limits and preparing documents required for the changes.

Recent changes to the West Virginia DPP programs restructured the hospital DPP by raising the quality-linked portion from 1% to 20% of total payments and eliminating the redistribution of unearned funds. Myers & Stauffer updated the preprint, helped BMS select new quality metrics under the West Virginia Quality Strategy, and communicated these updates to state leadership, hospitals, and stakeholders.

As the quality component of West Virginia's DPP has expanded, Myers & Stauffer has focused on developing a comprehensive quality strategy that ensure quality incentives are clinically meaningful, operationally feasible, and aligned with West Virginia's healthcare priorities. We evaluated measures to consider several factors, including relevance to hospital type, the size and characteristics of the affected patient population, the hospital's ability to influence performance, impact on health outcomes and reduced utilization, and alignment with West Virginia's Medicaid Quality Strategy. We work collaboratively with BMS to develop thoughtful target setting, tiered performance thresholds, and measure weighting. Together, these policy levers direct financial incentives toward the areas where improvements are expected to have the greatest impact on patients while ensuring hospitals are evaluated fairly based on services they provide. Our understanding and depth of knowledge will allow us to support BMS in the application of current and changing rules impacting its SDPs and related funding.

To enhance transparency, communication, and trust regarding the West Virginia DPP transitions, Myers & Stauffer recommended establishing the West Virginia DPP Work Group. Launched in 2024 in collaboration with BMS and the West Virginia Hospital Association (WVHA), this periodic work group unites stakeholders to collaborate on hospital quality metrics, preprints, and funding strategies.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

To assist with the implementation or maintenance of these programs, we will continue to perform the following as part of our approach:

- **Cost report/Survey Tool Development.** We have and will continue to develop survey tools and templates to assist in the calculation of these DPPs.
- **Cost Survey Collection from Providers.** We will collect commercial and Medicaid claims data from the providers to determine the directed payment limits for program spend. We will also collect quality data to determine quality payments earned, as applicable.
- **Assistance with the Maintenance of Provider Taxes.** We will assist with annual and interim calculations for provider tax rates, in accordance with program funding needs, evaluating hospital revenue, the federal match rates, and program payment totals. We will assist with implementing any requested provider taxes for these or new programs and monitoring collections to assure available funding and compliance with CMS rules and limits. We will also assist BMS with developing future tax waiver applications for CMS consideration.
- **Program Modeling.** We will develop annual and quarterly financial payment models as well as summary reports utilizing claims data, provider data, and survey data. We will work collaboratively with BMS to develop and evaluate the quality component through thoughtful target setting, tiered performance thresholds, and measure weighting, aligned with West Virginia's healthcare priorities, annually.
- **Provider Communications.** We will share analysis, substantiation and modeling with BMS, CMS, and other stakeholders. With every enhanced payment, exhibits will be prepared and sent to BMS for sharing with the MCOs and providers. We will also assist with stakeholder work groups and communications. We will manage and respond to provider and stakeholder inquiries efficiently, including public requests for information. We will operate and maintain the dedicated DPP website and email address for provider updates. Using this information, we will monitor hospital changes in eligibility status.
- **Department and Provider Trainings.** As needed, we will provide trainings to providers and the Department to educate on program changes.
- **SPA and Preprint Writing.** We will draft and review any SPA and/or preprints required of CMS for the approval of these programs and draft answers for any requests for additional information (RAI) received. We are familiar with the timing requirements of filing these documents and will help BMS meet necessary deadlines.
- **Payment Reconciliations as Applicable.** We are aware that some of these programs require reconciliation, and we will calculate the payments owed or due to providers which will ensure compliance with CMS rules. This typically occurs after the end of a quarter or rate year, and we will use final paid claims data to determine the reconciliation amounts.
- **Reviews of Provider Quality Data.** We will collect the quality numerator and denominator information annually from providers or their third-party designee and can perform review procedures on the data, as directed. We will determine which providers are eligible for a quality

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

add-on payment. We will prepare payment summaries for BMS approval and send them to the provider association.

- **Provider Tax Waiver and Funding Support.** We have worked with BMS to generate provider tax calculations. With transitions expected for provider tax collections, Myers & Stauffer can assist with a process for fund balance tracking. We will work with BMS, as needed, to develop a tax monitoring tool to ensure funds are appropriately received. We will also assist BMS with monitoring additional guidance related to H.R. 1 provider tax rules and assist BMS with provider tax reduction calculations to ensure that BMS is compliant with current regulations.
- **Average Commercial Rate Surveys/Calculations.** We have also performed data collection and analysis to determine annual ACR, program add-ons, developed transparent calculation tools to perform quarterly directed payment calculations, and drafted provider correspondence/trainings to proactively communicate program components. We will review annual surveys to ensure provider compliance and will perform the annual ACR calculations. Even though there are grandfathered limits for hospital directed payments going forward, we will still monitor them compared to the ACR as required. We will continue to perform these services with the implementation or renewal of any program.
- **Core Administrative and Program Support/Workplan Management.** We will develop and maintain general and special work plans and timelines to ensure the West Virginia directed payments are prepared in accordance with BMS forecasts and preprints are filed within CMS required timelines.
- **Data Management and Future Planning/Historical Analysis.** We will continue to maintain comprehensive data and policy records from past directed payments. We will use historical insights to guide the structure and calculation of future directed payments.

Following are summaries of the current DPPs and the processes we will perform for current program calculations. However, all programs will need to be modified in upcoming months and years to conform to federal guidance issued through the Medicaid and CHIP Managed Care Access, Finance, and Quality Rule, as well as H.R. 1. Changes will need to be made to monitor applicable program payment limits, phasedown the program limits, adhere to new preprint submission requirements, monitor provider tax limits, move away from separate payment term methodologies, eliminate reconciliations, and develop monitoring procedures. We are currently working with BMS and stakeholders to determine the best path forward for implementing these changes. We will continue to partner with BMS to navigate these changes and monitor additional CMS guidance as it is released.

**Milestones: Directed Payment Services Activities Specific to Directed Payment Services**

Our proposed directed payment services milestones and processes for the contract period are illustrated below. We will discuss with BMS during the kickoff meeting to refine the project tasks and completion dates, where necessary.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)***Hospital Directed Payment*

The SFY 2027 West Virginia Hospital DPP is estimated to be between \$1.3 billion-\$1.9 billion and includes approximately 62 hospitals. Myers & Stauffer will continue to assist BMS with preparation and submission of preprint amendments and responses to CMS questions during their ongoing review of the preprint. Upon approval, we will calculate the quarterly payment and prepare exhibits to communicate the payment details to BMS, MCOs, and hospitals.

Per the hospital DPP preprint requirements, Myers & Stauffer will collaborate with BMS to gather quarterly MCO claims history for eligible hospitals. Quarterly payment pools for inpatient and outpatient services are distributed to hospitals based on each facility's proportionate share of MCO payment volume during the applicable period. Quarterly distributions are capped at 80% of funding allocations, with the remaining 20% distributed in the fourth quarter based on hospital performance against minimum quality targets.

This payment approach ensures that all SDPs are associated with the utilization of program services by eligible Medicaid managed care members and directly tied to the volume of services measured by payment level. Higher base payments generate proportionally higher state allocations, directly correlated to the value of services, as established by base payment levels. The methodology aligns funds directly with actual patient volume and care costs and simplifies actuarial soundness reviews by relying on verified encounter data. Utilizing verified encounter data from the DPP rating period ensures full compliance with federal rules.

The total payment amount is allocated under the methodology approved by CMS in the preprint and checked against the pertinent ACR and preprint payment percentage, as applicable. Payment exhibits are provided to share with MCOs and to present developed directed payments to BMS and Medicaid providers.

The SFY 2027 West Virginia Hospital DPP quality component is estimated to be between \$260 million-\$380 million and includes approximately 62 hospitals. Myers & Stauffer will collect the quality numerator and denominator information annually from providers or their third-party designee and can perform review procedures on the data, as directed. We will determine which providers are eligible for a quality add-on payment. We will prepare payment summaries for BMS approval and send them to the provider association.

We will also continue our ongoing support toward the approval of the SFY 2026 West Virginia DPP Preprint. As annual preprint submissions are required by CMS for all SDPs, we will provide preparation and approval support for all preprints, as needed, during the contract period.

*Physician Directed Quarterly Payment*

West Virginia is renewing its DPP, which grants qualifying physicians at eligible acute care hospitals supplemental access fee funds tied to Medicaid utilization. Myers & Stauffer assisted BMS in preparing and submitting the preprint, as well as addressing CMS inquiries during the ongoing review. The preprint outlines the quarterly physician payment methodology by separate payment terms, facilitating state and

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

MCO tracking. This structure ensures accurate application of uniform percentage increase and equitable distribution among participating providers amid shifting utilization patterns.

The SFY 2027 West Virginia Physician DPP is projected at \$48 million, encompassing approximately 21 hospitals and 1,900 rendering providers. Following CMS approval of the preprint, Myers & Stauffer will determine quarterly payments and prepare exhibits for BMS, MCOs, and hospitals.

Our process will include:

- **Data Collection.** Survey eligible hospitals to gather National Provider Identifier (NPI) numbers for contracted and employed physicians.
- **Verification.** Review survey results, resolve discrepancies, and ensure no claim duplication between the Hospital and Physician DPP programs in coordination with hospitals and BMS.
- **Calculation.** Finalize the verified NPI list to extract eligible claims data for quarterly payment computations.

Using an NPI survey for physician DPP calculations offers provider-specific accuracy, precise mapping, and improved audit readiness. This approach eliminates ambiguity when aggregating multispecialty or consolidated provider billing structures. The final NPI list provides verifiable, documentation of eligible providers to satisfy federal audits for the program.

Myers & Stauffer will calculate the quarterly physician directed payment using eligible claims for qualified physicians who are either employed by or contracted and billed by eligible acute care hospitals, based on member utilization during the rating period. In compliance with the preprint, the hospital-physician employment DPP is allocated through a single pool and distributed evenly to all physicians based on utilization. Utilization units are measured using relative value units (RVUs), which are standardized across all participating providers and derived from the West Virginia Medicaid fee schedule. Quarterly distribution amounts will be determined by dividing the total budget pool by the actual utilization units for that quarter.

Utilizing RVUs to reprice historical Medicaid claims establishes a standardized, transparent, and resource-aligned methodology with precise geographic adjustments. This approach applies a uniform scale across all procedure codes to eliminate provider-specific charge variance. Furthermore, this methodology aligns with CMS guidance and satisfies the uniform performance-term requirements under 42 CFR § 438.6(c)(2)(ii)(B) for directed payment preprints.

Myers & Stauffer will verify that each quarterly payment pool aligns with applicable ACR limits, preprint rates, and state regulations. Following this verification, we will prepare and distribute comprehensive payment exhibits detailing the directed payment amounts to BMS for sharing with MCOs and participating Medicaid providers.

*Physician Average Commercial Rate Limit*

Myers & Stauffer supported BMS with the recent expansion of the West Virginia physician DPP, assisting with HB 2759 tax implementation, and collaborated with providers on CMS-compliant calculations. West



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

Virginia HB 2759 (2023) updated the healthcare provider tax to fund the nonfederal share required by CMS for practitioner-directed payment programs up to the maximum allowable limit and broadened the types of healthcare practitioners and specialized hospital facilities eligible. Myers & Stauffer assisted BMS with preprint approval and implementation of the increased tax rate. Once approved, Myers & Stauffer worked with providers to gather the needed information to prepare the calculation in compliance with the CMS limit.

Myers & Stauffer will evaluate the need to update the ACR for the SFY 2028 physician DPP preprint. We developed the West Virginia Physician ACR survey and calculation methodology with input from BMS and the DPP hospitals participating in the West Virginia DPP Work Group. The survey was intended to simplify hospital reporting with a goal of robust and transparent survey responses. The survey collects data from a representative sample of West Virginia DPP hospitals across diverse populations, regions, and facility types for their top five commercial payers.

ACRs are calculated and applied to Medicaid claims data to determine the statewide ACR per unit. We then multiply each per-unit ACR by reported Medicaid units for the survey period, then divide commercial equivalent payments by the survey's Medicaid payments to find the commercial-to-Medicaid ratio. The ratio is multiplied by Medicaid managed care base payments to calculate equivalent commercial payments for the rate period. Applying the payment ratio accommodates differences in service mix and tier-specific billing rates. Additionally, the Medicaid base rate per visit is adjusted using the rate certification's actuary-certified unit cost trends by physician service type to project the Medicaid base rate per visit to the payment period.

To demonstrate that managed care rates do not exceed the ACR, estimated unit rates (comprising Medicaid managed care and SDPs) are compared against the statewide ACR per unit. For the rate demonstration, projected total payments (Medicaid base, state directed, and commercial equivalent) are divided by base period visits to derive the final comparative rates.

*Payment Verification*

Myers & Stauffer developed and implemented the BMS-approved Medicaid directed payments report to capture structured data from MCOs. We assisted BMS with contract modifications that mandate MCOs to execute and report directed payments on a stricter schedule. We will continue to collect, review, and analyze post-payment reports to evaluate MCO adherence to state directives and report findings to BMS. Timely reporting of DPP payments helps BMS improve program oversight, ensure fiscal accuracy, and maintain regulatory compliance. Early data submission enables Myers & Stauffer and BMS to promptly identify and resolve payment discrepancies or missing provider disbursements.

*SFY 2028 Directed Payment Program Development and CMS Approval*

For annual and periodic CMS approval and renewal of the DPPs, West Virginia must submit updated SDP preprints which include a comprehensive quality evaluation plan and revised actuarial rate comparisons. Myers & Stauffer will prepare these preprints, encompassing the ACR demonstration alongside the calculation and analysis of the payment percentage increase. Similar to SFY 2023-2027 preprint preparation and support, Myers & Stauffer will:

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

- Develop a directed payment model. This model will project the directed payments into the contract period using appropriate projection factors developed by Myers & Stauffer. This model will also project the directed payments by hospital, population, and major service category and will contain checks to ensure all projections are compliant with the CMS-approved preprint.
- Collect commercial rate information and calculate ACR data compiled and calculated for inpatient hospital, outpatient hospital, physician, and anesthetist.
- Complete percentage of Medicare calculations, as necessary.
- Develop tax projections and confirm state appropriations availability.
- Prepare supporting tables that contain percentage of Medicare and ACR data, projected pool amounts.
- Develop quality metrics and targets and compile reporting results for both quality payments to hospitals and DPP program evaluation.
- Collect DPP information from our actuary.
- Present results to WVHA and DPP Work Group.
- Prepare accompanying exhibits in rate certification which illustrate projected payment amounts by rate cell.
- Provide BMS with directed payment deliverables that include Excel workbooks with all information, statewide and by MCO, and include itemization for non-ACA and ACA populations.
- Discuss any needed policy changes that should be accounted for in base data for the upcoming rate development with BMS.
- Incorporate documentation into the preprint. This includes a description of the methodology and policy surrounding the directed payment development and provides CMS information required to approve the DPP for the upcoming year.
- In response to the new requirements of H.R. 1, Myers & Stauffer will:
  - Prepare the SFY 2028 preprints before the submission deadline of July 1, 2027.
  - Prepare a process to collect forms from DPP hospitals to attest they do not participate in any hold harmless arrangement.
  - Collect attestation forms, review, and prepare for submission.
  - Assist with revising the West Virginia DPP program to a capitation rate payment rather than a separate term.
  - Assess timing of tax collections for modification to fund new payment type and/or payment timing.
  - Assist with any additional DPP information needed for MCO contracts, rate certifications, and MLR calculations.



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- Assist BMS with detailed DPP information needed to be reported in Transformed Medicaid Statistical Information System.
- Prepare DPP payment reporting to CMS.

Future program limits will be tied to a comparison to Medicare rates rather than ACRs. We will follow determinations from CMS on methodology(ies) for determining acceptable Medicare rates for the comparison. To the extent that optional approaches may be allowed, we will evaluate them for determining the most favorable outcome. We will assist BMS in determining annual limits to DPP payment pools and further assist BMS with the reallocation of funding across service and hospital types.

#### *Other Directed and Supplemental Payment Programs*

Myers & Stauffer stands ready to assist BMS with any additional provider types seeking directed payment, which has become an evolving payment mechanism, and other supplemental payments. We can assist with determining federal allowance, developing and collecting cost reports and survey tools, assisting with stakeholder engagement, preparing and reviewing preprint documents, calculating and implementing nonfederal share resources, and preparing rate models and notifications.

#### *Tax Calculation and Support*

Myers & Stauffer calculated the tax needed for the SFY 2023-2027 West Virginia DPP payments. To set the annual amount and prepare the preprint, we must first determine the nonfederal share of these payments. During this process, Myers & Stauffer will:

- Compile cost report data.
- Obtain tax collection and fund balance data.
- Evaluate revenue impact of new hospitals.
- Project tax receipts and available funds for the SFY, at current tax levels.
- Calculate tax amount needed to fund the DPP payment.
- Delivery of DPP payment pools and tax rate.
- Discuss with BMS the payment, rate, and any under- or over-funding concerns.
- Prepare tax notice.

Myers & Stauffer will prepare annual inpatient and outpatient revenue tax estimates using West Virginia Tax Division data. We verify these figures against hospital Medicare cost reports and adjust them for accuracy and rate-year changes.

H.R. 1 substantially restricts state authority regarding healthcare provider taxes by instituting an immediate nationwide moratorium on new levies and freezing existing rates. Additionally, the legislation reduces the safe harbor threshold for Medicaid expansion states from 6% to 3.5%, requiring affected states to phase in a 0.5 percentage point annual reduction starting in 2028 to reach compliance by 2032.

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Myers & Stauffer will support BMS in managing this phased reduction and evaluating its operational impact on West Virginia's provider tax programs.

## **Demonstrated Experience: Directed Payments**

### **West Virginia BMS**

Our Team supports the West Virginia hospital and physician DPPs. Our analysis and consulting has included support such as annual updates to the existing programs, assisting the State with significant program expansion in response to recent legislative changes calculation of payments, establishing quality measures and baselines, monitoring of revenue requirements, and facilitating a workgroup with the State and DPP stakeholders, including the WVHA. We have supported these stakeholder engagement activities to promote communication and collaboration regarding program oversight, regulatory changes, and quality improvement. Significant to our directed payment role in West Virginia is our tracking and deep understanding of the impacts of the federal changes to DPPs in recent years. We continue to provide the results of our analyses and recommendations to BMS to protect the flow of these vital funding streams.

### **Other State Medicaid Experience**

In addition to West Virginia, Myers & Stauffer has provided DPP support to several other states including Florida, Indiana, Iowa, Kentucky, Mississippi, Missouri, Nebraska, New Jersey, and New Mexico. In Kentucky, we worked closely with the Department to design, model, and implement DPPs for inpatient hospitals, outpatient hospitals, qualified practitioners, and ambulance providers. These initiatives included assisting with drafting rules, regulations, preprints, and State Plans; gathering data; and modeling financial data resulting in various analyses used in the decision-making process. We also continue to provide reimbursement calculations, assistance with annual approvals, and stakeholder outreach. These programs are matched with quality initiatives to ensure that as reimbursement is enhanced for providers, resources are dedicated to improving the quality of care provided to Kentuckians. Our work has brought significant federal funding into the Commonwealth to enhance reimbursement and provide needed resources for these providers and improve access to care.

## **Actuarial Analysis/Valuation of Costs/Savings Established by Implementing Programmatic Changes (4.2.1.3.14)**

The vendor should describe their approach and methodology to 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.

### **Approach and Methodology**

As part of the rate setting process, Milliman develops a West Virginia program savings adjustments. The exact process is tailored to the State and the program change. For example, in evaluating the savings associated with transitioning a population from FFS to managed care, our Team would evaluate:

- The historical costs under FFS.
- Potential utilization management impacts of managed care.
- Differences in reimbursement between FFS and managed care.
- BMS's requirement in the MCO contracts that provider reimbursement over 102.5% of FFS not be included in the Medicaid capitation rates.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

- The necessary nonbenefit costs associated with the MCOs administering the benefit, such as administration, quality improvement initiatives, and margin.
- The impact of the State's Health Maintenance Organization tax on state revenue and expenses.
- The administrative cost or savings to the State of moving the population to managed care (e.g., changes in IT contracts, enrollment broker vendor, etc.).

We would also consider the state's FMAP, which varies between administrative services and managed care payments, so the State receives a holistic picture of not only the impact to the capitation rates but also the impact to the state budget.

### Detailed Billing Report (4.2.1.3.15)

The vendor should describe their plan to provide a detailed billing report with each invoice for actuarial services, which details the hours billed per staffing position per staff member.

Our Team will provide a detailed billing report with each invoice for actuarial services which details the hours billed per staffing position, per staff member. Myers & Stauffer and Milliman have collaboratively provided a single invoice for all services under the contract to BMS for the last four plus years.

Our production of a detailed billing report is supported by our electronic time recording and reporting system Acumatica. This system permits the recording of time worked on individual tasks within projects, as well as the recording of explanatory notes describing the activities performed by staff.

Within a West Virginia project code specific to this scope of work, we will develop and utilize task and subtask descriptions to further specify key activities associated with the project and provide transparency and detail to support billing. For example, such tasks and subtasks may include monitoring and oversight functions, financial services, rate setting, and specific ad hoc work orders. Our system will facilitate accurate and detailed time recording at the task level and permit the level of granularity required to support billing of the fixed fee and hourly components of the resulting contract.

Since Acumatica also serves as our internal timesheet system for payroll, individual employee timesheets are reviewed by a supervisor on a weekly basis. This review allows us to identify and address any variances in expected hours, proper resource allocation, efficiencies, and the pace of work completion.

As a CPA firm, Myers & Stauffer's culture is one of meticulous attention to detail in our services and deliverables as well as our internal processes. We deploy a stringent, multi-level internal review process of our timekeeping activities and client invoicing. We have established a robust system of quality control designed to ensure our services and processes, including recording of time to projects and invoicing, adhere to contractual requirements and professional standards, and our engagements are properly managed. Additionally, as a CPA firm, our processes undergo periodic quality control inspection by outside peer reviewers, as mandated by AICPA.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Quarterly Report on Expected Total Program Revenues and Expenditures for WVCHIP (4.2.1.3.16)**

The vendor should describe their approach and methodology to 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.

**Approach and Methodology**

Milliman has successfully produced a quarterly report for WVCHIP documenting the total program revenues and expenditures for the current FY and six future years since 2023. Consistent with our current work, our Team will produce a quarterly report on expected total program revenues and expenditures for WVCHIP that covers the current FY plus six future years. To perform this task, we will prepare a detailed data request to acquire the necessary information from the State. This data request includes the following information:

- Federal draw worksheet.
- Deposit log for drug rebate.
- Deposit log for Health Management Systems (HMS) refunds.
- Deposit log for revenue contract.
- Federal funding statement.
- Operational statement.
- Changes in federal allotment balance.
- MCO capitation payment.
- Medicaid payment information for MCHIP members.
- Monthly enrollment.
- Profit and loss statement.
- Supplemental FFS payment lag triangles incurred and paid through June 2026.
- State appropriation fund.

We also use our own internal information such as capitation rate certifications, program change analyses, IBNR analyses, trend analyses, and population data to project enrollment, medical expenses, capitation expenses, pharmacy expenses, and administrative expenses for the CHIP. These assumptions are updated every quarter to produce an accurate quarterly report that can facilitate WVCHIP program monitoring.

We will work collaboratively with BMS to review our initial projections, discuss assumptions, and make edits, as necessary, to align with the most recent data available from the State and to consider federal and state regulatory changes. The final deliverable is a PDF report that documents the data, assumptions, and methodology, as well as results of the analysis indicating whether total program expenses will exceed 90% of total program revenues. This assessment is performed separately for both state and federal funding to allow the State to better understand the implications of the projections.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Annual Assurance to the Director (4.2.1.3.17)**

The vendor should describe their plan to 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.

**Approach and Methodology**

Milliman has successfully produced a quarterly report documenting the WVCHIP expenses compared to state and federal funding since 2023. Consistent with our current work, our Team will analyze the enrollment, pricing, and IBNR trends and will summarize the findings in a letter outlining whether costs will exceed 90% of funding for the program by FY. As discussed in *Quarterly Report on Expected Total Program Revenues and Expenditures for WVCHIP (4.2.1.3.16)*, we will produce a report outlining total projected revenues and expenses for CHIP. The final product will be a report that documents six years of projected expenses and revenue and documents whether the expenses are expected to exceed 90% of state and federal funding available to the program for each FY in the projection period.

**Ad Hoc Services (4.2.1.4)****Additional Consultation/Actuarial Services and Other Work, as Requested (4.2.1.4.1)**

The vendor should describe their plan to provide the Agency with additional consultation and actuarial services and complete other work as requested.

**Approach and Methodology**

Our Team recognizes that Medicaid programs operate in a rapidly evolving environment where federal guidance, state priorities, legislative changes, and emerging program issues frequently require timely analysis and expert level consultation. Accordingly, we will provide the Bureau with responsive, high-quality ad hoc policy, operational, financial, actuarial, and other support throughout the contract period as mutually agreed upon.

Our ad hoc consultation and services follows our established process described in our response to 4.2.1.1.22 and 4.2.1.4.2.

As shown in *Figure 12*, our approach to fulfilling requests for ad hoc services is built on five principles: responsiveness, technical expertise, collaboration, actionable recommendations, and quality assurance.

Figure 12. Core Principles of Ad Hoc Service Delivery

**Core Principles of Ad-Hoc Service Delivery**

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Responsiveness**

We will maintain a team of Medicaid SMEs who can rapidly respond to requests ranging from brief technical questions to complex analyses requiring multidisciplinary expertise. Upon receipt of an ad hoc request, we will respond quickly to:

- Confirm the scope, objectives, timeline, and expected deliverables with BMS.
- Assign personnel with the appropriate expertise.
- Develop a work approach to fulfill the request.
- Provide regular progress updates.
- Provide the services and/or deliverables consistent with the scope of work and aligned with applicable federal state and federal requirements and industry best practices.

Our consultants will always keep BMS's best interest at the forefront of our work and support informed decision-making while recognizing the operational realities of administering a Medicaid program.

**Technical Expertise**

Because ad hoc requests can vary considerably in size and complexity, we use a scalable staffing approach that allows us to quickly assemble a team with the appropriate technical expertise. Depending on the assignment, this may include a staffing model with resources such as Medicaid policy consultants, former state Medicaid executives, health economists, actuaries, financial analysts, clinicians, data scientists, quality improvement specialists, and project management professionals (PMPs).

Our multidisciplinary approach enables us to address complex issues from multiple perspectives while avoiding unnecessary costs by assigning staff members whose expertise highly aligns with the specific request.

When actuarial expertise is requested, our credentialed actuarial professionals will provide analyses that are technically sound, transparent, and compliant with applicable CMS requirements and ASOPs. Services may include financial modeling and forecasting, rate development support, trend and utilization analyses, capitation rate evaluation, cost projections for proposed policy changes, budget neutrality analyses for Section 1115 demonstrations, fiscal impact estimates, risk adjustment analyses, sensitivity testing and scenario modeling, and review of actuarial assumptions, methodologies, and documentation, among other reviews.

**Comprehensive Medicaid and CHIP Consultation**

We are prepared to provide consultation across every aspect of Medicaid and CHIP administration. When appropriate, we may benchmark the Bureau's policies and practices against those of peer Medicaid agencies and CHIPs to identify opportunities for improvement and incorporate emerging national best practices. In addition to our team's expertise working with all 50 states, we have also assisted Washington D.C. and the territories. We bring this experience to BMS and will leverage those experiences, where appropriate, to support BMS's request for additional services.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Collaborative Problem-Solving**

We believe the most effective consultation occurs through ongoing collaboration rather than one-time deliverables. Throughout each engagement, we will work closely with Bureau leadership and program staff to:

- Define the policy or operational issue in a clear manner.
- Identify available data and information sources.
- Evaluate multiple solution alternatives.
- Assess operational, financial, and regulatory implications.
- Identify implementation risks and mitigation strategies.
- Develop practical recommendations that can be successfully implemented.

Our recommendations will consider program goals, stakeholder impacts, implementation feasibility, administrative burden, fiscal sustainability, and compliance with federal and state requirements.

**Actionable Recommendations**

Many of our team members have previous careers in state government, and we understand the operational realities of administering the Medicaid program and CHIP. Therefore, our analyses and recommendations are grounded in that reality. We will provide actionable recommendations. We have no interest in producing reports with recommendations that seem feasible but are operationally or fiscally impossible to implement or operate.

**Quality Focus**

All our ad hoc analyses and deliverables will undergo an internal quality assurance review to verify technical accuracy, consistency, and completeness before submission to the Bureau. Deliverables will be written in a clear, concise manner that supports executive decision-making while providing sufficient technical documentation for program staff and federal review, as appropriate.



### What This Means for BMS

Our quality control policies and procedures are incorporated into all our engagements which means you can trust that our deliverables are complete, thorough, and precise. The work papers, analyses, and deliverables we produce for our clients are designed to ensure accuracy and understandability. We routinely provide our work product to our clients and their health plan, providers, and other stakeholders to substantiate the findings and results of our analyses. Because of this, we perform ongoing internal assessments of policies and procedures to identify inefficiencies or opportunities for improvement. This approach will enable Myers & Stauffer to consistently provide high-quality services that aid BMS in their administration of the Medicaid program.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Ad Hoc Statement of Work for Agency Review (4.2.1.4.2)**

The vendor should describe their plan to provide a Statement of Work, including but not limited to, the number of project hours, resources to be used, and cost affiliated with each ad hoc request for review by the Agency.

**Approach and Methodology**

Ad hoc scopes of work will be drafted based on our initial conversations with BMS. As we draft scopes of work, we will start by ensuring we have a thorough understanding of BMS's need for the service or deliverable and their intended use of our work product. This understanding will help us ensure our work product is designed to meet BMS's specific needs. We will clearly define the scope of services, deliverable specification, delivery format, timeline for delivery, and other relevant information. Any assumptions we have made regarding the Statement of Work (SOW) (e.g., reliance on the completeness of data received from the Bureau, timely responses to requests for information made to the MCOs, etc.) will be documented in the SOW.

With the scope and deliverables defined, we will include the number of project hours needed to complete the work, staffing resources to be involved, cost, and other information that may be requested by BMS. No work will begin until the ad hoc proposal has been approved by BMS.

**Programmatic Activities Needed Within Other Agencies or Divisions (4.2.1.4.3)**

The vendor should describe their approach and methodology to assist with programmatic activities needed within other Agencies or divisions of the Agency outside of the Managed Care Unit.

**Approach and Methodology**

While this RFP seeks services related to managed care, Myers & Stauffer's expertise extends to all aspects of Medicaid and CHIP policy, operations, and financing. With over 1,000 staff working exclusively with state, federal, and local health and human service programs, we will assemble a team with the appropriate expertise to meet the staffing needs of each scope of work. A distinguishing feature of Myers & Stauffer is that our team also includes individuals with expertise and experience that intersect with Medicaid and CHIP such as behavioral health, developmental disabilities, aging, child welfare, public health, supplemental nutrition assistance programs, and other public assistance and economic support programs.

By combining Myers & Stauffer's resources with Milliman's, which includes more than 150 actuaries, the Myers & Stauffer Team is able to serve not only the full continuum of Medicaid consulting needs, but we are also well-positioned to support other Department of Human Services bureaus, including the Bureau for Behavioral Health, Bureau for Social Services, Bureau for Family Assistance, and the Bureau for Child Support Enforcement, through ad hoc scope of work if desired.

We understand the Medicaid program touches multiple state agencies. A great example is the interrelated activities between the West Virginia Bureau for Social Services (BSS). BSS is charged with promoting the safety, permanency, and well-being of children and vulnerable adults. Many of the children served by BSS are also enrolled in the MHP program. As such, the Myers & Stauffer Team has been engaged with both agencies in activities such as the federal requirements governing both Medicaid



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and social services agency roles and responsibilities. Our approach will align with our demonstrated experience and include:

- Understanding each agency's situation and needs.
- Identifying and engaging our SMEs.
- Conducting research and analysis which may include the acquisition and analysis of data as well as more qualitative research through key informant interviews or other methods to understand the current environment, issues, and possible solutions.
- Evaluating options while considering both the operational and fiscal impact of each option.
- Providing our recommendations and rationale to each agency.
- Developing a roadmap to support implementation of the State's decision for moving forward.

Our approach has been reproduced across a number of agencies in other states including work with agencies for behavioral health, developmental disabilities, aging, public health, and education.

#### Key Area Research and Recommended Approaches (4.2.1.4.4)

The vendor should describe their approach and methodology to conduct research and recommend approaches in key areas of chronic care/disease management, pharmacy, eligibility and coverage, quality improvement, rural health, and others as requested.

#### **Approach and Methodology**

Upon request, the Myers & Stauffer Team will conduct research and provide recommendations in areas such as chronic care/disease management, pharmacy, eligibility and coverage, quality improvement, rural health, and others as requested. We will customize our approach based on the specific research area and the research question. Our approach and recommendations will be grounded in data, evidence-based practices, a deep understanding of all involved stakeholders, and the practicality of implementing our recommendations given the reality of the environment in which Medicaid operates. Our general approach includes the following steps.

- **Step 1: Define the Problem and Desired Outcomes.** We will begin with a clear understanding of BMS's objectives, current challenges, statutory and regulatory requirements, and desired outcomes. Our Team will work collaboratively with BMS leadership to define the scope of work, identify key policy questions, establish success measures, and prioritize issues requiring analysis.
- **Step 2: Environmental Scan and Background Research.** Next, our Team will conduct a comprehensive review of federal and state guidance to understand the current policy environment and emerging best practices. This may include sources such as federal Medicaid statutes and regulations, CMS guidance and informational bulletins, SMD letters, existing State Plan language and waiver authorities, legislative requirements, OIG and Government Accountability Office reports, Medicaid and CHIP Payment and Access Commission recommendations, peer-reviewed literature, publications by national organizations such as the National Academy for State Health Policy, National Association of Medicaid Directors, and the National Governors Association, as well as other states' successful Medicaid initiatives. The

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objective is to identify proven approaches while understanding the applicability to West Virginia's unique environment and needs.

- **Step 3: Data Collection and Operational Assessment.** Then, our Team evaluates the current West Virginia Medicaid program using quantitative and qualitative data. This may include potential data sources, such as claims and encounter data, enrollment and eligibility files, pharmacy utilization data, financial reports, quality measure performance, provider network information, member demographics, and other available resources and data.
- **Step 4: Stakeholder Engagement.** Where desired by BMS, we may undertake stakeholder engagement efforts including both internal and external stakeholders. We will deploy various methods to gain stakeholder perspectives, such as key informant interviews, focus groups, electronic surveys, listening sessions, or other forums. We will collect feedback and identify key themes as we support this work.
- **Step 5: Comparative and Best Practice Analysis.** Using information gathered during previous steps, we will compare BMS's current approach against other markers such as federal requirements, national best practices, peer Medicaid programs, and evidence-based models.
- **Step 6: Consultant's Report.** We will prepare our research in a report that clearly defines the research question, methods we utilized, assumptions made, data analyzed, findings, and limitations of the research, as well as our recommendations supported by our rationale for those recommendations.
- **Step 7: Implementation Planning.** Where requested in the scope of work, we will include a roadmap for implementation of recommendations. This roadmap may include components, such as recommended governance structure, staffing requirements, procurement impact, federal authority requests, policy modernization, funding needs, communication strategies, system impacts, and a framework for implementation oversight and monitoring, as well as other components.

#### Conflict Mitigation Plan (4.2.1.4.5)

The vendor should describe their plan to 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 mitigating any conflicts of interest that may arise during the term of the contract.

#### Approach and Methodology

As a CPA firm, Myers & Stauffer is held to the highest level of independence. We have voluntarily restricted our practice to only accept state, federal and government health and human service agencies as clients to avoid any real or perceived COI. That assurance is important to us, because it arms our clients with a level of confidence in our independence that other firms simply cannot offer.

Additionally, Myers & Stauffer maintains a formal COI Program policy and process designed to identify, disclose, evaluate, mitigate, and monitor any actual, potential, or perceived COIs involving the organization or its employees. On an annual basis, all Myers & Stauffer staff must complete a questionnaire and attestation disclosing any COIs.



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As the prime contractor in this proposal, we are also responsible for identifying, reporting, and managing any COIs of our subcontractor, Milliman. The Teaming Agreement executed between Myers & Stauffer and Milliman includes language requiring the disclosure of any COIs to Myers & Stauffer. Additionally, the Agreement includes an ethics clause requiring our subcontractor to abide by Myers & Stauffer's stringent ethical requirements. As we have done in the past, we will monitor any real or potential COIs Milliman may have and report them to BMS along with our mitigation strategy.

We have included our conflict mitigation plan in *Appendix A: Conflicts of Interest Mitigation Plan*. In completing our due diligence on our subcontractor, Milliman, we requested, reviewed, and included their Conflict Mitigation Plan as well in *Appendix A*.

## Provider Rate Setting Services (4.2.1.5)

### Compliant Provider Rate Setting Services (4.2.1.5.1)

The Vendor should describe their plan to provide all provider rate setting services, in compliance with the West Virginia Medicaid State Plan, which can be found at: <https://bms.wv.gov/cms/west-virginia-state-medicaidplan>, the CHIP state plan, which can be found at: <https://chip.wv.gov/rnedia/38021/download?inline> and the Agency Provider Manual, which can be found at: <https://bms.wv.gov/providers/policy-manuals>.

### Approach and Methodology

#### Current Medicaid and CHIP Rate Setting Environment

As the current West Virginia rate setting vendor, we have direct, hands-on experience performing the provider rate setting services requested in this RFP. Through our work across the spectrum of Medicaid and CHIP covered services and providers, we have experience with the majority of services covered under the West Virginia Medicaid State Plan, the CHIP State Plan, and the BMS Provider Manual.

Since 2001, we have served as the hospital and physician rate setting vendor, supporting West Virginia's three public payers — Medicaid, CHIP, and the Public Employees Insurance Agency (PEIA) — with annual updates to hospital and physician payment systems. More recently, we have assisted BMS with rate transformation initiatives for LTC services, including the transition of the nursing facility reimbursement methodology to a patient-driven payment model (PDPM)-based PPS and updates to the ICF/IID reimbursement system and data collection procedures.

In 2023, BMS began reevaluating Medicaid rate setting functions to identify areas where



### Focus on Quality Plus Innovation

Our large-scale rate setting contracts with states, such as West Virginia, Connecticut, Idaho, Indiana, Iowa, Kentucky, Mississippi, Nevada, and Virginia demonstrate that we are large enough to meet our clients' needs yet structured in a manner that affords our professionals the flexibility to design customized solutions. We manage this complexity within an environment where error can have serious consequences to health care outcomes, financial performance, and program integrity. Our focus on ensuring quality while developing innovative solutions designed for efficiency has proven to be a valuable combination for our clients.

### Customized Solutions

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enhancements could be made to Medicaid rate setting processes and communications. Due to BMS's concerns with the inherent complexity of many Medicaid rate setting methodologies, and in an effort to bring a national perspective and best practices to Medicaid rate setting, BMS engaged Myers & Stauffer to assume a number of Medicaid rate setting functions previously performed by the State. The rate setting transition began in CY 2023 with the transition of FQHC and RHC rate setting. Additional services were transitioned in 2024 and first focused on service types with rate effective dates in October 2024. Since the transition, our team has assumed rate setting for the following service types:

- Ambulance transportation (ground and air).
- Ambulatory surgical center (ASC).
- Clinical laboratory.
- Dental.
- Durable medical equipment (DME) and medical supplies.
- FQHC and RHC.
- Hospice.
- Hospital reimbursement calculators.
- Hospital graduate medical education (GME) payments.
- Physician-administered drugs (PADs)/injectable drugs/J-Codes.
- Reimbursement limits for the Children with Disabilities Community Service Program.
- Telehealth originating site fee.
- School-based health services and state-owned nursing facilities (FMAP).

We have also assisted BMS with developing a number of process improvements to the rate setting process. These include:

- Analyzed reimbursement policy and procedure deficiencies from past practices and identified areas for improvement.
- Developed SOPs to document rate setting processes.
- Developed a comprehensive rate matrix, documenting each Medicaid reimbursement rate type, rate review, updated timelines, and responsible parties. The rate matrix interfaces with the SOPs to form a complete documentary framework to assist BMS in monitoring and tracking rate updates.
- Some service types lack documented rate methodologies, impeding current decisions on rate increase requests from providers. We provided rate methodology options that define and document rate components for consistent, transparent, and standardized decision-making.



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- Performed a comprehensive fee schedule review to standardize the publication of rates, some of which were published in different areas of the State's website or not published entirely.
- Performed a comprehensive evaluation of Medicaid FQHC/RHC reimbursement policies in the Medicaid State Plan and Medicaid policy manual and made recommendations for improvement and alignment of policy between the State Plan and policy manual.

In 2026, our team assisted BMS with compliance activities relating to the Ensuring Access to Medicaid Services Final Rule, 89 FR 40542 (2024 Access Final Rule). Under the promulgated regulations, Medicaid agencies are required to publish and make all FFS rate schedules available on a public-facing website by July 1, 2026. States are also required to publish a comparative rate analysis comparing select Medicaid FFS rates to Medicare rates. Lastly, states are required to publish the average hourly rate paid for certain HCBS, including personal care, home health aid, homemaker, and habilitation services. We supported BMS with the publication of all required FFS fee schedules, preparation of the comparative rate analysis, and publication of average hourly rates for HCBS, all of which were accomplished prior to the July 1, 2026, compliance date.

Based on the experience we have gained supporting Medicaid and CHIP rate setting and reimbursement methodologies, we look forward to continuing our support for rate setting across the majority of Medicaid and CHIP-covered services. We will continue to use the rate setting processes that have been developed for West Virginia, while incorporating national best practices as applicable. Highlights of the rate setting services we will perform include:

- **Hospital Inpatient:** Annual rebase of the MS-DRG payment system, including updated relative weights and rate values and calculation of GME payments. Prepare hospital reimbursement calculators. Provide support for potential adoption of updated payment rates and methodologies for non-DRG services (LTC hospital, rehabilitation hospital, etc.).
- **Hospital Outpatient:** Consultation, as requested, regarding a potential update to an OPDS.
- **Nursing Facility:** Continued assistance with the transition to the PDPM methodology, implementation of a quality payment program, and replacement of the appraisal-based fair-rental value (capital) reimbursement methodology with a modeled capital payment system providing less annual rate volatility.
- **ICF/IID:** Updates to the reimbursement system and data collection procedures.
- **FQHC and RHC:** Review cost reports and set PPS rates for new centers and clinics and adjust existing rates for changes in the scope of services and annual inflationary increases. Assist BMS with policy changes as applicable.
- **CCBHC:** Review cost reports and set PPS rates in accordance with the approved Medicaid State Plan. Provide support for the State's participation in the CCBHC demonstration program, having been selected to participate in the demonstration program in May 2026.

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- **Fee Schedules:** Calculate annual updates to various fee schedules, including ambulance transportation (ground and air), ASCs, clinical laboratory, DME and medical supplies, physician and anesthesia services, and PADs.
- **Additional Providers:** Perform various research, analysis, and rate and methodology recommendations, as requested by BMS. Recent examples include research and analysis of payment rates and/or payment methodologies for LTAC services, PRTF services, applied behavioral analysis therapy services, dental services, and DME services.

**General Approach and Methodology for Rate Setting**

We understand that throughout the contract, BMS may require other rate setting services that are not specifically delineated in the RFP. We are accustomed to and welcome the opportunity to assist BMS on other aspects of Medicaid and CHIP reimbursement or other areas of the State's Medicaid program and CHIP. Our Team will be available to support additional rate setting initiatives that may be requested by BMS. We envision that most rate setting initiatives will be performed under the following general framework:

- **Develop an Understanding of Project Scope and Objectives.** Upon initiation of a new rate project, we know it is imperative that we fully understand BMS's objectives related to that activity. We want to understand the goals and results expected from the project, as well as any insights related to the service and recipient environment, allowing rate setting to be tailored to the service delivery environment appropriately. We will work with State staff and other stakeholders to gather pertinent background information, which may include:
  - Service definitions, provider qualifications, service levels, service settings, and populations served.
  - Goals, priorities, and incentives the State wishes to promote.
  - History of rate setting activities, including detailed information on the State's current rate methodology, if applicable. This includes identifying any recent rate or methodological updates.
  - Key cost components associated with the service delivery for the services to be evaluated.
  - Relevant issues related to access to services, provider availability, quality concerns, etc.
  - Identification of data available for review (data inventory).
  - Political, statutory, and other regulatory considerations.
  - Identification of stakeholders and establishment of stakeholder work groups, if applicable.
- **Conduct Data Gathering and Analysis Activities.** Next, we proceed with data gathering, review, analysis, and other project activities to complete the rate setting assignment. This may include engaging with providers and other stakeholders to collect insights and obtain data necessary for rate and/or payment methodology development. Data collection from providers may include cost survey development, provider training, and preparation of FAQs and other support



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materials, followed by collection of data from providers. Data may be collected from other sources, such claims data, other payer rates and/or policies, or industry research.

- **Calculate Modeled Rates.** Based on the data collection, aggregation, and analysis, we will calculate modeled rates for the applicable provider or service category. Rate development will be accompanied by documentation of data sources, assumptions, calculation methodologies, and other details supporting the rate design. Rate models will be dynamic and allow various inputs, assumptions, and weights to be adjusted to develop the final rates. We understand the rate setting process may be iterative with adjustments to rates occurring after BMS review and input.
- **Calculate Fiscal Impacts.** Fiscal impact calculations will be prepared by performing payment simulations based on Medicaid claims data. The payment simulations will comprise complete repricing of the Medicaid claims data. Our typical approach to this process begins with repricing the Medicaid claims data under the current rate structures and payment methodology parameters. This step is crucial to ensure that our payment modeling matches the payment made on the claim to establish a baseline for comparing modeled payments. If any variances in claim payments are identified, we will work with BMS or the State's fiscal agent contractor (if applicable) to resolve the variances. We will then calculate estimated Medicaid payments for the claims dataset using the new rates and/or payment parameters under consideration.
- **Evaluate Implementation Feasibility.** It will be critical to evaluate the feasibility of implementing any potential rate methodology change. There are numerous impacts to consider, including impacts on State staff, MMIS, provider administrative burden, and availability of data. Some considerations include:
  - Whether State staff resources are required and if new staff would be necessary, as well as burden to current staff.
  - MMIS impacts (i.e., whether the potential methodology involves straightforward fee schedule changes or would require MMIS changes).
  - How the potential methodology would impact provider billing, coding, and other administrative activities, and whether provider training would be required.
  - Whether data sources are available for State staff to make rate updates, or if the update process is complex and requires outside resources.
- **Communicate Work Products.** As we complete work assignments, we will prepare deliverables (including spreadsheet calculations, analysis, findings, observations, recommendations, written reports, summaries, etc.) for BMS. If requested, project team members will prepare additional work papers to clarify questions or points addressed in the deliverables. We will then incorporate comments and/or revisions into the reports and/or other deliverables before final release.
- **Assist in Obtaining Approvals and Communicating with External Entities.** We will support BMS with any necessary federal approvals through amendments to the Medicaid State Plan or other

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

authorities. We will assist BMS in communicating with and obtaining approvals from oversight entities, such as the legislature, governor's office representatives, etc. We will assist BMS in preparing communications of final results to providers and payers (MCOs and Gainwell).

We have either worked on or designed and implemented nearly every type of Medicaid and CHIP reimbursement methodology. This experience provides us with insights into the challenges of establishing successful and sustainable reimbursement systems. We are familiar with the regulatory, legislative, fiscal, political, and public relations challenges that states face in evaluating reimbursement rates and systems and undertaking revisions to those systems. Our Team is available to assist BMS with rate setting services for all Medicaid and CHIP providers and services, and we look forward to supporting BMS in this area.



### What This Means for BMS

Myers & Stauffer's knowledge and experience of rate setting in the Medicaid environment is unmatched. Since the 1980s, we have worked with more than 25 Medicaid agencies — including BMS — providing rate setting for nursing facilities, hospitals, and other providers; hospital rate setting MDS assessment processing and review consulting; UPL demonstration calculations; provider assessment/tax modeling and optimization; and other administrative services. The breadth and depth of our experience means BMS can rely on us to integrate rate setting activities, ongoing fiscal monitoring for state budgetary implications and current trends in provider costs and cost reporting.

## Other Tasks (4.2.1.5.2/3/4)

Other tasks include, but are not limited to:

4.2.1.5.3. Meeting with payers and providers to review payment policies

4.2.1.5.4. Work with the Agency on any changes to the applicable state plan

4.2.1.5.4.1. The final transmission of the updated rates and payment parameters must be completed one full month prior to the beginning of the rate year. The vendor will also provide each provider with their rates.

4.2.1.5.4.2. The vendor should describe their plan to prepare Upper Payment Limit (UPL) analysis to ensure State compliance with 42 CFR 447.271; 447.272 inpatient facilities; 447.304 non-institutional & 447.321 outpatient hospital & clinic provisions.

## Approach and Methodology

### Meetings with Stakeholders

Virtually all of Myers & Stauffer's engagements require some degree of information presentation and meeting facilitation involving stakeholders. We have demonstrated success managing group discussions and meetings, training individuals and groups, and engaging with a variety of stakeholders. We recognize that meaningful change is done with stakeholders, not to them. We know that appropriately engaging stakeholders in a respectful and collaborative way early and often is an investment that will increase stakeholder buy-in and accelerate advancement towards BMS's goals.

In supporting BMS with rate setting and reimbursement methodologies, we have had the opportunity to work with many stakeholder groups in West Virginia. Our team has provided longstanding provider



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stakeholder support for nursing facility, ICF/IID, hospital, FQHC, and HCBS provider associations and groups. Our approach to meeting with payers and providers to review payment policies is as follows:

- **Identify the Audience.** Successful stakeholder engagement requires meaningful inclusion of impacted groups. We are familiar with the current landscape of potential stakeholders in West Virginia, both internal (e.g., agency leadership and staff) and external (e.g., legislators, providers, provider associations, and other public representatives), and we will work with BMS to identify the appropriate stakeholder audience for each meeting and discussion.
- **Planning.** We will develop stakeholder engagement plans with the input of BMS. We will consider logistics (virtual versus in-person), stakeholder availability, work group or meeting format, and other meeting aspects to ensure participation. We will also consider necessary cadence of work groups and frequency of stakeholder engagement.
- **Prepare Communication Materials.** Based on the target audience and information to be presented, we will tailor communication materials, with BMS review and approval, to effectively communicate the information to the audience. Communication materials may include presentations, memos, calculation examples, financial impact analyses, dashboards, and other application methods to communicate the information effectively.
- **Deliver Communication to Stakeholders.** We will communicate with stakeholders based on the information to be communicated and as agreed upon with BMS through various methods, such as virtual or in-person meetings, informational webinars, PowerPoint slides, reports, provider bulletins, FAQ documents, and content and issue briefs.

Myers & Stauffer is accustomed to presenting rate setting methodologies, processes, and impacts in public meetings to a variety of stakeholders. We understand that a critical part of our role is not only to develop technically sound rate setting models, but also to communicate the rationale and the financial impacts clearly to stakeholders who may not have a technical background. Our team is experienced in translating complex methodologies, such as inpatient hospital DRG grouping logic, physician RBRVS payment formulas, or nursing facility acuity-based rate structures, into presentations that inform decision-making without overwhelming the audience.

We regularly prepare slide decks, summary briefs, and presentation materials designed for policymakers, hospital administrators, payers, legislative analysts, and public advisory groups. Each communication is tailored to ensure that stakeholders can understand what methodology was used, why the methodology was selected or modified, which data inputs informed the rates, the impact for providers and the Medicaid program overall, and which decisions are needed and options are available.

All presentation materials are developed in plain language with clear structure, supported by visual aids, such as charts, simplified rate calculations, and scenario summaries. Technical terminology is introduced only as necessary and always defined in accessible terms. Prior to each public-facing presentation, we will submit materials to BMS for review and incorporate any edits or feedback. We also offer to attend and support BMS-led presentations, helping facilitate discussion and address stakeholder questions.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Applicable State Plan Changes**

The Medicaid State Plan is the formal contract between a state and the federal government outlining how the state administers its Medicaid program. Any substantive change to how Medicaid operates, including changes to reimbursement methodologies, must be submitted to CMS through a SPA. These SPAs are subject to federal review, public transparency requirements, and, in many cases, detailed RAIs before approval.

We are well-versed in the procedural and technical steps that define the SPA process to ensure West Virginia's methodologies remain compliant with federal statutes, CMS regulations, and sub-regulatory guidance. Our Team will support BMS throughout the life cycle of the SPA process, which may include:

- **Policy Development and Internal Approval.**
  - The State develops a proposed policy change (e.g., updating reimbursement rates, changing the reimbursement methodology).
  - Internal stakeholders, including finance, legal, and Medicaid operations, must approve the change.
  - SPA language is drafted to reflect the new policy in a format consistent with CMS style and prior approvals.
- **Public Notice Requirement.**
  - Under 42 CFR § 447.205, BMS must publish public notice prior to the effective date of any SPA that changes payment methods or standards.
  - The notice must include a description of the change and its expected fiscal impact and must be published in an official state publication or website.
  - While not always required, states often accept public comments during this process to ensure stakeholder transparency.
- **Federal Review Submission.**
  - The SPA is submitted to CMS through the MACPro system, OneMAC system, or via email, depending on the type and timing of the change.
  - The clock begins on the 90-day federal review window, during which CMS can approve, deny, or issue an RAI.
- **CMS RAIs.**
  - If CMS requests clarification, the 90-day clock is paused.
  - The State must respond to the RAI with clarifying information, revised language, rate simulations, budget neutrality demonstrations, or legal citations as appropriate.
  - Once a satisfactory response is submitted, the review clock resumes.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

- **Approval and Effective Date.**
  - If CMS approves the SPA, it issues a formal approval letter along with the effective date.
  - In many cases, the SPA can be made retroactive to the first day of the calendar quarter in which it was submitted.
  - Following approval, the State must implement the policy change, update public documentation (e.g., provider billing manuals), and ensure alignment with MMIS configuration.
- **Ongoing Compliance and Audit Readiness.**
  - States must retain documentation supporting the SPA for CMS audits or inquiries.
  - Approved SPAs must be implemented as written, or subsequent revisions must be submitted through an additional SPA.

We take a structured, collaborative approach to SPA support, ensuring policy design, documentation, and CMS correspondence align and result in a clear path to approval. We have supported numerous state Medicaid agencies in responding to CMS RAIs on a range of reimbursement topics and will assist BMS as these questions arise. Our team is highly familiar with CMS' most common areas of inquiry, which often include requests for:

- Policy justifications that demonstrate compliance with 42 CFR § 447 Subpart C.
- Fiscal impact assessments.
- Clarification of rate calculations, peer grouping logic, or system configuration.
- Alignment with public notice language and effective dates.
- Supporting documentation of the State's change in reimbursement rates or methodologies.

We have supported multiple states in drafting and submitting reimbursement-related SPAs, often in tandem with rate structure reforms, funding adjustments, or federal compliance initiatives. Our contributions have included:

- Drafting SPA language for rate methodologies, base rate rebasing strategies, and policy adjusters.
- Proposing updates to State Plan language reflecting new payment formulas or provider eligibility changes.
- Documenting the interaction between payment rates, UPL requirements, and financing mechanisms.
- Preparing rate simulation exhibits, methodology memos, and narrative summaries required to justify policy intent and ensure CMS understanding.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

- Responding to RAIs related to methodology transparency, effective date justification, and financial neutrality.

Our approach is to anticipate potential CMS questions when preparing SPA materials so that if an RAI is required, a response can be assembled quickly and submitted well within CMS' review timeline. Understanding that timely responses are important, we will collaborate with BMS on an internal turnaround target that leaves BMS time to review our draft response before it goes to CMS. We work with State staff to ensure all submitted documentation remains consistent with the SPA's intent, language, and operational impact.

Beyond written RAI responses, we are also available to interact with CMS directly, at BMS's direction, on questions of how federal rules and regulations should be interpreted and applied to West Virginia's program. This can arise during a pending SPA review, but may also arise independently; for example, as CMS finalizes new rules, such as the provider tax loophole rule (CMS-2448-F), or moves forward with the proposed SDP rule (CMS-2449-P) or provider tax hold harmless rule (CMS-2452-P). In each case, we are available to join a call or meeting with CMS alongside BMS, or to provide the technical analysis BMS needs to represent its own position with confidence.

**Final Transmission of Updated Rates and Payment Parameters**

Our Team is prepared to communicate Medicaid rate updates to providers and other stakeholders, as requested by BMS. Most Medicaid rates have multiple communication pathways involving impacted providers and payers. Provider-specific rates need to be communicated to providers, allowing for provider review, response, and potential appeal. Rates that are not provider-specific are not communicated to individual providers but are communicated through publications and by posting to the applicable section of the Medicaid website. Rates are also communicated to the applicable payers — the MMIS vendor and MCOs.

We anticipate following the current rate communication process in which draft rates are provided to the BMS reimbursement team for review and approval. Once approved, our Team prepares final rate communications to providers (for provider-specific rates) and final rate files for posting to the State's website and for transmission to the MMIS vendor and MCOs. For rates that require changes to the MMIS functionality, we will assist BMS in developing change request documentation for submission to the MMIS vendor.

To ensure alignment with BMS expectation and MMIS system requirements, we will coordinate with BMS and the MMIS vendor prior to each rate setting cycle to confirm all formatting and technical requirements. Our process includes validating source data, applying methodology logic, performing quality review, and securely transmitting final files. We maintain version control on all deliverables and are available to support implementation, clarify provider questions, or make necessary updates.

This structured, collaborative approach ensures rate file development not only meets policy intent but also facilitates operational readiness and transparency.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****UPL Analysis Preparation**

We have been assisting BMS in complying with federal UPL requirements since 2018. Nationally, our team has more than 25 years of experience in preparing UPL demonstration calculations for nearly 30 state Medicaid agencies. As a result, we have developed a comprehensive understanding of a variety of UPL methodologies, including cost-based, PPS, and payment-to-cost or payment-to-charge systems. This experience has allowed us to become familiar with several unique approaches to developing UPL analyses. It has also allowed us to become familiar with approaches acceptable to CMS. We have assisted clients for many years with these UPL programs, several of which have successfully undergone considerable scrutiny and audit by CMS and OIG.

We anticipate providing BMS with consulting, analysis, and support for the operation of these programs. Our proposed services include maintaining an understanding of Medicare payment principles (including evolving interpretations by CMS and OIG), developing reasonable and defensible methodologies to facilitate the application of Medicare principles to Medicaid payments, and calculating the UPL amounts for applicable provider categories to support program objectives and required federal assurances.

Two federal developments make precise UPL work critically important, particularly for hospital services, and we will keep the State's demonstrations aligned with both. First, the aggregate UPL for FFS inpatient and outpatient hospital services remains Medicare-based under 42 CFR § 447.272 and 447.321. Second, the limit on the managed care portion of those payments is changing. SDPs were historically capped using the ACR, but under Section 71116 of Public Law 119-21 and the proposed rule at CMS-2449-P, the cap becomes a Medicare-based limit, 100% (or 110% for non-expansion states) of the total published Medicare rate, with grandfathering and a phase-down beginning January 1, 2028. Because both the UPL and the managed care limit are now measured against Medicare, the accuracy of Medicare rates and UPL analysis directly determine how much room the State has across both payment streams. We will prepare the UPL demonstrations using the current CMS templates in the MACFin system and update the methodology as CMS finalizes the SDP rule.

We will develop UPL calculation demonstration methodologies for each required service specific to the State's needs and which maximize the Medicare and Medicaid rate differential and the room under the UPL. Based on current UPL submissions to CMS, we will assist BMS with UPL calculations for the following service categories:

- Inpatient hospital.
- Outpatient hospital.
- Nursing facility.
- ICF/IID.
- Clinics.

Our Team is also familiar with PRTF and DME UPL demonstrations and available to support BMS, as needed. Currently, the UPL demonstration for PRTF services has not been required due to PRTF services being provided exclusively through managed care. In addition, the DME UPL is not required for West Virginia due to the State's DME rates being set at a percentage of Medicare.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

We understand and acknowledge that UPL methodologies must meet CMS requirements and guidance and must be approved by BMS prior to implementation. In preparing the UPL demonstrations, our Team will start with the UPL calculations, methodologies, and files used by the State for the most recent demonstrations submitted to CMS. We envision following the State's established methodologies but will be available to consult with the State on alternative methodologies, as requested, to explore options that maximize the UPL gap. *Table 4* provides a summary of the various methodologies we have used for our state Medicaid agency clients that will be available to BMS.

Table 4. UPL Methodologies

| <b>Myers &amp; Stauffer: UPL Methodologies</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Services</b>                                | <b>UPL Methodologies</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Inpatient Hospital Services</b>             | <b>Medicare DRG.</b> In this option, Medicaid utilization data and hospital financial data would be used to complete the analysis. Under this methodology, Medicare and Medicaid payments and discharges are aggregated by hospital to compute a Medicare and Medicaid payment per discharge. Medicaid utilization is classified into Medicare DRGs using the Medicare grouper to assign Medicare relative weights and calculate the Medicare CMI for Medicaid services. Medicare and Medicaid CMI values are used to case mix adjust the per discharge amounts. Beyond the PPS DRG payments, the comparison can also include capital payments, medical education payments, outlier payments, Medicare DSH payments, and any other additional reimbursement subject to the UPL determination. |
|                                                | <b>Inpatient Costs.*</b> This option uses total allowable Medicaid costs. Medicaid costs are identified using information contained in facility cost reports. The estimated Medicare payment is computed by calculating a cost-to-charge ratio (CCR), either a total or a Medicare-based CCR. The CCR is then applied to the corresponding Medicaid billed charges to determine the UPL.                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                | <b>Medicare Payment to Charge/Cost.</b> Another approach to determine a reasonable estimate of the Medicare UPL is to calculate the ratio of Medicare payments to either Medicare billed charges or costs. The ratio is then applied to the corresponding Medicaid billed charges or cost to determine the UPL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                | <b>Tax Equity and Fiscal Responsibility Act (TEFRA) Targets.</b> The computation of the Medicare UPL can be based on the Medicare payment methodology known as TEFRA, which specifies the computation of hospital-specific target rates and rates of increase. TEFRA was used by Medicare as a reimbursement methodology for all hospitals during the transition from retrospective cost reimbursement to the PPS. Medicare continues to use TEFRA principles to reimburse hospitals and units exempt from the PPS.                                                                                                                                                                                                                                                                           |
| <b>Outpatient Hospital Services</b>            | <b>Ambulatory Payment Classification (APC).</b> The APC model is based on Medicaid utilization data and hospital financial data. Using the APC grouper, Medicaid utilization is classified into Medicare APCs. The estimated Medicare payment is computed using Medicare APC payment policies. Similar to the IPPS model, it may be permissible to include the Medicare shortfall (the difference between APC reimbursement and costs) to the APC reimbursement, essentially using all allowable outpatient costs as the Medicare payment amount.                                                                                                                                                                                                                                             |
|                                                | <b>Outpatient Costs.*</b> A second model may be developed using total allowable Medicaid costs. Medicaid costs are identified using information contained in facility cost reports. The estimated Medicare payment is computed by calculating a CCR, either a total CCR or a Medicare CCR. The CCR is then applied to the corresponding Medicaid billed charges to determine the UPL.                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                | <b>Medicare Payment to Charge/Cost.</b> Another approach to determine a reasonable estimate of the Medicare UPL is to calculate the ratio of Medicare payments to either Medicare billed charges or costs. The ratio is then applied to corresponding Medicaid billed charges or cost to determine the UPL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

| <b>Myers &amp; Stauffer: UPL Methodologies</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Services</b>                                | <b>UPL Methodologies</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Nursing Facility Services</b>               | <p><b>PDPM Medicare PPS.*</b> In July 2018, CMS released the FY 2019 Skilled Nursing Facility PPS Final Rule, which requires the use of PDPM for payment of Part A Medicare stays in nursing facilities effective October 1, 2019. PDPM replaced the resource utilization group (RUG) classification model that had been used for decades and represented a paradigm shift in how Medicare determines reimbursement for residents. This change also had several implications for state Medicaid programs and nursing facility UPL methodologies.</p> <p>CMS provided guidance related to the use of a PDPM approach for required annual UPL demonstration in SMD Letter #22-005. This guidance requires use of only PDPM components that align with services included in the Medicaid nursing facility per diem rate. This is a change from historical UPL demonstration approaches under the RUG-IV-based Medicare PPS method. PDPM contains five case mix-adjusted components: physical therapy, occupational therapy, speech-language pathology, nontherapy ancillary, and nursing. Only the PDPM components related to services included in the state's nursing facility inpatient per diem rate may be considered for UPL purposes. We have assisted states in navigating CMS guidance, acquiring the necessary PDPM classification information and consulting on methods to maximize the Medicare to Medicaid payment differential. We have submitted several PDPM-based UPL methodology demonstrations that have been accepted by CMS.</p> |
|                                                | <p><b>RUG-Based Medicare PPS.</b> RUG-based Medicare PPS was retired on September 30, 2019; however, states continue to have the flexibility to prepare UPL calculations based on this methodology. This PPS methodology is an acuity-based pricing system with a specific rate paid for each resident based on the resident assessment classification and the facility's urban/rural designation. Under the RUG-IV-based PPS option, minimum data set (MDS) assessment data is used to determine the appropriate RUG classification and Medicare PPS rate for each Medicaid resident. Our team has all available grouper software necessary to determine the appropriate RUG classifications for each assessment. Individual resident PPS rates are aggregated to determine a facility average estimated Medicare PPS rate. Because the PPS rate is all-inclusive, an analysis to determine coverage differences between Medicare and Medicaid will need to be completed.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                | <p><b>Nursing Facility Costs.</b> This model is developed using total allowable Medicaid costs. Medicaid costs are identified using information contained in the facility cost reports. The estimated Medicare payment is computed using Medicare cost principles to calculate allowable Medicaid cost.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>ICF/IID</b>                                 | <p><b>ICF/IID Costs.*</b> This model is developed using total allowable Medicaid costs. Medicaid costs are identified using information contained in the facility cost reports. The estimated Medicare payment is computed using Medicare cost principles to calculate allowable Medicaid cost. The 112% of routine cost method is a common methodology approach for this provider type across the country.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Clinic Services</b>                         | <p><b>State Payment Rate to Medicare RBRVS Comparison.*</b> This UPL methodology is a payment-based approach in which Medicaid clinic rates are compared to the rate determined through the Medicare professional fee services RBRVS system. The comparison is done through a side-by-side comparison by the Current Procedural Terminology (CPT) code of the Medicaid payment to the Medicare payment.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                | <p><b>ASC.*</b> Comparison of the Medicaid ASC payment rate by Healthcare Common Procedure Coding System (HCPCS) code to the Medicare ASC fee schedule. For HCPCS codes that are not on the Medicare ASC fee schedule, other Medicare fee schedules can be used, such as the Medicare physician fee schedule non-facility rate; Medicare DME, prosthetics, orthotics, and supplies fee schedule; or Medicare average sales price fee schedule.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

| Myers & Stauffer: UPL Methodologies |                                                                                                                                                                                                                                                                                                                          |
|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Services                            | UPL Methodologies                                                                                                                                                                                                                                                                                                        |
|                                     | <b>End Stage Renal Disease (ESRD) Providers.*</b> Comparison of the Medicaid dialysis payment per treatment to the average Medicare payment per treatment for the state. The Medicare payment per treatment is published in the Medicare provider-level impact file associated with the annual Medicare ESRD Final Rule. |
| * Denotes current BMS methodology.  |                                                                                                                                                                                                                                                                                                                          |

In addition to incorporating the methodologies described above, our approach to assisting BMS with UPL demonstrations is as follows:

- Keep BMS Abreast of UPL Issues Raised by CMS.** Project staff assigned to this project prepare UPL demonstrations for multiple states and are continuously responding to questions raised by CMS. As new issues are raised by CMS, project staff will review the current West Virginia UPL demonstrations to identify any possible concerns in the methodology that may raise questions from CMS. All concerns will be communicated to the BMS team along with alternative methodologies and/or strategies to address our concerns. One specific issue that CMS continues to raise is ensuring that the UPL demonstration considers population, benefit, and acuity differences in Medicare and Medicaid. Myers & Stauffer has extensive experience in preparing payment-based demonstrations that recognize the acuity differences between Medicare and Medicaid populations.
- Keep BMS Updated on Changes in Medicare Reimbursement Policy and UPL Demonstration Requirements.** Healthcare provider reimbursement is a dynamic field that continues to evolve significantly over time. Assigned key project staff are members of firmwide practice area leadership groups that have expertise in proposed and finalized changes in Medicare reimbursement and UPL requirements. Key project staff will leverage this expertise and communicate the potential impact of any proposed or finalized changes. We will work with the BMS UPL team to mitigate the impact of identified changes through the implementation of acceptable demonstration modifications or the proposal of alternative calculation methodologies.
- Gather Necessary Data.** To perform the annual UPL findings, we will collect Medicaid payment and utilization statistics at the individual provider level. For the providers that file cost reports with the Medicaid program, we will also collect their cost report data. Ownership information (privately owned and operated, nonstate government owned and operated, or state-owned and operated) data will also be collected. For some service categories, we may also need Medicaid claims level data for the UPL analyses.
- Model Alternative UPL Demonstrations.** CMS continues to provide flexibility to states with respect to their UPL demonstration methodologies. Myers & Stauffer will review options for the Medicaid program and develop analyses for evaluation as to which UPL approach best meets BMS's program objectives. The most common approaches to demonstrating UPL compliance



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

follow either a cost-based, payment-to-charge ratio, charge-based, or prospective payment approach. We will work with BMS staff to identify the approach most appropriate for BMS.

- **Prepare Materials for UPL Submission to CMS.** Myers & Stauffer will assist BMS in preparing all materials required for submission by CMS. Currently, CMS requires (or may require) the following items prior to UPL demonstration approval:
  - **CMS-required UPL demonstration templates and notation.** Beginning with SFY 2019 UPL demonstrations, CMS began requiring states to complete a UPL demonstration template for each required UPL demonstration and, beginning in SFY 2022, CMS began using the MACFin Portal for UPL submission. The templates and the MACFin portal require additional notation to identify how current UPL demonstrations are mapped to required template fields.
  - **Submission of a UPL guidance document.** The guidance document (or narrative document) provides substantial details relating to the underlying methodology and calculation of the UPL demonstration. It identifies the data source, base rate, and payment information periods used in the calculation, as well as information pertaining to state funding resources. The guidance document is now web-based in MACFin, and as such, must be entered by State staff. Myers & Stauffer has a supplemental guidance document that allows the BMS team to copy and paste the applicable answers, streamlining the process.
- **Supporting rate documentation.** CMS may require states to submit additional detailed rate or payment calculation support prior to UPL demonstration approval.
- **Assist with Correspondence with CMS.** BMS may receive questions or formal CMS RAIs from CMS following the submission of the UPL demonstrations. We will assist in addressing these issues and drafting replies to CMS. Our services and commitment to a state do not end when the final UPL demonstration is delivered. We take pride in working with our state clients through the CMS acceptance process. We will leverage our years of experience communicating and defending UPL demonstrations to CMS and will provide our guidance and professional expertise to ensure the process is as smooth as possible for BMS.

### Services and Advice on Other Fee Schedule Matters (4.2.1.5.5)

The vendor should describe their plan to provide services and advice on other fee schedule matters as they arise, including, but not limited to, changes in federal or state regulations and will be subject to the limitations of the Division budget. These additional services may include appearances by the vendor's personnel before judicial, legislative, and executive bodies, employer and claimant groups, or others, to respond to questions related or to give reports. These services also include the preparation of written reports concerning fee schedule development, as deemed necessary by the Division. Preparation of testimony and testimony before administrative hearings, tribunals, and state and federal courts may be required.

### Approach and Methodology

Beyond core fee schedule development and maintenance, BMS needs expert level advisory capability that can respond as issues arise — driven by federal or state regulatory change, legislative activity, or contested proceedings — without exceeding BMS's available budget for these additional services. We anticipate providing support for BMS across the following three areas: ongoing monitoring and advisory support, representation and communication before external bodies and stakeholder groups, and formal

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

written reporting and testimony in administrative, legislative, and judicial settings. Further detail on these activities is described below.

**Ongoing Monitoring and Advisory Support**

Changes in federal or state legislative activity, CMS guidance, and SPAs have an impact on West Virginia Medicaid fee schedules. Our Team will monitor these activities directly and bring matters to BMS's attention as they emerge, so advisory support is proactive rather than reactive. We anticipate the following activities:

- Maintain a continuous regulatory tracking log covering CMS rulemaking, SPA activity, and West Virginia legislative/administrative rule changes affecting the Medicaid fee schedule.
- Monitor West Virginia legislative activity affecting Medicaid reimbursement and flag anything with fee schedule impact promptly, with a brief written summary containing issue, affected fee schedule sections, estimated fiscal/operational effect, and recommended response timeline.
- Provide advisory consultation on fee schedule matters as authorized by BMS.
- Use the same rate setting personnel already assigned to core fee schedule development tasks for ad hoc advice, so guidance is based on current, firsthand knowledge of the methodology.

**Appearances Before Judicial, Legislative, and Executive Bodies, and Stakeholder Groups**

Fee schedule matters may draw interest from multiple audiences, including legislators, Medicaid agency leadership, and provider or member groups affected by a proposed change. Consistent, accurate representation of BMS's position across all these audiences is the goal, coordinated with BMS at every step rather than delivered independently. We propose to:

- Assign a specific point of contact for appearances, with a backup designee to ensure continuity of coverage.
- Prepare for and appear before legislative committees, relevant health and human resources committees, or interim study committees on Medicaid fee schedule matters at BMS's request, including briefing materials in advance.
- Support BMS in appearances before executive branch reviewers (e.g., BMS leadership, governor's office budget review) to respond to questions on fee schedule design, methodology, or fiscal impact.
- Participate in meetings or facilitated sessions with impacted providers, provider associations, MCOs, and member/advocacy groups to explain fee schedule changes, respond to concerns, and gather input for BMS's consideration.
- Coordinate all external messaging with BMS in advance of any appearance to ensure consistency.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)***Prepare Written Reports and Prepare/Delivery Testimony*

We will prepare written reports and other written materials regarding fee schedule development and other aspects of fee schedule reimbursement. When a fee schedule matter moves to a contested proceeding, such as a provider appeal, testimony needs to hold up under scrutiny, not just explain the methodology in the abstract. We understand the importance of preparing accurate and understandable written materials and presenting complex subject matter to a variety of audiences. We anticipate performing the following activities:

- Prepare written reports on fee schedule development topics as directed by BMS, including methodology summaries, fiscal impact analyses of proposed changes, and comparative rate analyses against Medicare, PEIA, and surrounding state Medicaid programs.
- Support preparation of the legislative reports required under West Virginia law comparing Medicaid reimbursement rates to other payers, including any required explanation of plans to address identified rate deficiencies.
- Deliver reports in BMS's preferred format and timeline, with the ability to accommodate expedited turnaround tied to a legislative or CMS deadline.
- Prepare written and/or oral testimony for hearings or proceedings.
- Assign personnel with direct fee schedule methodology knowledge to serve as the testifying witness, drawing on a firm-wide bench that has supported Medicaid rate setting engagements in all 50 states and Washington D.C., which minimizes preparation time and the risk of inconsistent testimony across proceedings.
- Support BMS's legal counsel with exhibit preparation, data validation, and response to discovery requests related to fee schedule methodology, to the extent authorized by BMS.

We are aware that at times, cost report adjustments and other actions impacting reimbursement will be disputed or appealed. We have assisted state agency clients in both information dispute resolution meetings, along with full-blown administrative hearings, and even provided support on cases at the Circuit Court level. This support has ranged from providing documentation and analysis to the state agency to appearance in court and providing direct testimony.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****West Virginia BMS  
and PEIA****Demonstrated Experience: Rate Setting**

Myers & Stauffer has been the provider reimbursement contractor for PEIA and West Virginia Medicaid for over 25 years. In that role, we have served as a demonstrated expert across a broad range of provider rate setting and reimbursement methodologies for both BMS and PEIA. We have developed, updated, modeled, and supported implementation and assessment of reimbursement rates consistent with the State's approved State Plan and across a number of provider types. As a result of our performance and the integrity of our rate setting services, BMS shifted a broad group of rate setting functions from its Office of Accountability and Management Reporting to Myers & Stauffer in 2025. This also provides BMS with our national expertise and understanding of rate setting issues and opportunities which we bring to BMS's attention along with our recommendations regarding applicability to the state, as well as our rationale for those recommendations.

**Other State  
Medicaid  
Experience**

Since 2016, Myers & Stauffer has been a national leader in CCBHC rate setting. Specifically, we have assisted West Virginia, Alabama, Colorado, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Nebraska, New Hampshire, New Mexico, and Oregon with various components of planning, rate setting, and/or implementation of CCBHCs pursuant to Section 223 of the Protecting Access to Medicare Act of 2014.

Through our work, we have supported the development and rebasing of reimbursement rates, conducted fiscal impact analyses, reviewed costs for reasonableness in comparison to industry standards, led stakeholder engagement, provided cost report training to providers and State staff, produced policies and procedures for quality bonus payments, drafted quality payment-related amendments to the Medicaid State Plan, and other related services.

**Mandatory Project Requirements (4.2.2)****Managed Care Program Administration (4.2.2.1)**

The State Medicaid Managed Care Programs, both MHT and MHP, currently operate under 1915(b) waivers. Requests for services related to waiver analyses outside of the Managed Care waivers shall be accounted for under ad hoc services. Services provided under the ad hoc section will be performed at an hourly rate and will require execution of an approved SOW and delivery order before work can commence. WVCHIP delivers benefits to members using managed care under the state plan option at section 3.0 which can be found at: [https://chip.wv.gov/SiteCollectionDocuments/WVCHIP State Plan 11 13 24.pdf](https://chip.wv.gov/SiteCollectionDocuments/WVCHIP%20State%20Plan%2011%2013%2024.pdf). WVCHIP members participate under the MHT umbrella. Administration and oversight requirements are the same as Medicaid but there is no associated waiver reporting and WVCHIP is not included in the Medicaid 1915(b) waiver.

The Myers & Stauffer Team will comply with this requirement. We understand requests for services related to waiver analyses outside of the managed care waivers shall be accounted for under ad hoc services. We also understand services provided under the ad hoc section will be performed at an hourly rate and will require execution of an approved SOW and delivery order before work can commence. Finally, we understand WVCHIP members participate under the MHT umbrella, and administration and oversight requirements are the same as Medicaid, but there is no associated waiver reporting and WVCHIP is not included in the Medicaid 1915(b) waiver.

See additional details on waivers and in 4.2.1.1.9 through 4.2.1.1.11 and ad hoc services in 4.2.1.4 and 4.2.2.3.



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****Meeting Availability (4.2.2.1.1)**

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.

The Myers & Stauffer Team will comply with this requirement. We recognize the importance of in-person collaboration to build trust and effective partnerships. The Team agrees to be available within one business day for a virtual meeting or five business days to meet in person with BMS's Managed Care entities, provider groups, and other parties as determined necessary by the Bureau, at a location to be determined based on space availability, at no additional cost to the Bureau.

**Preparation of Legislative Reports (4.2.2.1.2)**

The Vendor shall provide assistance in the preparation of all required legislative reports, including, but not limited to, reports mandated under WV Code §9-5-22, Medicaid managed care reporting <https://code.wvlegislature.gov/9-5-22/>, and the annual MHT and MHP reports submitted to the Legislature.

The Myers & Stauffer Team will comply with this requirement. As we have since 2022, we will provide assistance in the preparation of all required legislative reports, including, but not limited to, reports mandated under WV Code §9-5-22, Medicaid managed care reporting, and the annual MHT and MHP reports submitted to the Legislature.

**Financial Services (4.2.2.2)****Fixed Hourly Rate (4.2.2.2.1)**

The vendor shall provide a fixed hourly rate for programmatic services and a fixed hourly rate for actuarial services.

The Myers & Stauffer Team will comply with this requirement. As presented in our Cost Proposal, we have provided a fixed hourly rate for programmatic services and a fixed hourly rate for actuarial services.

**Ad Hoc Services (4.2.2.3)****Staffing Requirements (4.2.2.3.1/2)**

The vendor shall agree that the Agency has the right to review and approve hiring of key staff and to request replacement staff if the Agency determines that qualifications and/or needs are not being adequately met.

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.

The Myers & Stauffer Team will comply with these requirements. We understand and agree that BMS has the right to review and approve the hiring of key staff and to request replacement staff if BMS determines that qualifications and/or needs are not being adequately met. Further, we will ensure that all staff performing work under this contract adhere to their designated roles and responsibilities throughout the duration of the contract.

**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)****No Conflicts of Interest (4.2.2.3.3)**

The Prime Vendor, and any subcontractor engaged for this contract, shall not have held, within the five (5) years prior to the contract start date or at any time during the term of the contract, any contracts with a managed care organization, provider, provider group, or provider association conducting business related to this contract in the State of West Virginia, or whose parent organization conducts business in the State of West Virginia. If any subcontractor currently interacts with any of the organizations, groups or associations in any capacity, they must disclose such interactions and provide a mitigation plan outlining how conflicts of interest will be prevented and managed. The mitigation plan must be submitted to the Agency for review and shall not be implemented until it receives written approval from the Agency.

The Myers & Stauffer Team will comply with this requirement. Unlike many of our competitors, Myers & Stauffer does not contract with or provide services to any individuals, corporations, healthcare providers, provider groups and associations, MCOs, health plans, or other government vendors — we provide services exclusively to government clients. We do not have any interest that may or could represent an actual, potential, or future COI.

While larger firms may boast of their vast experience with providers and health plans in the private sector, we stand firm in our commitment to exclusively serving government agencies. We understand how important this is, as COIs can compromise the fundamental integrity of government programs and erode public trust. A copy of our Conflict Mitigation Strategy is included in *Appendix A: Conflicts of Interest Mitigation Plan*.

Similarly, our subcontractor Milliman has a strong reputation for integrity and quality in all its work products, and these have been core values of Milliman since their formation in 1947. For this reason, Milliman follows strict procedures to avoid COIs in its work.

The Milliman consulting team proposed for this work has not and will not consult with any current or future capitated plan on any work related to the West Virginia Medicaid program. Milliman does disclose that other Milliman offices currently interact with The Health Plan (THP) and Highmark's parent company operating in other lines of business. While performing our work for BMS, Milliman deploys strict internal procedures and protocols consistent with its Conflict Mitigation Strategy, included as *Appendix A: Conflicts of Interest Mitigation Plan*. Consistent



### Concentrated Focus, No Conflicts of Interest

Myers & Stauffer has one business mission: to provide consulting, accounting, auditing, and program integrity services to governmental health and human services agencies in an efficient, cost-effective, and timely manner and to do so at the highest levels of integrity and accountability.

We are unique in that our entire practice is dedicated to assisting our state and federal partners — we do not provide services to any non-governmental entities. As a result, the firm is independent of the Medicaid agency, health plans, and providers, as defined by the Comptroller General of the United States.

Our restricted contracting model means we avoid COIs and biases and we have a rigorous internal compliance program. We are exceptionally sensitive to public scrutiny, performance expectations, and the high levels of accountability and integrity expected of government agencies and policymakers.

### Providing Peace of Mind for Our Public Clients



**PROJECT GOALS AND MANDATORY REQUIREMENTS (RFP SECTION 4.2)**

with the CFRP requirements, we are providing this plan to clearly demonstrate how any real or perceived COI are prevented and managed. We submit this plan for BMS's review and approval. Should the Bureau have questions or wish to see changes to the plan, we are glad to discuss and make those changes as mutually agreed upon.

Milliman has successfully mitigated all potential COIs over our 30-year relationship serving as actuary for state agencies. We will continue to successfully mitigate any potential conflicts in the future.

### **Service-Level Agreement (4.2.2.4)**

The vendor shall be bound to all service level agreements as defined within Exhibit B Service Level Agreements.

The Myers & Stauffer Team will comply with this requirement. We agree to be bound to all service-level agreements as defined within RFP Exhibit B Service-Level Agreements.



#### **What This Means for BMS**

We have decades of experience navigating the difficult task of making sense of what appears to be impossible to our clients. This means BMS can count on us to do the problem-solving and solution leg work, especially when new updates or changes are required. The diligence provided by the Myers & Stauffer Team allows BMS to focus on the executive administration of the program while we explore options, impacts, and roadmaps for implementation. Our "boots on the ground" experience and approach mean there is no challenge too small or too large for us to tackle.

## Qualifications and Experience (RFP Section 4.3)

### Qualification and Experience Information (4.3.1)

Vendor should provide information and documentation regarding its qualifications and experience in providing services or solving problems similar to those requested in this RFP. Information and documentation should include, but is not limited to, copies of any staff certifications or degrees applicable to this project, proposed staffing plans, descriptions of past projects completed (descriptions should include the location of the project, project manager name and contact information, type of project, and what the project goals and objectives were and how they were met), references for prior projects, and any other information that vendor deems relevant to the items identified as desirable or mandatory below.

Vendor should describe in its proposal how it meets the desirable qualification and experience requirements listed below.

Together, the Team of Myers & Stauffer and Milliman combines Medicaid managed care and actuarial knowledge and experience that exceeds the requirements in the RFP. Furthermore, our Team has a demonstrated track record of providing an impeccable level of expertise, service, and value to BMS.

Throughout our tenure as West Virginia's actuarial and managed care oversight consultant, we have supported BMS with numerous initiatives, including Medicaid managed care monitoring and oversight, capitation rate development, contract maintenance, MCO readiness reviews, implementation of day-one eligibility and other legislative mandates, DPPs and other finance initiatives, budget support, provider rate setting, waiver support, program integrity reviews, and numerous other efforts. We offer a project team that is knowledgeable and experienced across all these subject areas that is unmatched in professionalism, dedication, and experience.

Myers & Stauffer will seamlessly integrate Milliman's staff. This ensures we maintain quality control standards and provide a consistent, high-quality service approach. Myers & Stauffer and Milliman have a demonstrated record of success working together in prime and subcontractor roles not only in performing this scope of work for BMS but also in our work with other states. Our Team works in unison for planning, meetings, analysis, recommendations, and any team communications. Milliman fully functions as a member of the Myers & Stauffer Team, which means BMS will continue to experience a one team mindset, seamless communication, collaborative problem-solving, and deliverables/consulting services that encompass the expertise of each organization.



#### Comprehensive Experience for BMS

The Myers & Stauffer Team has provided actuarial and/or consulting services to public health clients, including state Medicaid and CHIP agencies, for nearly 50 years. This includes more than 10 years of experience in the development of capitation rates for Medicaid managed care organizations across 20 states and more than 20 years providing Medicaid managed care contract and policy development and/or oversight to nearly 30 states.

#### Exceeding Experience Expectations



## Knowledge of West Virginia's Healthcare Landscape and BMS's Operations

For more than 20 years, we have worked effectively with West Virginia state agencies on numerous Medicaid initiatives and have established solid working relationships with the agencies we have served. Our historical and current work demonstrates we understand the West Virginia-specific environment, including its challenges and opportunities. Through our collaborative work with the State, we have learned invaluable lessons that can only be gained through direct experience (*Figure 13*).

Figure 13. Client Profile #1 - Medicaid Actuarial and Managed Care Program Administration: West Virginia



**CLIENT PROFILE:**  
**West Virginia Department of Human Services**  
**Bureau for Medical Services**

### Medicaid Actuarial Services and Managed Care Program Administration

Since 2022, Myers & Stauffer, in partnership with Milliman, has provided oversight of BMS' two Medicaid managed care programs: Mountain Health Trust (MHT) and Mountain Health Promise (MHP). Our consulting services include services such as capitation rate setting, managed care organization (MCO) contract compliance oversight, MCO contract development and updates, provision of an MCO oversight dashboard tool, policy and fiscal analyses, legislative support, provider directed payment calculations, medical loss ratio (MLR) examinations, provider network adequacy assessments, financial services, non-MCO rate setting, and other ad hoc scopes of work.

### Relevant Services Provided to the State

#### Medicaid Managed Care Monitoring and Oversight

##### MLR Examinations

- Managed the transition of MLR calculations from attestation by a third-party vendor every three years to annual examinations, ensuring MCO compliance with MLR regulations and the Bureau for Medical Services (BMS) requirements.
- Conduct standing meetings with client leadership and MCOs to identify issues as they arise and provide assistance and resolution.

##### Encounter Data Validation (EDV) Analysis

- Conduct bi-monthly EDV analysis and reporting to ensure MCO compliance with contractual requirements.
- Maintain a Known Issues Log of all historical and ongoing data issues and propose solutions to the State and the Medicaid Management Information System vendor, resulting in high quality and reliable encounters for monitoring the MHT and MHP programs, as well as the West Virginia's Children's Health Insurance Program (WVCHIP).
- Advanced the quality and completeness of encounter data to over 99% which allows confident use of encounter data to set actuarially sound capitation rates.

##### Provider Network Analysis (PNA)

- Analyze MCO provider network adequacy reports to identify provider network gaps with emphasis on rural and underserved areas.
- Develop a final assessment of MCO provider network adequacy along with recommendations for use by BMS.
- Work with BMS to improve the PNA methodology for compliance with the CMS final rule.

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)****MCO Reporting**

- Oversight and analysis of required MCO reporting to identify trends in MCO performance and opportunities for improvement.
- Prepare and track submission of all required MCO regulatory and performance reporting, review MCO reports for contractual compliance, and work with client and MCOs to address issues in reporting.
- Responsible for completion and submission of the Managed Care Program Annual Report.

**MCO Member and Provider Materials**

- Conduct reviews of all MCO member and provider materials to ensure compliance with the MCO contract and state and federal regulations. Materials include enrollee handbooks, provider manuals, subcontractor agreements, and marketing plans, as well as others.
- Update document review requirements on an annual basis to adapt to policy or regulatory changes.
- Submit the Network Adequacy and Access Assurances Report to CMS to address annual oversight, financial reconciliations, or health plan data submissions through the Medicaid and CHIP Managed Care Reporting system.

**Rate Setting and Analyses****MCO Capitation Rate Setting**

- Conduct annual MCO capitation rate setting for the MHT and MHP programs, including mid-year adjustments, ensuring actuarially sound rates approved by CMS.
- Coordinate meetings and written communication with MCOs to address the rate setting process and rates prior to CMS submission.
- Provide fiscal impact analysis on proposed benefit and programmatic changes.

**Provider Rate Setting**

- Support Medicaid rate setting and payment methodology services related to inpatient hospital prospective payment system (PPS), outpatient hospital payment system, and physician Resource-Based Relative Value Scale system.
- Review service rates and make rate methodology design recommendations for home and community-based services (HCBS) waivers.
- Review cost reports and supporting documentation to develop PPS rates for federally qualified health centers (FQHCs) and rural health clinics (RHCs) and assist the State with adjusting PPS rates for changes in scope of services.
- Provide cost reporting training for Certified Community Behavioral Health Clinics (CCBHCs) and develop PPS-1 rates with quality incentives.
- Conduct provider payment reviews associated with rate changes implemented by the State and/or requested by providers. This includes calculating estimated fiscal impacts of the changes.
- Responsible for nursing facility patient-driven payment model implementation and Capital Reimbursement redesign.
- Support the transition of rate setting from the Office of Accountability and Management Reporting to BMS for the following services: ambulance, ambulatory surgery center, clinical lab, dental, durable medical equipment, graduate medical education, FQHC/RHC, home health, hospice, intermediate care facility, physician-administered drugs, physician fee schedule, substance use disorder (SUD), vaccines, and vision.



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)****Support for West Virginia Finance Initiatives****Financial Analyses and Reporting**

- Work closely with BMS to support the State's budget development, analysis of options to address shortfalls in BMS budget, and quantify their potential programmatic and fiscal impacts.
- Support BMS by evaluating draft and passed legislation to assess fiscal and operational impact to BMS.
- Calculate the annual incurred but not reported liability for the West Virginia Medicaid fee-for-service program.
- Support review of federal financial reporting (e.g., CMS-64 reports) to promote accuracy and ensure proper claiming of federal funds.
- Review provider rates for compliance and consistency with the West Virginia State Plan and CMS requirements.
- Conduct budget neutrality calculations for the 1115 Continuum of Care waiver.

**Reports and Briefs**

- During the annual legislative sessions, support client leadership in research, fiscal note analyses, preparation of leadership materials for committee presentations, and budgetary projections in response to legislative priorities.
- Develop budget reports highlighting long-term risks to the client budget and strategies to continually improve quality and fiscal efficiency.
- Maintain a repository of briefs, anticipating key topics and client needs, to ensure leadership has immediate access to data and policy insights for budget hearings, legislative sessions, and other engagements.

**Contracts and Waivers**

- Amends MHT and MHP managed care contracts on a semiannual basis, accounting for policy changes, updates to federal regulations, and stakeholder input.
- Manage communications with MCOs regarding managed care contract changes, including new reporting requirements.
- Support negotiations with CMS for approval of program enhancements and capitation rates.
- Support the 1915(b) waiver extension and renewal application for both MHT and MHP, including cost effectiveness analyses, and negotiations with CMS.

**Directed Payment Programs (DPP)**

- Support for the State's hospital and physician DPPs, including annual updates to the existing program and assisting the State with significant program expansion in response to recent legislative changes.
- Calculate payments and monitor revenue requirements for two programs: eligible hospitals and contracted providers.
- Draft preprints, as needed, for the hospital and physician DPPs and coordinate submission to CMS.
- Facilitate workgroup meetings with the State and DPP stakeholders, including the West Virginia Hospital Association, to promote communication and collaboration regarding program oversight, regulatory changes, and quality improvement.
- In collaboration with West Virginia Medicaid Finance, develop communications with MCOs regarding payments and timelines.

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)****Quality**

- Developed the BMS Quality Strategy for 2024-2027, including involvement of a stakeholder workgroup. The Quality Strategy included MHT and WVCHIP components and newer BMS initiatives, such as CCBHCs, DPP quality initiatives, and the MCO quality withhold program.
- Leading implementation of new quality initiatives under Senate Bill 820 (2024): Day one enrollment and MCO quality withhold program.

**Program Integrity**

- Conducted non-emergency medical transportation (NEMT) provider reviews and provided consulting services to establish and implement a Fraud Risk Management Plan that will serve as the framework for assessment of fraud risks facing the NEMT program.

**Client Support and Engagement**

- Develop annual reports for the MHT and MHP programs detailing member enrollment and demographics, MCO performance, and quality improvements.
- Support and oversee implementation of the 2024 Medicaid and CHIP Managed Care Final Rule.
- Facilitate standing meetings with client managed care and financial leadership to provide status updates, identify strategic priorities, and propose recommendations.
- Maintain and update the MC-Ops dashboard, a comprehensive data source for managed care demographics, MCO performance, and quality metrics over time. This tool supports the leadership decision-making process and provides readily available information for reporting purposes.
- Oversee preparation of client leadership presentations for MCO updates on managed care program changes, provider association meetings, national professional association conferences, and member advocate meetings.

**Impact on West Virginia's Public Health Programs**

- Implementing quality initiatives under Senate Bill 820 (2024) focusing on improving SUD outcomes: automatic day one enrollment into managed care and the MCO quality withhold program.
- Providing recommendations to improve contractual language, reporting requirements, oversight, and MCO accountability for services delivered to Medicaid and CHIP managed care members.
- Managing improvements in provider rate setting reviews and rate methodology design, including HCBS waivers, FQHCs/RHCs, and physician fee schedules to enhance provider satisfaction and outcomes.
- Supporting West Virginia in identifying issues and opportunities for improvement in MCO performance and quality.
- Supported BMS and the Bureau for Social Services in evaluating provider rate setting opportunities to improve in-state residential provider access for children and youth in foster care.
- Developed and implemented recommendations for enhancing encounter data integrity that resulted in improved accuracy, completeness, and timeliness of information available to BMS for MCO capitation rate setting, analytics, measuring quality, and evaluating the MHT and MHP managed care programs.
- Providing support for H.R.1. initiatives, such as In Lieu of Services, Food is Medicine, and Program of All-Inclusive Care for the Elderly (PACE) programs.



## Why Choose the Myers & Stauffer Team

Partnering with government health and human services agencies, we help clients accomplish their goals for the nation's most vulnerable populations. Combining our client-first approach with our insight into healthcare programs across the country, we offer the following benefits to BMS and those served by its programs:



### Seamless Transition

As the incumbent contractor, we use methodologies and systems that providers and BMS are already familiar with. Contracting with us allows for a seamless transition into the next contract period.



### Reliability

As documented by track record with BMS and Medicaid agencies across the country, we offer BMS reliability in meeting deadlines and providing quality staff who specialize in these types of engagements.



### Free of Conflicts

Myers & Stauffer is free of conflicts for this engagement. In addition, Myers & Stauffer is dedicated to servicing government healthcare and human services agencies in a way that avoids any conflicts in fact or appearance. We do not work for providers, individuals, health plans, or MCOs. The results of our provider oversight activities are free from real or perceived bias.



### Expertise

Our staff are experienced in Medicaid managed care, capitation payments, provider rate setting, policy consulting, auditing, reimbursement, accounting, and a diverse array of other services specific to the Medicaid program. Through continuing education, national surveillance, and our ongoing work with Medicaid and CHIP programs across the country, are premiere leaders in the field and well-positioned to support BMS.



### Specialization

We are laser-focused on serving government-sponsored healthcare and human services programs. We offer a unique perspective to states that is influenced by our national experience, yet customized to meet the specific needs of West Virginia.



### Technical Methodology

Our expertise and related experience will provide BMS with a partner known throughout the industry, and to the Bureau, for our technical excellence. Combined with our knowledge of BMS, we will provide services and supports that are evidence based, data driven, and technically sound.

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)****Capacity**

From the Contract Manager to our supporting team members, all staff engaged on our Medicaid contracts have the requisite level of experience and technical expertise to exceed expectations. We have a full complement of staff already in place to service this contract.

**Project Management**

We have extensive experience managing large, complex engagements that require coordinating numerous interrelated tasks. These contracts demand a high volume of expertly prepared deliverables and the expertise of highly specialized resources.

**Innovation**

We have a history of designing and implementing innovative approaches to keep pace with the ever-changing Medicaid and CHIP landscape. We are proven solvers of complex issues, facilitators of innovation, and we have a demonstrated history of supporting our clients' advancement of their Medicaid and CHIP programs.



### What This Means for BMS

The selection of the Myers & Stauffer Team will ensure the continuity of critical work and initiatives underway, alleviating the need for BMS staff to devote months to transition activities when it has access to a demonstrated, high-performing partner. Our Team not only meets but far exceeds all requirements and has proven the ability to provide all services sought through this RFP.

## Comprehensive Managed Care and Rate Capitation Experience (4.3.1.1)

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

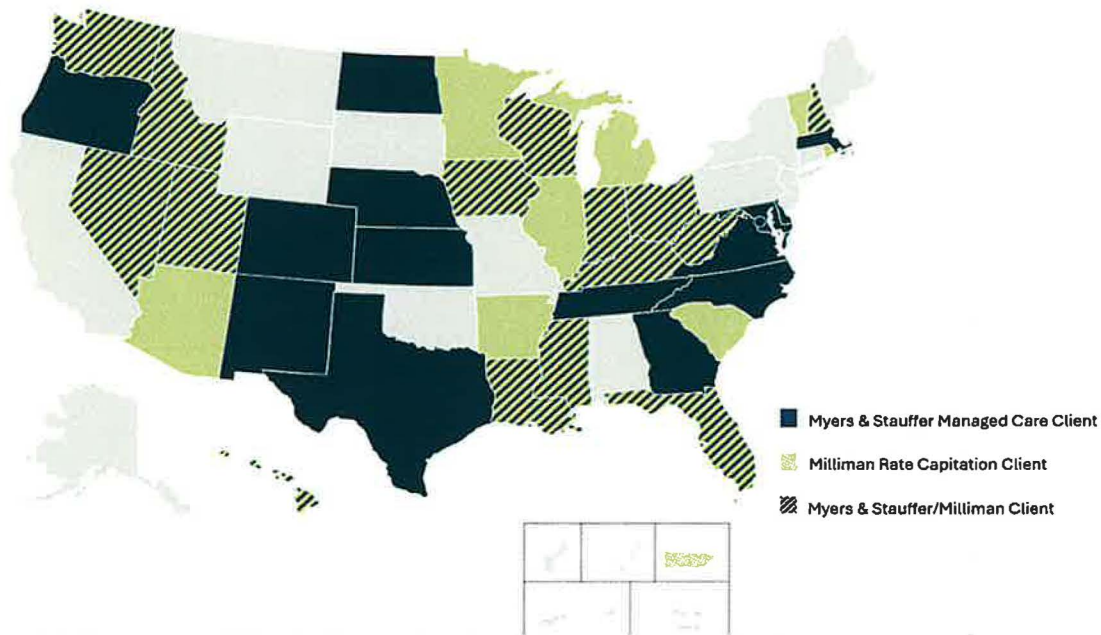
In addition to our work for BMS, the Myers & Stauffer Team combines Medicaid managed care and actuarial knowledge and experience that exceeds the requirements in the RFP. This experience complements our demonstrated track record of providing an impeccable level of expertise and value to BMS.

As shown in *Figure 14*, our Team brings BMS our Medicaid managed care consulting and capitation rate setting experience and best practices from more than 30 states.



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

Figure 14. Myers &amp; Stauffer Team: Current and Historical Managed Care and Capitation Client Map



Specifically, Myers & Stauffer and Milliman provided managed care consulting and capitation rate setting concurrently in following states: Hawai'i, Idaho, Kentucky, Mississippi, Utah, and Wisconsin. Our West Virginia-specific experience as the incumbent vendor, coupled with our extensive national expertise in Medicaid managed care, means the transition to this new contract will be seamless.

### Medicaid Managed Care Contract and Policy Development and/or Oversight

The Myers & Stauffer Team offers an exceptionally qualified and experienced consulting team that combines West Virginia-specific experience with nearly 70 combined years of organizational experience supporting federal, state, and local health and public health agencies. With more than 20 years of experience providing Medicaid managed care program administration and consulting services across 29 states, our Team far exceeds the minimum experience required in the RFP.

Our experience will provide BMS access to our considerable expertise with MCO strategic planning and best practices, program design, waiver development, procurement, program implementation, policy analysis, audits, operations, oversight, and evaluation. We have extensive experience conducting analyses of policy opportunities, legislation, regulations, and best practices. In addition to our Team's experience, many of these areas benefit from Myers & Stauffer staff's previous employment with state Medicaid agencies and CMS. Our scope of comprehensive services and staff expertise helps ensure that program design, procurement approaches, and ongoing oversight are aligned with the State's needs and poised to achieve BMS's intended goals and objectives. As the incumbent, we will be able to continue our work providing support to BMS to ensure appropriate rate setting and oversight of MCO operations

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

without disruption. As we do currently, we will leverage our multistate managed care knowledge and experience as we offer West Virginia-specific solutions.

We have worked with Medicaid agencies in MCO program design, procurements, contract development, program reviews, policy analyses, audits, EDV, implementation, and monitoring activities, and other areas. A few areas of our diverse experience are highlighted in the following.

- **Program Design:**

- Facilitating strategic planning activities to design or improve managed care programs, contracts, operations, and performance.
- Conducting options analyses (e.g., benefits, services, programmatic changes, etc.) and performing detailed fiscal and operational feasibility analyses.
- MCO program design, planning, and implementation.
- Development of managed care procurement vehicles (e.g., RFPs, RFAs, etc.) and draft contract language including performance standards.
- Designing, implementing, and evaluating DPPs authorized under 42 CFR § 438.6, including activities, such as strategic planning, stakeholder engagement, drafting of concept papers and the CMS preprint, creating financial models, and designing the evaluation methodology.
- Identifying and pursuing appropriate federal authorities (e.g., State Plan and waivers including 1115, 1135, 1915[b] and 1915[c]) to accomplish states' objectives.
- Supporting stakeholder engagement and communications, including providers, professional associations, and State-affiliated contractors.
- Working across various Medicaid divisions, as well as sister agencies, in the design and implementation of Medicaid managed care monitoring and oversight activities. These Medicaid divisions have included policy, operations, quality management, utilization management, member services, provider services, pharmacy services, fiscal services, IT and decision support, program integrity, and legal services, as well as internal operational work groups across divisions. Sister agency involvement has included departments of social services, behavioral health, disabilities, aging, juvenile justice, corrections, public health, education, and others.
- Conducting readiness reviews, management of MCO corrective actions, and MCO monitoring activities to ensure managed care enrolled individuals have access to healthcare



## Exceeding Managed Care Medicaid Contract/Policy Development/Oversight Experience Requirements

Myers & Stauffer exceeds all RFP specifications, having provided managed care consulting for 29 Medicaid agencies, including 16 where we have done so for more than five years.

### **Proven Experience Means Proven Results**



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

services and our Medicaid agency clients have prompt access to data needed to manage healthcare programs.

- **Financial:**

- Conducting actuarially sound Medicaid managed care capitation rate setting and risk adjustment for state agencies.
- Performing provider payment reviews associated with rate changes implemented by the State and/or requested by providers, including calculating estimated fiscal impacts of the changes.
- Evaluating provider rate methodologies and performing rate setting, analysis, and fiscal modeling across the continuum of Medicaid service providers in both Medicaid FFS and Medicaid managed care environments.
- Providing state DPP design, implementation, and operational support services to advance states' quality and access agendas.
- Conducting MLR audits consistent with CMS requirements and best practices.
- Supporting states' financial and budget processes.

- **Legislative/Regulatory Support:**

- Coordinating states' fiscal note analyses, topic-specific briefs and reports, and presentations during states' legislative sessions and special hearings.
- Evaluating the impact of federal and state legislation and rules on states' managed care programs.
- Supporting negotiations with CMS for approval of program enhancements and capitation rates.

- **Compliance/Oversight:**

- Monitoring of MCO and state compliance with contractual, federal, and state regulations and reporting requirements.
- Conducting EDV analyses and providing MCO-specific reporting to improve data integrity and compliance with MCO contract requirements.
- Performing statewide PNA analyses, reviewing standardized reports for contractual compliance, conducting secret shopper testing, and making recommendations.
- Managing data analytics and presenting MCO performance in useful formats, including the customization and deployment of interactive and user-friendly dashboards.
- Preparing program assessments and evaluations, along with quality and performance improvement recommendations.

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

- Program integrity strategic planning, oversight, and coordination of activities with states, MCOs, the DOJ, the Federal Bureau of Investigation, CMS, and MFCUs.
- Implementing automated MCO deliverable tracking and reporting systems.
- Facilitating the development of, or revision to, MCO contracts in support of states' goals and monitoring MCO performance and contract compliance.
- Conducting EQR activities to assess compliance with CMS requirements including the quality, timeliness, and access to care provided by the MCOs.
- Developing or revising contract compliance monitoring tools, including MCO reporting templates, to support analysis activities conducted by agency staff.
- Providing training support for agency staff in their understanding of managed care and best practices in effectively monitor managed care programs.

Through our Team's history of successful work with state Medicaid agencies and managed care programs, we have gained significant expertise with managed care concepts, programs, and best practices. In addition, our staff are 100% dedicated to public healthcare programs, and many have previous experience serving in leadership positions within Medicaid agencies, CMS, Medicaid health plans, fiscal agent contractors, healthcare providers, and a multitude of state and local social service agencies. Our Team includes:

- |                                                   |                                                  |
|---------------------------------------------------|--------------------------------------------------|
| • Medicaid, managed care, and health policy SMEs. | • Certified medical record auditors.             |
| • Medicaid financing and reimbursement SMEs.      | • Analysts.                                      |
| • Actuaries.                                      | • Pharmacists.                                   |
| • Healthcare attorneys.                           | • Medical directors.                             |
| • CPAs.                                           | • Registered nurses.                             |
| • CFEs.                                           | • Certified coders.                              |
| • Data scientists.                                | • Reimbursement system specialists.              |
|                                                   | • Certified professionals in healthcare quality. |

We also have former staff from both state and federal health agencies and private sector healthcare entities including Medicaid directors, behavioral health and public health administrators, LTC directors, state Medicaid Surveillance and Utilization Review coordinators, SHOs, hospital accountants, Medicare intermediary auditors, and a number of other professionals.

As shown in *Table 5*, the Myers & Stauffer Team has the required experience to leverage our multistate knowledge and experience as we offer state-specific solutions. We have shaded rows where we meet or exceed the five years' experience in Medicaid managed care contract and policy development and/or oversight experience.



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

Table 5. Managed Care Experience

| <b>Myers &amp; Stauffer: Medicaid Managed Care Experience</b> |                             |              |                             |                       |                            |                              |                                 |
|---------------------------------------------------------------|-----------------------------|--------------|-----------------------------|-----------------------|----------------------------|------------------------------|---------------------------------|
| <b>Client</b>                                                 | <b>Dates of Service</b>     | <b>Role</b>  | <b>Technical Assistance</b> | <b>Policy Support</b> | <b>Financial Oversight</b> | <b>Operational Oversight</b> | <b>Encounter Data Oversight</b> |
| <b>State Medicaid Programs</b>                                |                             |              |                             |                       |                            |                              |                                 |
| CO Dept of Health Care Policy & Financing <sup>1</sup>        | 2016-Present                | Prime        | •                           | •                     | •                          | •                            |                                 |
| DC Dept Health Care Finance                                   | 2023-Present                | Prime        | •                           | •                     | •                          |                              |                                 |
| FL Health Care Administration                                 | 2022-Present                | Prime        | •                           | •                     | •                          |                              |                                 |
| GA Dept of Community Health <sup>1</sup>                      | 2007-Present                | Prime        | •                           | •                     | •                          | •                            | •                               |
| HI Dept of Human Services <sup>1</sup>                        | 2018 - 2020<br>2022-Present | Prime        | •                           | •                     | •                          |                              |                                 |
| ID Dept of Health & Welfare <sup>1</sup>                      | 2021-Present                | Prime        | •                           | •                     | •                          |                              | •                               |
| IN Family & Social Services Administration                    | 2022-Present                | Sub          | •                           | •                     |                            |                              | •                               |
| IA Dept of Human Services <sup>1</sup>                        | 2016-Present                | Prime        | •                           | •                     | •                          | •                            |                                 |
| KS Dept of Health & Environment                               | 2025-Present                | Sub          | •                           |                       | •                          |                              | •                               |
| KY Cabinet for Health & Family Services <sup>1</sup>          | 2018-Present                | Prime        | •                           | •                     | •                          | •                            |                                 |
| LA Dept of Health <sup>1</sup>                                | 2012-Present                | Prime        | •                           | •                     | •                          | •                            | •                               |
| MD Dept of Health <sup>1</sup>                                | 2006-Present                | Prime        | •                           | •                     | •                          |                              |                                 |
| MA MassHealth                                                 | 2022-Present                | Prime        | •                           | •                     | •                          |                              | •                               |
| MS Division of Medicaid <sup>1</sup>                          | 2015-Present                | Prime        | •                           | •                     | •                          | •                            | •                               |
| NE Dept of Health & Human Services                            | 2022-Present                | Prime        | •                           | •                     | •                          |                              | •                               |
| NV Health Authority                                           | 2015-2017                   | Prime        | •                           | •                     | •                          | •                            | •                               |
| NH Dept of Health & Human Services                            | 2022-Present                | Prime        | •                           | •                     | •                          | •                            |                                 |
| NM Health Care Authority <sup>1</sup>                         | 2015-Present                | Prime        | •                           | •                     | •                          | •                            |                                 |
| NC Dept of Health & Human Services                            | 2018-2019                   | Prime        | •                           |                       | •                          |                              |                                 |
| ND Dept of Health & Human Services                            | 2024-2025                   | Sub          | •                           |                       | •                          |                              |                                 |
| OH Dept of Medicaid                                           | 2020-2022                   | Prime        | •                           | •                     | •                          |                              |                                 |
| OR Health Authority <sup>1</sup>                              | 2019-Present                | Prime        | •                           |                       | •                          |                              |                                 |
| TN TennCare <sup>1</sup>                                      | 2021-Present                | Prime        | •                           | •                     | •                          | •                            |                                 |
| TX Health & Human Services Commission <sup>1</sup>            | 2014-Present                | Prime        | •                           | •                     | •                          | •                            |                                 |
| UT Dept of Health <sup>1</sup>                                | 2020-Present                | Prime        | •                           | •                     | •                          |                              | •                               |
| VA Dept of Medical Assistance Services <sup>1</sup>           | 2012-Present                | Prime        | •                           | •                     | •                          |                              |                                 |
| WA Health Care Authority                                      | 2012-2016                   | Prime        | •                           | •                     | •                          |                              |                                 |
| <b>WV BMS</b>                                                 | <b>2022-Present</b>         | <b>Prime</b> | ★                           | ★                     | ★                          | ★                            | ★                               |
| WI Dept of Health Services <sup>1</sup>                       | 2018-Present                | Prime /Sub   | •                           | •                     | •                          |                              | •                               |

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

| Myers & Stauffer: Medicaid Managed Care Experience |                  |             |                      |                |                     |                       |                          |
|----------------------------------------------------|------------------|-------------|----------------------|----------------|---------------------|-----------------------|--------------------------|
| Client                                             | Dates of Service | Role        | Technical Assistance | Policy Support | Financial Oversight | Operational Oversight | Encounter Data Oversight |
| Federal Programs                                   |                  |             |                      |                |                     |                       |                          |
| CMS (Multiple Contracts) <sup>1</sup>              | 2008-Present     | Prime / Sub | •                    | •              | •                   | •                     |                          |

<sup>1</sup>Have provided services for more than five years.

Additionally, we offer the following two representative client profiles (*Figure 15. Client Profile #2 - Managed Care Oversight and Other Services: Kentucky* and *Figure 16. Client Profile #3 - Managed Care Oversight: Georgia*) to demonstrate our varied experience in supporting states with program design, MCO monitoring and oversight, procurement, and implementation activities.



Figure 15. Client Profile #2 - Managed Care Oversight and Other Services: Kentucky



**CLIENT PROFILE:**  
**Kentucky Cabinet for Health and Family Services and  
Department of Medicaid**

## Audit, Rate Setting, and Consulting Services

Since 1998, Myers & Stauffer has assisted the Commonwealth of Kentucky (the Commonwealth) with a variety of engagements to support the administration and reporting for the Medicaid program. Over the course of more than 28 years, we have become a trusted advisor to both the Cabinet for Health and Family Services (CHFS) and Department for Medicaid Services (DMS) in that we routinely take on new projects for the agency, performing research, ensuring compliance, providing quality deliverables, and offering advice to our client representatives. We provide timely solutions to some of the Commonwealth's most challenging health care delivery issues.

### Relevant Services Provided to the State

**Medicaid Managed Care Organization Request for Proposal Development (2024-Present)**  
Assist with the development of an RFP that incorporates best practices, innovation, and value-based purchasing and is compliant with federal and state laws, regulations, and policies. Performed a similar scope of work from 2018-2021 supporting implementation of the contracts.

**Managed Care Consulting Services (2018-2022)**  
Provided Medicaid managed care strategic planning, extensive stakeholder engagement, and review of managed care contracts in comparison states for DMS. Work included:

- Recommendations for the next generation of managed care in Kentucky, drafting the Medicaid MCO procurement documents and procurement evaluation tools, and supporting the resulting contracts' implementation.
- Review of managed care quality and oversight team skill sets, training needs, and organizational structure.
- Strategic planning and development of the Supporting Kentucky Youth (SKY) Program for children and youth in out-of-home care, children receiving adoption assistance, youth who are dually involved, former foster care youth, and Medicaid-eligible youth in the juvenile justice system.
  - Worked with DMS, Department for Community Based Services (DCBS), Department of Juvenile Justice, and Department for Behavioral Health, Developmental and Intellectual Disabilities to develop program design and resulting contract materials.
  - Facilitated cross-agency collaboration for implementation of the SKY Program and supported DCBS planning to prepare for implementation and administration of the program.

**Medicaid Pharmacy Administration Consulting (2021-Present)**  
Designed a managed care single pharmacy benefit management (PBM) model, provided project management support and subject matter expertise for contract implementation activities, and continued support for ongoing operations of the model and for the DMS pharmacy program. Also supporting DMS with implementation activities for a new PBM contract for the fee-for-service delivery system and management of the single preferred drug list and rebates. Additionally, provided support for the Commonwealth's Medicaid pharmacy benefit including, but not limited to, analyses of drug ingredient reimbursement methodologies, professional dispensing fees, 340B policy compliance procedure coded over-the-counter drugs, drug rebate performance, and MCO PBM rates related to enacted legislation.

**Medicaid Rate Setting (1998-Present)**  
When the Commonwealth adopted a case mix methodology for nursing facilities in 1998, Myers and Stauffer began performing rate setting and consulting services for Kentucky. Since the project's inception, rate setting activities have grown to include many provider types beyond nursing facilities, such as:

- Institutions for mental diseases.
- Rural health clinics.
- Veteran Nursing Facilities.
- Federally qualified health centers.

 Myers & Stauffer

## QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)



- Community mental health centers.
- Certified community behavioral health clinics (CCBHCs).
- Hospitals.
- Freestanding psychiatric facilities.
- Rehabilitation facilities.
- Long-term, acute care hospitals.
- Intermediate-care facilities for individuals with intellectual disabilities.
- Commission for Children with Special Health Care Needs.
- Specialized children service clinics.
- Home health for public health departments.
- Psychiatric residential treatment facilities.
- Program for All-inclusive Care for the Elderly.
- Hospice providers.
- Ambulatory surgical centers.

We partner with the Commonwealth to perform a range of services, including: Rate and settlement calculations.

- Agreed-upon procedures.
- Disproportionate share examinations and payment calculations.
- Directed payment programs for hospitals and ambulance providers.
- Pharmacy payment monitoring/ad-hoc analysis.
- Value based nursing facility payments.
- Annual upper payment limit demonstrations for each federally mandated provider type.
- Ad-hoc analyses include projects involving data modeling, reimbursement rate setting projections, rebasing analyses, and research.
- Regulation and state plan amendment reviews.
- Appeals support.

#### Medicaid Waivers and Other Consulting (2020-Present)

- **Independent Assessment 1915(b) Waiver Program (2020-2021):** Performed an independent assessment of 1915(b) waiver for the Kentucky Medicaid Managed Care Program as required by CMS for renewal of the waiver program. Developed a research design, analyzed the quality, access, and cost-effectiveness of the program over a two-year program period and developed a final report for submission to CMS, which was subsequently approved.
- **1915(i) State Plan Amendment (SPA) (2024-Present):** Supports the 1915(i) cross-agency initiative, which facilitates community-based care for Medicaid-eligible individuals with severe mental illness (SMI) and co-occurring substance use disorders (SUDs). Provide project management services, as well as change management services supporting the design and implementation of services to enhance community participation and treatment access. Also provide technical assistance to support policy development, system integration, and stakeholder training. Our work involves creating communication strategies to increase awareness and engagement, along with monitoring systems to ensure compliance and effectiveness.
- **Children's Waiver Program Restructuring (2024-Present):** Comprehensive review of existing programs, stakeholder engagement, and the design of new models to enhance service delivery for initiative and to develop innovative strategies to ensure children and youth in need of placement receive appropriate care and housing resources. Key activities include identifying service gaps, ensuring alignment with Medicaid guidelines, and restructuring waiver programs to provide a continuum of care. Technical assistance also supports the development of performance metrics to evaluate program outcomes and create sustainability plans.
- **SMI 1115 Demonstration (2024-Present):** Support activities that include the development of community-based care programs, workforce training, and the integration of telehealth services. Technical assistance to support program design, stakeholder collaboration, and the implementation of policy, regulations, protocols, and data-driven performance measures to ensure improved health outcomes.
- **SUD 1115 Demonstration: Recovery Residence (2024-Present):** Program design, policy alignment, and stakeholder training to operationalize recovery residences. Deliverables include guidelines for program management, outreach strategies, and data collection protocols to assess program impact.



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

- **Recuperative Care 1115 Demonstration (2022-Present):** Technical assistance designing recuperative care models, establishing partnerships with community organizations, and integrating services with Medicaid systems. Deliverables include comprehensive implementation plans, evaluation frameworks, and strategies for sustainability and scalability.
- **Reentry 1115 Waiver Demonstration (2023-Present):** Developed DMS Reentry 1115 waiver application submitted in December 2023 and approved by CMS in July 2024. Provide project management and technical assistance services to support DMS with its reentry 1115 demonstration and Consolidated Appropriations Act projects.
- **Transforming Care for the State's Children (2024-Present):** Technical assistance and change management services to guide state leadership in the development and execution of strategic initiatives for this comprehensive, multi-year initiative aimed at enhancing the existing system of care for all Kentucky children, youth, and families.
- **School-Based Behavioral Health Services Enhancement (2024-Present):** Developed and currently supports the CMS-funded school-based services grant application to enhance access to behavioral health services for school-aged children through the implementation of evidence-based care models.
- **Statewide Behavioral Health Needs Assessment (2023-2025):** Conduct comprehensive analysis of Commonwealth's behavioral health system to identify service gaps, unmet needs, and improvement opportunities.
- **Community Co-Response (CCR) Project (2022-Present):** Provide technical assistance, including strategic planning, workforce training, and the development of operational frameworks to develop and implement co-response models where law enforcement and behavioral health specialists work together to respond to crises.
- **Shared Consultant for Targeted Case Management (2022-Present):** Restructure of Medicaid payment models for medically necessary treatment services.
- **CCBHC Demonstration Grant and Quality Measures Consulting (2021-Present):** Supports the Department's CCBHC Demonstration Program implementation, operations, and ongoing policy development with a strong focus on quality and monitoring and oversight activities.
- **Multisystemic Therapy (MST) Pilot Evaluation Consultant (2021-Present):** Conduct an independent evaluation of the MST pilot program.
- **Mobile Crisis Intervention (MCI) Consulting Services (2021-2024):** Project management support, technical assistance, and strategic planning to DMS, supporting the Commonwealth's MCI Planning Grant Project with the goal to expand and strengthen Kentucky's mobile crisis services to better assist those experiencing a behavioral health crisis and divert them from hospitals, jails, and prisons.
- **Community Engagement Waiver (2025):** Supports state legislation passed in 2025 to require mandatory work requirements for able-bodied adults enrolled in Medicaid.

### Impact on Kentucky's Public Health Programs

- Promoted an efficient managed care delivery system for more than 1.2 million Kentuckians.
- Designed a health care delivery system focused on the needs of vulnerable children and youth served through foster care, adoption assistance, and the juvenile justice system.
- Facilitating a high-fidelity model that creates a true continuum of care for Kentucky's children with high needs.
- Created strategies to reduce Kentucky's home and community-based services waiver waitlist for children to connect them with services sooner.
- Helped integrate behavioral health providers and law enforcement to promote treatment over incarceration where appropriate.
- Supported increased payments to providers to recognize quality and improved health outcomes.



Figure 16. Client Profile #3 - Managed Care Oversight: Georgia



## Oversight and Support of Care Management Organizations

Since 2007, Myers & Stauffer has provided oversight of care management organizations (CMOs) for the Georgia Department of Community Health (DCH). The CMOs are the risk-based managed care organizations in Georgia Medicaid that accept risk for Medicaid and Children's Health Insurance Program (CHIP) populations with the exception of individuals who are aged, blind, or disabled and those receiving long-term care services and supports.

### Relevant Services Provided to the State

Myers & Stauffer assists DCH with oversight and monitoring of the Georgia Families CMOs. We assess the policies and procedures of the program and provide oversight and monitoring of Georgia CMOs. This work includes: contract compliance; subcontractor oversight; encounter reconciliation and validation; performance testing; on-site audits; recommendations for process and contractual improvements; financial reconciliations; review of internal controls; medical loss ratio (MLR) audits; and claim repricing.

We also provide DCH with technical assistance to review subcontractor policies and procedures, contracts, systems, and staff, along with information reported by the CMOs, in order to ascertain whether subcontractors conducted a satisfactory level of program integrity activities.

Myers & Stauffer maintains an online report portal where the CMOs provide their daily, weekly, monthly, and annual reports. The portal tracks timely submission and identifies contract compliance issues using automated technology. We have developed online dashboards capturing the information provided in these reports as well as information gathered from submitted encounters. We also support DCH with the submissions of annual Managed Care Program Annual Report, MLR Report, Network Adequacy and Access Assurances Report, and Medicaid Data Collection Tool for Managed Care Reporting to CMS.

Specific services include:

- Monitoring and reporting of health plan compliance with contractual and regulatory provisions.
- On-site financial and performance audits of the CMOs and their significant subcontractors and recommendations for process and contractual improvements.
- Financial reconciliations and MLR audits.
- Consultation with the Medicaid actuaries to provide input during the rate setting process.
- Reviews of internal controls.
- Post-payment review of claims for accuracy and contract compliance.
- Testing for network adequacy and availability and analyses on care management provider directories and appointment wait times.



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

- Research and recommendations regarding the development of policies and procedures related to the CMO program.
- Bi-monthly reconciliation of encounter data submitted by health plans and their delegated vendors to the Medicaid Management Information System vendor to ensure completeness and accuracy.
- Collaboration with DCH's fiscal agent to identify issues with accurately storing and reporting health plan submitted encounter data.
- Recommendations of operational changes to enhance the reliability of encounter data.
- Reconciliation/testing of Affordable Care Act required payment increases for compliance with state/federal statutes.
- Review of International Classification of Diseases, 10th Revision, for readiness and identification of potential red flags to be addressed by the health plan and the Department.
- Post-payment review of claims for accuracy and contract compliance.
- Global analysis of claim payment, denial trends, and other care management performance-related utilization trends.
- Preparation of written and oral reports, including presentations to DCH, the Board of Community Health, and legislative committees.
- Support of onboarding and go-live of four CMOs through development of a Command Center strategy with clear lines of reporting, accountability, and authority across the CMOs and state staff.
- Assistance to DCH with the readiness review of CMOs. Reviews include assessing the CMOs' facility and system integration, member and provider outreach, training, communications, provider network management, and call center operations; determining system readiness for claim processing and timely provider payments; determining readiness to submit encounter claims; assessing subcontractor readiness; and assessing other systems readiness, including benefits coordination, member/provider appeals, utilization review, quality improvement, and reporting.

### **Impact on Georgia's Public Health Programs**

- Recommendations to improve encounter data resolution positively impacted DCH's ability to analyze, manage, and evaluate the program by enhancing accuracy, completeness, and timeliness of the information available to them.
- Enhancement of contractual language and CMO accountability allowed DCH to focus on clear, measurable performance expectations, robust quality monitoring, and assess corrective action plans or liquidated damages for non-compliance. DCH has been more proactive and can identify issues and opportunities for improvement, which allows DCH to anticipate problems and take preventative measures. It facilitates the identification of areas where improvements could be made, ultimately leading to better outcomes for the Georgia Families and Georgia Families 360 programs they manage.
- Readiness reviews for the CMOs and their subcontractors to ensure a smooth and successful implementation of Georgia Families and Georgia Families 360 programs. These reviews focus on key areas like network sufficiency, continuity of care protocols, and the adequacy of claims processing systems to minimize disruptions and provider issues. As part of its contract compliance reviews, we have identified a number of issues, including: inappropriate neonatal intensive care unit payments; inaccurate and untimely encounter data; untimely submission of hospital statistical and reimbursement reports; inaccurate processing and payment of claims; inadequate provider networks and provider directories; and risks and weaknesses in internal controls through on-site audits. DCH uses the findings and recommendations provided in all analyses and reports to ensure the plans are operating in accordance with contractual requirements. Ultimately, our work has helped support better compliance by providing the DCH in-depth insight into program issues.
- Assist with the implementation and assessment of corrective action plans as a result of the findings identified in ongoing monitoring and oversight of the CMO regulatory reports and on-site compliance audits.

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)****References: Managed Care**

We encourage the evaluation committee to contact these references for more information about the project or more detail regarding their experience with Myers & Stauffer.

**References: Managed Care****Kentucky Cabinet for Health and Family Services**

Veronica Judy-Cecil, Senior Deputy Commissioner

PH: 502-564-7042

Email: veronica.judycecil@ky.gov

**Dates of Service:** 2018-Present

**Scope of Work:** Managed Care Consulting Services.

See *Figure 15. Client Profile #2 - Managed Care Oversight and Other Services:* Kentucky for details.

**Georgia Department of Community Health**

Lynette Rhodes, Chief Health Policy Officer

PH: 404-656-7513

Email: LRhodes@dch.ga.gov

**Dates of Service:** 2007-Present

**Scope of Work:** Care Management Analysis and Consulting Managed Care Consulting.

See *Figure 16. Client Profile #3 - Managed Care Oversight:* Georgia for details.

**Maryland Department of Health**

Jennifer Maher, CFO

PH: 410-767-1394

Email: Jennifer.maher@maryland.gov

**Dates of Service:** 2006-Present

**Scope of Work:** Managed Care Audits and Consulting.

Myers & Stauffer provides agreed-upon procedures (AUPs) and related accounting services to ensure that MCO expenditures are in compliance with state and federal laws and regulations. Services include the review of cost data, a detailed claims review, and verification of procedures used by the

**Medicaid Managed Care Actuarial Services**

The Myers & Stauffer Team's actuarial partner, Milliman, has provided actuarial services to public health clients, including state Medicaid and CHIP agencies, for over 30 years with more than 20 states served during that time.

Milliman's staff consists of the highest credentialed Medicaid practice in the country in terms of the number of credentialed actuaries on staff and the level of their education. Key lead actuarial personnel proposed for the BMS contract have achieved the highest level of professional certification available to actuaries in the United States, including fellowship (FSA) in the SOA, as well as membership in the American Academy of Actuaries (MAAA).



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

The Medicaid actuarial space requires a highly unique set of skills that only certain firms can provide. Because only the state's actuary of record can set and certify the rates to be accepted by CMS, the State owns the entire process of setting the rates. Even in a situation when plans may bid rates during the procurement, only the state actuary is able to sign the CMS certification and be responsible for the soundness of the rates. State agencies must choose an actuarial consultant who is not only experienced but also puts the needs of the State at the forefront.

Our proposed lead and staff actuaries have the necessary Medicaid managed care rate setting experience to meet the requirements of this solicitation. While our lead actuaries have Medicaid health plan experience, their expertise is focused on the managed care capitation rate setting process for at least 10 years. Our staff actuaries also specialize in Medicaid managed care rate setting, which exceeds the requirements of this solicitation.

The following list summarizes how our actuarial subcontractor meets and exceeds the requirements to serve as the certifying actuarial vendor for the West Virginia Medicaid programs:

- **Rate Certifications.** Milliman actuaries are qualified and prepared to certify actuarially sound rates for programs receiving federal financial participation (FFP) while incorporating the broad and deep Medicaid managed care experience they have accumulated. They have also set rates for numerous state-only funded programs, and while not reviewed by CMS, they adhere to the same quality standard for those programs as well.
- **Risk Adjustment.** Milliman has extensive experience in developing and applying risk adjustments to Medicaid managed care capitation rates. For acute care rates, they have expertise in developing customized state-specific modeling weights for the Chronic Disability Payment System in several states. Although this is a primary risk adjustment tool in Medicaid, they have experience using a variety of other tools to best meet state needs. In addition, they have developed state-specific behavioral health and LTC risk adjustment tools.
- **Capitated Health Plan Negotiation.** Milliman has a long history of developing constructive partnerships with capitated health plans and state Medicaid agencies to develop rates that are sufficient but not excessive and provide adequate service access and quality. To ensure capitated health plans fully understand the rate setting methodology and assumptions, Milliman, in collaboration with the State, holds both collective and individual meetings with plans prior to rate setting, after draft capitation rates, and to present final results. This approach is best, as it allows prompt submission of rates to CMS and further ensures that all parties are able to follow the capitation rate calculations and understand all data, methodology, and assumptions used in the process. This process leads to fact-based productive dialogue during rate discussions with health plans.
- **Capitated Health Plan Re-Procurement Support.** Milliman has assisted more than 15 state clients in their Medicaid capitated health plan re-procurement efforts. Selecting quality capitated health plans is an important part of administering a Medicaid managed care program to ensure beneficiaries receive quality care in a cost-effective manner. Milliman has supported

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

many states with strategy considerations in designing the procurement structure, as well as structuring the requested information related to capitation rates, provider contracting, managed care savings opportunities, and administrative costs. They assist states with better understanding the information submitted by the capitated health plans, especially in cases where technical information was requested.

- **Supporting Documentation and other Stakeholder Communications.** For all major deliverables, Milliman will provide reports that clearly document the methodology and assumptions used to develop results. Clarity, transparency, and responsiveness are invaluable in establishing trust with capitated health plans and other key stakeholders. For any items needing further clarification or refinement, Milliman has worked with more than 22 states, including West Virginia, to ensure they and the capitated health plans understand the methodology underlying the original or revised results.
- **Evaluating Legislative and Policy Changes.** Milliman is familiar with the legislative cycles that often impact Medicaid rate setting and financial projections and will work with BMS to incorporate new legislative and policy initiatives into the capitation rate development process on a timely basis.
- **Medicaid Policy Analysis.** Milliman actuaries have worked with clients to review and analyze major federal legislation and regulation affecting the Medicaid program and CHIP. They work with clients to understand and implement federal policy changes in the best interest of their programs.
- **Quality.** Milliman is committed to maintaining their national reputation for integrity and high-quality work. They ensure the highest quality results through internal control procedures, resulting in capitation rates that are as accurate as possible for the populations and benefits covered under a Medicaid managed care program. All work is peer reviewed before being submitted to clients. Milliman's actuarial credentialing process goes beyond the SOA, requiring individuals to demonstrate competency through experience, technical knowledge, and high sensitivity to quality before being granted authority to sign deliverables.
- **Collaboration and Training Opportunities.** Milliman provides opportunities for state Medicaid agency clients to discuss issues with one another. They host a live, free State Medicaid Client Forum annually attended by the financial and policy leaders of Milliman's state Medicaid agency clients. Milliman's many Medicaid subject matter experts present with State clients on current issues facing Medicaid programs nationwide and allow state Medicaid agency participants to openly share ideas and concerns. In addition, Milliman often hosts webinars discussing hot topics or recent federal regulation changes.
- **Innovation.** Milliman pursues continuous improvement of the data sources, methodologies, and strategies underlying the rate development services provided to state Medicaid agency clients.
- **Independence.** Milliman is wholly owned and managed by approximately 450 principals that have been elected in recognition of their technical, professional, and business achievements.



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

Their sole business is providing independent consulting services and products to clients. The consultants of the firm are neither permitted to own stock in any insurance or reinsurance company, nor are they allowed to own stock in client organizations. Due to these policies, Milliman, like Myers & Stauffer, provides analyses and opinions that are entirely independent and objective. Most importantly, they are not accountable to public shareholders or investment firms whose sole goal is maximizing profit. Rather, they put clients' needs first as their entire business model depends on their continued satisfaction.



### Exceeding Actuarial Experience Requirements

Milliman exceeds all RFP specifications, currently serving as the prime vendor certifying rates for 19 Medicaid agencies, including 16 for more than 10 years. Milliman has also supported past capitation rate setting projects in Arizona, Iowa, Indiana, and Nevada.

### Proven Experience Means Proven Results

- **Transparency.** Milliman is committed to transparency in the rate setting process with respect to the underlying data, assumptions, and adjustments used in the capitation rate development. They strive for a collaborative relationship with state Medicaid agency clients where Milliman is viewed as a trusted partner. At the same time, they work towards a professional, positive relationship with the contracted capitated health plans with open lines of communication so issues can be identified and addressed proactively. They have found this type of relationship results in productive, fact-based discussions with capitated plans regarding their encounter data, financial data, and questions about the assumptions used in rate development. It is important for the capitated health plans to trust the rate development process and the information they receive from the State's actuary. Milliman often hears from health plans that their level of transparency in rate setting is by far the best in the industry.

Milliman and Myers & Stauffer will continue to work closely together and draw from the expertise of each organization to ensure policy decisions and other technical assistance provided to BMS is highly coordinated between these areas and the rate setting process.

As shown in *Table 6*, our Team will leverage our actuarial knowledge and experience as we offer state-specific solutions. As stated previously, Milliman exceeds all RFP specifications, currently serving as the prime vendor certifying rates for 19 Medicaid agencies, including 16 where we have done so for more than 10 years continuously. We have shaded rows where we meet or exceed the 10 years' experience in the development of capitation rates for Medicaid MCOs.

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

Table 6. Capitation Rate Experience

| <b>Milliman: Capitation Rate Clients</b>                                  |                          |             |                                                |                                           |                               |                                     |
|---------------------------------------------------------------------------|--------------------------|-------------|------------------------------------------------|-------------------------------------------|-------------------------------|-------------------------------------|
| <b>Client</b>                                                             | <b>Contract Duration</b> | <b>Role</b> | <b>Capitation Rate Setting/Risk Adjustment</b> | <b>Similar Program to MHT<sup>1</sup></b> | <b>Waiver Dev and Support</b> | <b>Fee for Service Rate Support</b> |
| AR Dept of Human Services                                                 | 2018-Present             | Prime       | •                                              | •                                         |                               | •                                   |
| AZ Health Care Cost Containment System                                    | 2019-2022                | Prime       | •                                              |                                           |                               |                                     |
| FL Agency for Health Care Administration                                  | 1999-Present             | Prime       | •                                              | •                                         | •                             | •                                   |
| HI Dept of Human Services                                                 | 2005-Present             | Prime       | •                                              | •                                         | •                             | •                                   |
| ID Dept of Health and Welfare                                             | 2010-Present             | Prime       | •                                              |                                           | •                             |                                     |
| IL Dept of Healthcare and Family Services                                 | 1998-Present             | Prime       | •                                              | •                                         | •                             |                                     |
| IA Dept of Human Services                                                 | 2015-2018                | Prime       | •                                              | •                                         | •                             | •                                   |
| IN Family & Social Services Administration                                | 2000-2025                | Prime       | •                                              | •                                         | •                             | •                                   |
| KY Cabinet for Health and Family Services                                 | 2020-Present             | Prime       | •                                              | •                                         | •                             |                                     |
| LA Dept of Health                                                         | 2023-Present             | Prime       | •                                              | •                                         | •                             |                                     |
| MI Dept of Health and Human Services                                      | 1997-Present             | Prime       | •                                              | •                                         | •                             | •                                   |
| MN Dept of Human Services                                                 | 1992-Present             | Prime       | •                                              | •                                         | •                             |                                     |
| MS Division of Medicaid                                                   | 2008-Present             | Prime       | •                                              | •                                         |                               | •                                   |
| NV Dept of Health and Human Services and NV Health Authority <sup>2</sup> | 2002-2020, 2026-Present  | Prime       | •                                              | •                                         | •                             |                                     |
| NH Dept of Health and Human Services                                      | 2013-Present             | Prime       | •                                              | •                                         | •                             | •                                   |
| OH Dept of Medicaid <sup>2</sup>                                          | 2007-2011, 2015-Present  | Prime       | •                                              | •                                         | •                             | •                                   |
| Puerto Rico Dept of Health                                                | 2001-2022, 2026-Present  | Prime       | •                                              | •                                         | •                             | •                                   |
| RI Dept of Human Services                                                 | 2019-Present             | Prime       | •                                              | •                                         |                               |                                     |
| SC Dept of Health and Human Services                                      | 2008-Present             | Prime       | •                                              | •                                         | •                             | •                                   |
| UT Dept of Health and Human Services <sup>2</sup>                         | 2010-Present             | Prime       | •                                              | •                                         |                               | •                                   |
| VT Agency of Human Services                                               | 2012-2020, 2026-Present  | Prime       | •                                              | •                                         | •                             |                                     |
| WA Health Care Authority                                                  | 1996-Present             | Prime       | •                                              | •                                         |                               | •                                   |
| <b>WV Dept of Human Services</b>                                          | <b>2022-Present</b>      | <b>Sub</b>  | ★                                              | ★                                         | ★                             | ★                                   |
| WI Dept of Health Services                                                | 2015-Present             | Prime       | •                                              | •                                         |                               | •                                   |

<sup>1</sup> Indicates a program with nondual populations enrolled similar to MHT (e.g., TANF, SSI, Expansion) covering most physical health services. While we also support capitation rate development for wraparound services, such as dental, nonemergency medical transportation, or stand-alone behavioral health programs, this column indicates certification of the full medical program. <sup>2</sup> Have provided services for more than 10 years. <sup>3</sup> Program similar to MHT (2002-2020).

In addition to the summary information provided above, *Figure 17* and *Figure 18*, provide case summaries of representative actuarial clients to demonstrate our wide-ranging experience in supporting



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

states with not only actuarial rate setting but also with program design, MCO monitoring and oversight, procurement, and implementation activities. Milliman's experience in these areas allows the Myers & Stauffer Team to collectively support BMS in a seamless manner.

Figure 17. Client Profile #4 - Capitation Rate and Actuarial Consulting: Washington



**CLIENT PROFILE:**  
**Washington Health Care Authority**

## Actuarial Consultant Services

Since 1996, Milliman has worked with the Washington Health Care Authority (HCA) on a variety of actuarial and benefits needs throughout the agency that vary in scope and nature. The typical needs and the most impacted agency organizations are described in detail below. The largest work efforts are rate setting for the Apple Health managed care organizations (MCOs) (Medicaid), rate setting for the self-insured Public Employees Benefit Board (PEBB) and School Employees Benefits Board (SEBB) plans, and rate negotiations with the PEBB and SEBB MCOs.

### Relevant Services Provided to the State

#### Actuarial Analysis

Perform actuarial analysis necessary to support Apple Health programs and functions, including:

- On an as-needed basis, perform actuarial analysis and develop recommendations on possible changes to Apple Health program structure, premium subsidy policies and related issues to improve health care quality for Apple Health clients, and overall program cost effectiveness.
- Provide actuarial analysis and evaluation of proposed legislation relating to Apple Health programs to HCA staff and, as needed, staff legislative committees.
- Provide actuarial consulting services for development of capitation rates for Apple Health programs using standard practices, norms, and benchmarks in the health care industry, including the following:
  - Centers for Medicare & Medicaid Services (CMS) certification of rates.
  - Potential benefits and risks associated with each option, including impact on utilization, cost, and coordination of care.
  - Options to improve the quality of health care delivered to Apple Health clients.
  - Improve affordability to the State (i.e., health care purchasing).
- Work and communicate with MCOs to collect and process data, including confirmation of completeness and data integrity.
- Provide actuarial services to promote transparency and access to measures on quality of care, utilization, efficiency measures, and cost projections.
- Assist in developing an overall risk management strategy for Apple Health programs, including methods to manage risk selection associated with offering multiple health insurance products and health plans; geographic, demographic, and health status risk associated with the Apple Health population; and the financial exposure associated with new technologies, procedures, and pharmaceuticals.
- Peer review, as requested, of budget and legislative processes, fiscal notes, legislative mandates, or procurement activities to ensure projections, modeling, and assumptions are reasonable. Identification of areas of concern and sensitivity to brief turnaround requirements are critical.

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

- Provide assistance with meeting preparation and attend, or actively participate in, various HCA technical, strategic planning, or key stakeholder meetings, and legislative hearings.
- Assist in the analysis of medical and pharmaceutical claims/encounter data to cost management targets and assessment of formulary rebate methodologies.
- Assist with declaration responses to legal disputes in collaboration with HCA staff and HCA's Assistant Attorney General.

**Apple Health Contracts**

- Assist the Apple Health management team in evaluation of procurement methodology and approaches.
- Assist in the development of criteria for procuring health plan contracts for Apple Health programs, including criteria weighting as necessary.
- Provide assistance with meeting preparation and attend, or actively participate in the coordination, solicitation, negotiation, or performance review of Apple Health program contracts. Work may include, but is not limited to:
  - Recommend when it is appropriate to solicit proposals from new vendors for contracts supporting the delivery of benefits.
  - Assist in the development and execution of any request for proposal (RFP) or renewal for insured carriers, including development of evaluation criteria, consulting or taking the lead in vendor negotiations, participation in the solicitation selection committee, implementation planning, and stakeholder briefs.
  - Provide advice on vendor contracting, strategic partnerships, and health plan performance improvement strategies, including structuring performance incentives in health plan contracts using qualitative and quantitative performance metrics.
  - Assist with negotiations with health plan vendors on their respective medical rate submissions; identify technical problems; work with vendors to identify and correct assumptions, and negotiate appropriate payment amounts based on Legislative funding, populations served, provider networks, financial experience, and other factors that influence rate development.

**Other HCA Program Actuarial and Financial Consulting**

- Actuarial and financial analysis of selected health services and the Washington State preferred drug list.
- State-only health care programs.
- Utilization analysis.
- Cost benefit analysis.
- Peer review of work performed by HCA staff.
- Health services consulting.
- Market research and trend analysis.
- Communication strategies and activities related to technology assessment, employee wellness, etc.
- Public meeting assistance.





## Impact on Washington's Public Health Programs

Over the past 25 years, worked closely with HCA (including prior agencies supporting this work), to support the development of key HCA programs, including most recently:

- Expansion of managed care to disabled members in the Apple Health program.
- Expansion of managed care to foster care members in the Apple Health program.
- Medicaid expansion through the Affordable Care Act (ACA), including conversion of the Medical Care Services program into the Apple Health program.
- Served a key role in developing the PEBB Accountable Care Program.
- Collaborated with HCA staff, Office of Financial Management, and Legislative staff in the development and implementation of the SEBB program.
- Support for the Washington Cascade Care program.
- Support for the development of 90/180 day civil commitment beds.
- Support for the Safety Net Assessment Fund.
- Developing rate structures to support the investment in primary care, prevention, and health promotion.
- Ongoing evaluation and support of efficient and cost-effective benefit programs.
- Supporting analytics designed to improve outcomes for high-need, high-cost individuals.
- Analyzing payment reform and alignment.
- Furthering the objectives of consistent unit cost evaluation across programs and provider types.
- Aligning the payment methodologies to support community-driven initiatives to improve population health.
- Programs of All-Inclusive Care for the Elderly rate development and support.
- Expansion of Alien Emergency Medical (AEM) to managed care.
- Support for various state initiatives, including re-entry, behavioral health fee schedule development, and Certified Community Behavioral Health Clinic (CCBHC).

Figure 18. Client Profile #5 - Capitation Rate and Actuarial Consulting: Hawai'i



## Actuarial Consultant Services

Milliman has supported the QUEST programs since 2005. This includes the prior QUEST program (without full expansion), Medicaid expansion, QUEST Expanded Access (QExA) with medical and long-term services and supports (LTSS), the conversion of Medicaid and dually eligible members to managed care, development of the Community Care Services (CCS) behavioral health program, and the transition to the QUEST Integration program. Milliman has been able to support these programs addressing the unique challenges in Hawai'i with five managed care organizations (MCOs) with varied mix of enrollment serving a relatively small population.

The scope of work has included the following:

- Develop methodology for the capitated rates.
- Calculate MCO-specific rates for the 1115 waiver.
- Develop behavioral health rates under CCS.
- Develop rates for budget neutrality purposes.
- Develop other carved-out rates as needed by the State.
- Work with the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary on rate approval.
- Reset risk adjustment factors.
- Assist in the development of the medical request for proposal (RFP).
- Calculate risk share settlements.
- Calculate primary care physician enhancement.
- Resolve MCO encounter data issues.
- Attend in-person rate development meetings.
- Payment Transformation Support including directed payments, fee schedules, and States Advancing All-Payer Health Equity Approaches and Development (AHEAD) support.

## Relevant Services Provided to the State

### Actuarial Analysis

Perform actuarial analysis necessary to support QUEST Integration programs and functions.

- Provide actuarial consulting services for development of capitation rates for QUEST Integration programs using standard practices, norms, and benchmarks in the health care industry, including the following:
  - CMS certification of rates.
  - Potential benefits and risks associated with each option, including impact on utilization, cost, and coordination of care.
  - Options to improve the quality of health care delivered to QUEST Integration clients.
- Provide actuarial analysis and evaluation of proposed legislation relating to QUEST Integration programs to Med-QUEST Division (MQD) staff and, as needed, staff legislative committees.



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

- Work and communicate with MCOs to collect and process data, including confirmation of completeness and data integrity.
- Provide actuarial services to promote transparency and access to measures on quality of care, utilization, efficiency measures, and cost projections.
- Assist in developing an overall risk management strategy for QUEST Integration programs, including methods to manage risk selection associated with offering multiple health insurance products and health plans; geographic, demographic, and health status risk associated with the QUEST Integration population; and the financial exposure associated with new technologies, procedures, and pharmaceuticals.
- Directed payment support and payment reform.

### **Impact on Hawai'i's Public Health Programs**

Over the past 20 years, worked closely with MQD to assist in a number of key program changes, including:

- Expansion of managed care to disabled members, including those dually eligible for Medicare.
- Conversion of LTSS services to managed care.
- Medicaid expansion through the Affordable Care Act (ACA).
- Implementation of risk adjustment in QUEST Integration.
- Establishment of risk mitigation programs to better manage the risk between MQD and MCOs, and among MCOs.
- Development of a separate behavioral health program (CCS).
- Current work on payment reform by assisting in a diagnosis-related group conversion.
- Provider tax support.
- Procurement support.
- Financial risk mitigation support.
- Utilization analytics, including Milliman Health Waste Calculator.
- Support of housing support program.
- Supporting Hawai'i in AHEAD program, including global budgets for hospitals.
- Support for current 1115 waiver renewal, including reentry and health-related social needs (HRSN) services.
- Home and community-based services (HCBS) and applied behavior analysis (ABA) fee schedule development, including stakeholdering.

Milliman has been able to transfer institutional knowledge as MQD staff has changed, and has listened intently as MQD shared the future vision of a program to serve the most vulnerable Hawai'ians.

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)****References: Actuarial/Rate Capitation**

We encourage the Evaluation Committee to contact these references for more information about the project or more details regarding their experience with Milliman.

**References: Actuarial/Rate Capitation****Washington Health Care Authority**

**Catrina Lucero, Chief Financial Officer**

**PH: 360-725-0876**

**Email: [catrina.lucero@hca.wa.gov](mailto:catrina.lucero@hca.wa.gov)**

**Dates of Service:** 1996-Present

**Scope of Work:** Milliman has supported Washington's Medicaid program for decades, including managed care rate setting, multiple MCO procurements, FFS to managed care transitions, Medicaid expansion, and statewide integration of physical and behavioral health. Milliman assists the State with data validation and analyses, monitoring of health plan performance, health care trend analyses, capitation rate setting, risk adjustment, CMS documentation, and various policy analyses. See additional information in *Figure 17*.

**Hawai'i Med-QUEST Division**

**Meredith R. Nichols, Med-QUEST Administrator**

**PH: 808-692-8050**

**Email: [mnichols@dhs.hawaii.gov](mailto:mnichols@dhs.hawaii.gov)**

**Dates of Service:** 2005-Present

**Scope of Work:** Working across five MCOs serving a relatively small population, Milliman has assisted Hawai'i with capitated rate methodology and calculation, behavioral health and carve-out rate development, budget neutrality rates, CMS rate approval coordination, risk adjustment, RFP support, risk share and PCP enhancement calculations, encounter data troubleshooting, and payment transformation initiatives including directed payments and AHEAD support. See additional information in *Figure 18*.

**Utah Department of Health and Human Services**

**John Curless, Director, Office of Reimbursement**

**PH: 801-598-1244**

**Email: [jcurless@utah.gov](mailto:jcurless@utah.gov)**

**Dates of Service:** 2012-Present

**Scope of Work:** For more than a decade, Milliman has provided actuarial services to Utah, including managed care rate development, risk adjustment, behavioral health, budget monitoring, waiver support, Medicaid expansion, and analysis supporting state directed payments. Certifications include medical and behavioral health integrated programs, separate medical and behavioral health certifications, dental, CHIP, and high needs programs. In addition to our actuarial work, our consultants have presented to Utah legislative committees, assisted in drafting legislation and regulations, and participated in numerous other committees and task forces regarding the Utah healthcare market.



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)****CMS Certifications (4.3.1.2)**

The vendor should provide documentation to demonstrate its 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.

See *Appendix B: Example Certifications and CMS Communications* for certification examples. These were submitted to CMS meeting the 90-day submission guideline.

Our Team understands the importance of submitting rates to CMS for timely review. CMS tracks the time it takes for states to submit rates as part of its state scorecard available at Medicaid.gov. We have attached the cover page and signature sheet for two certifications that demonstrate compliance with CMS' 90-day submission guideline for two programs similar in scope to MHT. In *Appendix B*, we have also provided documentation from CMS that shows the certifications were confirmed to be submitted to CMS in advance of the 90-day submission. In particular, the email notes that the only states to have successfully submitted the certifications 90 days or more in advance for FFY 2025 were Hawai'i, Indiana, Oregon, Tennessee, and Washington. Of those states, Milliman certified the Hawai'i, Indiana, and Washington rates in FFY 2025.

**Medicaid Provider Rate Development Experience (4.3.1.3)**

The vendor should provide documentation to demonstrate having a minimum of ten (10) years of experience in the development of Medicaid provider rates for institutional and non-institutional provider services. Experience must include a minimum of 10 years of experience in at least three (3) states where the vendor developed Medicaid acuity-based payment rates for hospital and nursing facility services. The vendor should also have experience in at least three (3) states with developing non-institutional provider rates for Home and Community-Based Services (HCBS), Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Certified Community Behavioral Health Clinics (CCBHC), Psychiatric Residential Treatment Facility (PRTF), pharmacy, and fee schedule services. The vendor should be experienced in developing cost reports or cost surveys and designing and performing review procedures to ensure the accuracy and integrity of reported data. Experience designing and performing review procedures under American Institute of Certified Public Accountants (AICPA) standards preferred. Experience must be commensurate with the size and scope of the West Virginia Medicaid program.

**Overview of Rate Setting Experience**

Myers & Stauffer is the premiere rate setting accounting firm for state Medicaid agencies with a team dedicated to public healthcare that provides consulting services related to rate setting, payment methodology design, supplemental payments, DSH reimbursement and audit, cost report development and review, Medicaid financing, UPL, State Plan and rule drafting, claims adjudication review, pay-for-performance (P4P) analysis, and other various analytical and consulting services. Our rate setting and consulting services help states achieve their mission of aligning payment methodologies/policies to promote value, accountability, equity, and efficiency.

Our provider rate setting experience, including program/financial analysis, provides us with insights into the challenges of establishing successful and sustainable reimbursement systems. We are familiar with the regulatory, legislative, fiscal, political, and public relations challenges that states face in evaluating reimbursement systems and undertaking large-scale revisions. In addition, our team routinely works with large datasets and is able to perform detailed analysis and create models that help key program stakeholders and decision-makers to understand the impact of various alternatives.

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

As methodologies have evolved over the years, so has our experience and involvement in assisting agencies in adopting changes to rate setting systems. We have rate setting experience using methodologies based on cost, fee schedules, medians, and service-level approaches, among many others. Our rate setting experience also includes incorporating acuity/case mix methodologies. We have performed rate setting and rate analysis engagements addressing many different categories of healthcare providers. Rate setting areas of expertise include:

- **Inpatient and Outpatient Hospital**, including DRG-based systems and OPSS approaches (APC and enhanced ambulatory patient group [EAPG]) to include grouper software decisions, relative weight calculations, payment modeling and analysis related to calculating base rates and conversion factors, developing policies to address special circumstances in each state, and preparing budget and fiscal impact modeling.
- **Nursing Facilities, ICFs/IID, and Other LTC Facilities**, including prospective cost and price-based reimbursement systems, as well as systems that incorporate acuity adjustment (i.e., RUG and PDPM case mix systems for nursing facilities).
- **HCBS Waiver Services, Cost Report and Reimbursement Methodology Development, Rate Review Studies, and Cost Report Review and Settlement.**
- **Pharmacy Dispensing Fee and Ingredient Reimbursement Systems**, including establishing and maintaining state maximum allowable cost programs and average actual acquisition cost methodology.
- **FQHC and RHC PPS and Cost-Based Methodologies**, including establishing new PPS rates, adjusting existing PPS rates for Medicare Economic Index inflationary increases or due to a change in scope of services, determining Medicaid cost reimbursement and settlements, and performing wraparound payments for managed care environment.
- **Community Mental Health Center (CMHC) Rate Setting and CCBHC Rate Setting.**
- **PRTF Prospective Cost and Price-Based Reimbursement Systems.**
- **ESRD Providers and Physician and Practitioner Reimbursement Systems** including procedural coding, fee schedule maintenance, and coverage policies and procedures.
- **Dental Reimbursement** including maintenance and development of fee schedule, analysis of utilization trends, and analysis of charges and growth factors.



## Exceeding Medicaid Provider Rate Development Experience Requirements

Myers & Stauffer exceeds all RFP specifications, having more than ten years of experience setting rates for hospitals in 10 states and nursing facilities in 22 states. We have also set rates for non-institutional providers in 17 states for more than 10 years.

## Proven Experience Means Proven Results



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

- **Transportation** including basic/advanced life support ambulance, taxi, wheelchair vans, and common carrier analyses, procedure code maintenance, analysis of inflation factors, and fee development.
- **Emergency Ambulance Transportation Supplemental Payment and Provider Assessment Fee Program.**
- **Home Health Services** including retrospective and prospective reimbursement systems.
- **Other Ancillary Medical Services** such as DME, medical supplies, blood factors, and PADs.
- **SPA Assistance.**
- **Medicaid Funding Consulting** includes provider assessments, intergovernmental transfer (IGT), and certified public expenditure (CPE) programs.
- **Development of DSH Payment Methodologies** including State Plan development and the ongoing operation of their DSH payment systems.
- **Value-Based Payment and Pay-For-Performance System** design and monitoring.
- **Medicaid Policy Consulting.**

*Table 7* highlights our current Medicaid rate setting and reimbursement experience. We have shaded rows where we meet or exceed the requirements of 10 years' experience in rate setting for institutional and non-institutional provider types. This includes development of Medicaid acuity-based payment rates for hospitals in 10 states and nursing facilities in more than 22 states. In addition, we have more than 10 years of experience providing rate setting to other provider types in 17 states.

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

Table 7. Medicaid Rate Setting and Reimbursement Services

| <b>Myers &amp; Stauffer: Medicaid Rate Setting and Reimbursement Services</b> |                                       |                   |                                             |                                        |                                       |                          |                                  |                                    |
|-------------------------------------------------------------------------------|---------------------------------------|-------------------|---------------------------------------------|----------------------------------------|---------------------------------------|--------------------------|----------------------------------|------------------------------------|
| <b>State Agency/CMS</b>                                                       | <b>Service Areas/Dates of Service</b> |                   |                                             |                                        |                                       |                          |                                  |                                    |
|                                                                               | <b>Institutional Providers</b>        |                   | <b>Non-Institutional Providers</b>          |                                        |                                       |                          |                                  |                                    |
|                                                                               | <b>IP/OP<br/>Hospital</b>             | <b>NF/ICF/IID</b> | <b>RBRVS/<br/>Professional<br/>Services</b> | <b>DME/Other<br/>Fee<br/>Schedules</b> | <b>FQHC/ RHC/<br/>CCBHC/<br/>PRTF</b> | <b>Pharmacy</b>          | <b>HCBS</b>                      | <b>Value-Based<br/>Initiatives</b> |
| AL Medicaid Agency                                                            |                                       |                   |                                             |                                        | 2025-Present                          | 2008-Present             |                                  |                                    |
| AK Dept of Health                                                             | 2019-Present                          | 2019-2020         | 1997-1998                                   |                                        |                                       | 2011, 2019,<br>2023-2024 | 2007-2008;<br>2012-2021;<br>2026 |                                    |
| AZ Dept of Econ Sec                                                           |                                       |                   |                                             |                                        |                                       |                          | 2024-Present                     | 2015-Present                       |
| AR Dept of Human Svcs                                                         | 2021- Present                         | 2019-Present      |                                             | 2021-Present                           | 2021-Present                          | 1998, 2001,<br>2015      | 2022-Present                     |                                    |
| CA Dept of Health Care Svcs                                                   |                                       | 2025-Present      |                                             |                                        |                                       | 2001, 2007,<br>2011      |                                  | 2025-Present                       |
| CMS                                                                           |                                       |                   |                                             |                                        |                                       | 2011-Present             |                                  |                                    |
| CO Dept of Health Care Policy & Financing <sup>1</sup>                        | 2013-Present                          | 1984-Present      |                                             |                                        | 2013-Present                          | 2016-Present             | 2017-Present                     | 2016-Present                       |
| CT Dept of Social Svcs <sup>1</sup>                                           | 2013-2017                             | 2013-Present      |                                             |                                        |                                       | 2016, 2024               | 2021-2025                        |                                    |
| DE Dept of Health & Human Svcs                                                |                                       |                   |                                             |                                        | 2023-Present                          |                          |                                  |                                    |
| FL Agency for Health Care Admin                                               | 2014-2018                             |                   |                                             |                                        |                                       |                          |                                  |                                    |
| GA Dept of Community Health <sup>1</sup>                                      | 2009-Present                          | 1999-Present      |                                             |                                        | 1999-Present                          | 2018                     |                                  |                                    |
| HI Dept. of Human Svcs <sup>1</sup>                                           | 2007-Present                          | 2007-Present      |                                             |                                        | 2007-Present                          |                          |                                  | 2016-2023                          |
| ID Dept of Health & Welfare <sup>1</sup>                                      | 2020-Present                          | 1992-Present      |                                             |                                        | 2001-Present                          | 2003-Present             | 2016-Present                     | 2019-Present                       |
| IL Dept of Healthcare & Family Svcs                                           | 2020-Present                          | 2020-Present      | 2020-Present                                | 2020-Present                           | 2020-Present                          |                          | 2020-Present                     |                                    |
| IN Family & Social Svcs Admin <sup>1</sup>                                    | 1996-Present                          | 1982-Present      | 1996-Present                                | 1996-Present                           | 1996-Present                          | 2003-Present             | 2009-2021                        | 2011-Present                       |
| IA Dept of Health & Human Svcs <sup>1</sup>                                   | 2004-Present                          | 2004-Present      | 2004-Present                                | 2004-Present                           | 2004-Present                          | 2004-Present             | 2004-Present                     |                                    |
| KS Dept. for Aging & Disability Svcs <sup>1</sup>                             | 2010-2016                             | 1981-Present      | 1994-Present                                |                                        | 2007-Present                          | 2017, 2025               | 2025-2026                        |                                    |



## QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)

| Myers & Stauffer: Medicaid Rate Setting and Reimbursement Services |                                |              |                              |                         |                        |                                |              |                         |
|--------------------------------------------------------------------|--------------------------------|--------------|------------------------------|-------------------------|------------------------|--------------------------------|--------------|-------------------------|
| State Agency/CMS                                                   | Service Areas/Dates of Service |              |                              |                         |                        |                                |              |                         |
|                                                                    | Institutional Providers        |              | Non-Institutional Providers  |                         |                        |                                |              |                         |
|                                                                    | IP/OP Hospital                 | NF/ICF/IID   | RBRVS/ Professional Services | DME/Other Fee Schedules | FQHC/ RHC/ CCBHC/ PRTF | Pharmacy                       | HCBS         | Value-Based Initiatives |
| KY Cabinet for Health & Family Svcs <sup>1</sup>                   | 2009-Present                   | 1998-Present | 2018-Present                 |                         | 2008-Present           | 2012-Present                   |              | 2021-Present            |
| LA Dept of Health <sup>1</sup>                                     |                                | 2001-Present |                              |                         | 2014-Present           | 1999-Present                   |              | 2012-2025               |
| Maine Dept Health & Human Svcs                                     |                                |              | 2016-2017                    |                         |                        | 2016, 2024                     |              |                         |
| MD Dept of Health <sup>1</sup>                                     |                                | 1982-Present |                              |                         | 2007-Present           | 2011-Present                   | 2020-Present |                         |
| Univ of Mass/Mass Health                                           |                                |              |                              | 2022-Present            | 2026-Present           | 2014, 2026                     |              |                         |
| MI Dept of Health & Human Svcs                                     |                                |              |                              |                         | 2021-Present           | 2016                           |              | 2018-2023               |
| MN Dept of Human Svcs                                              | 2022-Present                   |              |                              |                         |                        | 2022-Present                   |              |                         |
| MS Div of Medicaid <sup>1</sup>                                    | 2023-Present                   | 2014-Present | 2023-Present                 | 2023-Present            | 2025-Present           | 2021-2023                      |              | 2023-Present            |
| MO Dept of Social Svcs                                             | 2022-Present                   | 2020-Present |                              |                         |                        |                                |              | 2020-Present            |
| MT Dept of Public Health & Human Svcs <sup>1</sup>                 |                                | 1997-Present |                              |                         | 2025-Present           |                                |              | 2020-Present            |
| NC Dept of Health & Human Svcs                                     | 2002-Present                   | 2004-Present |                              |                         |                        | 2015-Present                   |              |                         |
| ND Dept of Health & Human Svcs                                     | 2021-2023                      |              |                              |                         | 2025-Present           | 2014, 2026                     |              | 2021-Present            |
| NE Dept of Health & Human Svcs <sup>1</sup>                        |                                | 2021-2024    |                              |                         |                        |                                |              |                         |
| NV Dept. of Health & Human Svcs/ NV Health Authority <sup>1</sup>  |                                | 2009-Present |                              |                         | 2010-Present           | 2014                           | 2023         | 2016-2017               |
| New Hampshire                                                      |                                |              |                              |                         |                        | 2014, 2026                     | 2022-2024    | 2017-2020               |
| NJ Dept of Human Svcs <sup>1</sup>                                 | 2004-2014; 2024-Present        | 2010-2014    |                              |                         |                        |                                | 2013         | 2013-2018               |
| NM Health Care Auth <sup>1</sup>                                   | 2006-Present                   | 1993-Present |                              |                         | 2018-Present           |                                |              |                         |
| NY Dept of Health                                                  |                                | 2025-Present |                              |                         |                        |                                | 2026-Present |                         |
| OH Dept of Medicaid <sup>1</sup>                                   | 2026-Present                   | 2019-Present |                              | 2026-Present            |                        | 2014, 2018, 2020, 2022-Present |              |                         |
| OK Health Care Auth <sup>1</sup>                                   |                                | 2016-Present |                              |                         |                        |                                |              |                         |

## QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)

| Myers & Stauffer: Medicaid Rate Setting and Reimbursement Services |                                |                     |                                    |                               |                              |                     |                     |                            |
|--------------------------------------------------------------------|--------------------------------|---------------------|------------------------------------|-------------------------------|------------------------------|---------------------|---------------------|----------------------------|
| State Agency/CMS                                                   | Service Areas/Dates of Service |                     |                                    |                               |                              |                     |                     |                            |
|                                                                    | Institutional Providers        |                     | Non-Institutional Providers        |                               |                              |                     |                     |                            |
|                                                                    | IP/OP<br>Hospital              | NF/ICF/IID          | RBRVS/<br>Professional<br>Services | DME/Other<br>Fee<br>Schedules | FQHC/ RHC/<br>CCBHC/<br>PRTF | Pharmacy            | HCBS                | Value-Based<br>Initiatives |
| Oregon Health Auth                                                 |                                |                     |                                    |                               | 2024-Present                 | 2011-Present        |                     |                            |
| PA Dept of Public Welfare <sup>1</sup>                             | 2021-Present                   | 1992-Present        |                                    |                               |                              |                     |                     |                            |
| RI Office of Health & Human Svcs                                   |                                |                     |                                    |                               |                              | 2014, 2026          |                     |                            |
| SC Dept of Health & Human Svcs                                     |                                | 2018-Present        |                                    |                               | 2022, 2024                   | 2019                |                     |                            |
| SD Dept of Social Svcs                                             | 2020-Present                   | 2019-Present        |                                    |                               | 2025-Present                 | 2019                |                     | 2019; 2026-<br>Present     |
| TN TennCare <sup>1</sup>                                           |                                | 2012-Present        |                                    |                               | 2022-Present                 | 2018-2023           |                     | 2018-Present               |
| TX Health & Human Svcs Comm                                        |                                |                     |                                    |                               |                              | 2002, 2013,<br>2016 |                     | 2014-2018;<br>2020-2023    |
| UT Dept of Health & Human Svcs                                     | 2021-Present                   |                     |                                    |                               | 2023-Present                 | 2019-Present        | 2020-Present        |                            |
| VT Health Access                                                   | 2026-Present                   | 2020-Present        | 2026-Present                       | 2026-Present                  | 2026-Present                 | 2026-Present        |                     | 2026-Present               |
| VA Dept of Medical Assistance<br>Svcs <sup>1</sup>                 | 1993-Present                   | 1993-Present        |                                    |                               | 1993-Present                 | 2014, 2019,<br>2024 |                     |                            |
| WA Health Care Auth                                                |                                |                     |                                    |                               |                              | 2024                |                     | 2016-2023                  |
| <b>WV PEIA/ BMS</b>                                                | <b>2001-Present</b>            | <b>2022-Present</b> | <b>2001-Present</b>                | <b>2024-Present</b>           | <b>2023-Present</b>          | <b>2026</b>         | <b>2023-Present</b> | <b>2024-Present</b>        |
| WI Dept of Health Svcs                                             |                                | 2021-Present        |                                    |                               |                              |                     |                     |                            |
| WY Dept of Health <sup>1</sup>                                     |                                | 1988-Present        |                                    |                               |                              |                     |                     |                            |

**CCBHC:** Certified Community Behavioral Health Clinic; **DME:** Durable Medical Equipment; **FQHC:** Federally Qualified Health Center; **HCBS:** Home and Community-Based Svcs; **ICF/IID:** Intermediate Care Facility for Individuals with Intellectual Disabilities; **IP/OP:** Inpatient/Outpatient; **NF:** Nursing Facility; **PRTF:** Psychiatric Residential Treatment Facility; **RBRVS:** Resource-Based Relative Value Scale; **RHC:** Rural Health Clinic

<sup>1</sup>Have provided hospital and/or nursing facility rate setting services for more than 10 years.



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

## Hospital Rate Setting Experience

Myers & Stauffer is the ideal candidate to provide rate analysis and reimbursement services for BMS. We represent the highest level of technical experience providing the services requested in this RFP. Our team supports more state Medicaid programs with hospital reimbursement than any other vendor.

We understand this SOW will require the successful bidder to possess a unique set of skills, and we are confident that our qualifications will provide the greatest benefits for BMS. We have been assisting our Medicaid state clients with inpatient and outpatient hospital reimbursement methodology development, rate setting, and policy since the 1990s. We have supported 23 states, including West Virginia, in the development, implementation, modification, and ongoing updates to DRG-based systems for inpatient hospital services and OPPI (APC and EAPG) approaches for outpatient hospital reimbursement, and also were recently awarded hospital reimbursement contracts in two additional states. We help states determine inpatient base rates and outpatient conversion factors, estimate claim cost, calculate CCRs, establish state-specific relative weights or adopt national relative weights, calculate per diem rates, prepare payment simulation calculations for fiscal modeling, calculate cost coverage, monitor and update rates post-implementation, assist with stakeholder engagement activities, and provide support for the MMIS vendor and Medicaid MCO rate loads and claim payments.

Our team knows cost reporting, how to analyze cost data, and how to apply that data for rate setting and benchmarking. We also assist states in a number of other related activities, including incorporating cost data for rate setting and benchmarking, supporting P4P programs, preparing UPL demonstrations, calculating provider assessments, engaging with providers and other stakeholders, developing communication materials, conducting training sessions, preparing SPAs, drafting regulations, and supporting states in discussions with CMS. Our services include:

- Evaluation of reimbursement systems, policy options, cost drivers, and grouper/classification types and versions.
- Extensive experience with inpatient and outpatient grouping and classification systems and software. We are a working partner with Solventum Health Information Systems, the developer of most grouper systems in use in the United States and have experience with all three of the inpatient grouper types in use by state Medicaid programs (APR-DRG, MS-DRG, and TRICARE), as



## Focus on Quality Plus Innovation

Our large-scale rate setting contracts with states such as West Virginia, Connecticut, Idaho, Indiana, Iowa, Kentucky, Mississippi, Nevada, Ohio, and Virginia demonstrate that we are large enough to meet our clients' needs yet structured in a manner that affords our professionals the flexibility to design customized solutions. We manage this complexity within an environment where error can have serious consequence to healthcare outcomes, financial performance, and program integrity. Our focus on ensuring quality while developing innovative solutions designed for efficiency has proven to be a valuable combination for our clients.

### Customized Solutions

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

well as the outpatient EAPG and Medicare-based APC system. We work with other Solventum tools, including Solventum quality products, and provide statistical analysis based on potentially preventable events.

- Efficiently handling large, multidimension relational databases of financial and cost data.
- Calculating inpatient base rates, outpatient conversion factors, relative weights, and related statistics that reflect current care trends.
- Modeling policy adjusters based on age, category of services, or hospital.
- Preparing case mix indices (CMIs) and other statistics for rebasing.
- Providing reimbursement system recommendations and payment values, including outlier payment, CCRs, GME/indirect medical education, transfers, and other payment add-ons.
- Payment strategies and rates related to the treatment of specific types of services or stays, such as psychiatric, rehabilitation, LTAC, alternate level of care (awaiting placement), transplants, long-acting reversible contraception, etc.
- Designing and implementing OPPS methodologies based on the Medicare APC and EAPG reimbursement structures.
- Preparing payment simulations, calculating budget and fiscal impact models, and analyzing cost coverage.
- Assisting with implementation issues and confirmation that the MMIS calculates reimbursement in accordance with policy.
- Supporting stakeholder engagement, executive and/or legislative presentations, and industry communications and reference materials, including Excel-based rate calculators.
- Preparation and support for SPAs and administrative rule changes.
- Reimbursement system maintenance and evaluations.

Table 8 illustrates a high-level summary of services for our hospital engagements. Our team has arguably the most significant direct experience in the country with hospital rate setting for state Medicaid agencies.

Table 8. Hospital Rate Setting

| Myers & Stauffer: Hospital Rate Setting Experience |     |               |                                  |                                 |                           |                                                          |                      |                                   |                               |
|----------------------------------------------------|-----|---------------|----------------------------------|---------------------------------|---------------------------|----------------------------------------------------------|----------------------|-----------------------------------|-------------------------------|
| Medicaid Agency                                    | DRG | OPPS APC/EAPG | Calc Base Rates/CCRs/Other Rates | State-Specific Relative Weights | National Relative Weights | Payment Simulations/Fiscal Impact/Cost Coverage Analyses | Monitor/Update Rates | Stakeholder Engagement Activities | Fiscal Agent Support for MMIS |
| Alaska <sup>1</sup>                                | •   |               | •                                |                                 | •                         | •                                                        | •                    | •                                 | •                             |
| Colorado <sup>1</sup>                              | •   |               | •                                |                                 |                           | •                                                        |                      | •                                 | •                             |



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| <b>Myers &amp; Stauffer: Hospital Rate Setting Experience</b> |            |                      |                                           |                                        |                                  |                                                                  |                              |                                          |                                      |
|---------------------------------------------------------------|------------|----------------------|-------------------------------------------|----------------------------------------|----------------------------------|------------------------------------------------------------------|------------------------------|------------------------------------------|--------------------------------------|
| <b>Medicaid Agency</b>                                        | <b>DRG</b> | <b>OPPS APC/EAPG</b> | <b>Calc Base Rates/ CCRs/ Other Rates</b> | <b>State-Specific Relative Weights</b> | <b>National Relative Weights</b> | <b>Payment Simulations/ Fiscal Impact/Cost Coverage Analyses</b> | <b>Monitor/ Update Rates</b> | <b>Stakeholder Engagement Activities</b> | <b>Fiscal Agent Support for MMIS</b> |
| Connecticut                                                   | •          | •                    | •                                         |                                        | •                                | •                                                                | •                            | •                                        | •                                    |
| Georgia <sup>1</sup>                                          | •          | •                    | •                                         | •                                      |                                  | •                                                                | •                            | •                                        | •                                    |
| Idaho <sup>1</sup>                                            | •          | •                    | •                                         |                                        | •                                | •                                                                | •                            | •                                        | •                                    |
| Illinois <sup>1</sup>                                         | •          | •                    | •                                         |                                        | •                                | •                                                                | •                            | •                                        |                                      |
| Indiana <sup>1</sup>                                          | •          | •                    | •                                         | •                                      |                                  | •                                                                | •                            | •                                        | •                                    |
| Iowa <sup>1</sup>                                             | •          | •                    | •                                         | •                                      |                                  | •                                                                | •                            | •                                        | •                                    |
| Kansas                                                        | •          |                      | •                                         | •                                      |                                  | •                                                                | •                            |                                          | •                                    |
| Kentucky <sup>1</sup>                                         | •          | •                    | •                                         |                                        | •                                | •                                                                | •                            | •                                        | •                                    |
| Minnesota <sup>1</sup>                                        | •          |                      | •                                         |                                        | •                                | •                                                                | •                            |                                          |                                      |
| Mississippi <sup>1</sup>                                      | •          | •                    | •                                         |                                        | •                                | •                                                                | •                            | •                                        | •                                    |
| Missouri <sup>1</sup>                                         | •          |                      | •                                         |                                        | •                                | •                                                                |                              | •                                        | •                                    |
| New Jersey <sup>1</sup>                                       | •          |                      | •                                         | •                                      |                                  | •                                                                | •                            | •                                        |                                      |
| New Mexico <sup>1</sup>                                       | •          |                      | •                                         | •                                      |                                  | •                                                                | •                            | •                                        |                                      |
| N. Carolina <sup>1</sup>                                      | •          |                      | •                                         | •                                      |                                  | •                                                                | •                            | •                                        | •                                    |
| N. Dakota                                                     | •          | •                    | •                                         |                                        | •                                | •                                                                |                              |                                          |                                      |
| Ohio <sup>1</sup>                                             | •          | •                    | •                                         | •                                      |                                  | •                                                                | •                            | •                                        | •                                    |
| Pennsylvania <sup>1</sup>                                     | •          |                      | •                                         |                                        | •                                |                                                                  |                              |                                          |                                      |
| S. Dakota <sup>1</sup>                                        | •          | •                    | •                                         |                                        | •                                | •                                                                |                              | •                                        | •                                    |
| Utah <sup>1</sup>                                             | •          |                      | •                                         |                                        |                                  |                                                                  | •                            | •                                        |                                      |
| Vermont <sup>1</sup>                                          | •          | •                    | •                                         |                                        | •                                | •                                                                | •                            | •                                        | •                                    |
| Virginia <sup>1</sup>                                         | •          | •                    | •                                         | •                                      |                                  | •                                                                | •                            | •                                        | •                                    |
| <b>W. Virginia<sup>1</sup></b>                                | <b>★</b>   | <b>★</b>             | <b>★</b>                                  | <b>★</b>                               |                                  | <b>★</b>                                                         | <b>★</b>                     | <b>★</b>                                 | <b>★</b>                             |

<sup>1</sup> Active Myers & Stauffer contract.

## Nursing Facility Rate Setting Experience

Myers & Stauffer's knowledge and experience in the Medicaid nursing facility environment is unmatched. Our firm's nursing facility rate setting support and MDS work dates back to the late 1980s when we served as the Kansas Medicaid agency management contractor for the federal Multistate Nursing Home Case Mix and Quality Demonstration. Since that time, we have assisted states with ensuring access to care for higher need residents through implementing acuity-based reimbursement systems, maintaining those systems through changes in resident classification systems (RUG-III/RUG-IV/PDPM) and MDS data structure changes (MDS 2.0 to 3.0), providing oversight of provider MDS assessment submissions, consulting on special population reimbursement issues, and navigating federal and state regulatory changes.

We have worked with more than 25 Medicaid agencies, including BMS, providing nursing facility rate setting, MDS assessment processing and review, consulting, UPL demonstration calculation, provider assessment/tax modeling and optimization, and other administrative services. Our experience includes development of reimbursement systems, establishing and defending reimbursement rates, ongoing MDS data processing and CMI calculations, completing MDS assessment exception reviews, evaluating

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modifications to resident classification systems (RUG-based and PDPM-based), preparing UPL demonstrations with cost- and payment-based methodologies, developing and maintaining cost reporting instruments, developing and maintaining protected health information-secure, web-based platforms for provider submissions and communications, performing cost report audits, and a diverse mix of other consulting services. We also assist our clients with cost and rate database design and perform data management and analysis services. This helps our clients better integrate rate setting activities and ongoing fiscal monitoring for state budgetary implications and current trends in provider costs and cost reporting.

Our nationwide nursing facility experience includes the following:

- **Nursing Facility Rate Setting and MDS Data Processing.** Myers & Stauffer is the national leader in nursing facility acuity-based (case mix) rate setting system consulting and support. Our services include the development and maintenance of rate setting systems, evaluation of PDPM-based acuity systems, regulatory and sub-regulatory language development, and daily processing of large quantities of MDS data to support these systems and provide reporting to the State and provider communities.
- **MDS Assessment Exception Reviews.** Our firm essentially created this review protocol for state Medicaid agencies across the country. Since the implementation of acuity-based rate setting for nursing facilities in the late 1990s, we have been assisting states to ensure the accuracy and integrity of the acuity information used for rate setting.
- **Development and Evaluation of Nursing Facility Quality Programs and Payment Initiatives.** Myers & Stauffer has assisted several states with implementing, maintaining, and evaluating nursing facility VBP and/or P4P programs. We have extensive experience using publicly available CMS measures, payroll-based journal staffing information, and state-specific data collection to implement and operationalize quality incentive programs.
- **Medicaid Financing Initiatives.** Our firm provides subject matter expertise and demonstration calculation support related to the implementation and modification of state provider assessment (tax) programs, CPE programs, or IGT programs. These programs help states leverage FFP to ensure sufficient funding exists to operate the Medicaid program and that sufficient and appropriate reimbursement remains for service providers.
- **Nursing Facility Desk Review and Audit Services.** As a CPA firm, Myers & Stauffer provides desk review and audit services to state Medicaid programs across the country. For nursing facility providers, we support several state oversight efforts to review provider cost reports to ensure appropriate classification and allowability of expenditures in line with federal and state-specific regulations, as well as appropriate reporting and allocation of home office expenditures and related-party transactions.

*Table 9* provides an overview of our current national nursing facility reimbursement experience.



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Table 9. National Nursing Facility Reimbursement Experience

| <b>Myers &amp; Stauffer: National Nursing Facility Reimbursement Experience</b> |                                                                                                |   |   |   |   |   |   |                                     |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---|---|---|---|---|---|-------------------------------------|
| <b>State/Agency</b>                                                             | <b>Services Provided</b>                                                                       |   |   |   |   |   |   |                                     |
|                                                                                 | <b>Process MDS Resident Acuity Data</b>                                                        |   |   |   |   |   |   |                                     |
|                                                                                 | <b>Rate Setting and Reimbursement Model Design</b>                                             |   |   |   |   |   |   |                                     |
|                                                                                 | <b>Financial Analysis/Modeling</b>                                                             |   |   |   |   |   |   |                                     |
|                                                                                 | <b>Medicare UPL Demonstration Calculations</b>                                                 |   |   |   |   |   |   |                                     |
|                                                                                 | <b>MDS Data Verification or Consult on Review Process</b>                                      |   |   |   |   |   |   |                                     |
|                                                                                 | <b>PDPM or System Evaluation/Consulting</b>                                                    |   |   |   |   |   |   |                                     |
|                                                                                 | <b>Provider Training: MDS/Resident Assessment Instrument Manual/ Reimbursement Methodology</b> |   |   |   |   |   |   | <b>Cost Report Audit and Review</b> |
|                                                                                 |                                                                                                |   |   |   |   |   |   |                                     |
| AK Dept of Health and Social Services                                           |                                                                                                |   |   | • |   |   |   |                                     |
| AR Dept of Human Services <sup>1</sup>                                          | •                                                                                              |   |   | • |   |   |   | •                                   |
| CA Department of Health Care Services <sup>1</sup>                              |                                                                                                | • | • |   |   | • |   |                                     |
| CO Dept of Health Care Policy & Financing <sup>1</sup>                          | •                                                                                              | • | • | • | • | • | • | •                                   |
| CT Dept of Social Services <sup>1</sup>                                         | •                                                                                              | • | • | • | • | • | • | •                                   |
| FL Agency for Health Care Administration <sup>1</sup>                           | •                                                                                              |   |   |   |   |   |   | •                                   |
| GA Dept of Community Health <sup>1</sup>                                        | •                                                                                              | • | • | • |   | • |   | •                                   |
| HI Dept of Human Services <sup>1</sup>                                          | •                                                                                              | • | • | • |   | • |   |                                     |
| ID Dept of Health and Welfare <sup>1</sup>                                      | •                                                                                              | • | • | • |   | • |   | •                                   |
| IL Dept of Healthcare and Family Services <sup>1</sup>                          |                                                                                                | • | • |   |   | • |   |                                     |
| IN Family and Social Services Administration <sup>1</sup>                       | •                                                                                              | • | • | • | • | • | • | •                                   |
| IA Dept of Human Services <sup>1</sup>                                          | •                                                                                              | • | • | • |   | • |   | •                                   |
| KS Dept for Aging and Disability Services <sup>1</sup>                          | •                                                                                              | • | • | • | • | • | • | •                                   |
| KY Cabinet for Health and Family Services <sup>1</sup>                          | •                                                                                              | • | • | • | • | • | • |                                     |
| LA Dept of Health <sup>1</sup>                                                  | •                                                                                              | • | • | • | • | • | • |                                     |
| MD Dept of Health <sup>1</sup>                                                  | •                                                                                              | • | • | • | • | • | • | •                                   |
| MS Division of Medicaid <sup>1</sup>                                            | •                                                                                              | • | • | • | • | • | • | •                                   |
| MO Dept of Social Services <sup>1</sup>                                         | •                                                                                              | • | • | • | • | • |   | •                                   |
| MT Dept of Public Health and Human Services <sup>1</sup>                        | •                                                                                              | • | • | • |   |   |   |                                     |
| NE Dept of Health and Human Services                                            |                                                                                                | • | • |   |   | • |   | •                                   |
| NV Dept of Health and Human Services <sup>1</sup>                               | •                                                                                              | • | • | • | • | • | • | •                                   |
| NJ Dept of Human Services                                                       |                                                                                                |   |   | • |   |   |   |                                     |
| NM Health Care Authority <sup>1</sup>                                           |                                                                                                | • | • | • |   |   |   | •                                   |
| NC Dept of Health and Human Services <sup>1</sup>                               | •                                                                                              | • | • | • | • | • | • | •                                   |
| NY State Dept of Health <sup>1</sup>                                            |                                                                                                | • | • |   |   | • | • |                                     |
| OH Dept of Medicaid <sup>1</sup>                                                | •                                                                                              | • | • | • | • | • | • |                                     |
| PA Dept of Public Welfare <sup>1</sup>                                          | •                                                                                              | • | • | • |   | • | • |                                     |
| SD Dept of Social Services <sup>1</sup>                                         | •                                                                                              | • | • | • |   | • |   |                                     |
| TN Bureau of TennCare <sup>1</sup>                                              | •                                                                                              | • | • |   | • | • | • |                                     |
| VA Dept of Medical Assistance Services <sup>1</sup>                             |                                                                                                |   |   | • |   |   |   | •                                   |
| VT Dept of Vermont Health Access <sup>1</sup>                                   | •                                                                                              | • | • |   |   | • | • |                                     |

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

| <b>Myers &amp; Stauffer: National Nursing Facility Reimbursement Experience</b> |                                                                                         |   |   |   |  |   |                              |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---|---|---|--|---|------------------------------|
| State/Agency                                                                    | Services Provided                                                                       |   |   |   |  |   |                              |
|                                                                                 | Process MDS Resident Acuity Data                                                        |   |   |   |  |   |                              |
|                                                                                 | Rate Setting and Reimbursement Model Design                                             |   |   |   |  |   |                              |
|                                                                                 | Financial Analysis/Modeling                                                             |   |   |   |  |   |                              |
|                                                                                 | Medicare UPL Demonstration Calculations                                                 |   |   |   |  |   |                              |
|                                                                                 | MDS Data Verification or Consult on Review Process                                      |   |   |   |  |   |                              |
|                                                                                 | PDPM or System Evaluation/Consulting                                                    |   |   |   |  |   |                              |
|                                                                                 | Provider Training: MDS/Resident Assessment Instrument Manual/ Reimbursement Methodology |   |   |   |  |   |                              |
|                                                                                 |                                                                                         |   |   |   |  |   | Cost Report Audit and Review |
| WV Dept of Human Services <sup>1</sup>                                          |                                                                                         | ★ | ★ | ★ |  | ★ |                              |
| WY Dept of Health <sup>1</sup>                                                  | •                                                                                       | • | • | • |  | • |                              |

<sup>1</sup> Current contracts.

## Noninstitutional Provider Rate Setting Experience

Our Team has significant experience related to noninstitutional rate setting, payment methods, service and utilization examination, and analytics (see *Table 7. Medicaid Rate Setting and Reimbursement Services*). We have experience with a wide range of noninstitutional reimbursement structures and rate setting methods at the provider level (e.g., FQHC, RHC, CCBHC, PRTF, and numerous others), as well as procedure coding systems and fee schedule reimbursement based on those systems. This includes CPT, HCPCS, and Current Dental Terminology systems. We support multiple states with fee schedule rate setting for a wide range of services and have a thorough understanding of procedure coding, modifiers and their impacts, and other aspects of fee schedule programs.

Drawing upon this experience, we can assist BMS with noninstitutional reimbursement policies, reimbursement systems, and rate setting services that meet the programmatic goals of the State. Our approach to developing or updating Medicaid noninstitutional rates entails reviewing current Medicaid reimbursement methodologies and fee schedules and developing an understanding of the environment relating to the maintenance and updates to the rates or fee schedules, including the State's objectives and provider and member needs. The process of updating noninstitutional rates typically involves evaluating available data sources for rate updates, obtaining data from available data sources, potentially surveying other states, collecting cost or charge data, analyzing claims, developing a financial model, computing revised fee schedule rates, calculating fiscal impact estimates, reviewing with the client, and upon approval, communicating revised rates to various stakeholders, such as the State's fiscal agent, MCOs (if applicable), and providers.

We will review current reimbursement regulations, policies, methodologies, and payments made under those methodologies, assist BMS in updating noninstitutional rates, and, if desired, modifications to the reimbursement programs that follow national trends. Any proposed reimbursement systems will include fiscal impact models so that BMS can evaluate the impact on both the state and other interested stakeholders. We will be available for regular consultation with BMS staff to support the development and implementation of updated noninstitutional rates. Services with Medicare rates, fee schedules, and policies, including relevant proposed and final rules, will be analyzed for updates or changes.



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)****References: Rate Setting**

We encourage the Evaluation Committee to contact these references for more information about the project or more details regarding their experience with Myers & Stauffer.

**References: Rate Setting****Iowa Department of Human Services**

Kathy Harper, Executive Officer 2

PH: 515-321-7686

Email: kathy.harper@hhs.iowa.gov

**Dates of Service:** 2004-Present

**Scope of Work:** Rate Setting and Consulting

Myers & Stauffer provides rate setting for providers including nursing facilities, ICF/IID, residential care facilities, home and community-based waiver providers, targeted case management, adult rehabilitation option, FQHC, home health, RHC, psychiatric medical institutions for children, critical access hospitals, acute psychiatric hospitals, and general acute care hospitals, as well as determining other calculations such as UPLs, supplemental payments, and reimbursement for drugs.

**Kentucky Cabinet for Health and Family Services**

Amy Richardson, Director

PH: 502-564-4321

Email: Amy.richardson@ky.gov

**Dates of Service:** 1998-Present

**Scope of Work:** Rate setting and Consulting

Myers & Stauffer provides rate setting and consulting for hospitals (freestanding psychiatry, rehabilitation, distinct part unit, LTAC, inpatient and outpatient), LTC facilities, ICF/IID, FQHCs, RHCs, CMHCs, and hospice. Includes requesting, receiving, and tracking cost reports for various provider types and tracking data with the Medicaid Rate Setting Information System, a computer program designed to track the due dates for provider cost reports, store the cost report data, and calculate the rates. Also perform hospital outpatient cost report reviews and related settlement calculations.

**Indiana Family & Social Services Administration**

Kathy Leonard, Director of Reimbursement and Actuary

PH: 317-233-9282

Email: Kathleen.Leonard@fssa.IN.gov

**Dates of Service:** 2008-Present

**Scope of Work:** Rate Setting and Reimbursement Methodology Consulting

Myers & Stauffer provides rate setting, reimbursement methodology consulting, fiscal impact analysis, UPL and supplemental payment analysis, provider tax calculations, and other consulting services for numerous provider categories, including nursing facilities, hospitals, home health agencies, hospice providers, physicians, FQHCs, RHCs, transportation, and other ambulatory provider services. The project involves calculating rates based on data sources including provider cost reports and claims data.

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

## Cost Report Experience

### Cost Report Analysis

States undertake cost collection activities to calculate cost settlements, evaluate their rate structures and payment levels, and develop new methodologies and rates. States also use cost reports to collect not only cost data but also other information that supports the calculation of rates for each unit of service. Cost reports usually capture all direct and indirect costs, and states may elect to capture other important information such as staffing ratios, staff turnover rates, hourly wage rates, and census or encounter data.

States typically have three sources for collecting cost data for cost-based reimbursement:

- Medicare cost report.
- Medicaid-specific cost report or cost survey.
- Hybrid of the above.

Our team knows cost reporting and analysis. We handle nearly 13,000 healthcare provider cost reports annually as indicated in *Table 10*. This table illustrates our approximate annual cost reports collected for use in various functions such as rate calculations, rate modeling, audits, UPLs, cost settlements, and cost coverage calculations. Our cost report analysis experience is extensive and spans more than four decades. Our ability to audit, perform desk reviews, prepare cost report tools, and analyze cost report information on behalf of our Medicaid agency clients has long been a strength of Myers & Stauffer.

Table 10. Cost Reports Processed Annually

| <b>Myers &amp; Stauffer: Approximate Provider Cost Reports<br/>Processed Annually for State Medicaid Clients</b> |                    |                      |                  |                      |            |                         |              |             |             |              |              |
|------------------------------------------------------------------------------------------------------------------|--------------------|----------------------|------------------|----------------------|------------|-------------------------|--------------|-------------|-------------|--------------|--------------|
| <b>State Medicaid<br/>Agency</b>                                                                                 | <b>SNF/<br/>NF</b> | <b>ICFs/<br/>IID</b> | <b>Hospitals</b> | <b>FQHC/<br/>RHC</b> | <b>HHA</b> | <b>Clinic/<br/>CMHC</b> | <b>EPSDT</b> | <b>GEMT</b> | <b>HCBS</b> | <b>Other</b> | <b>Total</b> |
| Arkansas                                                                                                         | 220                | 50                   | 150              | 13                   | -          | -                       | -            | -           | -           | -            | <b>433</b>   |
| Colorado                                                                                                         | 189                | 3                    | -                | 61                   | 8          | 25                      | -            | -           | 2           | 2            | <b>290</b>   |
| Connecticut                                                                                                      | 189                | 67                   | -                | 20                   | 90         | -                       | -            | -           | -           | 1            | <b>367</b>   |
| Delaware                                                                                                         | 12                 | -                    | -                | -                    | -          | -                       | -            | -           | -           | -            | <b>12</b>    |
| District of<br>Columbia                                                                                          | -                  | 23                   | 3                | 8                    | 15         | 1                       | -            | -           | 12          | 17           | <b>79</b>    |
| Florida                                                                                                          | 212                | -                    | 3                | -                    | -          | -                       | -            | 88          | -           | -            | <b>303</b>   |
| Georgia                                                                                                          | 350                | -                    | 152              | -                    | -          | -                       | -            | -           | -           | 105          | <b>607</b>   |
| Hawai'i                                                                                                          | 33                 | 3                    | 24               | -                    | -          | -                       | -            | -           | -           | -            | <b>60</b>    |
| Idaho                                                                                                            | 74                 | 40                   | 91               | 17                   | 47         | -                       | -            | -           | 25          | 2            | <b>296</b>   |
| Indiana                                                                                                          | 514                | 441                  | 172              | 39                   | -          | 32                      | -            | 90          | -           | 10           | <b>1,298</b> |
| Iowa                                                                                                             | 424                | 89                   | 190              | 504                  | -          | 4                       | 31           | 80          | 226         | 18           | <b>1,566</b> |
| Kentucky                                                                                                         | 322                | 11                   | 335              | 15                   | 8          | 26                      | -            | 55          | 9           | 18           | <b>799</b>   |
| Louisiana                                                                                                        | 250                | 650                  | -                | -                    | -          | -                       | -            | -           | 700         | 5            | <b>1,605</b> |
| Maryland                                                                                                         | 218                | 2                    | 13               | 9                    | -          | -                       | 2            | 19          | -           | 41           | <b>304</b>   |
| Minnesota*                                                                                                       | -                  | -                    | 146              | -                    | -          | -                       | -            | -           | -           | -            | <b>146</b>   |



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| <b>Myers &amp; Stauffer: Approximate Provider Cost Reports<br/>Processed Annually for State Medicaid Clients</b> |                    |                      |                  |                      |            |                         |              |             |             |              |               |
|------------------------------------------------------------------------------------------------------------------|--------------------|----------------------|------------------|----------------------|------------|-------------------------|--------------|-------------|-------------|--------------|---------------|
| <b>State Medicaid Agency</b>                                                                                     | <b>SNF/<br/>NF</b> | <b>ICFs/<br/>IID</b> | <b>Hospitals</b> | <b>FQHC/<br/>RHC</b> | <b>HHA</b> | <b>Clinic/<br/>CMHC</b> | <b>EPSDT</b> | <b>GEMT</b> | <b>HCBS</b> | <b>Other</b> | <b>Total</b>  |
| Missouri                                                                                                         | 476                | -                    | 140              | -                    | -          | -                       | -            | 70          | -           | -            | <b>686</b>    |
| Mississippi                                                                                                      | 50                 | -                    | -                | -                    | -          | -                       | -            | -           | -           | -            | <b>50</b>     |
| Montana                                                                                                          | 57                 | -                    | -                | -                    | -          | -                       | -            | -           | -           | -            | <b>57</b>     |
| Nebraska                                                                                                         | 193                | 20                   | -                | -                    | -          | -                       | -            | -           | -           | -            | <b>213</b>    |
| Nevada                                                                                                           | 51                 | 8                    | 13               | 6                    | -          | -                       | -            | 21          | -           | 15           | <b>114</b>    |
| New Hampshire                                                                                                    | -                  | -                    | 29               | -                    | -          | -                       | -            | -           | -           | -            | <b>29</b>     |
| New Jersey                                                                                                       | -                  | -                    | 86               | -                    | -          | -                       | -            | -           | -           | -            | <b>86</b>     |
| New Mexico                                                                                                       | 68                 | 39                   | 47               | -                    | 14         | -                       | -            | 11          | -           | -            | <b>179</b>    |
| N. Carolina                                                                                                      | 61                 | -                    | 66               | -                    | -          | -                       | -            | -           | -           | 2            | <b>129</b>    |
| N. Dakota                                                                                                        | 75                 | 16                   | 42               | -                    | -          | -                       | -            | -           | -           | 52           | <b>185</b>    |
| Pennsylvania                                                                                                     | 612                | -                    | -                | -                    | -          | -                       | -            | -           | -           | -            | <b>612</b>    |
| S. Carolina                                                                                                      | 167                | -                    | 23               | 23                   | -          | -                       | -            | -           | -           | -            | <b>213</b>    |
| Texas                                                                                                            | -                  | -                    | 653              | -                    | -          | -                       | -            | -           | -           | -            | <b>653</b>    |
| Utah                                                                                                             | 97                 | 13                   | -                | -                    | -          | -                       | -            | -           | -           | -            | <b>110</b>    |
| Vermont                                                                                                          | -                  | -                    | -                | 9                    | -          | -                       | -            | -           | -           | -            | <b>9</b>      |
| Virginia                                                                                                         | 603                | 81                   | 112              | 66                   | -          | -                       | -            | -           | -           | 67           | <b>929</b>    |
| Washington                                                                                                       | -                  | -                    | -                | -                    | -          | -                       | -            | 141         | -           | -            | <b>141</b>    |
| Wisconsin                                                                                                        | 323                | 5                    | -                | -                    | -          | -                       | -            | -           | -           | -            | <b>328</b>    |
| Wyoming                                                                                                          | 34                 | 1                    | -                | -                    | -          | -                       | -            | -           | -           | -            | <b>35</b>     |
| <b>Total</b>                                                                                                     | <b>5,874</b>       | <b>1,562</b>         | <b>2,490</b>     | <b>790</b>           | <b>182</b> | <b>79</b>               | <b>33</b>    | <b>520</b>  | <b>974</b>  | <b>355</b>   | <b>12,923</b> |

SNF: Skilled Nursing Facility; NF: Nursing Facility; ICF/IID: Intermediate Care Facilities for Individuals with Intellectual Disabilities; FQHC: Federally Qualified Health Center; RHC: Rural Health Center; HHA: Home Health Agency; CMHC: Community Mental Health Center; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; GEMT: Ground Emergency Medical Transportation; HCBS: Home and Community-Based Services.

\*Inpatient rate setting and DSH audits.

We are highly skilled in analyzing cost data and applying that data for rate setting and benchmarking. We also assist states in a number of other related activities, including incorporating cost data for rate setting and benchmarking, supporting P4P programs, preparing UPL demonstrations, calculating provider assessments, engaging with providers and other stakeholders, developing communication materials, conducting training sessions, preparing SPAs, drafting regulations, and supporting states in discussions with CMS.

## Experience Designing and Performing Review Procedures Under AICPA Standards

As a CPA firm with a focus on auditing and consulting for governmental healthcare and human services programs, many of our engagements are conducted in accordance with standards or abide by guidance set under the AICPA, Governmental Accounting Standards Board, Governmental Accounting Advisory Council, and/or Public Company Accounting Oversight Board. In addition, we perform a significant number of government audits, compliance examinations, AUP engagements, and performance audits that adhere to state administrative and accounting regulations, generally accepted government auditing

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

standards, generally accepted accounting principles, generally accepted auditing standards, and other state and federal regulatory reporting requirements. Many of these engagements require that we design review procedures under the applicable standards, including AICPA standards, and perform the procedures in accordance with the standards.

We are a member of the AICPA's Governmental Audit Quality Center. Membership demonstrates our commitment to audit quality in the critical area of governmental audits, including audits performed under government auditing standards.

As a CPA firm, financial and compliance auditing are a large component of our services. As a result, we have an extensive knowledge of auditing and accounting standards and their applications. Our CPAs and auditors are well versed in compliance with federal regulations and interpretation of AICPA guidance, as well as Medicaid and Medicare regulations, principles, and policies. Specifically, we are fully able to address the requirements of our state clients due to our extensive experience and best practice insights gained from having supported Medicaid and social services programs in all 50 states, CMS, and many other public benefit programs.

## **Mandatory Qualification/Experience Requirements (4.3.2)**

### **Mandatory Key Position Staffing Qualifications (4.3.2.1)**

The following mandatory qualification/experience requirements must be met by the Vendor as a part of its submitted proposal. Vendor should describe how it meets the mandatory requirements and includes any areas where it exceeds the mandatory requirements. Failure to comply with mandatory requirements will lead to disqualification, but areas where the mandatory requirements are exceeded will be included in technical scores where appropriate. The mandatory qualifications/experience requirements are listed below.

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

The Myers & Stauffer Team will staff this engagement to meet and exceed BMS's expectations. Our proposed professional resources are highly skilled in the Medicaid managed care policy, operations, capitation rate setting, financing, and compliance fields. Our Team is fully equipped and ready to begin work immediately upon contract award. Nearly all members of our proposed team have supported the West Virginia Medicaid program, as we have performed this work under the current contract. It will not be necessary for us to build capacity or spend contract hours training new staff.

We have reviewed Milliman's staffing model to ensure it has streamlined a highly efficient process related to actuarial rate setting that provides timely results of the highest quality. All work is managed by actuarial consultants with the highest level of credentials. Milliman has 82 FSAs and 74 ASAs that specialize in Medicaid agency work. This number of credentialed staff allows us to provide high-quality work on an ongoing basis and devote additional resources during times of increased workload.



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

Our proposed team members have the responsibility and authority to work collaboratively and across internal organizational lines, and across prime and subcontractor staff, to support this scope of work. This collaborative environment is how we approach work both internally and with our clients.

### Required Key Staff

Myers & Stauffer strives to maintain staffing consistency on all engagements. Upon contract award, we will seek BMS's approval of our proposed staffing plan. Our proposed staff are committed to this engagement for the duration of the contract and will not be changed without BMS approval. In the unlikely event of staff turnover, we will offer replacement personnel with equal or greater credentials and experience. We will provide written notice and a request for approval of staffing changes proactively, except in the event of an immediate vacancy. If an immediate vacancy occurs, we will convey that information to BMS with a plan to address immediate and longer-term staffing needs. In the unlikely event BMS does not approve our proposed staff or a staff member leaves the firm, we will present alternative candidates with the appropriate experience and skill set by drawing from our existing staff of Medicaid and actuarial professionals for BMS consideration.



### Not Just Experience, West Virginia Experience

Our leadership team has years of experience serving West Virginia, which allows us to support our clients with a legacy-level historical understanding and institutional knowledge that cannot be acquired quickly or easily. You know our team well, and the level of support and commitment we bring to our work each day. We are proud of our long-standing relationship with West Virginia, and even more proud that our team will remain intact and ready to serve West Virginia in this next contract cycle. While we pride ourselves on consistency and constancy, this does not mean doing things the same way they have always been done before. We continue to be on the forefront of issues challenging Medicaid programs across the nation and are always looking for new solutions to new problems as they arise. The same team you know and trust is prepared for any new questions, problems, or issues that may occur.

### Ready to Tackle New Challenges

### Overview of Key Staff

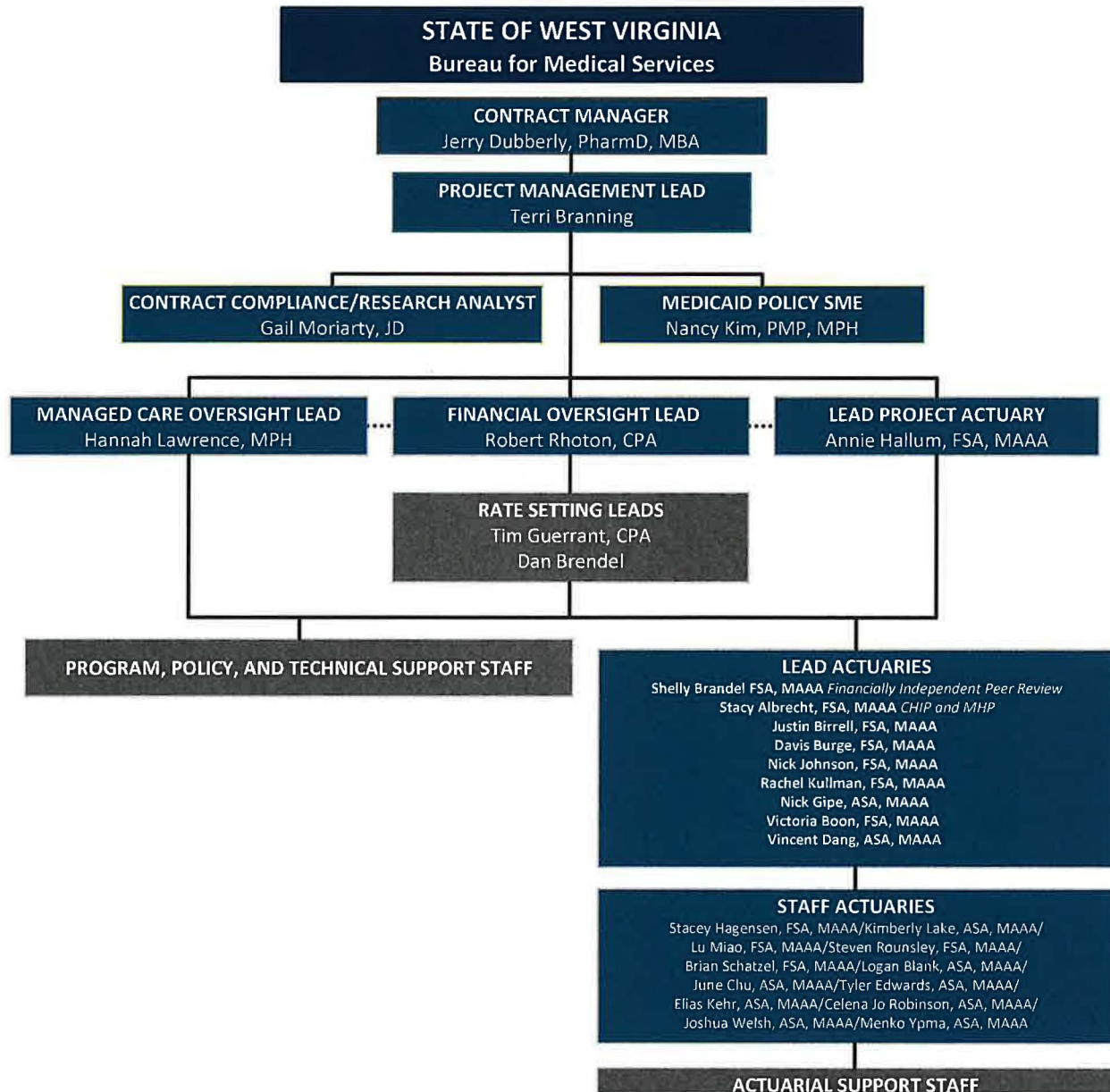
BMS leadership will have direct access to all key positions and other staff. Our key leadership team members and their staff will be responsive to BMS, and each will be responsible for ensuring collaboration, timely communications, and coordinated project updates to all parties, as needed. While we provide a single point of entry to the Myers & Stauffer Team through our designated Contract Manager for BMS, the Bureau will not be encumbered by having to follow a hierarchical structure to access the resources it needs. We present our team through the following:

- **Figure 19. Project Team Organizational Chart.** An overview of our team structure.
- **Table 11. Key Staff At-a-Glance.** A quick guide to the qualifications of our proposed key staff and how they exceed all staffing requirements.
- **Table 12. Proposed Key Staff.** A detailed summary of the qualifications and experience of our proposed key staff and how they exceed all staffing requirements.

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- **Appendix C: Resume.** Detailed biographies and experience of our key staff.
- **Appendix D: Certifications and Degrees.** Evidence of required certifications and degrees.

Figure 19. Project Team Organizational Chart





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Table 11. Key Staff At-a-Glance

| <b>Myers &amp; Stauffer Team: Key Staff At-a-Glance</b> |                             |                                                    |                            |               |                          |                                    |
|---------------------------------------------------------|-----------------------------|----------------------------------------------------|----------------------------|---------------|--------------------------|------------------------------------|
| <b>Role</b>                                             | <b>Degree/Certification</b> |                                                    | <b>Years of Experience</b> |               | <b>WV BMS Experience</b> | <b>Requirements Meets/Exceeds?</b> |
|                                                         | <b>Required</b>             | <b>Actual</b>                                      | <b>Required</b>            | <b>Actual</b> |                          |                                    |
| Contract Manager                                        | BS                          | Doctorate, Master of Business Administration (MBA) | 5                          | 30+           | ✓                        | <b>Exceeds</b>                     |
| Project Management Lead                                 | BS                          | BS                                                 | 5                          | 40+           | ✓                        | <b>Exceeds</b>                     |
| Managed Care Oversight Lead                             | BS                          | Master of Public Health (MPH), BSPH                | 3                          | 10+           | ✓                        | <b>Exceeds</b>                     |
| Finance Oversight Lead                                  | CPA, BS                     | CPA, BA - Accounting                               | 5                          | 10+           | ✓                        | <b>Exceeds</b>                     |
| Contract Compliance/ Research Analyst                   | BS                          | Juris Doctor (JD), BA                              | 2                          | 4+            | -                        | <b>Exceeds</b>                     |
| Medicaid Policy SME                                     | BS                          | MPH, PMP                                           | 10                         | 18+           | -                        | <b>Exceeds</b>                     |
| Lead Actuaries                                          | FSA or MAAA                 | FSA or ASA, MAAA                                   | 10                         | 10-25+        | ✓ <sup>1</sup>           | <b>Exceeds</b>                     |
| Staff Actuaries                                         | FSA or MAAA                 | FSA or ASA, MAAA                                   | 5                          | 5+            | ✓ <sup>1</sup>           | <b>Exceeds</b>                     |

<sup>1</sup> Actuarial pool includes actuaries with BMS experience.

### What This Means for BMS

Our Team provides direct access to project and firm leadership with Medicaid and CHIP expertise and works alongside BMS to solve strategic and operational issues. We have the staffing capacity to provide the appropriate level of expertise in real time to support the inevitable challenges from changes in the Medicaid environment. Not only do we have highly qualified and credentialed staff, but we have demonstrated — as a Team — our commitment to collaboration with the BMS's staff and other stakeholders. This means BMS can trust our Team to work hand-in-hand with you on every detail, no matter how large or small.

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

Table 12. Proposed Key Staff

| <b>Myers &amp; Stauffer Team: Proposed Key Staff</b>                                                                           |                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Proposed Key Staff Name/Title/ Role</b>                                                                                     | <b>Qualifications Requirements</b>                                                                                                                                                                                        | <b>Overview of Qualifications</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Requirements of the Role</b>                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Overview of Engagement Responsibilities</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Contract Manager</b><br>(1 FTE)<br><br><b>Jerry Dubberly, PharmD, MBA</b><br><i>Principal (Partner)</i><br>Myers & Stauffer | Minimum of a bachelor's degree, with five years' experience in Medicaid or Medicaid and CHIP managed care operations, either with a state agency, federal agency, or rendering services under contract to a state agency. | Jerry exceeds all requirements including: <ul style="list-style-type: none"> <li>✓ More than 30 years of Medicaid/public healthcare experience, including as partner in charge of Medicaid managed care engagements.</li> <li>✓ Former SMD of Georgia managing three successful Medicaid MCO contracts serving more than 1.3 million Medicaid and CHIP lives.</li> <li>✓ Leads Myers &amp; Stauffer's current BMS Medicaid Actuarial Services and Managed Care Program Administration and Oversight engagement with authority to commit the firm and its resources.</li> <li>✓ Doctor of Pharmacy/MBA.</li> </ul>  | <ul style="list-style-type: none"> <li>✓ Have the ability and authority to commit the vendor and its resources, conduct oversight of the engagement, and ensure all deliverables and services are consistent with contract requirements, work plan tracking, project tracking, and taking minutes.</li> <li>✓ Available for quarterly meetings with BMS leadership and staff, and ad hoc meetings (virtual and on-site), as needed.</li> </ul> | Jerry will fulfill all requirements of the role, as well as: <ul style="list-style-type: none"> <li>✓ Operate in current capacity as contract signatory.</li> <li>✓ Responsible for delivery of all contract deliverables.</li> <li>✓ Responsible for subcontractor contract and performance.</li> <li>✓ Serve as a SME, as needed, to support deliverable production and client/internal needs.</li> </ul>                                                                                                                                                |
| <b>Project Management Lead</b><br>(1 FTE)<br><br><b>Terri Branning</b><br><i>Senior Manager</i><br>Myers & Stauffer            | Minimum of a bachelor's degree and five years' experience, or eight years' experience with Medicaid or Medicaid and CHIP managed care.                                                                                    | Terri exceeds all requirements including: <ul style="list-style-type: none"> <li>✓ More than 40 years of healthcare industry experience, including executive leadership roles in Medicaid, managed care, and self-funded health plans.</li> <li>✓ Current Project Management Lead for BMS Medicaid Actuarial Services and Managed Care Program Administration and Oversight engagement.</li> <li>✓ Healthcare consultant to Georgia Medicaid client during transition to full-risk managed care.</li> <li>✓ Former Executive Business Analyst for Georgia DCH.</li> <li>✓ Bachelor's degree in nursing.</li> </ul> | <ul style="list-style-type: none"> <li>✓ Oversee that all contractual deliverables are fulfilled and provided within the required time frames.</li> <li>✓ Conduct oversight of the engagement and ensure all deliverables and services are consistent with contract requirements, work plan tracking, and project tracking.</li> </ul>                                                                                                         | Terri will fulfill all requirements of the role, as well as: <ul style="list-style-type: none"> <li>✓ Support the Executive Program Director to ensure all contract deliverables are completed timely and are of the highest quality.</li> <li>✓ Assign and coordinate work across the Program Administration Lead, the Financial Administration Lead, and the Actuarial Lead.</li> <li>✓ Maintain day-to-day contact and relationship with the client.</li> <li>✓ Serve as the central point of contact.</li> <li>✓ Serve as a SME, as needed.</li> </ul> |



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

| <b>Myers &amp; Stauffer Team: Proposed Key Staff</b>                                                                |                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Proposed Key Staff Name/Title/ Role</b>                                                                          | <b>Qualifications Requirements</b>                                                                                                                                                                                                      | <b>Overview of Qualifications</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>Requirements of the Role</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>Overview of Engagement Responsibilities</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Managed Care Oversight Lead (1 FTE)</b><br><br><b>Hannah Lawrence, MPH</b><br><i>Manager</i><br>Myers & Stauffer | Minimum of a bachelor's degree and three years' experience, or five years in Medicaid or Medicaid and CHIP managed care operations, either with a state agency, federal agency, or rendering services under contract to a state agency. | Hannah exceeds all requirements including: <ul style="list-style-type: none"> <li>✓ More than 10 years of experience consulting on projects related to Medicaid quality and program oversight.</li> <li>✓ Currently serves as BMS Medicaid Actuarial Services and Managed Care Program Administration and Oversight engagement contract liaison responsible for Medicaid managed care program management.</li> <li>✓ Provides strategic consulting through analysis and research in a wide variety of initiatives with healthcare agencies.</li> <li>✓ Supports State initiatives, including Medicaid and child welfare services department, behavioral health provider capacity needs assessments, technical assistance to Medicaid managed care programs, including evaluation of subcontractor oversight and contract compliance, and administrative reviews for state departments of education child and adult care food programs.</li> <li>✓ MPH (health services, policy, and management).</li> </ul> | <ul style="list-style-type: none"> <li>✓ Oversight of managed care operations and deliverables under the contract.</li> <li>✓ Responsibility for other projects assigned by the Deputy Commissioner, Division of Managed Care and Program Integrity.</li> <li>✓ Coordinate with the Finance Project Lead in the execution of deliverables defined in the contract.</li> <li>✓ Available for quarterly meetings with BMS leadership and staff, and ad hoc meetings (virtual and on-site), as needed.</li> <li>✓ Develop meeting agendas and send out to all parties 24 hours prior to meeting.</li> <li>✓ Take meeting attendance, meeting notes, record action items and track action item completion.</li> <li>✓ Send out approved meeting notes to participants.</li> </ul> | Hannah will fulfill all requirements of the role, as well as: <ul style="list-style-type: none"> <li>✓ Work under the direction of the Project Management Lead.</li> <li>✓ Serve as the primary point of contact for the Director of the Office of Managed Care.</li> <li>✓ Support BMS with tracking project activities, next steps, and actions needed from BMS.</li> <li>✓ Serve as the day-to-day lead on MCO oversight and monitoring work.</li> <li>✓ Proactively schedule and communicate upcoming project administrative work based on annual/cyclical work, as well as new projects.</li> <li>✓ Coordinate activities with the Actuarial Lead and Financial Lead with the involvement of the Project Management Lead.</li> </ul> |

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

| <b>Myers &amp; Stauffer Team: Proposed Key Staff</b>                                                                                       |                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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| <b>Proposed Key Staff Name/Title/ Role</b>                                                                                                 | <b>Qualifications Requirements</b>                                                                                                                                                                                                                                                                                                                       | <b>Overview of Qualifications</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Requirements of the Role</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>Overview of Engagement Responsibilities</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Financial Oversight Lead (1 FTE)</b><br><br><b>Robert Rhoton, CPA</b><br><i>Senior Manager</i><br>Myers & Stauffer                      | Minimum of a bachelor's degree in finance, accounting, business administration, or related field, must be a CPA with five years' experience in financial management in Medicaid or Medicaid and CHIP programs, regulations, reimbursement processes, financial analysis, budgeting, forecasting and managing Medicaid provider rate setting engagements. | Rob exceeds all requirements including: <ul style="list-style-type: none"> <li>✓ More than 11 years of experience providing public accounting, financial auditing, compliance, and consulting services to multiple state Medicaid agencies.</li> <li>✓ Experience with BMS through contracts for CCBHC and SUD rate setting and consulting and 1115 waiver budget neutrality analysis.</li> <li>✓ Areas of expertise include financial analysis, cost projections, and budget neutrality workbooks for various Medicaid programs and attest engagements of providers.</li> <li>✓ Bachelor's degree in accounting and business/economics.</li> <li>✓ CPA.</li> </ul> | <ul style="list-style-type: none"> <li>✓ Liaison with the Deputy Commissioner of Finance and the CFO in the oversight of finance and budget initiatives and other projects within the scope of the contract.</li> <li>✓ Coordinate the deliverables of the actuarial vendor with BMS Finance.</li> <li>✓ Coordinate with the Program Administration Lead in the execution of deliverables in the contract.</li> <li>✓ Available for quarterly meetings with BMS leadership and staff, and ad hoc meetings (virtual and on-site), as needed.</li> </ul> | Rob will fulfill all requirements of the role, as well as: <ul style="list-style-type: none"> <li>✓ Work under the direction of the Project Management Lead.</li> <li>✓ Serve as the day-to-day lead for all financial service needs.</li> <li>✓ Serve as the point of contact for Deputy Commissioner of Finance and CFO.</li> <li>✓ Coordinate with the Lead Actuary and Program Administration Lead, acting under the direction of the Project Management Lead.</li> </ul> |
| <b>Contract Compliance/ Research Analyst (.50 FTE)</b><br><br><b>Gail Moriarty, JD</b><br><i>Healthcare Consultant</i><br>Myers & Stauffer | Minimum of a bachelor's degree, with two years' experience working with Medicaid or Medicaid and CHIP, either with a state agency, federal agency, or rendering services under contract to a state agency.                                                                                                                                               | Gail exceeds all requirements including: <ul style="list-style-type: none"> <li>✓ More than four years of healthcare law, policy-related experience, and Medicaid consulting.</li> <li>✓ Focus research and administrative assistance services to state, federal, and local healthcare and social service agencies addressing healthcare reimbursement issues, as well as analyzing issues of public health law and policy.</li> <li>✓ Licensed attorney with JD.</li> </ul>                                                                                                                                                                                        | <ul style="list-style-type: none"> <li>✓ Assistance in policy research and development, contract development and maintenance, contract compliance and reporting, and other MCO oversight activities as outlined within the solicitation.</li> </ul>                                                                                                                                                                                                                                                                                                    | Gail will fulfill all requirements of the role, as well as: <ul style="list-style-type: none"> <li>✓ Work under the direction of the Project Management Lead.</li> <li>✓ Serve as SME, as needed.</li> </ul>                                                                                                                                                                                                                                                                  |



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

| <b>Myers &amp; Stauffer Team: Proposed Key Staff</b>                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Proposed Key Staff Name/Title/ Role</b>                                                                                                 | <b>Qualifications Requirements</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>Overview of Qualifications</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Requirements of the Role</b>                                                                                                                                                                                               | <b>Overview of Engagement Responsibilities</b>                                                                                                                                                                                                                                                                                                                                               |
| <b>Medicaid Policy SME (.50 FTE)</b><br><br><b>Nancy Kim, MPH, PMP</b><br><i>Senior Manager</i><br>Myers & Stauffer                        | <p>Minimum of a bachelor's degree, with 10 years' experience in Medicaid or Medicaid and CHIP policy research and development, either with a state agency, federal agency, or rendering services under contract to either agency type.</p> <p>Experience crafting CMS managed care reports including 1915 (b) waiver applications/amendments, Medicaid and CHIP Program Medicaid Policy Subject Matter Annual Report (MACPAR) and Fraud, Waste, Abuse compliance reports.</p> | <p>Nancy exceeds all requirements including:</p> <ul style="list-style-type: none"> <li>✓ More than 18 years of government-sponsored healthcare experience and has managed projects and provided technical assistance to numerous state Medicaid managed care programs.</li> <li>✓ Extensive experience evaluating and implementing federal regulations and various federal waiver authorities.</li> <li>✓ Worked with states to evaluate readiness to implement managed care programs, as well as serving as a rate review contractor.</li> <li>✓ Worked with states to assess federal rules and guidance and determine impact to Medicaid operations.</li> <li>✓ MPH.</li> <li>✓ PMP.</li> </ul> | <ul style="list-style-type: none"> <li>✓ Consultation services on federal Medicaid regulation and policy and serve as a SME under both the program oversight contract development and actuarial services sections.</li> </ul> | <p>Nancy will fulfill all requirements of the role, as well as:</p> <ul style="list-style-type: none"> <li>✓ Work under the direction of the Project Management Lead.</li> <li>✓ Serve as an SME, as needed.</li> </ul>                                                                                                                                                                      |
| <b>Lead Actuary (1 FTE)</b><br><br><u>Lead Project Actuary:</u><br><b>Annie Hallum, FSA, MAAA</b><br><i>Consulting Actuary (Principal)</i> | <p>Minimum of 10 years' experience with Medicaid or Medicaid and CHIP Managed Care rate setting.</p> <p>Be either an FSA and/or MAAA.</p>                                                                                                                                                                                                                                                                                                                                     | <p>We are proposing at least 10 qualified lead actuaries including a Lead Project Actuary. All our lead actuaries exceed all requirements including:</p> <ul style="list-style-type: none"> <li>✓ At least 10 years of Medicaid managed care rate setting experience working for state agencies. Some with over 25 years of Medicaid managed care experience.</li> <li>✓ Lead Project Actuary has more than three years of experience leading</li> </ul>                                                                                                                                                                                                                                           | <ul style="list-style-type: none"> <li>✓ Oversee that all deliverables within each approved SOW are fulfilled as defined within the SOW.</li> </ul>                                                                           | <p>Annie, along with the 9 other lead actuaries, will fulfill all requirements of the role, as well as:</p> <ul style="list-style-type: none"> <li>✓ Work under the direction of the Project Management Lead.</li> <li>✓ Coordinate closely with the Program Administration Lead and the Financial Administration Lead acting under the direction of the Project Management Lead.</li> </ul> |

## QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)

| Myers & Stauffer Team: Proposed Key Staff                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                                                                                                                                                                        |                          |                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------|
| Proposed Key Staff Name/Title/Role                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Qualifications Requirements | Overview of Qualifications                                                                                                                                                                                             | Requirements of the Role | Overview of Engagement Responsibilities |
| <p><u>CHIP &amp; MHP Lead:</u><br/> <b>Stacy Albrecht, FSA, MAAA</b><br/> <i>Consulting Actuary</i></p> <p><u>Financially Independent Peer Review:</u><br/> <b>Shelly Brandel, FSA, MAAA</b><br/> <i>Consulting Actuary (Principal)</i></p> <p><u>Lead Actuaries:</u><br/> <i>Consulting Actuary (Principal):</i><br/> <b>Justin Birrell, FSA, MAAA</b><br/> <b>Davis Burge, FSA, MAAA</b><br/> <b>Nick Johnson, FSA, MAAA</b><br/> <b>Rachel Kullman, FSA, MAAA</b><br/> <i>Consulting Actuary</i><br/> <b>Nick Gipe, ASA, MAAA</b></p> <p><u>Actuary:</u><br/> <b>Victoria Boon, FSA, MAAA</b><br/> <i>Associate Actuary</i><br/> <b>Vincent Dang, ASA, MAAA</b></p> |                             | <p>actuarial services for BMS Medicaid. Actuarial Services and Managed Care Program Administration and Oversight engagement.</p> <p>✓ Milliman's team has at least 82 Medicaid FSAs to accommodate BMS, as needed.</p> |                          |                                         |



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)****Myers & Stauffer Team: Proposed Key Staff**

| Proposed Key Staff Name/Title/ Role                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Qualifications Requirements                                                                                                                                                                                                                                                                                            | Overview of Qualifications                                                                                                                                                                                                                                                                                                                                                                                                    | Requirements of the Role                                                                                                | Overview of Engagement Responsibilities                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Staff Actuary (2 FTEs)</b><br><br><i>Consulting Actuary:</i><br><b>Stacey Hagensen, FSA, MAAA</b><br><b>Kimberly Lake, ASA, MAAA</b><br><br><i>Actuary:</i><br><b>Lu Miao, FSA, MAAA</b><br><b>Steven Rounsley, FSA, MAAA</b><br><b>Brian Schatzel, FSA, MAAA</b><br><br><i>Associate Actuary:</i><br><b>Logan Blank, ASA, MAAA</b><br><b>June Chu, ASA, MAAA</b><br><b>Tyler Edwards, ASA, MAAA</b><br><b>Elias Kehr, ASA, MAAA</b><br><b>Celena Jo Robinson, ASA, MAAA</b><br><b>Joshua Welsh, ASA, MAAA</b><br><b>Menko Ypma, ASA, MAAA</b> | <p>The staff actuaries will assist the Project Lead Actuary and Lead Actuaries in providing the deliverables defined within each approved SOW.</p> <p>Minimum of five years' experience with Medicaid or Medicaid and CHIP managed care rate setting or other insurance pricing.</p> <p>Either an FSA and/or MAAA.</p> | <p>Our staff actuaries exceed all requirements including:</p> <ul style="list-style-type: none"> <li>✓ All our staff actuaries have at least five years' experience with Medicaid managed care rate setting or other insurance pricing.</li> <li>✓ All our staff actuaries are credentialed with at least an ASA and MAAA.</li> <li>✓ Milliman's team has at least 74 Medicaid ASAs to accommodate BMS, as needed.</li> </ul> | <p>The staff actuaries will assist the Lead Actuary in providing the deliverables defined within each approved SOW.</p> | <p>Our staff actuaries will fulfill all requirements of the role, as well as:</p> <ul style="list-style-type: none"> <li>✓ At least four staff actuaries will assist the lead actuaries with providing the deliverables defined within each approved SOW.</li> </ul> |

**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)****Additional Staff: SMEs and Technical, Financial, and Clerical Support Staff**

In addition to our proposed key staff, we will have positions not designated as key positions by BMS as well as supporting staff available to assist these team members with project work, as needed. *Table 13* includes these additional roles that will be assigned to this engagement.

Table 13. Additional Staff

| <b>Myers &amp; Stauffer: Additional Staff</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Role</b>                                               | <b>Overview of General Qualifications</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Rate Setting Leads</b>                                 | <b>Tim Guerrant, CPA - Member (Partner), Myers &amp; Stauffer</b> <ul style="list-style-type: none"> <li>✓ Nearly 30 years of experience, including providing rate setting, reimbursement system design, and consulting services for government healthcare agencies.</li> <li>✓ Extensive experience in Medicaid rate setting across a wide spectrum of healthcare services, including inpatient and outpatient hospital, physician, dental, FQHC, RHC, fee schedule services, waiver services, and behavioral health services.</li> <li>✓ SME in Medicaid financing and compliance issues, including UPL demonstrations, healthcare provider taxes, IGTs, and CPEs.</li> <li>✓ Conducts reimbursement and policy research and prepares analytical studies and reports, including fiscal impact modeling and reimbursement rate analysis.</li> <li>✓ Provides consulting services related to Medicaid SPAs, Medicare and Medicaid legislation and policy issues, and Medicaid financing and compliance issues.</li> <li>✓ Partner in charge of the firm's rate setting/federal compliance engagement team.</li> <li>✓ CPA.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                           | <b>Dan Brendel - Principal (Partner), Myers &amp; Stauffer</b> <ul style="list-style-type: none"> <li>✓ Nearly 20 years of experience providing rate setting, consulting, and public accounting services to state Medicaid agencies addressing healthcare reimbursement and oversight issues.</li> <li>✓ More than 15 years of direct experience providing nursing facility rate setting development services, including internal and external stakeholders.</li> <li>✓ Leads various Medicaid nursing facility rate setting, MDS assessment exception review, HCBS rate setting, accounting, auditing, UPL demonstration calculation, and other consulting engagements for a variety of provider types with a particular focus on LTC.</li> <li>✓ Expertise in Medicaid rate setting engagements, nursing facility PDPM transition and implementation, MDS assessment exception review programs, assisting states with the development of policy and SPAs, developing supplemental and DPPs, development and implementation of VBP and P4P quality programs, provider assessment fee and UPL consulting, cost reporting instrument development, development of standard work papers and review programs for auditing engagements, communicating with clients and providers, and developing and delivering internal and external training.</li> <li>✓ Partner in charge of the firm's nursing facility rate setting and MDS verification engagement team.</li> <li>✓ B.B.A., Accounting, University of Miami.</li> </ul> |
| <b>Technical, Financial and Clerical Staff</b>            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Managed Care/Policy Program: Policy and Technical/</b> | <ul style="list-style-type: none"> <li>✓ Medicaid/public healthcare compliance, policy, and consulting experience with specialization in managed care support and provider network analysis.</li> <li>✓ Experience may range from two to more than 10 years depending on the level of skill required.</li> <li>✓ Minimum of bachelor's degree in accounting, healthcare, or other relevant major.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |



**QUALIFICATIONS AND EXPERIENCE (RFP SECTION 4.3)**

| <b>Myers &amp; Stauffer: Additional Staff</b>                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Role</b>                                                     | <b>Overview of General Qualifications</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Financial Support Staff</b>                                  | <ul style="list-style-type: none"> <li>✓ May hold one or more of the following certifications: CPA, CFE, or Certified in Healthcare Compliance.</li> </ul>                                                                                                                                                                                                                                                                                                                                  |
| <b>Rate Setting Program: Policy and Technical Support Staff</b> | <ul style="list-style-type: none"> <li>✓ Medicaid/public healthcare consulting experience with specialization in rate setting for public health programs.</li> <li>✓ Experience may range from two to more than 10 years depending on the level of skill required.</li> <li>✓ Minimum of bachelor's degree in accounting, healthcare, or other relevant major.</li> <li>✓ May hold one or more of the following certifications: CPA, CFE, or Certified in Healthcare Compliance.</li> </ul> |
| <b>Actuarial Services: Support Staff</b>                        | <ul style="list-style-type: none"> <li>✓ Robust staff of data and actuarial analysts that do not yet meet the qualifications of a lead or staff actuary but are able to support the work performed.</li> <li>✓ Minimum of bachelor's degree in business, economics, statistics, public health, or related.</li> <li>✓ Proficiency in data analysis tools (e.g., Excel, SQL).</li> <li>✓ Strong analytical and critical thinking skills.</li> </ul>                                          |

### Additional Staffing Capacity

BMS will benefit from the expansive staffing capacity and resources made available by both Myers & Stauffer and Milliman. With Myers & Stauffer's proposal of an existing team, as well as 1,000-plus professionals nationally, we are able to staff this engagement immediately with a tenured team. We also have the flexibility to reallocate staff, as needed, to further support BMS's needs and the requirements of this engagement. Every one of Myers & Stauffer's professionals is exclusively dedicated to public healthcare agencies, allowing us to truly understand the needs and objectives of our clients.

Additionally, our actuarial partner, Milliman, is committed to maintaining their global reputation for integrity and high-quality work. All actuarial work is managed by actuarial consultants with the highest level of credentials. Milliman has 82 FSAs and 74 ASAs that specialize in Medicaid agency work. This number of credentialed staff allows us to provide high-quality work on an ongoing basis and devote additional resources during times of increased workload.

Table 14 shows our "client-facing" staff resources that are available should the need arise. In addition, we have more than 200 administrative, paraprofessional, specialist, and internal staff supporting our clients.

Table 14. Firm-Wide Staff Resources

| <b>Resources Across Firms</b> |                                         |                               |
|-------------------------------|-----------------------------------------|-------------------------------|
| <b>Staff Resource</b>         | <b>Government Healthcare Experience</b> | <b>Approx Number of Staff</b> |
| Member/Principal (Partner)    | 15-35+ years                            | 40+                           |
| Director/Senior Manager       | 7-20+ years                             | 150+                          |
| Manager                       | 4-15+ years                             | 150+                          |
| Senior Accountant/Associate   | 2-7+ years                              | 200+                          |
| Staff Accountant/Associate    | 0-3+ years                              | 200+                          |
| Actuaries (FSA/ASA)           | 5+ years                                | 150+                          |

## Sharing in our Clients' Success

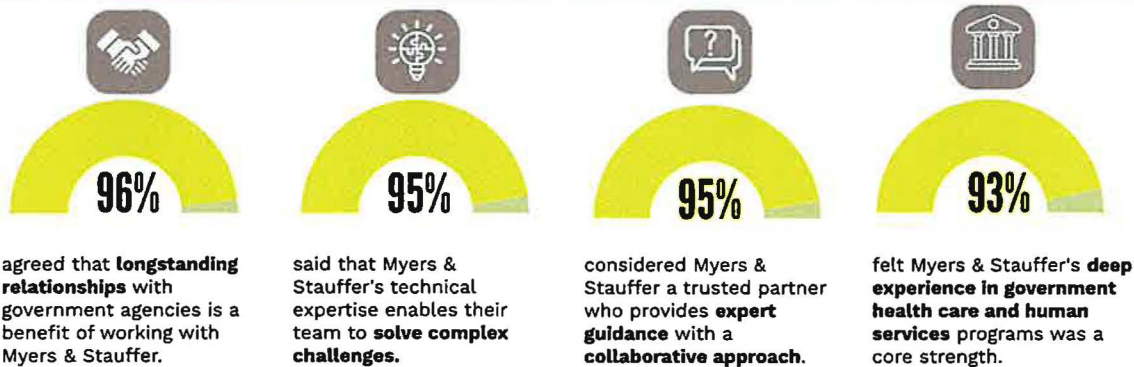
With more than five decades serving Medicaid agencies, Myers & Stauffer has demonstrated qualifications and experience to meet and exceed all requirements in this RFP. In 2025, we surveyed approximately 100 state and federal government clients to measure the success of our service delivery, expertise, and reputation. As shown in *Figure 20*, like many of our other clients, for more than four years, BMS has experienced our commitment to our clients and the quality of our work. We look forward to continuing our work with BMS.

Figure 20. Client Success

**98%** of clients ranked their satisfaction level as 'very satisfied' or 'satisfied'  
Not one respondent ranked our performance as unsatisfactory.



Myers & Stauffer provides accurate financial and compliance expertise to public programs, serves as a trusted consultant for strategy decisions, and ensures transparency and accountability in public programs.



### What Clients Say About Working with Myers & Stauffer

Myers & Stauffer has been very instrumental in the development of new and improved financial oversight operations for our agency. We have relied on their expertise to provide up-to-date knowledge and direction of new regulations and how other states are best performing in maintaining their fiduciary responsibilities. Myers & Stauffer has also been very valuable to us when we have had challenges to any proposed financial amendments we have implemented to ensure that we are following the appropriate line of authority from CMS.

— Deputy Administrator, State Medicaid Agency

Myers & Stauffer's understanding of our timeline-driven environment is extremely important and has allowed the State to meet the requirement of federal match funds, adding dollars to the budget. The Contractor has a plethora of knowledge, experience, and relationships that consistently meet or exceed our expectations.

— Deputy Director, State Medicaid Agency

Myers & Stauffer has done an excellent job since the beginning of our engagement, performing the duties required under the contracts with the State. We have been highly satisfied with the timeliness and accuracy of the work that has been done. In addition, we have always found the staff to be knowledgeable, professional, and responsive, as well as cooperative and pleasant to work with... the State has had various complicated and nuanced requirements that Myers & Stauffer has successfully managed to provide accommodations for.

— Finance Manager, State Medicaid Agency



## V. REQUIRED FORMS

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In this section, we have included copies of the following RFP forms:

- Original and Addendum Cover Pages.
- Addendum Acknowledgment Form.
- Designated Contact Information Form.
- Availability of Information Form.
- Federal Funds Addendum.
- HIPAA Business Associate Agreement Addendum.

Please note that we have included a page-numbered copy of each form followed by the signed original of each.

## Original and Addendum Cover Pages

|                                                                                   |                                                                                                                                          |                                                                               |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
|  | Department of Administration<br>Purchasing Division<br>2019 Washington Street East<br>Post Office Box 50130<br>Charleston, WV 25305-0130 | State of West Virginia<br>Centralized Request for Proposals<br>Service - Misc |
|                                                                                   |                                                                                                                                          |                                                                               |

|                                                                                                         |                                                |                                                   |
|---------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------|
| <b>Proc Folder:</b> 1945653<br><b>Doc Description:</b> MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN |                                                | <b>Reason for Modification:</b>                   |
| <b>Proc Type:</b> Central Master Agreement                                                              |                                                |                                                   |
| <b>Date Issued</b><br>2026-07-16                                                                        | <b>Solicitation Closes</b><br>2026-08-25 13:30 | <b>Solicitation No</b><br>CRFP 0511 BMS2700000001 |
| <b>Version</b><br>1                                                                                     |                                                |                                                   |

|                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>BID RECEIVING LOCATION</b><br>BID CLERK<br>DEPARTMENT OF ADMINISTRATION<br>PURCHASING DIVISION<br>2019 WASHINGTON ST E<br>CHARLESTON WV 25305<br>US |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>VENDOR</b><br>Vendor Customer Code: 000000191225<br>Vendor Name : Myers and Stauffer LC<br>Address : 1349 W.<br>Street : Peachtree St. NE, Ste. 1600<br>City : Atlanta<br>State : GA Country : United States Zip : 30309<br>Principal Contact : Jerry Dubberly, PharmD, MBA<br>Vendor Contact Phone: 404-524-9519 Extension: N/A |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                             |
|-------------------------------------------------------------------------------------------------------------|
| <b>FOR INFORMATION CONTACT THE BUYER</b><br>Crystal G Hustead<br>(304) 558-2402<br>crystal.g.hustead@wv.gov |
|-------------------------------------------------------------------------------------------------------------|

|                                                                                                           |                  |                 |
|-----------------------------------------------------------------------------------------------------------|------------------|-----------------|
| Vendor<br>Signature X  | FEIN# 48-1164042 | DATE 09/01/2026 |
| All offers subject to all terms and conditions contained in this solicitation                             |                  |                 |





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

State of West Virginia  
Centralized Request for Proposals  
Service - Misc

Proc Folder: 1945653

Doc Description: MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN

Reason for Modification:

Proc Type: Central Master Agreement

| Date Issued | Solicitation Closes | Solicitation No         | Version |
|-------------|---------------------|-------------------------|---------|
| 2026-07-16  | 2026-08-25 13:30    | CRFP 0511 BMS2700000001 | 1       |

**BID RECEIVING LOCATION**

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

**VENDOR**

Vendor Customer Code: 000000191225

Vendor Name : Myers and Stauffer LC

Address : 1349 W.

Street : Peachtree St. NE, Ste. 1600

City : Atlanta

State : GA

Country : United States

Zip : 30309

Principal Contact : Jerry Dubberly, PharmD, MBA

Vendor Contact Phone: 404-524-9519

Extension: N/A

**FOR INFORMATION CONTACT THE BUYER**

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

Vendor

Signature X

FEIN# 48-1164042

DATE 09/01/2026

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

SEPTEMBER 9, 2026

## V. REQUIRED FORMS

|                                                                                   |                                                                                                                                          |                                                                               |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
|  | Department of Administration<br>Purchasing Division<br>2019 Washington Street East<br>Post Office Box 60130<br>Charleston, WV 25305-0130 | State of West Virginia<br>Centralized Request for Proposals<br>Service - Misc |
|                                                                                   |                                                                                                                                          |                                                                               |

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|---------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------------------------------|----------------|
| <b>Proc Folder:</b> 1945653<br><b>Doc Description:</b> MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN |                            | <b>Reason for Modification:</b><br>ADDENDUM 1<br>TO PROVIDE ANSWERS TO<br>VENDOR QUESTIONS |                |
| <b>Proc Type:</b> Central Master Agreement                                                              |                            |                                                                                            |                |
| <b>Date Issued</b>                                                                                      | <b>Solicitation Closes</b> | <b>Solicitation No</b>                                                                     | <b>Version</b> |
| 2026-08-14                                                                                              | 2026-08-25 13:30           | CRFP 0511 BMS2700000001                                                                    | 2              |

**BID RECEIVING LOCATION**

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

**VENDOR**

**Vendor Customer Code:** 000000191225  
**Vendor Name :** Myers and Stauffer LC  
**Address :** 1349 W.  
**Street :** Peachtree St. NE, Ste. 1600  
**City :** Atlanta  
**State :** GA **Country :** United States **Zip :** 30309  
**Principal Contact :** Jerry Dubberly, PharmD, MBA  
**Vendor Contact Phone:** 404-524-9519 **Extension:** N/A

**FOR INFORMATION CONTACT THE BUYER**

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

**Vendor Signature X**  **FEIN#** 48-1164042 **DATE** 09/01/2026  
 All offers subject to all terms and conditions contained in this solicitation





Department of Administration  
Purchasing Division  
2019 Washington Street East  
Post Office Box 50130  
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State of West Virginia  
Centralized Request for Proposals  
Service - Misc

Proc Folder: 1945653

Doc Description: MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN

Reason for Modification:

ADDENDUM 1  
TO PROVIDE ANSWERS TO  
VENDOR QUESTIONS

Proc Type: Central Master Agreement

| Date Issued | Solicitation Closes | Solicitation No         | Version |
|-------------|---------------------|-------------------------|---------|
| 2026-08-14  | 2026-08-25 13:30    | CRFP 0511 BMS2700000001 | 2       |

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crystal.g.hustead@wv.gov

Vendor  
Signature X

FEIN# 48-1164042

DATE 09/01/2026

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

## V. REQUIRED FORMS

|                                                                                   |                                                                                                                                          |                                                                               |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
|  | Department of Administration<br>Purchasing Division<br>2019 Washington Street East<br>Post Office Box 50130<br>Charleston, WV 25305-0130 | State of West Virginia<br>Centralized Request for Proposals<br>Service - Misc |
|                                                                                   |                                                                                                                                          |                                                                               |

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|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------|
| <b>Proc Folder:</b> 1945653<br><b>Doc Description:</b> MEDICAID MANAGED CARE RATE SETTING/PROGRAM ADMIN<br><b>Proc Type:</b> Central Master Agreement |                                                | <b>Reason for Modification:</b><br>ADDENDUM 2<br>TO EXTEND OPENING DATE |
| <b>Date Issued</b><br>2026-08-20                                                                                                                      | <b>Solicitation Closes</b><br>2026-09-09 13:30 | <b>Solicitation No</b><br>CRFP 0511 BMS2700000001                       |
|                                                                                                                                                       |                                                | <b>Version</b><br>3                                                     |

**BID RECEIVING LOCATION**

BID CLERK  
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 2019 WASHINGTON ST E  
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**Vendor Contact Phone:** 404-524-9519 **Extension:** N/A

**FOR INFORMATION CONTACT THE BUYER**

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

**Vendor Signature X**  **FEIN#** 48-1164042 **DATE** 09/01/2026  
 All offers subject to all terms and conditions contained in this solicitation

*Original, Signed Form Submitted with Cost Proposal.*



## Addendum Acknowledgment Form

**ADDENDUM ACKNOWLEDGEMENT FORM****SOLICITATION NO.: BMS2700000001**

**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)

|                                                    |                                          |
|----------------------------------------------------|------------------------------------------|
| <input checked="" type="checkbox"/> Addendum No. 1 | <input type="checkbox"/> Addendum No. 6  |
| <input checked="" type="checkbox"/> Addendum No. 2 | <input type="checkbox"/> Addendum No. 7  |
| <input type="checkbox"/> Addendum No. 3            | <input type="checkbox"/> Addendum No. 8  |
| <input type="checkbox"/> Addendum No. 4            | <input type="checkbox"/> Addendum No. 9  |
| <input type="checkbox"/> Addendum No. 5            | <input type="checkbox"/> 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.

Myers and Stauffer LC

Company



Authorized Signature

09/01/2026

Date

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

**ADDENDUM ACKNOWLEDGEMENT FORM**  
**SOLICITATION NO.: BMS2700000001**

**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)

|                                                    |                                          |
|----------------------------------------------------|------------------------------------------|
| <input checked="" type="checkbox"/> Addendum No. 1 | <input type="checkbox"/> Addendum No. 6  |
| <input checked="" type="checkbox"/> Addendum No. 2 | <input type="checkbox"/> Addendum No. 7  |
| <input type="checkbox"/> Addendum No. 3            | <input type="checkbox"/> Addendum No. 8  |
| <input type="checkbox"/> Addendum No. 4            | <input type="checkbox"/> Addendum No. 9  |
| <input type="checkbox"/> Addendum No. 5            | <input type="checkbox"/> 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.

Myers and Stauffer LC

Company



Authorized Signature

09/01/2026

Date

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

Revised 6/8/2012



## Designated Contact Information 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) Jerry Dubberly, PharmD, MBA- Principal

(Address) 1349 W Peachtree Street, NE, Suite 1600 Atlanta, GA 30309

(Phone Number) / (Fax Number) 404-524-9519/404-524-0728

(email address) JDubberly@mslc.com

**CERTIFICATION AND SIGNATURE:** By signing below, or submitting documentation through www.OASIS, 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.

Myers and Stauffer LC

(Company)



(Signature of Authorized Representative)

Jerry Dubberly, PharmD, MBA - Principal - 09/01/2026

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

404-524-9519/404-524-0728

(Phone Number) (Fax Number)

JDubberly@mslc.com

(Email Address)

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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.

Myers and Stauffer LC

(Company)



(Signature of Authorized Representative)

Jerry Dubberly, PharmD, MBA - Principal - 09/01/2026

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

404-524-9519/404-524-0728

(Phone Number) (Fax Number)

JDubberly@mslc.com

(Email Address)



## Availability of Information Form

### REQUEST FOR PROPOSAL

#### CRFP BMS2700000001-Medicaid Managed Care Rate Setting

Example:

Proposal 1 Cost is \$1,000,000

Proposal 2 Cost is \$1,100,000

Points Allocated to Cost Proposal is 300

Proposal 1: Step 1 –  $\$1,000,000 / \$1,000,000 = \text{Cost Score Percentage of 1 (100\%)}$

Step 2 –  $1 \times 300 = \text{Total Cost Score of 300}$

Proposal 2: Step 1 –  $\$1,000,000 / \$1,100,000 = \text{Cost Score Percentage of 0.909091 (90.9091\%)}$

Step 2 –  $0.909091 \times 300 = \text{Total Cost Score of 272.7273}$

- 6.8. **Availability of Information:** Proposal submissions become public and are available for review immediately after opening pursuant to West Virginia Code §5A-3-11(h). All other information associated with the RFP, including but not limited to, technical scores and reasons for disqualification, will not be available until after the contract has been awarded pursuant to West Virginia Code of State Rules §148-1-6.3. d.

By signing below, I certify that I have reviewed this Request for Proposal in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that, to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

Myers and Stauffer L.C.

Revised 07/01/2021

## REQUEST FOR PROPOSAL

### CRFP BMS2700000001-Medicaid Managed Care Rate Setting

(Company)



Jerry Dubberly, PharmD, MBA - Principal

(Representative Name, Title)

404-524-9519/404-524-0728

(Contact Phone/Fax Number)

09/01/2026

(Date)

Revised 07/01/2021



# REQUEST FOR PROPOSAL

## CRFP BMS2700000001-Medicaid Managed Care Rate Setting

(Company)



Jerry Dubberly, PharmD, MBA - Principal

(Representative Name, Title)

404-524-9519/404-524-0728

(Contact Phone/Fax Number)

09/01/2026

(Date)

## Federal Funds Addendum

Attachment 1

### **FEDERAL FUNDS ADDENDUM**

2 C.F.R. §§ 200.317 – 200.327

**Purpose:** This addendum is intended to modify the solicitation in an attempt to make the contract compliant with the requirements of 2 C.F.R. §§ 200.317 through 200.327 relating to the expenditure of certain federal funds. This solicitation will allow the State to obtain one or more contracts that satisfy standard state procurement, state federal funds procurement, and county/local federal funds procurement requirements.

**Instructions:** Vendors who are willing to extend their contract to procurements with federal funds and the requirements that go along with doing so, should sign the attached document identified as: "REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317)"

Should the awarded vendor be unwilling to extend the contract to federal funds procurement, the State reserves the right to award additional contracts to vendors that can and are willing to meet federal funds procurement requirements.

**Changes to Specifications:** Vendors should consider this solicitation as containing two separate solicitations, one for state level procurement and one for county/local procurement.

**State Level:** In the first solicitation, bid responses will be evaluated with applicable preferences identified in sections 15, 15A, and 16 of the "Instructions to Vendors Submitting Bids" to establish a contract for both standard state procurements and state federal funds procurements.

**County Level:** In the second solicitation, bid responses will be evaluated with applicable preferences identified in Sections 15, 15A, and 16 of the "Instructions to Vendors Submitting Bids" omitted to establish a contract for County/Local federal funds procurement.

**Award:** If the two evaluations result in the same vendor being identified as the winning bidder, the two solicitations will be combined into a single contract award. If the evaluations result in a different bidder being identified as the winning bidder, multiple contracts may be awarded. The State reserves the right to award to multiple different entities should it be required to satisfy standard state procurement, state federal funds procurement, and county/local federal funds procurement requirements.

**State Government Use Caution:** State agencies planning to utilize this contract for procurements subject to the above identified federal regulations should first consult with the federal agency providing the applicable funding to ensure the contract is compliant.

**County/Local Government Use Caution:** County and Local government entities planning to utilize this contract for procurements subject to the above identified federal regulation should first consult with the federal agency providing the applicable funding to ensure the contract is compliant. For purposes of County/Local government use, the solicitation resulting in this contract was conducted in accordance with the procurement laws, rules, and procedures governing the West Virginia Department of Administration, Purchasing Division, except that vendor preference has been omitted for County/Local use purposes and the contract terms contained in the document entitled "REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317)" have been added.



**FEDERAL FUNDS ADDENDUM****REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY  
CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317):**

The State of West Virginia Department of Administration, Purchasing Division, and the Vendor awarded this Contract intend that this Contract be compliant with the requirements of the Procurement Standards contained in the Uniform Administrative Requirements, Cost Principles, and Audit Requirements found in 2 C.F.R. § 200.317, et seq. for procurements conducted by a Non-Federal Entity. Accordingly, the Parties agree that the following provisions are included in the Contract.

**1. MINORITY BUSINESSES, WOMEN'S BUSINESS ENTERPRISES, AND LABOR SURPLUS AREA FIRMS:  
(2 C.F.R. § 200.321)**

- a. The State confirms that it has taken all necessary affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible. Those affirmative steps include:
  - (1) Placing qualified small and minority businesses and women's business enterprises on solicitation lists;
  - (2) Assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;
  - (3) Dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority businesses, and women's business enterprises;
  - (4) Establishing delivery schedules, where the requirement permits, which encourage participation by small and minority businesses, and women's business enterprises;
  - (5) Using the services and assistance, as appropriate, of such organizations as the Small Business Administration and the Minority Business Development Agency of the Department of Commerce; and
  - (6) Requiring the prime contractor, if subcontracts are to be let, to take the affirmative steps listed in paragraphs (1) through (5) above.
- b. Vendor confirms that if it utilizes subcontractors, it will take the same affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible.

**2. DOMESTIC PREFERENCES:  
(2 C.F.R. § 200.322)**

- a. The State confirms that as appropriate and to the extent consistent with law, it has, to the greatest extent practicable under a Federal award, provided a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United

States (including but not limited to iron, aluminum, steel, cement, and other manufactured products).

- b. Vendor confirms that will include the requirements of this Section 2. Domestic Preference in all subawards including all contracts and purchase orders for work or products under this award.

- c. Definitions: For purposes of this section:

(1) "Produced in the United States" means, for iron and steel products, that all manufacturing processes, from the initial melting stage through the application of coatings, occurred in the United States.

(2) "Manufactured products" means items and construction materials composed in whole or in part of non-ferrous metals such as aluminum; plastics and polymer-based products such as polyvinyl chloride pipe; aggregates such as concrete; glass, including optical fiber; and lumber.

**3. BREACH OF CONTRACT REMEDIES AND PENALTIES:**

(2 C.F.R. § 200.327 and Appendix II)

- (a) The provisions of West Virginia Code of State Rules § 148-1-5 provide for breach of contract remedies, and penalties. A copy of that rule is attached hereto as Exhibit A and expressly incorporated herein by reference.

**4. TERMINATION FOR CAUSE AND CONVENIENCE:**

(2 C.F.R. § 200.327 and Appendix II)

- (a) The provisions of West Virginia Code of State Rules § 148-1-5 govern Contract termination. A copy of that rule is attached hereto as Exhibit A and expressly incorporated herein by reference.

**5. EQUAL EMPLOYMENT OPPORTUNITY:**

(2 C.F.R. § 200.327 and Appendix II)

Except as otherwise provided under 41 CFR Part 60, and if this contract meets the definition of "federally assisted construction contract" in 41 CFR Part 60-1.3, this contract includes the equal opportunity clause provided under 41 CFR 60-1.4(b), in accordance with Executive Order 11246, "Equal Employment Opportunity" (30 FR 12319, 12935, 3 CFR Part, 1964-1965 Comp., p. 339), as amended by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and implementing regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

**6. DAVIS-BACON WAGE RATES:**

(2 C.F.R. § 200.327 and Appendix II)



**V. REQUIRED FORMS**

Vendor agrees that if this Contract includes construction, all construction work in excess of \$2,000 will be completed and paid for in compliance with the Davis-Bacon Act (40 U.S.C. 3141-3144, and 3146-3148) as supplemented by Department of Labor regulations (29 CFR Part 5, "Labor Standards Provisions Applicable to Contracts Covering Federally Financed and Assisted Construction"). In accordance with the statute, contractors must:

- (a) pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor.
- (b) pay wages not less than once a week.

A copy of the current prevailing wage determination issued by the Department of Labor is attached hereto as Exhibit B. The decision to award a contract or subcontract is conditioned upon the acceptance of the wage determination. The State will report all suspected or reported violations to the Federal awarding agency.

**7. ANTI-KICKBACK ACT:**  
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that it will comply with the Copeland Anti-KickBack Act (40 U.S.C. 3145), as supplemented by Department of Labor regulations (29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States"). Accordingly, Vendor, Subcontractors, and anyone performing under this contract are prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled. The State must report all suspected or reported violations to the Federal awarding agency.

**8. CONTRACT WORK HOURS AND SAFETY STANDARDS ACT**  
(2 C.F.R. § 200.327 and Appendix II)

Where applicable, and only for contracts awarded by the State in excess of \$100,000 that involve the employment of mechanics or laborers, Vendor agrees to comply with 40 U.S.C. 3702 and 3704, as supplemented by Department of Labor regulations (29 CFR Part 5). Under 40 U.S.C. 3702 of the Act, Vendor is required to compute the wages of every mechanic and laborer on the basis of a standard work week of 40 hours. Work in excess of the standard work week is permissible provided that the worker is compensated at a rate of not less than one and a half times the basic rate of pay for all hours worked in excess of 40 hours in the work week. The requirements of 40 U.S.C. 3704 are applicable to construction work and provide that no laborer or mechanic must be required to work in surroundings or under working conditions which are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

**9. RIGHTS TO INVENTIONS MADE UNDER A CONTRACT OR AGREEMENT.**  
(2 C.F.R. § 200.327 and Appendix II)

**V. REQUIRED FORMS**

If the Federal award meets the definition of "funding agreement" under 37 CFR § 401.2 (a) and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement," the recipient or subrecipient must comply with the requirements of 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

**10. CLEAN AIR ACT**  
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that if this contract exceeds \$150,000, Vendor is to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401-7671q) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251-1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

**11. DEBARMENT AND SUSPENSION**  
(2 C.F.R. § 200.327 and Appendix II)

The State will not award to any vendor that is listed on the governmentwide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp., p. 189) and 12689 (3 CFR part 1989 Comp., p. 235), "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

**12. BYRD ANTI-LOBBYING AMENDMENT**  
(2 C.F.R. § 200.327 and Appendix II)

Vendors that apply or bid for an award exceeding \$100,000 must file the required certification. Each tier certifies to the tier above that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier must also disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the non-Federal award.

**13. PROCUREMENT OF RECOVERED MATERIALS**  
(2 C.F.R. § 200.327 and Appendix II; 2 C.F.R. § 200.323)

Vendor agrees that it and the State must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the



Environmental Protection Agency (EPA) at 40 CFR part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds \$10,000 or the value of the quantity acquired during the preceding fiscal year exceeded \$10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

**14. PROHIBITION ON CERTAIN TELECOMMUNICATIONS AND VIDEO SURVEILLANCE SERVICES OR EQUIPMENT.**  
(2 C.F.R. § 200.327 and Appendix II; 2 CFR § 200.216)

Vendor and State agree that both are prohibited from obligating or expending funds under this Contract to:

- (1) Procure or obtain;
- (2) Extend or renew a contract to procure or obtain; or
- (3) Enter into a contract (or extend or renew a contract) to procure or obtain equipment, services, or systems that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. As described in Public Law 115–232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).
  - (i) For the purpose of public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities).
  - (ii) Telecommunications or video surveillance services provided by such entities or using such equipment.
  - (iii) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of the National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

In implementing the prohibition under Public Law 115–232, section 889, subsection (f), paragraph (1), heads of executive agencies administering loan, grant, or subsidy programs shall prioritize available funding and technical support to assist affected businesses, institutions and organizations as is reasonably necessary for those affected entities to transition from covered communications equipment and services, to procure replacement equipment and services, and to ensure that communications service to users and customers is sustained.

SEPTEMBER 9, 2026

**V. REQUIRED FORMS**

**State of West Virginia**

**Vendor Name:** Myers and Stauffer LC

**By:** \_\_\_\_\_

**By:** 

**Printed Name:** \_\_\_\_\_

**Printed Name:** Jerry Dubberly, PharmD, MBA

**Title:** \_\_\_\_\_

**Title:** Principal

**Date:** \_\_\_\_\_

**Date:** 09/01/2026



State of West Virginia

By: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Vendor Name: Myers and Stauffer LC

By:  \_\_\_\_\_

Printed Name: Jerry Dubberly, PharmD, MBA

Title: Principal

Date: 09/01/2026

# HIPAA Business Associate Agreement Addendum

## WV STATE GOVERNMENT

### HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective as of the date of execution of the Addendum.

The Associate performs certain services on behalf of or for the Agency pursuant to the underlying Agreement that requires the exchange of information including protected health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act"), any associated regulations and the federal regulations published at 45 CFR parts 160 and 164 (sometimes collectively referred to as "HIPAA"). The Agency is a "Covered Entity" as that term is defined in HIPAA, and the parties to the underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and to bring the underlying Agreement into compliance with HIPAA.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas, it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, the HITECH Act and its associated regulations, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE: the parties agree that in consideration of the mutual promises herein, in the Agreement, and of the exchange of PHI hereunder that:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.
  - a. **Agency Procurement Officer** shall mean the appropriate Agency individual listed at: <http://www.state.wv.us/admin/purchase/vrc/agencyli.html>.
  - b. **Agent** shall mean those person(s) who are agent(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).
  - c. **Breach** shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except as excluded in the definition of Breach in 45 CFR § 164.402.
  - d. **Business Associate** shall have the meaning given to such term in 45 CFR § 160.103.
  - e. **HITECH Act** shall mean the Health Information Technology for Economic and Clinical Health Act. Public Law No. 111-05. 111<sup>th</sup> Congress (2009).



**V. REQUIRED FORMS**

- f. **Privacy Rule** means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and 164.
- g. **Protected Health Information or PHI** shall have the meaning given to such term in 45 CFR § 160.103, limited to the information created or received by Associate from or on behalf of Agency.
- h. **Security Incident** means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.
- i. **Security Rule** means the Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR Parts 160 and 164.
- j. **Subcontractor** means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

**2. Permitted Uses and Disclosures.**

- a. **PHI Described.** This means PHI created, received, maintained or transmitted on behalf of the Agency by the Associate. This PHI is governed by this Addendum and is limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the original Agreement, and is described in Appendix A.
- b. **Purposes.** Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original Agreement, or as required by law, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or Associate, or violate the minimum necessary and related Privacy and Security policies and procedures of the Agency. The Associate is directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Agency.
- c. **Further Uses and Disclosures.** Except as otherwise limited in this Addendum, the Associate may disclose PHI to third parties for the purpose of its own proper management and administration, or as required by law, provided that (i) the disclosure is required by law, or (ii) the Associate has obtained from the third party reasonable assurances that the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party by the Associate; and, (iii) an agreement to notify the Associate and Agency of any instances of which it (the third party) is aware in which the confidentiality of the information has been breached. To the extent practical, the information should be in a limited data set or the minimum necessary information pursuant to 45 CFR § 164.502, or take other measures as necessary to satisfy the Agency's obligations under 45 CFR § 164.502.

**V. REQUIRED FORMS****3. Obligations of Associate.**

- a. **Stated Purposes Only.** The PHI may not be used by the Associate for any purpose other than as stated in this Addendum or as required or permitted by law.
- b. **Limited Disclosure.** The PHI is confidential and will not be disclosed by the Associate other than as stated in this Addendum or as required or permitted by law. Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual's PHI unless Agency gives written approval and the individual provides a valid authorization. Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Associate will report to Agency any use or disclosure of the PHI, including any Security Incident not provided for by this Agreement of which it becomes aware.
- c. **Safeguards.** The Associate will use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the PHI, except as provided for in this Addendum. This shall include, but not be limited to:
  - i. Limitation of the groups of its workforce and agents, to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary or a Limited Data Set;
  - ii. Appropriate notification and training of its workforce and agents in order to protect the PHI from unauthorized use and disclosure;
  - iii. Maintenance of a comprehensive, reasonable and appropriate written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations, in compliance with the Security Rule;
  - iv. In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information.
- d. **Compliance With Law.** The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.
- e. **Mitigation.** Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum, and report its mitigation activity back to the Agency.



**V. REQUIRED FORMS****f. Support of Individual Rights.**

- i. **Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying, and in electronic format, if requested, within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524 and consistent with Section 13405 of the HITECH Act.
- ii. **Amendment of PHI.** Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an Individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.
- iii. **Accounting Rights.** Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.528 and consistent with Section 13405 of the HITECH Act. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:
  - the date of disclosure;
  - the name of the entity or person who received the PHI, and if known, the address of the entity or person;
  - a brief description of the PHI disclosed; and
  - a brief statement of purposes of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.
- iv. **Request for Restriction.** Under the direction of the Agency, abide by any individual's request to restrict the disclosure of PHI, consistent with the requirements of Section 13405 of the HITECH Act and 45 CFR § 164.522, when the Agency determines to do so (except as required by law) and if the disclosure is to a health plan for payment or health care operations and it pertains to a health care item or service for which the health care provider was paid in full "out-of-pocket."
- v. **Immediate Discontinuance of Use or Disclosure.** The Associate will immediately discontinue use or disclosure of Agency PHI pertaining to any individual when so requested by Agency. This includes, but is not limited to, cases in which an individual has withdrawn or modified an authorization to use or disclose PHI.

- g. **Retention of PHI.** Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.
- h. **Agent's, Subcontractor's Compliance.** The Associate shall notify the Agency of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract and shall be delivered to the Agency Procurement Officer. The Associate will ensure that any of its subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder. The Agency may request copies of downstream subcontracts and agreements to determine whether all restrictions, terms and conditions have been flowed down. Failure to ensure that downstream contracts, subcontracts and agreements contain the required restrictions, terms and conditions may result in termination of the Agreement.
- j. **Federal and Agency Access.** The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI, as well as the PHI, received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504. The Associate shall also make these records available to Agency, or Agency's contractor, for periodic audit of Associate's compliance with the Privacy and Security Rules. Upon Agency's request, the Associate shall provide proof of compliance with HIPAA and HITECH data privacy/protection guidelines, certification of a secure network and other assurance relative to compliance with the Privacy and Security Rules. This section shall also apply to Associate's subcontractors, if any.
- k. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, compliance with 74 FR 19006 Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII is required, to the extent practicable. If Associate chooses not to adopt such methodologies as defined in 74 FR 19006 to secure the PHI governed by this Addendum, it must submit such written rationale, including its Security Risk Analysis, to the Agency Procurement Officer for review prior to the execution of the Addendum. This review may take up to ten (10) days.
- l. **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 immediately by e-mail 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 in 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](http://www.state.wv.us/admin/purchase/vrc/agencyli.htm) and,



**V. REQUIRED FORMS**

unless otherwise directed by the Agency in writing, the Office of Technology at [Incident@wv.gov](mailto:Incident@wv.gov) or <https://aops.wv.gov/otir/Default.aspx>.

The Associate shall immediately investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within 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.

Agency will coordinate with Associate to determine additional specific actions that will be required of the Associate for mitigation of the Breach, which may include notification to the individual or other authorities.

All associated costs shall be borne by the Associate. This may include, but not be limited to costs associated with notifying affected individuals.

If the Associate enters into a subcontract relating to the Agreement where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum, all such subcontracts or downstream agreements shall contain the same incident notification requirements as contained herein, with reporting directly to the Agency Procurement Officer. Failure to include such requirement in any subcontract or agreement may result in the Agency's termination of the Agreement.

- m. **Assistance in Litigation or Administrative Proceedings.** The Associate shall make itself and any subcontractors, workforce or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inaction or actions by the Associate, except where Associate or its subcontractor, workforce or agent is a named as an adverse party.

#### **4. Addendum Administration.**

- a. **Term.** This Addendum shall terminate on termination of the underlying Agreement or on the date the Agency terminates for cause as authorized in paragraph (c) of this Section, whichever is sooner.
- b. **Duties at Termination.** Upon any termination of the underlying Agreement, the Associate shall return or destroy, at the Agency's option, all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents

**V. REQUIRED FORMS**

and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying Agreement.

- c. **Termination for Cause.** Associate authorizes termination of this Agreement by Agency, if Agency determines Associate has violated a material term of the Agreement. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.
- d. **Judicial or Administrative Proceedings.** The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA/HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined. Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA/HITECH and shall be responsible for any and all costs associated with prosecution.
- e. **Survival.** The respective rights and obligations of Associate under this Addendum shall survive the termination of the underlying Agreement.

**5. General Provisions/Ownership of PHI.**

- a. **Retention of Ownership.** Ownership of the PHI resides with the Agency and is to be returned on demand or destroyed at the Agency's option, at any time, and subject to the restrictions found within section 4.b. above.
- b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an individual must be held confidential and is also the property of Agency.
- c. **Electronic Transmission.** Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an individual must not be transmitted to another party by electronic or other means for additional uses or disclosures not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.
- d. **No Sales.** Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.
- e. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
- f. **Interpretation.** The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.
- g. **Amendment.** The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.
- h. **Additional Terms and Conditions.** Additional discretionary terms may be included in the release order or change order process.



SEPTEMBER 9, 2026

**V. REQUIRED FORMS****AGREED:**

Name of Agency: \_\_\_\_\_

Name of Associate: Jerry Dubberly, PharmD, MBA

Signature: \_\_\_\_\_

Signature: 

Title: \_\_\_\_\_

Title: Principal, Myers and Stauffer LC

Date: \_\_\_\_\_

Date: 09/01/2026Form - WVBAA-012004  
Amended 06.28.2013

APPROVED AS TO FORM THIS 26th  
DAY OF Sept 20 26  
BY   
Patrick Morrissey  
Attorney General

AGREED:

Name of Agency: \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Associate: Jerry Dubberly, PharmD, MBA

Signature: 

Title: Principal, Myers and Stauffer LC

Date: 09/01/2026

Form - WVBA-012004  
Amended 06.26.2013

APPROVED AS TO FORM THIS 26th  
DAY OF Jan 20 13  
  
Patrick Morrissey  
Attorney General  
BY \_\_\_\_\_



## VI. APPENDICES

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- Appendix A: Conflicts of Interest Mitigation Plan
- Appendix B: Example Certifications
- Appendix C: Resumes
- Appendix D: Certifications and Degrees

## Appendix A: Conflicts of Interest Mitigation Plan

### Myers & Stauffer Conflicts of Interest Mitigation Plan

Myers & Stauffer takes a comprehensive approach to ensure and verify the absence of any actual or potential conflicts of interest in our client engagements. This approach includes four components:

1. Restriction of our client base to state, federal, and local government clients only.
2. Maintenance of independence in decision-making.
3. Evaluation of new projects internally against our client base.
4. Collection and maintenance of employee representations of independence, integrity, and objectivity.
5. Performance of due diligence background reviews of proposed subcontractors.

First, unlike most of our competitors, Myers & Stauffer's business practice intentionally restricts the firm's client base to government healthcare and social services agencies. We do not accept healthcare providers or health plans as clients. This intentional restriction minimizes the potential of developing a real or perceived conflict of interest (COI) among regulated entities such as health plans and providers.

Second, Myers & Stauffer intentionally avoids participation in engagements that could require making management decisions on behalf of a client. As a certified public accounting (CPA) firm, we are required by professional standards promulgated by the American Institute of Certified Public Accountants (AICPA) to maintain independence both in fact and in appearance. To maintain such independence, Myers & Stauffer provides our clients with consulting and analytical services and certain audit or attest functions to support the management of their programs; we do not accept engagements that could impede our ability to support our clients with their analytical needs or that could limit our ability to perform engagements that opine on the effectiveness of the operational aspects of government programs.

Third, Myers & Stauffer applies a systematic client vetting process that evaluates a proposed client engagement or new scope of work with our other contracts to identify potential conflicts that could interfere with or otherwise contradict the services that will be provided. Information, such as state agency, provider categories, provider names, a description of the work to be completed, or other relevant information is reviewed by management for any potential COIs. In the event that a potential conflict is identified, a mitigation strategy is developed and reviewed with the client.

Fourth, Myers & Stauffer requires members of the workforce to sign and submit an annual "Independence, Integrity, and Objectivity Representation" form, as pictured below. Through this process, workforce members identify circumstances or relationships that may create a potential threat to independence, COI, or violation of the firm's ethical requirements policy. In adherence to the firm's quality management policies and procedures, an internal quality management committee presents issues identified from this process to firm management so appropriate action can be taken.



## Exhibit A: Independence, Integrity, and Objectivity Representation


**Myers & Stauffer**

### Independence, Integrity, and Objectivity Representation

*Reviewed August 2026*

Personnel name:  Office location:

**INSTRUCTIONS:** This representation should be completed when hired and annually thereafter. It is required for all professional personnel, including seasonal and part-time individuals employed by the firm as well as contractors. This representation and attachments should be routed to the Independence Lead to review and retain in the Quality Management files.

I have read and understand the Myers and Stauffer policies and procedures regarding relevant ethical requirements as stated in the firm's Quality Management Manual. I represent that:

1. I am familiar with and will adhere to the independence, integrity, and objectivity rules, regulations, and interpretations of the American Institute of Certified Public Accountants (AICPA) Code of Professional Conduct; the firm's Ethical Requirements policies and procedures; and Generally Accepted Government Auditing Standards, when applicable. If I am a CPA, I am familiar with and will adhere to relevant AICPA Professional Standards and requirements of state boards of accountancy and CPA societies for states germane to my practice area.
2. Except as disclosed in the fields below, I am not aware of any prohibited investments, transactions, or relationships with any health care providers that have provided or currently provide services to Medicare or Medicaid beneficiaries.
3. Except as disclosed in the fields below, I have no financial relationships with pharmaceutical, medical device, or medical supply manufacturers, including relationships that may be reportable under the CMS Open Payments program, that could impair or appear to impair my independence, integrity, or objectivity.
4. Any situation where I am either not independent or I am unsure whether I am independent is listed and explained in the fields below.
5. Any situation in which I am not able to determine or unsure as to whether I am able to exercise objectivity in performing an engagement is disclosed in the fields below.
6. I am not currently under any investigation or disciplinary proceeding, and no such matter is pending with the AICPA or any other professional organization or regulatory agency. There are no matters that would cause a reasonable person to conclude that I lack integrity in the performance of my professional responsibilities.

**Based on your understanding of the policies outlined above, select the statement that best reflects your situation:**

☐ I affirm that I have no conflicts to disclose and am in compliance with the professional standards and firm policies described above.

☐ I may have a potential conflict (please fill in both sections below to be reviewed by our Quality Management Leadership).

| Client or Provider | Possible Issues |
|--------------------|-----------------|
|                    |                 |

Signature \_\_\_\_\_

Date \_\_\_\_\_

*For Administrative Use Only*

Reviewed by Independence Lead: \_\_\_\_\_

Date: \_\_\_\_\_

Lastly, Myers & Stauffer thoroughly reviews available background information on our potential subcontractors. We employ a due diligence process, operating under a mutual confidentiality agreement, to discuss the current work, relationships, and possible conflicts that the potential subcontractor may have. As we advance to the contracting agreement stage, we incorporate a Third-Party Code of Conduct in our subcontractor agreement that defines an actual or potential COI that applies not only to the subcontractor but also the subcontractor's personnel and their family members. The subcontractor is contractually required to immediately disclose any potential or actual COI to the

Myers & Stauffer Chief Compliance Officer. Conflicts of interest or failure to comply with notification requirements is a contract violation that may result in termination of the subcontractor agreement.

Should any conflict be identified, we will report such findings to the client along with an assessment of:

- Whether the conflict is actual, potential, or perceived.
- The likelihood that the relationship could impair independent judgment or performance of work under the client contract.
- Potential mitigation strategies and the realistic effectiveness of those measures.

We will tailor our proposed mitigation strategy to the situation and in accordance with the direction provided and approved of by our client. Depending on the nature of the conflict, our mitigation strategy may include:

- Removing affected personnel from specific assignments.
- Assigning independent staff who have no conflicting interests.
- Establishing organizational firewalls between business units.
- Restricting access to confidential or procurement-sensitive information.
- Performing independent quality assurance reviews of affected work products.
- Implementing enhanced supervisory oversight.
- Removing conflicted individuals from meetings, evaluations, recommendations, or decisions involving the conflict.
- Replacing subcontractors or personnel when mitigation cannot adequately eliminate the risk.

Myers & Stauffer is committed to perform an active and responsive mitigation strategy that effectively assesses conflicts of interest, minimizes risk and meets the client's approval.

## Subcontractor Conflicts of Interest Mitigation Plan

### Milliman Organizational Conflict Mitigation Plan

State agencies and Milliman have successfully mitigated all potential conflicts of interest over our 30-year relationship serving as actuary for state agencies. We will continue to successfully mitigate any potential conflicts in the future. Additionally, the Milliman consulting team proposed for this work has not and will not consult with any current or potential capitated plan on any work related to the West Virginia Medicaid program.

Milliman has a strong reputation for integrity and quality in all its work products, and these have been core values of Milliman since our formation in 1947. Because of the depth of our expertise and the scope of our clientele, potential conflicts arise often, and Milliman has long-established procedures that prevent inappropriate sharing of information in such situations.

Milliman follows strict procedures to avoid conflicts of interest in our work. Milliman has successfully used these procedures in numerous situations for all types of clients. Specifically, we have successfully



implemented our conflict avoidance process in numerous states where different Milliman consultants work either for the state Medicaid agency or for Medicaid health plans within a state.

Our conflict mitigation plan is built around the following procedural steps and safeguards. This process takes place before a consultant can proceed with a new project and continues during the project if there is any change in the situation.

- At the beginning of any client relationship, the lead Milliman consultant for the new client is required to notify all other consultants of the nature of the relationship through our conflict check notification system. This process ensures that other Milliman consultants with potential conflicts of interest are aware of the new relationship and can act accordingly. Milliman consultants are also required to use the conflict check notification system for any client project with existing clients that has the potential for conflicts with other clients.
- After a potential COI has been identified, the next step is to notify all affected parties. All parties must agree to the conflict avoidance arrangements before any new project or any work with a new client can begin. Milliman maintains a need-to-know policy, meaning that no judgment or material factual information will be shared between Milliman consultants representing competing parties unless Milliman is jointly retained by those parties or such disclosure is approved by all of the affected clients. This policy restricts concurrent similar assignments from competing clients without sufficient physical separation of the consulting services for the competing clients.
- We create internal structures so all information is kept strictly confidential to the specifically assigned client team. Milliman regularly builds walls between teams of consultants for projects with similar circumstances. We utilize separate teams of consultants and support staff, secure file storage, and a communication blackout between teams of consultants. In addition, any Milliman actuarial consultants leading each project are Members of the American Academy of Actuaries and are thereby bound to confidentiality by the Actuarial Code of Conduct.

Milliman's Organizational Conflict Mitigation Plan is administered by the Corporate Secretary and the relevant Global Practice Director. Mary Clare is Milliman's Chief Legal Officer and Corporate Secretary. Mike Weiland is Milliman's Global Health Practice Director. Mr. Weiland sits on Milliman's Board of Directors and provides leadership for all Milliman health consulting and product practices around the world.

In addition to our client and project-specific conflict mitigation procedures and safeguards, Milliman also has strict policies that guard against personal conflicts of interest and the release of confidential information:

- Milliman maintains an employee policy that restricts any ownership or financial interest in outside organizations that pose a COI. The policy restricts ownership of any insurance companies and prohibits financial interest by an employee in any entity that the employee consults for in his/her practice.

- Each employee who has access to client information is required to sign an agreement with Milliman regarding the protection of sensitive client information. Milliman maintains internal procedures designed to protect the confidentiality of sensitive client information, including administrative, technical, and physical safeguards as appropriate for the information. In addition, employees are instructed regarding any specific handling procedures required by contract with respect to client information.
- Milliman's Governing Principle on Fee Arrangements stipulates that neither the firm nor any employee may accept or share in contingent fees or any other form of compensation that may cause, or give the appearance of causing, a compromise of professional objectivity or independence.



## Appendix B: Example Certifications and CMS Communications

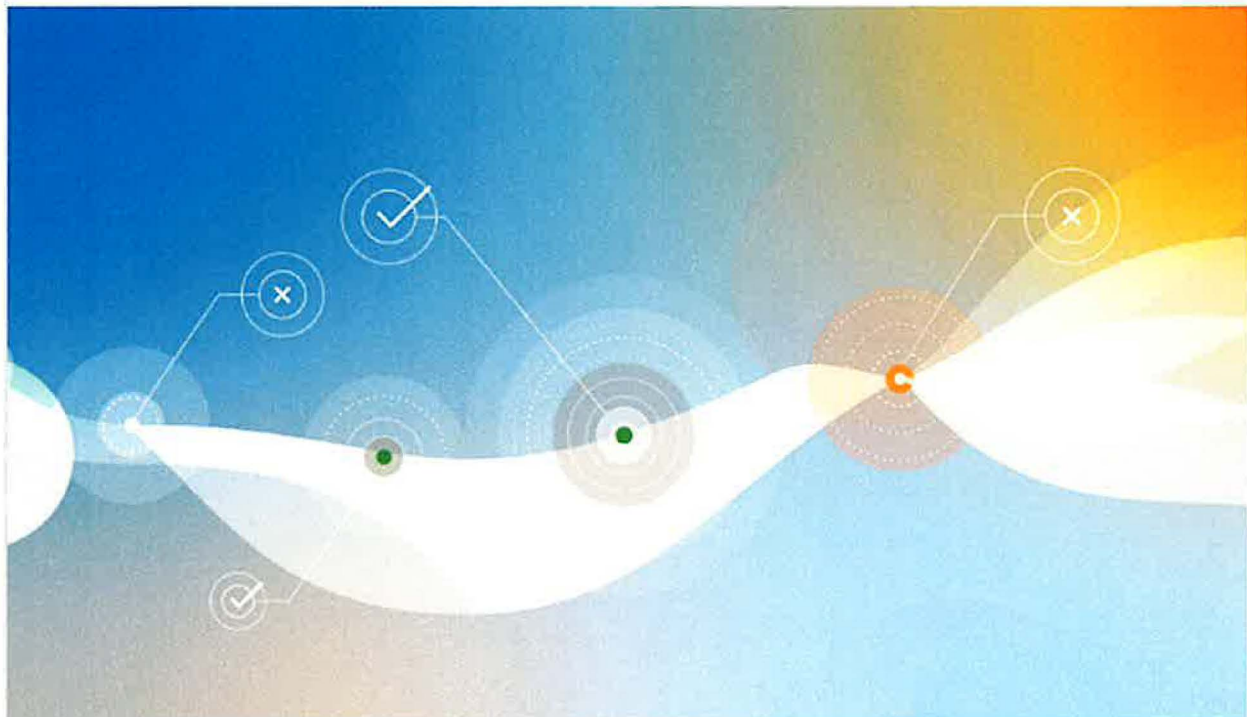
### Example #1: Washington

# Apple Health Integrated Managed Care: CY 2026 Capitation Rate Development

October 3, 2025

**Davis G Burge**, FSA, MAAA  
**Joseph E Whitley**, MPP  
**Annie P Hallum**, FSA, MAAA

**Daniel T Gerber**, ASA, MAAA  
**Mac Xu**, FSA, MAAA  
**Brian T Schatzel**, ASA, MAAA  
**Katrina P Sevilla**, FSA, MAAA, CERA



 **Milliman**

MILLIMAN REPORT

## Actuarial Certification

I, Davis G. Burge, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by the State of Washington Health Care Authority (HCA) and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for the state's managed care program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the twelve-month period of calendar year (CY) 2026.

To the best of my information, knowledge, and belief, for the CY 2026 period, the capitation rates offered by HCA are actuarially sound and comply with the requirements of 42 C.F.R. §438.4 and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

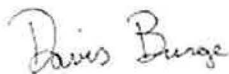
- have been developed in accordance with standards specified in 42 C.F.R. § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on MCOs, PIHPs, and PAHPs in 42 C.F.R. § 438.206, 42 C.F.R. § 438.207, and 42 C.F.R. § 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under 42 C.F.R. § 438.8, of at least 85 percent for the rate year.

I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

This certification is intended for the State of Washington and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

The capitation rates developed herein may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with HCA. The health plan may require rates above, equal to, or below the actuarially sound capitation rates that are associated with this certification.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.



October 3, 2025

Davis G Burge, FSA, MAAA  
Principal & Consulting Actuary

Date



## Example #2: Hawai'i

MILLIMAN REPORT

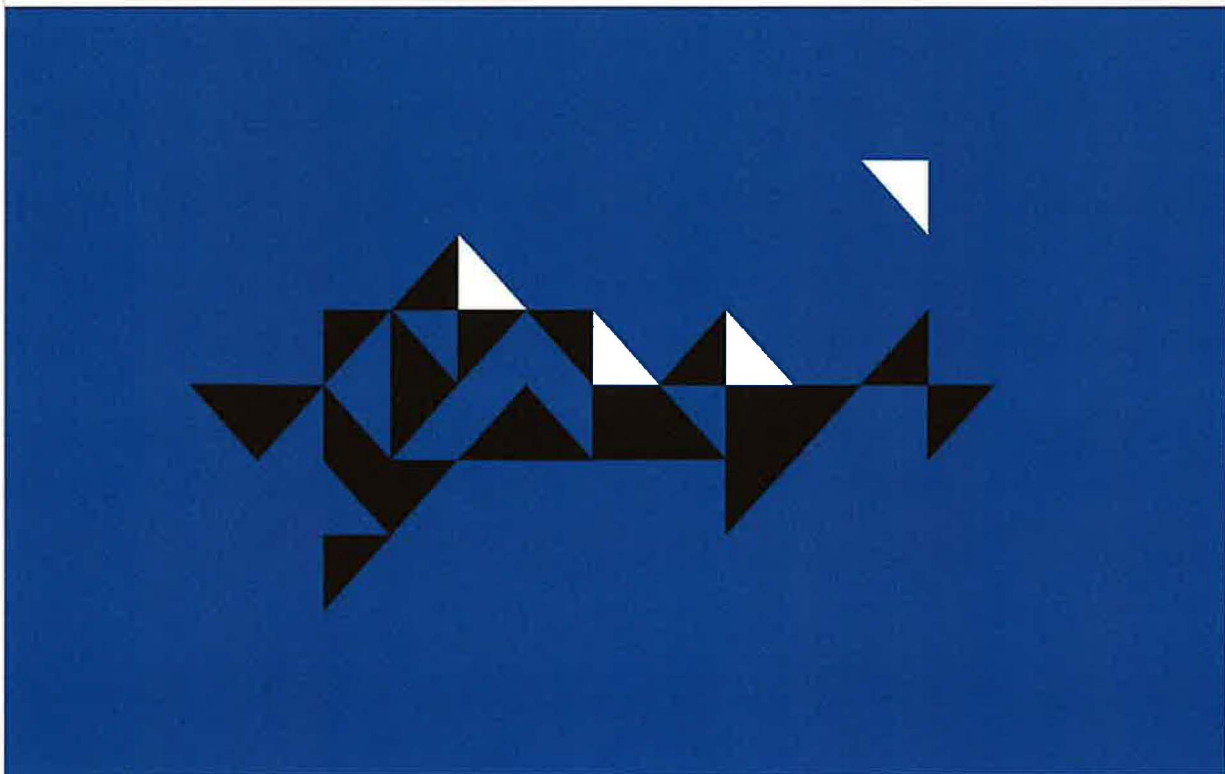
# QUEST Integration Program: CY 2026 Capitation Rate Development

State of Hawai'i, Department of Human Services – Med-QUEST Division

September 30, 2025

Rachel Kullman, FSA, MAAA  
Stacy Albrecht, FSA, MAAA  
Justin Birrell, FSA, MAAA

Nick Gipe, ASA, MAAA  
Vince Dang, ASA, MAAA  
Lauren Brening, ASA, MAAA  
Danika Froese, ASA, MAAA



## MILLIMAN REPORT

**XII. Actuarial Certification**

I, Rachel E. Kullman, am a Principal & Consulting actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by The Hawai'i Department of Human Services – Med-QUEST Division and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for the state's managed care program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the 12-month period of calendar year (CY) 2026.

To the best of my information, knowledge and belief, for the CY 2026 period, the capitation rates offered by Med-QUEST are actuarially sound and comply with the requirements of 42 C.F.R. § 438.4 and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

- have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on MCOs, PIHPs, and PAHPs in § 438.206, 438.207, and 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year.

I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

This certification is intended for Med-QUEST and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted MCO's situation and experience. Models used in the preparation of our analysis were applied consistent with their intended use.

The capitation rates developed herein may not be appropriate for any specific MCO. An individual MCO will need to review the rates in relation to the benefits that it will be obligated to provide. The MCO should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with Med-QUEST. The MCO may require rates above, equal to, or below the actuarially sound capitation rates that are associated with this certification.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.



September 30, 2025

Rachel Kullman, FSA, MAAA  
Principal & Consulting Actuary

Date





Milliman is among the world's largest providers of actuarial, risk management, and technology solutions. Our consulting and advanced analytics capabilities encompass healthcare, property & casualty insurance, life insurance and financial services, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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## Communications from CMS

From: Cope, Tristan (CMS/OACT) <Tristan.Cope@cms.hhs.gov>  
Sent: Tuesday, July 28, 2026 12:56 PM  
To: Justin Birrell <justin.birrell@milliman.com>  
Cc: Annie Hallum <Annie.Hallum@milliman.com>  
Subject: RE: CMS Scorecard - Managed Care Capitation Rate Review

CAUTION: This email originated from outside of Milliman. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Hi Justin,

Based on my records, for FFY 2025, Hawai'i, Indiana, Oregon, Tennessee, and Washington met the 90+ day submission benchmark for at least one of their programs.

Thanks,  
Tristan

Tristan Cope, ASA  
Deputy Director, Medicare and Medicaid Cost Estimates Group  
Office of the Actuary  
Centers for Medicare & Medicaid Services  
(410) 786-7939

From: Justin Birrell <justin.birrell@milliman.com>  
Sent: Tuesday, July 28, 2026 12:41 PM  
To: Cope, Tristan (CMS/OACT) <Tristan.Cope@cms.hhs.gov>  
Cc: Annie Hallum <Annie.Hallum@milliman.com>  
Subject: CMS Scorecard - Managed Care Capitation Rate Review

Tristan,

In the past you have been very helpful sharing for each year states who met the 90+ day capitation rate submission benchmark.

FFY 2023 – Hawai'i, Indiana, Minnesota, New Hampshire, Oklahoma, Washington  
FFY 2024 – Hawai'i, Indiana, Oklahoma, Oregon, Washington

Would you be able to share any more recent data for this metric?

Thank you!

Justin Birrell, FSA, MAAA  
Principal & Consulting Actuary  
Milliman  
1301 Fifth Avenue, Suite 3600  
Seattle, WA 98101-2005 USA

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## Appendix C: Resumes

### Contract Manager

Jerry Dubberly, PharmD, MBA - Principal (Partner), Myers & Stauffer

### Project Management Lead

Terri Branning - Senior Manager, Myers & Stauffer

### Managed Care Oversight Lead

Hannah Lawrence, MPH - Manager, Myers & Stauffer

### Finance Oversight Lead

Robert Rhoton, CPA - Senior Manager, Myers & Stauffer

### Contract Compliance/Research Analyst

Gail Moriarty, JD - Healthcare Consultant, Myers & Stauffer

### Medicaid Policy Subject Matter Expert

Nancy Kim, PMP, MPH - Senior Manager, Myers & Stauffer

### Lead Actuaries

Annie Hallum, FSA, MAAA - Principal and Consulting Actuary, Milliman  
Justin C. Birrell, FSA, MAAA - Principal and Consulting Actuary, Milliman  
Shelly S. Brandel, FSA, MAAA - Principal and Consulting Actuary, Milliman  
Davis Burge, FSA, MAAA - Principal and Consulting Actuary, Milliman  
Nick Johnson, FSA, MAAA - Principal and Consulting Actuary, Milliman  
Rachel Kullman, FSA, MAAA - Principal and Consulting Actuary, Milliman  
Stacy Albrecht, FSA, MAAA - Consulting Actuary, Milliman  
Nick Gipe, ASA, MAAA - Consulting Actuary, Milliman  
Victoria Boon, FSA, MAAA - Actuary, Milliman  
Vincent Dang, ASA, MAAA - Associate Actuary, Milliman

### Staff Actuaries

Stacey Hagensen, FSA, MAAA - Consulting Actuary, Milliman  
Kimberly Lake, ASA, MAAA - Consulting Actuary, Milliman  
Lu Miao, FSA, MAAA - Actuary, Milliman  
Steven Rounsley, FSA, MAAA - Actuary, Milliman  
Brian Schatzel, FSA, MAAA - Actuary, Milliman  
Logan Blank, ASA, MAAA - Associate Actuary, Milliman  
June Chu, ASA, MAAA - Associate Actuary, Milliman  
Tyler Edwards, ASA, MAAA - Associate Actuary, Milliman  
Elias Kehr, ASA, MAAA - Associate Actuary, Milliman  
Celena Jo Robinson, ASA, MAAA - Associate Actuary, Milliman  
Joshua Welsh, ASA, MAAA - Associate Actuary, Milliman  
Menko Ypma, ASA, MAAA - Associate Actuary, Milliman

# Jerry Dubberly, PharmD, MBA

Principal (Partner), Myers & Stauffer

## ROLE: CONTRACT MANAGER

- ✓ More than 35 years of Medicaid/public healthcare experience, including as partner-in-charge of Medicaid managed care engagements.
- ✓ Former State Medicaid Director of Georgia, managing three successful Medicaid MCO contracts serving more than 1.3 million Medicaid and Children's Health Insurance Program lives.
- ✓ Leads Myers & Stauffer's current Bureau for Medical Services Medicaid Actuarial Services and Managed Care Program Administration and Oversight engagement and authority to commit the firm and its resources.
- ✓ Doctorate in Pharmacy/ Master's of Business Administration.

Jerry leads the Consulting practice area within the firm. He focuses on providing executive support and strategic planning assistance to Medicaid and other government-sponsored health and human services programs. He has assisted our clients with delivery system and payment transformation initiatives, including the design, implementation, and oversight of managed care programs, integration of behavioral and physical health services, architecture of value-based payment (VBP) programs, advancing home and community-based services (HCBS) and support models, and other delivery system and payment enhancements. He has also been at the forefront of analytics and evaluation of programs and developing continuous improvement strategies to improve the effectiveness and efficiency of those programs.

Prior to joining Myers & Stauffer, Jerry served as Georgia's Medicaid Director, where he was responsible for oversight and management of the managed care organization (MCO) contracts and the contractors' performance. He brings a wide range of experience with Medicaid policy and financing, delivery of integrated care models, pharmacy services, clinical practice, health information technology, and a variety of other state and federal healthcare programs.

## EDUCATION

Pharm.D., Pharmacy, University of Arkansas Medical Sciences, 2005  
M.B.A., Health Services Management, University of Tennessee at Chattanooga, 1995  
B.S., Pharmacy, University of Georgia, 1990

## EXPERIENCE

35 years of professional experience

## LICENSES/CERTIFICATIONS

Registered Pharmacist

## RELEVANT WORK EXPERIENCE

### Myers & Stauffer (2015-Present), Principal (Partner)

- **West Virginia Department of Human Services, Bureau for Medical Services (2021-Present):** Supports the Team's oversight of the West Virginia managed care program and the delivery of actuarial services. This includes MCO contract reviews and amendments, procurement and readiness reviews, plan performance, provider network adequacy, quality strategy development, state directed payments, medical loss ratio audits, legislative and budget support, and all other contractual areas of responsibility. Accountable for all of the Myers & Stauffer Team's contractual responsibilities.
- **Hawai'i Department of Human Services (2018-2022):** Supported managed care procurement, post-implementation MCO stabilization, and aspects of VBP program design and quality strategy development for the State's delivery system reform efforts.



- **Kentucky Cabinet for Health and Family Services (2018-Present):** Provides technical assistance for the Medicaid managed care program, including opportunity analyses for program improvement, managed care procurement activities, contract maintenance and updates, drafting and supporting requests for federal authorities, and directed payment program design and operations as well as supporting a number of other Medicaid policy and program areas.

**Georgia Department of Community Health (2004-2015), Medicaid Director, Deputy Director Medical Assistance Policy Section, Director of Pharmacy Services**

- **Oversight and Expansion of Medicaid MCOs:** As the Medicaid Director, Jerry held ultimate responsibility for oversight and monitoring of three Medicaid MCOs covering more than 1.3 million Georgians. He also led an initiative to build an enhanced care coordination and increased medical oversight managed care model for children in foster care, adoption assistance, and certain children in the juvenile justice system to achieve improved health outcomes.
- **Aged, Blind, and Disabled (ABD) Care Coordination Project:** Recognizing the ABD population's absence of meaningful access to medical coordination and case management, along with their significant fiscal contribution to total Medicaid expenditures, a program was designed to address this gap. The program was developed to include features of patient-centered medical homes, primary care case management, disease management, and care coordination.
- **Executive Sponsor of Medicaid Management Information System (MMIS) Implementation:** This effort replaced the Georgia MMIS system utilized to pay claims, manage utilization, and provide all federal and state reporting. To accomplish this objective, the implementation approach was defined by the business owners with the systems staff supporting the business needs of the organization. This project culminated in what providers and the Centers for Medicare & Medicaid Services deemed as the smoothest implementation in recent history.
- **Procurement of a Medicaid Pharmacy Benefits Manager (PBM) Contract:** As Pharmacy Director, his responsibilities included Request for Proposal creation, evaluation of responses, contracting, and implementation of the PBM vendor contract. This effort resulted in savings of more than \$12.2 million over the 5.5-year life of the contract. Designed end-user functionality of new pharmacy claims processing platform. This project required analysis of current system functionality, current and future business needs, and efficiency and ease of use for end-users. Each of these parameters had to be evaluated and implemented under the guidance and limitations of industry transaction standards.

# Terri Branning

## Senior Manager, Myers & Stauffer

### ROLE: PROJECT MANAGEMENT LEAD

- ✓ More than 40 years of public healthcare industry experience, including executive leadership roles in Medicaid, managed care, and self-funded health plans.
- ✓ Current Project Management Lead for Bureau for Medical Services (BMS) Medicaid Actuarial Services and Managed Care Program Administration and Oversight engagement.
- ✓ Healthcare consultant to Georgia Medicaid client during transition to full-risk managed care.
- ✓ Former Executive Business Analyst for Georgia Department of Community Health (DCH).
- ✓ Bachelor's degree in nursing.

Terri has worked in the healthcare industry for over 40 years. She has extensive experience supporting state Medicaid agencies with strategic planning, healthcare funding, program design, process improvement, managed care organization (MCO) procurements, readiness reviews, implementation planning, monitoring and oversight, stakeholder engagement, and program management. She has supported states with new initiatives, including implementation of a Certified Community Behavioral Health Clinics (CCBHC) Demonstration, and development of specialized managed care programs for children and youth in foster care or receiving adoption assistance services. Her experience spans both public and private healthcare settings, which has provided her with in-depth knowledge of managed care delivery models.

### EDUCATION

B.S., Nursing, Emory University, 1979

### EXPERIENCE

40 years of professional experience

### RELEVANT WORK EXPERIENCE

#### Myers & Stauffer (2015-Present), Senior Manager

- **West Virginia Department of Human Services, Bureau for Medical Services (2022-Present):** Provide ongoing Medicaid actuarial services and managed care program administration and oversight, including MCO capitation rate development and certification, ongoing data management, policy analysis, research, MCO contract updates and maintenance, 1915(b) waiver renewals and amendments, assessment of provider network adequacy, MCO reporting, medical loss ratio audits,

and maintenance of data management dashboards.

- As the Project Management Lead, responsible for oversight of all contract deliverables and ensuring completion within the time frames agreed upon with BMS.
- Managed the transition of the incumbent BMS vendor to Myers & Stauffer and Milliman in 2022, including implementation planning, review of relevant materials and documentation supporting transition planning, and development of a comprehensive data warehouse for capitation rate setting, analytics, and reporting.
- Directs contractual deliverables and activities with the Myers & Stauffer and Milliman team, BMS leadership, BMS departments, contracted MCOs, and BMS contractors, such as BerryDunn.
- Facilitates meetings with BMS managed care and financial leadership to provide updates, identify strategic priorities, and propose recommendations.
- Manages BMS leadership support required for legislative sessions, Committee meetings, and budget hearings, including research, budgetary projections, fiscal analyses, and preparation of topic-specific briefs, reports, and other presentation materials.
- Supports the oversight of the 1915(b) managed care waivers, including renewals, amendments, and negotiations with the Centers for Medicare & Medicaid Services.
- Oversees Myers & Stauffer and Milliman in the development and implementation of MCO contract amendments to account for policy changes, updates to federal regulations, and stakeholder input.



- Partners with Milliman in the MCO capitation rate setting process and communications with BMS and MCOs.
- Coordinates deliverables with BMS Finance on budget reporting, fiscal impact analyses, directed payment programs, tracking, and provider rate setting.
- Coordinates Myers & Stauffer and Milliman planning and implementation of quality initiatives: automatic day one enrollment into managed care, the MCO quality withhold program, and oversight of the State Fiscal Year 2024-2027 Quality Strategy.
- Oversees preparation of client leadership presentations for MCO updates for provider association meetings and national conferences.
- Directed fiscal analyses and reporting on the unwinding of the public health emergency for the COVID-19 pandemic.
- Provided oversight of the transition of the West Virginia Children's Health Insurance Program into the Mountain Health Trust program.
- **Hawai'i Department of Human Services (2018-2022):** Supported managed care procurement and aspects of value-based payment (VBP) program design for the State's delivery system transformation efforts:
  - Managed the development of a Request for Information to obtain stakeholder insights about VBP models and other delivery system considerations. Conducted stakeholder engagement with the State's contracted MCOs and external quality review organization.
  - Coordinated MCO managed care program design considerations and developed the MCO Request for Proposal (RFP) for the Medicaid managed care procurement.
  - Led the development of MCO policy manual modules.
  - Supported development of the Medicaid Quality Strategy.
- **Kentucky Cabinet for Health and Family Services (2018-Present):** Provided technical assistance to the Department for Medicaid Services, including supporting managed care procurement activities and recommendations for performance management oversight of the contracted MCOs:
  - Managed development of program design considerations for procurement of MCOs to administer services to Medicaid enrollees, including development of a new managed care single MCO delivery model, Supporting Kentucky Youth (SKY), for children and youth in foster care or receiving adoptive assistance, and certain youth involved in the juvenile justice system. Drafted the SKY RFP and MCO contract requirements.
  - Supported the Medicaid and child welfare services departments with implementation of the SKY program and MCO contract. Conducted an environmental assessment of the child welfare services department and recommended staffing, business processes, technology, communications, and training.
  - Assisted with MCO readiness reviews, including development of a readiness review tool.
- **Nevada Department of Health and Human Services (2017):** Supported implementation and onboarding of four Medicaid MCO contracts and development of a managed care information strategy, and reviewed key business processes for redesign and reengineering to improve the effectiveness and efficiency of the Medicaid Division:
  - Assisted with planning and evaluation of the State Innovation Model.
  - Developed and implemented the MCO onboarding Command Center to support an efficient and well-organized MCO onboarding process.
  - Created an external dashboard reporting on MCO performance results for public posting.
  - Directed the development of the application for the CCBHC Demonstration. Provided project management for implementation, monitoring, and oversight of the CCBHC program after the Demonstration was awarded to Nevada.
- **Georgia Department of Community Health (2017):** Oversight and monitoring of Georgia Families care management organizations (CMOs):
  - Assisted with CMO readiness reviews and CMO onboarding Command Center operations.
  - Assisted with the development of CMO performance dashboards during onboarding.

**Georgia Department of Community Health (2010-2015), Executive Business Analyst**

- Led major Medicaid procurements and supported implementation with dedicated internal project teams.
- Developed and implemented a Medicaid program in collaboration with multiple child-serving state agencies to transition approximately 24,000 children and youth in foster care, adoption assistance, and the juvenile justice system into risk-based managed care with enhanced care coordination and increased clinical oversight.
  - Developed the new program CMO contract and supported development of capitation rates.
  - Led the CMO readiness review and supported the management and resolution of corrective actions.

**Georgia Department of Community Health (2007-2010), Consultant**

- Consultant to DCH during program design, procurement, and implementation of the Medicaid managed care program, which transitioned more than one million Medicaid beneficiaries to full-risk managed care. Led readiness review and Command Center activities for onboarding the new CMOs. Responsible for DCH Commissioner stakeholder reporting and monitoring corrective actions for CMOs' claims processing and provider network development.
- Served as the interim Chief of the State Health Benefit Plan with responsibility for administering benefits for more than 700,000 Georgia state and public school employees and retirees with a \$2.6 billion budget.

**HealthCare Advisory Services, Atlanta, Georgia (1994-2006), President**

- Served in leadership roles and provided managed care expertise to healthcare systems and provider organizations in the southeast U.S.

**CIGNA HealthCare of Georgia, Atlanta Georgia (1983-1994), Vice President and Health Plan Manager for Georgia and Alabama; Director of Operations; Director of Planning, Analysis and Development; Director of Provider Relations****Egleston Children's Hospital and Grady Memorial Hospital, Atlanta, Georgia (1979-1983), Pediatric Critical Care Nurse**



# Hannah Lawrence, MPH

Manager, Myers & Stauffer

## ROLE: MANAGED CARE OVERSIGHT LEAD

- ✓ More than 10 years of Medicaid experience, including Medicaid managed care consulting contracts.
- ✓ Currently serves as Bureau for Medical Services (BMS) Medicaid Actuarial Services and Managed Care Program Administration and Oversight engagement contract liaison responsible for Medicaid managed care program management.
- ✓ Medicaid managed care policy and operations expertise.
- ✓ Master's Degree in Public Health.

Hannah provides strategic consulting to state governments through analysis and research of managed care data, ensuring compliance with state and federal regulations, and developing processes to measure outcomes of technical and administrative business functions.

Prior to joining Myers & Stauffer, Hannah spent several years supporting the state of South Carolina in managing the Medicaid Promoting Interoperability Program (formerly the Medicaid Electronic Health Record [EHR] Incentive Program) by advancing the adoption and meaningful use of certified EHR technology and health information exchange (HIE) in the state. She has extensive experience working directly with providers and facilitating conversations regarding health information technology (health IT) and HIE. In her role, she was responsible for communications with the Centers for Medicare & Medicaid Services (CMS) and industry leadership and provided oversight of the program.

## EDUCATION

M.P.H., Health Services, Policy and Management, University of South Carolina, 2014

B.S.P.H., Community Health, Indiana University, 2012

## EXPERIENCE

10 years of professional Medicaid experience

## LICENSES/CERTIFICATIONS

Pursuing Project Management Professional (PMP) Certification

## RELEVANT WORK EXPERIENCE

### Myers & Stauffer (2017-Present), Manager

- **West Virginia Department of Human Services, Bureau for Medical Services (2021-Present):** Support managed care program oversight, including ongoing data management, Medicaid waiver support, policy analysis, research, assessment of provider network adequacy, managed care organization (MCO) reporting and analytical tool development and maintenance (including dashboards), and MCO contract development and maintenance.
  - Support BMS with day-to-day Medicaid managed care program management, including both the delivery and management of activities, as directed by BMS, toward effective outcomes.
  - Support and provide guidance to the Office of Managed Care Director on projects, programmatic changes, and operational processes.
  - Facilitate and manage operational meetings to support the client and its contractors as it relates to addressing vendor inquiries and concerns.
  - Conduct research and develop recommendations to support the development of compliant business operations, processes, and policies in accordance with state-specific Medicaid managed care program requirements.
  - Manage Mountain Health Promise (MHP) and MHP MCO contract development and maintenance.
  - Support Mountain Health Trust and MHP waiver amendment and renewal processes.
  - Support the design of new programmatic features upon request (e.g., Day One Enrollment).

- Draft annual managed care program reports, including legislative reporting and briefs.
- **Arizona Health Care Cost Containment System (AHCCCS) (2023-2024):** Provide project management, staff augmentation, and executive consultant services for activities related to American Rescue Plan Act of 2021 (ARPA) funds as approved by CMS and the Substance Abuse and Mental Health Services Administration.
  - Served as primary point of contact to client, including leading all key meetings and project activities.
  - Provided project management support for all ARPA career, education, and training workforce development initiatives.
  - Supported AHCCCS communications department in marketing and communications needs.
  - Monitored public commentary and support project management for the State's Parents as Paid Caregivers project.
  - Supported the development of the AHCCCS Mental Health and Community Mental Health Block Grant manual.
- **Kentucky Cabinet for Health and Family Services (2018-2024):** Provide technical assistance to the Department for Medicaid Services (DMS) for its Medicaid managed care program, including supporting managed care procurement activities and recommendations for the Department's performance management oversight of the contracted MCOs.
  - Reviews and analyzes the current managed care program, including current contracts and national best practice literature, to support the development of option analyses detailing a best-in-class system, noting best practices and recommendations for change.
  - Assist in the development of questions to survey MCOs to review the existing Kentucky Medicaid MCO environment and provide feedback and key considerations to DMS.
- **Virginia Department of Medicaid Assistance Services (2021-2022):** Promoting Interoperability Program Environmental Scan and State Medicaid Health IT Plan Update.
- **Mississippi Division of Medicaid (2019-2021):** Outsourced Financial Reviews of Mississippi Coordinated Access Network and Health IT/HIE.



# Robert Rhoton, CPA

## Senior Manager, Myers & Stauffer

### ROLE: FINANCE PROJECT LEAD

- ✓ More than 10 years of experience in financial management in Medicaid programs, including regulations, reimbursement processes, financial analysis, budgeting, forecasting, and managed care rate setting.
- ✓ Experience with the Bureau for Medical Services (BMS) through contracts for CCBHC and SUD rate setting and consulting and 1115 Waiver Budget Neutrality Analysis.
- ✓ Bachelor's degree in accounting and business economics.
- ✓ Certified Public Accountant.

Rob specializes in healthcare rate setting, compliance, and financial auditing. Specific to West Virginia, he has experience performing general financial analysis, fiscal impact analysis, budgetary projections, rate setting, and reimbursement process consulting associated with the State's Certified Community Behavioral Health Clinic (CCBHC) program, 1115 Waiver, substance use disorder (SUD) residential program, and mobile crisis program. His Medicaid audit experience includes performing and reviewing attest engagements of CCBHCs, nursing facilities, federally qualified health centers (FQHCs), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), and hospitals. He has performed rate setting engagements for CCBHCs, FQHCs, and rural health clinics (RHCs), as well as ad hoc projects such as Mobile Crisis Units, SUD residential Institutions for Mental Disease (IMD) services, Peer Recovery and Support Services, and other home and community-based services (HCBS). Rob also has extensive experience providing training for both state employees and provider groups.

### EDUCATION

B.A., Accounting and Business Economics, Randolph-Macon College, 2014

### EXPERIENCE

12 years of professional experience

### LICENSES/CERTIFICATIONS

Certified Public Accountant

### RELEVANT WORK EXPERIENCE

#### Myers & Stauffer (2014–Present), Senior Manager

- **West Virginia Department of Human Services, Bureau for Medical Services (2023–Present):** Provides general financial analysis for a variety of projects; specifically, consulting and rate setting services for the CCBHC program. Financial/fiscal impact analysis for annual BMS budget purposes, budget neutrality calculations for the 1115 waiver renewal, and rate setting services for the SUD residential program and the mobile crisis program.
  - Served as the Project Manager during the initial CCBHC program creation with responsibility for project oversight, quality of deliverables, and ongoing communications with the client.
  - Consulted on all aspects of the CCBHC program as it related to reimbursement. Provided ad hoc consulting, including out-of-state program research, financial/fiscal impact analysis, and Substance Abuse and Mental Health Services Administration (SAMHSA) grant and State Plan Amendment (SPA) writing.
  - Oversaw the entire prospective payment system (PPS) rate setting process, including state and provider training, ongoing technical assistance for providers, and cost report audits.
  - Performed fiscal analysis and budgetary projections to assist BMS with their mid-year medical services budget process.
  - Performed financial analysis, including cost and utilization estimation, for various state programs to update and complete the 1115 waiver budget neutrality analysis for the most recent waiver renewal.

- Participated in the Centers for Medicare & Medicaid Services (CMS) negotiations as part of the waiver renewal process, answering questions from CMS associated with the budget neutrality analysis.
- Presented the budget neutrality model to CMS officials, answering questions and providing detailed explanations behind the reasoning and purpose of calculations.
- Created a rate setting model incorporating provider-specific, national, and statewide metrics to calculate updated rates per American Society of Addiction Medicine level for the existing SUD residential providers.
- Created a rate setting model incorporating state-specific and national-level data to calculate fee-for-service reimbursement rates for the mobile crisis program.
- Collaborated with the State's project manager vendor and actuarial vendor to ensure timeliness of deliverables.
- **New Hampshire Department of Health and Human Services (2023-Present):** Performed CCBHC rate setting engagements and provided general reimbursement consulting as the State implements their CCBHC program.
  - Serve as the Project Manager with responsibility for project oversight, quality of deliverables, and ongoing communications with the client.
  - Consulted and oversaw the creation and implementation of the reimbursement portion of the CCBHC program for the State, including provider training, cost report audits, and general financial analysis/consulting.
- **Louisiana Department of Health (2025-Present):** Performed CCBHC rate setting engagements and provided general reimbursement consulting as the State implements their CCBHC program.
  - Serve as the Project Manager with responsibility for project oversight, quality of deliverables, and ongoing communications with the client.
  - Consulted and oversaw the creation and implementation of the reimbursement portion of the CCBHC program for the State, including provider training, cost report audits, and general financial analysis/consulting.
- **Kansas Department for Aging and Disability Services (KDADS) (2025-Present):** Provided subject matter expert consulting to the state CCBHC audit team.
  - Serve as the Project Manager with responsibility for project oversight, quality of deliverables and ongoing communications with the client.
  - Consulted with the CCBHC audit team and KDADS leadership on their CCBHC program to provide trainings and guidance as the State continues in the CCBHC demonstration.
- **Delaware Department of Substance Abuse and Mental Health (2024-Present):** Provided subject matter expert consulting to the State CCBHC audit team.
  - Serve as the Project Manager with responsibility for project oversight, quality of deliverables, and ongoing communication with the client and other vendors in the workgroup.
  - Consulted and guided the State CCBHC project team as they prepare to implement the CCBHC program in Delaware.
- **Nevada Health Authority (2019-Present):** Performed general financial and programmatic consulting and cost report audit services to ensure state and federal regulations are met for nursing facilities, ICFs, hospitals, State sister agencies, ground emergency medical transport providers, and targeted case management providers. Myers & Stauffer also performs agreed-upon procedures on FQHCs for the purposes of initial, baseline, and change in scope rate setting.
  - Serve as the Project Manager with responsibility for project oversight, quality of deliverables, and ongoing communications with the client.
  - Provide cost report/technical trainings to Agency staff on an annual basis.
- **Nevada Health Authority (2020-2021):** Performed a rate setting engagement to set rates for IMD providers and the associated budget neutrality analysis for the 1115 waiver.



- Created rate setting models utilizing publicly available and provider-specific data. Utilized the rate models to create the 1115 budget neutrality analysis to be submitted with the State's 1115 waiver.
- Collaborated with healthcare subject matter experts to ensure rate setting assumptions met industry standards and guidelines.

## Gail Moriarity, JD

### Healthcare Consultant, Myers & Stauffer

#### ROLE: CONTRACT COMPLIANCE/RESEARCH ANALYST

- ✓ More than four years of work on Medicaid projects.
- ✓ J.D. and Member of the Massachusetts Bar.

Gail has four years of healthcare experience, including healthcare law and policy-related experience. In her role at Myers & Stauffer, she has worked on several projects across both the Consulting and Pharmacy engagement teams. Her work focuses on providing research and administrative assistance services to state, federal, and local healthcare and social services agencies addressing healthcare reimbursement issues, as well as analyzing issues of public health law and policy. As a licensed attorney in the state of Massachusetts, she also serves as a legal/policy resource for teams and projects across the firm.

#### EDUCATION

J.D. with focus in health policy, Suffolk University, 2024

B.A., Human Rights Studies and Psychology/Minor in Spanish, University of Dayton, 2016

#### EXPERIENCE

10 years of professional experience

#### LICENSES/CERTIFICATIONS

Juris Doctor

Member of the Massachusetts Bar, Active in Good Standing (License Number BA-213783)

#### RELEVANT WORK EXPERIENCE

##### Myers & Stauffer (2021-Present), Healthcare Consultant

- **Arizona Health Care Cost Containment System (2023-Present):** Provides project management, staff augmentation, and executive consultant services for the Arizona Health Care Cost Containment System for activities related to American Rescue Plan Act of 2021 funds as approved by the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration.
  - Serves as the healthcare consultant for this engagement and assists on various client deliverables including, but not limited to, issues related to federal grants management and compliance.
  - Assists with project management activities, operational support, stakeholder engagement, and reporting.
- **Kentucky Cabinet for Health and Family Services (2023-Present)**
  - Provides a variety of services for the state of Kentucky, including rate setting, waiver support, procurement support, and pharmacy consulting services.
    - Provides research and policy support for the State's Section 1115 demonstration waiver and related initiatives.
  - Consulting services on Medicaid targeted case management program, policy, and directions, including how best to optimize resources.
    - Provides research and policy support.
  - Assisting with the development of a Request for Proposal for managed care organizations that incorporates best practices, innovation, and value-based purchasing and is compliant with both federal and state laws, regulations, and policies.
    - Provides research and policy support.



- **Indiana Family & Social Services Administration (2023-Present):** Medicaid rate setting, reimbursement methodology consulting, fiscal impact analysis, provider tax calculations, and compliance services impacting all Medicaid providers and services.
  - Provides research and policy support.
- **Centers for Medicare & Medicaid Services (2023-Present):** CMS rate setting for the National Average Drug Acquisition Cost, updated via a monthly voluntary national survey process and weekly through changes in published prices. Additional ad hoc analysis is performed as requested. Myers & Stauffer also consults in areas of reimbursement, including specialty drugs, blood clotting factor, and the 340B drug program.
  - Assists in research and writing deliverables, including legislative and policy reporting on topics including, but not limited to, drug pricing transparency and the federal 340B drug pricing program.

**Massachusetts Executive Office of Health and Human Services (2022), Legal Intern, Litigation**

- Researched legal and regulatory issues involving MassHealth, CMS guidance, and Massachusetts Commission Against Discrimination enforcement matters.
- Drafted motions to dismiss, proposed decision memoranda, and other litigation-related documents under Massachusetts Rules of Civil Procedure.
- Assisted with legal research and writing supporting agency decision-making in administrative adjudications and quasi-judicial proceedings.

**Massachusetts Commonwealth Care Alliance (2022), Legal Affairs Intern**

- Supported in-house legal team on a project involving healthcare business initiatives, conducting legal research and presenting findings to internal stakeholders.

**ProLink Healthcare (2016-2021), Account/Client Relationship Manager**

- Managed over 25 hospital accounts in Indiana, addressing their staffing needs.
- Consulted with C-suite and upper management within hospitals to build staffing plans.
- Managed a team of recruiters that fulfilled clients' staffing needs.
- Oversaw payroll, compliance, hiring, and terminations for all staff within client hospitals.

# Nancy Kim, PMP, MPH

## Senior Manager, Myers & Stauffer

### ROLE: MEDICAID POLICY SUBJECT MATTER EXPERT

- ✓ Nearly 20 years of experience crafting Centers for Medicare & Medicaid Services (CMS) managed care reports, including 1115 waivers/amendments, 1915(b) waiver applications/amendments, independent assessments, Medicaid and Children's Health Insurance Program (CHIP) Annual Reports, and Fraud, Waste, and Abuse compliance reports.
- ✓ Master's degree in health policy and administration.
- ✓ Bachelor's degree in education and social policy.

Nancy directs projects and provides technical assistance support to various states' Medicaid managed care programs, which include training staff in monitoring key program metrics and performance issues related to managed care organizations (MCOs), assisting in the maintenance of a data repository which houses performance measure data used to create performance profile reports, and researching key policy topics for the states, such as dual eligibles and value-based purchasing (VBP).

Prior to joining Myers & Stauffer, Nancy was a Senior Research Analyst for NORC at the University of Chicago, responsible for planning qualitative and quantitative data collection for various federal agencies, including case studies, environmental scans, informant interviews, focus groups, and expert panels. She was also a Public Health Analyst at the U.S. Department of Health and Human Services, Health Resources and Services Administration.

### EDUCATION

M.P.H., Health Policy and Administration, Yale University, 2009  
B.S., Education and Social Policy, Northwestern University, 2006

### EXPERIENCE

18 years of professional experience

### LICENSES/CERTIFICATIONS

Project Management Professional

### RELEVANT WORK EXPERIENCE

#### Myers & Stauffer (2021-Present), Senior Manager

- **Iowa Health and Human Services (2024-Present):** Provides project management, staff augmentation, and executive consultant services for the State.
  - Serves as project manager for the engagement and assists the State with various technical assistance needs.
  - Provides support for the development of 1115 waiver applications/amendments, development of State Plan Amendment language, tracking and monitoring of new federal regulations, and guidance on interpreting new federal rules.
- **Arizona Health Care Cost Containment System (2022-Present):** Provides project management, staff augmentation, and executive consultant services for the State for activities related to the implementation of new federal regulations.
  - Serves as the project manager to support the implementation of the Parents as Paid Caregivers program, including stakeholder management.
  - Served as project manager for the engagement and assists the State in the implementation of their American Recovery Plan Act of 2021 (ARPA) Home and Community-Based Services (HCBS) Spending Plan.
  - Served as project manager for implementation of new federal rules, specifically Ensuring Access to Medicaid Services and Medicaid and CHIP Managed Care Final Rules.
  - Provides technical assistance and operational support on select ARPA initiatives, including issuing directed payments to providers, implementing the National Core Indicators for Aging and Disabilities



survey, assisting with the amendments to the 1115 waiver, assessing the State's Olmstead plan, and supporting workforce development.

- Assisted with the development of a block grant manual for the Community Mental Health Services Block Grant and Substance Use Prevention, Treatment, and Recovery Services Block Grant program.
- Provided technical assistance and operational support for fee-for-service activities within the State, specifically assisting with prior authorization reporting and supporting trainings to fee-for-service providers.
- **Arkansas Department of Human Services (2021-Present):** Conduct an independent evaluation/assessment of the State of Arkansas's Section 1915(b) Waiver for the Provider-led Arkansas Shared Savings Entity (PASSE) project for the State's Medicaid program (Waiver Number: AR.0007.R00.01), as mandated in Title 42 Code of Federal Regulations § 431.55(b)(4).
  - Assist with the analysis of State documents and reports to evaluate access and quality of the programs.
  - Conduct stakeholder engagement with internal State staff as well as external stakeholders, including MCOs and other state vendors, to elicit information about the PASSE program.
  - Work with the state to develop a final report to submit to CMS regarding findings from the independent assessment of the State's program.

#### **Guidehouse (2012-2021), Associate Director, Health Care**

- Direct projects and provide technical assistance support to various states' Medicaid managed care programs, which include conducting procurement and contracting activities, training staff in monitoring key program metrics and performance issues related to MCOs, assisting in the maintenance of a data repository which houses performance measure data used to create performance profile reports, and researching key policy topics for the states, such as dual eligibles and VBP.
- Develop a national survey for states regarding the health and welfare of their 1915(c) waiver participants. This included conducting a literature scan, compiling data from existing 1915(c) waiver applications, and releasing a national survey. Findings were presented in a series of national training calls with CMS.
- Support rate rebasing for a 1915(c) waiver program by conducting stakeholder engagement meetings, administering a provider survey, and developing a rate model for each service.
- Review State's compliance with federal and state regulations related to the 1915(c) waiver application for HCBS and provide guidance with regards to rate setting methodologies, quality and oversight measures, and critical incident management systems.

#### **NORC at the University of Chicago (2010-2012), Senior Research Analyst, Health Care Research**

- Performed and led a wide range of research activities, such as the planning of qualitative and quantitative data collection activities, for the development of reports to various federal agencies, including case studies, environmental scans, informant interviews, focus groups, and expert panels.
- Major projects included: a report on the use of open source technologies in safety net settings, a study on payment incentives for providers excluded from the Health Information Technology for Economic and Clinical Health Act, a report on assistive services technologies for seniors and persons with disabilities, a report on the use of health information technology (health IT) in oral health for Medicaid providers, and a study to support the national Early and Periodic Screening, Diagnostic and Treatment workgroups.

#### **United States Department of Health and Human Services – Health Resources and Services Administration – Office of Health Information Technology (2009-2010), Public Health Analyst**

- Facilitated the successful reporting requirements of grantees on governmentwide and agency-specific measures related to meaningful use of health IT systems.
- Reviewed proposed rules and programmatic guidance, including Stage 1 of Meaningful Use, to provide key recommendations on policies and procedures to senior agency administrators.

# Annie Hallum, FSA, MAAA

## Principal and Consulting Actuary, Milliman

### ROLE: ACTUARIAL PROJECT LEAD

- ✓ 16 years of experience with Medicaid Managed Care rate setting.
- ✓ Fellow of the Society of Actuaries (FSA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Annie is a principal and consulting actuary with Milliman's Seattle Health practice. She joined the firm in 2009 and has 16 years of experience providing actuarial support and consulting to state Medicaid agencies. Annie's experience includes capitation rate setting, cost effectiveness projections, fiscal analysis, benchmarking of experience, and provider payment design and evaluation.

### EDUCATION

B.S., Statistics, *magna cum laude*, University of Washington, 2009  
B.A., Mathematics and Economics, *magna cum laude*, University of Washington, 2009

### EXPERIENCE

16 years of professional actuarial experience, including:

- **Medicaid managed care rate setting:**
  - West Virginia (2022-Present).
  - Hawai'i (2010-2015, 2019-2020).
  - Nevada (2009-2015).
  - Utah (2019-Present).
  - Vermont (2019-2021, 2026-Present).
  - Washington (2009-2015, 2019-Present).
  - Wyoming (2017-2018).
- **Other rate setting and actuarial or policy consulting (e.g., provider payment rates, dual eligible strategy, etc.):**
  - Colorado (2019).
  - Idaho (2017-2018, 2026-Present).
  - Minnesota (2017-2018).
  - Nebraska (2017-2018, 2021-Present).
  - Nevada (2025-Present).

### RELEVANT WORK EXPERIENCE

#### Milliman (2009-2015, 2019-Present), Principal & Consulting Actuary

- **State of West Virginia, Bureau for Medical Services**
  - Development and certification of Medicaid capitation rates for Temporary Assistance for Needy Families (TANF), the Children's Health Insurance Program (CHIP), foster care, disabled, and expansion (2022-Present).
  - Risk adjustment (2022-Present).
  - Provider payment rate and other fiscal analyses (2022-Present).
  - Assistance with fiscal modeling for 1915(b), 1915(c), and 1115 waivers, State Plan Amendment (SPA) changes, and other Medicaid policy and budget work (2022-Present).
- **State of Hawai'i, Department of Health and Human Services**
  - Development of Medicaid capitation rates for Community Care Services (2019-2020) and Quest Integration (2012-2015).
  - Risk mitigation settlements (2019-2022).



- Development of Affordable Care Act enhanced physician fee schedule for provider payments as well as quarterly calculation of enhanced payments by provider (2013-2015).
- **State of Nevada, Department of Healthcare Financing and Policy**
  - Development of Medicaid capitation rates for TANF, State CHIP (SCHIP), disabled, and expansion populations (2009-2015).
  - Risk adjustment and risk mitigation settlements (2010-2015).
  - Dual eligible strategy development and procurement assistance (2025-Present).
- **State of Utah, Department of Health**
  - Development and certification of Medicaid capitation rates for TANF, SCHIP, disabled, and expansion populations (2019-Present).
  - Risk adjustment (2019-Present).
  - Assistance with 1115 waiver design and evaluation (2019-2021).
- **State of Vermont, Agency of Human Services**
  - Development and certification of Medicaid capitation rates for TANF, disabled, long-term services and supports (LTSS), and expansion populations (2019-2021, 2026-Present).
- **State of Washington, Health Care Authority**
  - Development and certification of Medicaid capitation rates for TANF, SCHIP, foster care, disabled, expansion, and Program of All-Inclusive Care for the Elderly (PACE) populations (2010-2015, 2019-Present).
  - Risk adjustment (2010-2015, 2019-Present).
  - Provider payment rate and hospital tax program updates (2018, 2020-Present).
- **State of Wyoming, Health Care Authority**
  - Development and certification of Medicaid capitation rates for PACE and youth behavioral healthcare management populations (2017-2018).
- **State of Colorado, Department of Healthcare Policy and Financing**
  - Development of all-payer hospital budget model (2019).
- **State of Idaho, Division of Medicaid**
  - Assisted with provider payment rate development for LTSS (2017-2018).
  - Review of Medicaid Managed Care dental rates (2018).
  - Assistance with capitation rates for dual eligibles (2026-Present).
- **State of Minnesota, Department of Health**
  - Assisted with payment rate calculations and simulation modeling of the fiscal impact of updating its Medicaid inpatient All Patient Refined Diagnosis-Related Group (APR-DRG) payment system (2018).
- **State of Nebraska, Division of Medicaid**
  - Assisted with payment rate calculations and simulation modeling of the fiscal impact of annual updates to its Medicaid inpatient APR-DRG-based methodology and converting its outpatient payment system from a cost-based methodology to Enhanced Ambulatory Patient Groupings (2017-2018).
  - Development of disproportionate share hospital allotment and upper payment limit calculations (2017-2018, 2021-Present).

# Justin C. Birrell, FSA, MAAA

## Principal and Consulting Actuary, Milliman

### ROLE: LEAD ACTUARY

- ✓ More than 25 years of Medicaid Managed Care rate setting.
- ✓ Fellow of the Society of Actuaries (FSA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Justin joined Milliman's Seattle Health practice in 1995. He has 30 years of actuarial experience with a variety of health-related issues. His primary focus over the last 25 years has been Medicaid. This involves work for states including Florida, Hawai'i, Idaho, Nevada, Utah, Washington, West Virginia, and Vermont, as well as non-state clients where he has supported Medicaid populations in Kentucky, Arizona, Georgia, Washington D.C., and Massachusetts. He has worked on a variety of projects, including medical, long-term care, behavioral health, transportation, disease management, procurement, healthcare reform, and other state-specific analyses. In addition to the development of capitation rates, Justin has worked with states to negotiate final rates and produce required Centers for Medicare & Medicaid Services (CMS)

documentation.

### EDUCATION

B.S., Mathematics Brigham Young University, 1994

### EXPERIENCE

30 years of professional experience with approximately 25 years in Medicaid managed care, including Florida, Hawaii, Idaho, Nevada, Utah, Vermont, Washington, and West Virginia.

- Current work in multiple states to develop rates and an appropriate structure integrating both the Medicare and Medicaid component of costs into a rate for members eligible for both programs.
- Experience in developing rate structures for integrated (medical, mental health, chemical dependency, and long-term care) healthcare models for Medicaid recipients that improve healthcare and reduce expenditures, including CMS documentation of rates and rate structures.
- Expertise in the development and documentation of Medicaid capitation rates in multiple states for managed care services for Temporary Assistance for Needy Families (TANF), Aged, Blind, disabled, and other unique Medicaid populations, including those eligible for Medicare as well as those only eligible for Medicaid benefits.
- Experience in documentation of cost effectiveness for Medicaid programs.
- Experience risk-adjusting Medicaid capitation rates.
- Experience in developing non-emergency transportation rates for Medicaid populations.
- Expertise in analyzing large claims databases and healthcare modeling.
- Design and evaluation of pay-for-performance incentives in Medicaid managed care programs.
- Development of Program of All-Inclusive Care for the Elderly (PACE) rates.
- Supporting the development of the Achieving Healthcare Efficiency through Accountable Design (AHEAD) program.

### RELEVANT WORK EXPERIENCE

#### Milliman (1995-Present), Principal and Consulting Actuary

- **State of West Virginia, Bureau for Medical Service**
  - Development and certification of Medicaid capitation rates for TANF, Children's Health Insurance Program (CHIP), foster care, disabled, and expansion (2022-Present).
  - Risk adjustment (2022-Present).
  - Provider payment rate and other fiscal analyses (2022-Present).
- **Florida Agency for Health Care Administration (AHCA) – External Peer Reviewer**



- Acute care services for children, parents, pregnant women, disabled, HIV/AIDS, Serious Mental Illness, child welfare, long-term care, and dual eligible populations. Long-term services and supports (LTSS) for elderly and physically disabled populations. Additionally, development of PACE, Special Needs Plan, dental, and Non-Emergency Medical Transportation rates. Member of Florida's Statewide Medicaid Managed Care procurement negotiation team (1999-Present).
- Chronic Illness and Disability Payment System plus Prescription Drug with category weights customized to Florida covered benefits and provider payment levels, including model customization for serious mental illness individuals and children receiving private duty nursing services. Use of functional assessment-based risk scores for the PACE program (2010-Present).
- **State of Hawai'i, Department of Human Services**
  - Preparation and management of risk adjustment analysis for managed care plans (2014-Present).
  - Development of Medicaid capitation rates for TANF, disabled, dually eligibles, State CHIP (SCHIP) and expansion populations including medical, LTSS, and behavioral health (2005-Present).
  - Development of projections of the impact of benefit and enrollment changes including the impact of Patient Protection and Affordable Care Act (PPACA) legislation on state expenditures (2012-2014).
  - Development of reporting guide to evaluate plan performance and medical loss ratio (MLR) review (2005-Present).
  - Produced data book and scoring methodology for managed care organization (MCO) procurements (2005-Present).
  - Fiscal impact analyses on ad hoc basis (2005-Present).
  - Support for 1115 Waiver and pricing of Health-Related Social Needs benefits (2023-Present).
  - Support for AHEAD development (2024-Present).
  - Fee schedule development and support for state-directed payments (2010-Present).
- **State of Idaho, Department of Health and Welfare**
  - Development of projections of the impact of benefit and enrollment changes including the impact of PPACA legislation on state expenditures and peer review of work for department (2013-Present).
- **State of Nevada, Division of Health Care Financing and Policy**
  - Development of Medicaid capitation rates (TANF and SCHIP) for dual demonstration program (2013-2019).
  - Fiscal impact analyses on ad hoc basis (2002-2009).
- **State of Utah, Department of Health**
  - Development of behavioral health and non-emergency transportation rates (2010-Present).
  - Support for state-directed payments (2024-Present).
- **State of Vermont, Agency of Human Service**
  - Development of Medicaid expansion capitation rates for newly eligible population (2012-2020).
- **State of Washington, Health Care Authority**
  - Preparation and management of risk adjustment analysis for managed care plans including LTSS risk adjustment (2000-Present).
  - Development of Medicaid capitation rates for TANF, disabled, dually eligibles, SCHIP and expansion populations some programs included LTSS and behavioral health as well as medical (2000-Present).
  - Development of cost effectiveness documentation for new programs (2012-Present).
  - Development of reporting templates for expansion risk mitigation and financial reporting including MLR evaluation (2000-Present).
  - Produced data book and scoring methodology for MCO procurements (2000-Present).
  - Fiscal impact analyses on ad hoc basis (2000-Present).
- **State of Washington, Aging and Long-Term Support Administration**
  - Development of PACE rates (2007-Present).

## Shelly S. Brandel, FSA, MAAA

Principal and Consulting Actuary, Milliman

### ROLE: LEAD ACTUARY/ FINANCIALLY INDEPENDENT PEER REVIEW

- ✓ More than 25 years of experience with rate setting in managed Medicaid and Medicare healthcare programs.

- ✓ Fellow of the Society of Actuaries (FSA).

- ✓ Member of the American Academy of Actuaries (MAAA).

- **Other experience:**

- Review of Medicaid capitation rate development for Financial Alignment Initiative demonstration programs in five states on behalf of the Centers for Medicare & Medicaid Services (CMS) (2012-Present).
- Virginia Medicaid forecasting and rate setting review (2019).
- Maryland Medicaid managed care rate setting study (2018).
- Medicaid managed care rate review on behalf of health plan associations in New Jersey, Virginia, and Pennsylvania (2010-2018).
- Nebraska Program of All-Inclusive Care for the Elderly (PACE) Upper Payment Limits (UPLs) (2010-2012).

Shelly is a Principal and Consulting Actuary with Milliman's Chicago-Milwaukee-Hartford Health practice. She originally joined the firm in 1995 and re-joined in 2008. Shelly's expertise is in managed Medicaid and Medicare healthcare programs, with more than 25 years of consulting experience in these areas. She also has extensive experience with Medicare Advantage Part D and Prescription Drug Plans.

### EDUCATION

B.S., Mathematics & Statistics, Miami University, 1995

### EXPERIENCE

25 years of professional experience, including:

- **Medicaid managed care development and certification:**

- Wisconsin (2015-Present).
- Florida (2010-2014).
- Oklahoma (2008-2013).

### RELEVANT WORK EXPERIENCE

#### Milliman (1995-2004, 2008-Present), Principal and Consulting Actuary

- **Wisconsin Department of Health Services**

- Managed care capitation rate development and certification, risk adjustment, and fee-for-service modeling.
- Managed care capitation development for Wisconsin's BadgerCare and Supplemental Security Income Medicaid managed care programs that provide acute care services for children, parents, pregnant women, childless adults, disabled, and dual eligible populations. Implemented financial reporting template to collect health plan financial data and established process for encounter data validation to financial data. Programs are administered by Medicaid managed care organizations (MCOs).
- Development of Chronic Illness and Disability Payment System plus Prescription Drug risk adjustment with category weights customized to Wisconsin covered benefits and provider payment levels.
- Modeling of provider reimbursement rates for care coordination services provided to individuals enrolled in hospital-based special needs program for medically complex children.

- **Florida Agency for Health Care Administration**

- Managed care capitation rate development and certification.
- Behavioral services provided by Prepaid Mental Health Plans.
- Acute care services for dual eligibles enrolled in Medicare Advantage Dual Special Needs Plans.



- **Oklahoma Health Care Authority (OHCA)**
  - Managed care capitation rate development and certification.
  - Non-emergency transportation services provided by OHCA's contracted statewide vendor to children, parents, and disabled populations.
- **Nebraska Department of Health and Humana Services**
  - Managed care capitation rate development and certification.
  - PACE UPL rates.
- **University of Maryland, Baltimore County**
  - Managed care rate setting study.
  - Medicaid managed care rate setting and payment innovation study to recommend potential improvements to Maryland's Medicaid managed care rate setting system.
- **Commonwealth of Virginia, Department of Medical Assistance Services**
  - Managed care rate study.
  - Medicaid forecasting and rate setting review to recommend potential improvements to Virginia's forecasting process.
- **Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office**
  - Financial alignment initiative assistance.
  - Review of Medicaid portion of capitation rate development for five state "dual demonstration" programs.
  - Preparation of calculations for risk mitigation mechanism results. Provision of feedback and advice on financial-related terms in three-way contracts between CMS, states, and MCOs. Provision of strategic advice around program structure and evaluation approach.
- **New Jersey Association of Health Plans**
  - Medicaid consulting.
  - Review acute care capitation rates for children, parents, adults, disabled, and elderly populations.
  - Summarize and project aggregate financial results using health plan financial data.
- **Virginia Association of Health Plans**
  - Medicaid consulting.
  - Review acute care capitation rates for the Medallion and Family Access to Medical Insurance Security populations.
  - Provide comments on actuarial recommendations from the Virginia General Assembly, Joint Legislative Audit and Review Commission.
- **Pennsylvania Health Care Association**
  - Medicaid consulting.
  - Summarize and project aggregate financial results using health plan financial data. Review managed care efficiency adjustments included in capitation rates.

# Davis Burge, FSA, MAAA

## Principal and Consulting Actuary, Milliman

### ROLE: LEAD ACTUARY

- ✓ 15 years of Medicaid Managed Care rate setting experience.
- ✓ Fellow of the Society of Actuaries (FSA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Davis is a principal and consulting actuary with Milliman's Seattle Health practice. He joined the firm in 2010 and has more than 15 years of experience in Medicaid managed care rate setting, spanning the full life cycle from data analysis and risk-adjusted capitation rate development through actuarially sound rate certification. He serves as the signing certifying actuary on multiple Medicaid rate certifications and has consulted to state Medicaid agencies, including Hawai'i, Idaho, Illinois, Nevada, Utah, and Washington.

### EDUCATION

B.S., Mathematics, *summa cum laude*, Pacific Lutheran University, 2011  
B.A., Physics, *summa cum laude*, Pacific Lutheran University, 2011

### EXPERIENCE

15 years of professional actuarial experience, including:

- **Medicaid managed care rate setting:**
  - Idaho (2011-2016, 2020-Present).
  - Washington (2012-2018, 2020-Present).
  - Hawai'i (2010-2019, 2020).
  - Nevada (2011-2012).
  - Utah (2018-2019).
- **Program and population experience:** Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP)/State CHIP (SCHIP), foster care, disabled/Aged, Blind, and Disabled (ABD), Medicaid expansion, managed long-term care (MLTC), standalone and integrated behavioral health, dental, value-based/alternative payment models (APMs), and state-funded coverage for populations ineligible for federally funded Medicaid.

### RELEVANT WORK EXPERIENCE

#### Milliman (2010-Present), Principal & Consulting Actuary

- **State of Idaho, Department of Health and Welfare**
  - Development and certification of Medicaid managed care capitation rates for dental services (2020-Present).
  - Development and certification of behavioral health managed care capitation rates for the Idaho Behavioral Health Plan (2022-Present).
  - Risk adjustment, financial reporting, and strategic support for the Healthy Connections Value Care value-based purchasing program (2020-Present).
  - Medicaid budget forecasting support for the Department (2020-2021, 2023-Present).
  - Actuarial Cost Model Development for Medicaid Fee-For-Service Experience (2011-2016).
- **State of Washington, Health Care Authority**
  - Development and certification of Apple Health Integrated Managed Care capitation rates—combining physical and behavioral health for the TANF, SCHIP, disabled, and expansion populations—supporting the State's transition to fully integrated managed care (2012-2016, 2020-Present).
  - Development and certification of Behavioral Health Services Only capitation rates for members whose physical health is covered outside managed care (2020-Present).



- Development and certification of the Apple Health Expansion program—Washington’s state-funded coverage program for residents ineligible for federally funded Medicaid—since its inception (2024-Present).
- Rate development of Apple Health Integrated Foster Care capitation rates (2018, 2020-Present).
- Rate development and analytic support for the Rural All-Payer APM (2017-2018).
- Policy and program strategy support, including quantification and implementation of program changes, with ongoing client communication and data management (2012-2018, 2020-Present).
- **State of Illinois, Department of Healthcare and Family Services**
  - Actuarial peer review of Medicaid managed care program capitation rates for the State’s non-citizen coverage program, serving as reviewing actuary outside the project team (2024-Present).
  - Actuarial peer review of Medicaid provider reimbursement rates developed by Milliman for the State, serving as reviewing actuary outside the project team (2025-Present).
- **State of Hawai’i, Department of Health and Human Services**
  - Development and certification of Medicaid managed care capitation rates for TANF, disabled, MLTC, CHIP, foster care, and expansion populations (2010-2020).
  - Development and certification of standalone behavioral health managed care capitation rates (2010-2019).
  - Health plan financial and medical loss ratio (MLR) reporting, with ongoing client communication, data management, and program strategy support (2010-2019).
- **State of Utah, Department of Health**
  - Development and certification of comprehensive Medicaid managed care capitation rates for CHIP (2019).
  - Development and certification of capitation rates for an integrated physical health and behavioral health program (2018-2019).
  - Development and certification of dental managed care capitation rates for CHIP and TANF populations (2019).
  - Health plan financial and MLR reporting, with ongoing client communication, data management, and program strategy support (2018-2019).
- **State of Nevada, Division of Health Care Financing and Policy**
  - Development and certification of comprehensive Medicaid managed care capitation rates for the non-disabled TANF population (2011-2012).
  - Actuarial peer review of Medicaid provider reimbursement rates developed by Milliman for the State, serving as reviewing actuary outside the project team (2026).

# Nick Johnson, FSA, MAAA

## Principal and Consulting Actuary, Milliman

### ROLE: LEAD ACTUARY

- ✓ 17 years of experience with Medicaid and Medicare Advantage managed care rate setting.
- ✓ Fellow of the Society of Actuaries (FSA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Nick is a principal and consulting actuary specializing in healthcare in Milliman's Seattle Health Practice. He joined the firm in 2009. Nick's primary expertise is helping clients understand the financial implications of trends and changes in the healthcare delivery system, particularly in dual eligible populations.

Nick has worked with a broad range of clients, including health plans, state Medicaid agencies, integrated delivery systems, provider groups, and the Veterans Health Administration. He has significant experience in Medicare Advantage, Medicare Part D, Medicaid, commercial, and Affordable Care Act markets.

### EDUCATION

M.S., Applied Statistics, Portland State University, 2009  
B.A., Mathematics, Augustana College, 2006

### EXPERIENCE

17 years of professional experience, including:

- **Medicaid managed care:**
  - State Medicaid Managed Long-Term Services and Supports and Program of All-Inclusive Care for the Elderly (PACE) capitation rate development.
  - Medicare/Medicaid integration strategy and financial modeling.
  - Nursing home to Home and Community-Based Services transition monitoring.
  - Forecasting and analysis of programmatic changes.
- **Medicare Advantage/Part D:**
  - Medicare Advantage and Dual Eligible Special Needs Plan (D-SNP) bid development and certification.
  - Product development and feasibility analysis.
  - Dual integration strategic guidance.
  - Risk-sharing contract support for health plans and providers.

### RELEVANT WORK EXPERIENCE

#### Milliman (2009-Present), Principal & Consulting Actuary

- **State of Washington, Department of Social and Health Services (2018-Present)**
  - Development of Medicaid capitation rates for PACE populations.
- **State of Ohio, Department of Medicaid (2024-Present)**
  - Medicare/Medicaid integrated financing actuarial modeling and policy guidance.
- **Multiple states (2024-Present)**
  - Analysis of Medicare/Medicaid financial savings opportunities and policy options.
- **State of Idaho, Division of Medicaid (2021-Present)**
  - Review and subject matter expert for Idaho Medicaid Plus and Medicare Medicaid Coordinated Plan capitation rates.
- **Nevada Association of Counties (2020)**



- Development of long-term cost projection for non-federal share of long term-care costs for Medicaid beneficiaries.
- **Health Plan in Southwestern US (2011-Present)**
  - Medicare Advantage and D-SNP bid development.
  - Medicaid rate review and actuarial modeling.
- **California Health Plans (2021-Present)**
  - D-SNP feasibility assessment, bid development, and financial modeling.
  - Medi-Cal rate review.

# Rachel Kullman, FSA, MAAA

## Principal and Consulting Actuary, Milliman

### ROLE: LEAD ACTUARY

- ✓ 13 years of experience in Medicaid rate setting.

- ✓ Fellow of the Society of Actuaries (FSA).

Member of the American Academy of Actuaries (MAAA).

Rachel is a principal and consulting actuary with Milliman's Seattle Health practice. She joined the firm in 2013 and has more than a decade of actuarial experience and experience providing actuarial support and consulting to state Medicaid agencies and health plans.

Rachel has provided actuarial consulting services to state Medicaid agencies, the Department of Veterans Affairs, and provider organizations. Her experience includes capitation rate setting, financial projections, benchmarking of experience, and incurred but not reported reserve estimates.

### EDUCATION

B.S., Mathematics, *summa cum laude*, University of Missouri, 2010

### EXPERIENCE

10 years of professional actuarial experience, including:

- Capitation rate setting.
- Cost projection.
- Other support.

### RELEVANT WORK EXPERIENCE

#### Milliman (2013-Present), Principal & Consulting Actuary

- **State of Hawai'i, Department of Health and Human Services**
  - Development of Medicaid capitation rates for Temporary Assistance for Needy Families (TANF), disabled, dual eligibles, State Children's Health Insurance Program (SCHIP), and expansion populations (2013-Present).
  - Development of Medicaid capitation rates for Serious Mental Illness population (2021-Present).
  - Risk mitigation settlements (2013-Present).
  - Risk adjustment (2021-Present).
  - Provider payment rate and other fiscal analyses (2020-Present).
  - Rate modification related to Affordable Care Act (ACA) health insurer fee (2013-2020).
  - Development of ACA enhanced physician fee schedule for provider payments as well as quarterly calculation of enhanced payments by provider (2013-2018).
- **State of Washington, Health Care Authority**
  - Development of Medicaid capitation rates for TANF, disabled, SCHIP, and expansion populations (2015-2022).
  - Risk mitigation settlements (2014-Present).
  - Risk adjustment (2025-Present).
  - Rate modification related to ACA health insurer fee (2013-2020).



# Stacy Albrecht, FSA, MAAA

Consulting Actuary, Milliman

## ROLE: LEAD ACTUARY (CHIP AND MHP)

- ✓ More than 10 years of experience with Medicaid managed care rate setting.
- ✓ Fellow of the Society of Actuaries (FSA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Stacy is a consulting actuary with Milliman's Seattle Health Practice. She joined the firm in 2013 and has more than 10 years of experience providing actuarial support and consulting to state Medicaid agencies. Stacy's experience includes capitation rate setting, incurred but not reported reserve estimates, fiscal projections, Medicare and Medicaid integration, and risk adjustment.

## EDUCATION

B.S., Actuarial Science, *magna cum laude*, Central Washington University, 2013

## EXPERIENCE

10 years of Medicaid managed care experience, including:

- **Medicaid managed care rate setting:**
  - Hawai'i (2014-Present).
  - Washington (2014-Present).
  - Utah (2018-Present).
  - West Virginia (2023-Present).
  - Idaho (2020-2021).

## RELEVANT WORK EXPERIENCE

### Milliman (2013-Present), Consulting Actuary

- **State of West Virginia, Bureau for Medical Services**
  - Development of Medicaid capitation rates for Mountain Health Promise (2023-Present).
  - Development of Medicaid capitation rates for Children's Health Insurance Program (CHIP) (2025-Present).
- **State of Hawai'i, Department of Health and Human Services**
  - Development of medical, long-term care, and behavioral health Medicaid capitation rates for Temporary Assistance for Needy Families (TANF), disabled, dually eligibles, State CHIP (SCHIP), and expansion populations (2014-Present).
  - Development of Medicaid capitation rates for Community Care Services behavioral health population (2017-2021).
  - Development of reporting guide to evaluate plan performance and medical loss ratio (MLR) review (2014-Present).
  - Produced data book and scoring methodology for managed care organization procurements (2014-Present).
  - Development of analyses for legislative sessions (2014-Present).
  - Fiscal impact analyses on ad hoc basis (2014-Present).
  - Client communication and data management (2014-Present).
  - Policy and program strategy, quantification, and implementation (2014-Present).
  - Prepare documents for Centers for Medicare & Medicaid Services review and respond to CMS questions (2014-Present).

- **State of Utah, Department of Health**
  - Development and certification of Medicaid capitation rates for SCHIP, behavioral health, developmental disability, and expansion programs (2018-Present).
  - Assistance with 1115 waiver design and evaluation (2018-Present).
  - Development of reporting guide to evaluate plan performance and MLR review (2018-Present).
  - Client communication and data management (2018-Present).
  - Policy and program strategy, quantification, and implementation (2018-Present).
- **State of Idaho, Department of Health and Welfare**
  - Expansion budget development (2020-2021).
- **State of Washington, Health Care Authority**
  - Development of Medicaid capitation rates for TANF, disabled, SCHIP, and expansion populations (2014-Present).
  - Payment enhancement to physicians and safety net hospitals (2014-Present).
  - Client communication and data management (2014-Present).

# Nick Gipe, ASA, MAAA

Consulting Actuary, Milliman

## ROLE: LEAD ACTUARY

- ✓ 11 years of experience in Medicaid rate setting.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Nick is a consulting actuary with Milliman's Seattle Health Practice. He joined the firm in 2015 and has nearly 10 years of experience providing actuarial support and consulting to state Medicaid agencies and health plans. Nick has provided actuarial consulting services to state Medicaid agencies, health plans, and provider organizations. His experience includes capitation rate setting, financial projections, benchmarking of experience, and trend development.

## EDUCATION

B.S., Applied Mathematics and Statistics, Johns Hopkins University, 2015

## EXPERIENCE

10 years of professional actuarial experience, including:

- Capitation rate setting.
- Cost projection.
- Other support.

## RELEVANT WORK EXPERIENCE

### Milliman (2015-Present), Consulting Actuary

- **State of Hawai'i, Department of Health and Human Services (2015-Present)**
  - Development of Medicaid capitation rates for Temporary Assistance for Needy Families (TANF), disabled, dual eligibles, State Children's Health Insurance Program (SCHIP), and expansion populations.
- **State of Hawai'i, Department of Health and Human Services (2015-Present)**
  - Development of Medicaid capitation rates for Community Care Services behavioral health population.
- **State of Washington, Health Care Authority (2018-2021, 2024-2025)**
  - Development of Medicaid capitation rates for TANF, disabled, SCHIP, and expansion populations.
- **Nevada Association of Counties (2020)**
  - Development of long-term cost projection for non-federal share of long term-care costs for Medicaid beneficiaries.
- **Health Plan in Southwestern US (2015-Present)**
  - Medicare Advantage and Dual Eligible Special Needs Plan bid development.
  - Medicaid rate review and actuarial support.



# Victoria Boon, FSA, MAAA

Actuary, Milliman

## ROLE: LEAD ACTUARY

- ✓ 10 years of experience with Medicaid state agencies and health plans.
- ✓ Fellow of the Society of Actuaries (FSA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Victoria is an actuary with Milliman's Seattle Health practice. She joined the firm in 2016 and has 10 years of experience. Victoria has provided actuarial consulting services to state Medicaid agencies, the Department of Veterans Affairs, and health plans. Victoria's experience includes capitation rate setting, fiscal analysis, and provider payment design.

## EDUCATION

B.S., Actuarial Science, *summa cum laude*, Washington State University, 2015

## EXPERIENCE

10 years of Medicaid managed care experience, including:

- Washington Medicaid (2016-2022).
- Hawai'i Medicaid (2016-Present).
- Utah Medicaid (2018-Present).
- Puerto Rico Medicaid (2019-2022).

## RELEVANT WORK EXPERIENCE

### Milliman (2016-Present), Associate Actuary

- **State of Hawai'i, Department of Health and Human Services**
  - Development of medical Medicaid capitation rates.
  - Risk mitigation settlements.
  - Assisting with payment rate calculations and simulation modeling of the fiscal impact of converting its Medicaid inpatient payment system from per diem rates to an All Patient Refined Diagnosis-Related Group (APR-DRG)-based methodology, including subsequent updates to grouper versions and rate factors.
  - Hospital APR-DRG payment system rebasing.
  - Development of hospital supplemental payment models.
- **State of Utah, Department of Health**
  - Development of dental and medical Medicaid capitation rates for State Children's Health Insurance Program (SCHIP) populations.
- **State of Washington, Health Care Authority**
  - Development of medical Medicaid capitation rates for Temporary Assistance for Needy Families, disabled, SCHIP, and expansion populations.
  - Hospital APR-DRG payment system rebasing.

# Vincent Dang, ASA, MAAA

Associate Actuary, Milliman

## ROLE: LEAD ACTUARY

- ✓ 10 years of experience in Medicaid capitation rate setting.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Vincent is an associate actuary with Milliman's Seattle Health Practice. He joined the firm in 2016 and has 10 years of experience providing actuarial support and consulting to state Medicaid agencies.

## EDUCATION

B.A., Statistics, University of California, Berkeley, 2016  
B.A., Economics, University of California, Berkeley, 2016

## EXPERIENCE

10 years of professional actuarial experience

## RELEVANT WORK EXPERIENCE

### Milliman (2016-Present), Associate Actuary

- **State of Hawai'i, Department of Health and Human Services (2016-Present)**
  - Development of Medicaid capitation rates for Temporary Assistance for Needy Families, disabled, dually eligibles, State Children's Health Insurance Program, and expansion population.
  - Risk mitigation and settlements.
- **State of Utah, Department of Health and Human Services (2023-Present)**
  - Development of Medicaid behavioral health capitation rates for Medicaid populations.
- **State of Washington, Health Care Authority (2018-2021)**
  - Developed model to estimate community bed capacity requirements for civil commitments transitioning from state psychiatric hospitals.
  - Evaluated inpatient and outpatient reimbursement levels relative to fee-for-service through the application of Diagnosis-Related Group and Enhanced Ambulatory Patient Grouping payment methodologies.
  - Developed model to analyze historical trends in physical health benefit costs and to estimate prospective trends for Medicaid capitation rates.
- **State of Idaho, Department of Health and Welfare (2023-Present)**
  - Development of Medicaid budget forecast.
  - Calculation of total cost of care program results.

# Stacey Hagensen, FSA, MAAA

Consulting Actuary, Milliman

## ROLE: STAFF ACTUARY

- ✓ More than five years of experience with Medicaid managed capitation rate development.
- ✓ Fellow of the Society of Actuaries (FSA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Stacey is a consulting actuary with Milliman's Seattle Health Practice. She joined the firm in 2013 and has more than 13 years of experience providing actuarial support and consulting to state Medicaid agencies, the Department of Veterans Affairs, and Medicare Advantage plans. Stacey's experience includes risk adjustment settlement and program changes.

## EDUCATION

B.S., Mathematics, *summa cum laude*, Pacific Lutheran University, 2012  
B.A., Economics, *summa cum laude*, Pacific Lutheran University, 2012

## EXPERIENCE

10 years of professional experience

## RELEVANT WORK EXPERIENCE

### Milliman (2013-Present), Consulting Actuary

- **State of West Virginia, Bureau for Medical Services (2022-2025)**
  - Risk adjustment for Mountain Health Trust capitation rates.
- **State of Washington, Health Care Authority (2015-2020)**
  - Program change and fee schedule analysis for Medicaid programs.



## Kimberly Lake, ASA, MAAA

### Consulting Actuary, Milliman

#### ROLE: STAFF ACTUARY

- ✓ More than five years of experience with Medicaid managed capitation rate development.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Kimberly is a consulting actuary with Milliman's Seattle Health Practice. She joined the firm in 2016 and has more than 10 years of experience providing actuarial support and consulting to state Medicaid agencies, commercial health plans, and Medicare clients.

#### EDUCATION

B.S., Mathematics/Minor in Financial Planning, *summa cum laude*, Lindenwood University, 2015

#### EXPERIENCE

10 years of professional actuarial consulting experience

#### RELEVANT WORK EXPERIENCE

##### Milliman (2016-Present), Consulting Actuary

- **State of Washington, Health Care Authority (2025-Present)**
  - Capitation rate development for the state Medicaid program (Foster Care population and specialty behavioral health programs for all populations).
  - Risk mitigation and settlements.
- **Sharp Health Plan (2016-Present)**
  - Affordable Care Act Rate developments and filings.
  - ACA Risk Adjustment projections and settlements.
  - Medicare Part C bid development (2016-2019).
  - Ad hoc actuarial support.
- **State of Hawai'i, Department of Health and Human Services (2016-2019)**
  - Development of Medicaid capitation rates for Temporary Assistance for Needy Families, disabled, dually eligibles, State Children's Health Insurance Program, and expansion population.

# Lu Miao, FSA, MAAA

Actuary, Milliman

## ROLE: STAFF ACTUARY

- ✓ Five years of experience with Medicaid managed care rate setting.
- ✓ Fellowship of the Society of Actuaries (FSA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Lu is an actuary with Milliman's Seattle Health Practice. She joined the firm in 2021 and has five years of experience providing actuarial support and consulting to state Medicaid agencies. Lu's experience includes capitation rate setting, incurred but not reported reserve estimates and fiscal projections.

## EDUCATION

M.A., Statistics, University of California, Santa Barbara, 2016  
B.S., Actuarial Science, Tianjin University of Finance and Economics, China, 2014

## EXPERIENCE

9 years of professional actuarial experience, including:

- **Medicaid managed care rate setting:**
  - West Virginia (2022-Present).
  - Idaho (2023-Present).
  - Washington (2022-Present).
- **Financial forecasting and modeling of managed care initiatives (2017-2021)**

## RELEVANT WORK EXPERIENCE

### Milliman (2021-Present), Actuary

- **State of West Virginia, Bureau for Medical Services**
  - Development of Medicaid capitation rates for Mountain Health Trust and Children's Health Insurance Programs (2022-Present).
  - Quarterly financial forecasting on CHIP program to review funding status (2023-Present).
- **State of Idaho, Department of Health and Welfare**
  - Development of Idaho behavioral health plan capitation rates (2023-Present).
- **State of Washington, Health Care Authority**
  - Development of capitation rates for Wraparound with Intensive Services program (2023-Present).
  - Trend analysis and data processing support for the development of Medicaid capitation rates.

### Molina Healthcare (2017-2021), Senior Actuarial Analyst

- Work on 15 States healthcare claim data to support financial forecasting and modeling of managed care initiatives.
- Trend analysis, flu analysis and exhibit visualization to support financial forecasting.
- Pharmacy price analysis and new drug impact prediction.

# Steven Rounsley, FSA, MAAA

Actuary, Milliman

## ROLE: STAFF ACTUARY

- ✓ Nine years of experience with Medicaid managed care rate setting.
- ✓ Fellow of the Society of Actuaries (FSA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Steven is an actuary with Milliman's Seattle Health Practice. He joined the firm in 2016, and has nearly 10 years of experience providing actuarial support to state Medicaid agencies, Medicare Advantage plans, commercial insurance companies, and the Department of Veterans Affairs. Steven's experience includes capitation rate setting, data cleansing and processing, fee schedule impact analyses, and claims repricing.

## EDUCATION

B.S., Actuarial Science, *magna cum laude*, Central Washington University, 2016

## EXPERIENCE

9 years of professional experience

## RELEVANT WORK EXPERIENCE

### Milliman (2016-Present), Actuary

- **State of West Virginia, Bureau for Medical Services (2022-Present)**
  - Development of Medicaid capitation rates for Temporary Assistance for Needy Families (TANF), State Children's Health Insurance Program (SCHIP), disabled, foster care, and expansion populations.
  - Development of claims reserve estimates, enrollment projections, fee schedule impacts, trend assumptions, program change impacts, non-benefit cost assumptions, and Mountain Health Trust rate development.
  - Data manager.
  - CHIP quarterly projection lead.
- **State of Washington, Health Care Authority (2016-Present)**
  - Development of Medicaid capitation rates for TANF, SCHIP, disabled, and expansion populations.
  - Development of claims reserve estimates, enrollment projections, and trends projections.
- **State of Nevada, Division of Health Care Financing and Policy (2017-2019)**
  - Development of Medicaid capitation rates for TANF, disabled, and expansion populations.
  - Processing of managed care claims.
- **State of Hawai'i, Department of Health and Human Services (2019-2020)**
  - Development of COVID-19 rate adjustment factors.



# Brian Schatzel, FSA, MAAA

Actuary, Milliman

## ROLE: STAFF ACTUARY

- ✓ More than eight years of experience developing Medicaid capitation rates and fiscal analyses.
- ✓ Fellow of the Society of Actuaries (FSA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Brian is an actuary with Milliman's Seattle Health practice. He joined the firm in 2018 and has more than eight years of experience in healthcare consulting. Brian has experience in rate development across the healthcare spectrum, including Medicare Advantage, Medicare Supplement Insurance (Medigap), Commercial Dental, and Medicaid. Brian has supported state Medicaid agencies in capitation and delivery case rates development, risk adjustment, fiscal analysis and budgeting, and state-directed payment analysis.

## EDUCATION

B.A., Business Administration, *magna cum laude*, University of Washington, Michael G. Foster School of Business, 2018

## EXPERIENCE

8 years of professional experience

## RELEVANT WORK EXPERIENCE

### Milliman (2018-Present), Associate Actuary

- **State of West Virginia, Health and Human Services (2022-Present)**
  - Development of Medicaid capitation rates for foster care population.
  - Provider payment rate analysis.
- **State of Washington, Health Care Authority (2018-Present)**
  - Development of Medicaid capitation and delivery case rates for Temporary Assistance for Needy Families, State Children's Health Insurance Program, disabled, and expansion populations.
  - Sub-capitation arrangement analysis.
  - Risk adjustment development.
  - Fiscal budget projections and analysis.
  - State directed payment projections and managed care organization compliance analysis.
  - Value-based purchasing and provider incentives analysis.
  - In-lieu-of services cost effectiveness analysis, projections, and reporting.
  - Risk corridor settlement development.

# Logan Blank, ASA, MAAA

Associate Actuary, Milliman

## ROLE: STAFF ACTUARY

- ✓ More than two years of experience with Medicaid Managed Care rate setting.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Logan is an associate actuary who joined Milliman's Seattle Health Practice in 2024. Logan has more than 10 years of healthcare-specific actuarial work and more than two years of Medicaid managed care rate setting experience with the states of West Virginia and Washington. Logan's other experience includes Medicare advantage rate development with a focus on Dual Eligible Special Needs Plans (D-SNPs), commercial rate development, valuation, and predictive analytics.

## EDUCATION

B.S., Mathematics and Statistics/Minor in Actuarial Science, University of Florida, 2015

## EXPERIENCE

10 years of professional experience with more than 5 years in rate setting, including:

- **Medicaid managed care rate setting:**
  - West Virginia (2024).
  - Washington (2025-Present).

## RELEVANT WORK EXPERIENCE

### Milliman (2024-Present), Associate Actuary

- **State of West Virginia, Health and Human Services (2024-Present)**
  - Development of acuity factors for the State Fiscal Year (SFY) 2025 Medicaid managed care rates' mid-year update and SFY 2026 rates.
- **State of Washington, Health Care Authority**
  - Lead actuary and primary support to certifying actuary for the development of Integrated Physical and Behavioral Health Expansion (Apple Health Expansion) managed care rates.
  - Ongoing monitoring of experience for Integrated Physical and Behavioral Health Expansion.
  - Development of acuity factors for the Calendar Year 2027 Integrated Physical and Behavioral Health Expansion managed care rates.
- **California D-SNP Feasibility and Bidding**
  - Part of a team assisting regional health plans prepare for CalAim's new integrated care requirements, which includes the launching of integrated D-SNP plans.
  - Assisting clients set strategy and prepare bids for Medicare Advantage bidding for their new D-SNPs.
- **State D-SNP Integration Support**
  - Part of a team supporting states to make policy decisions around further integration of their D-SNPs.

### Belong Health (2022-2024), Actuarial Associate

- Worked on a small analytics team at a startup whose model was to partner with local health plans who were entering the D-SNP market.
- Work spanned multiple functional areas, serving as the main Medicare Advantage and D-SNP subject matter expert, including collaborating with partners on rate development.

### Aetna (2016-2022), Actuarial Assistant

- **Commercial Predictive Analytics and Valuation**
  - Worked in collaboration with data science to develop predictive analytics models for use in commercial underwriting and rate development.

- **Medicare Advantage Rate Development**
  - Developed Part C bids as part of the Arizona/Nevada regional team and was the owner of the primary Part C pricing model.
- **Valuation**
  - Managed the valuation process for various products and regions.

**Capital Health Plan (2015-2016), Actuarial Analyst**

- Supported Small Group and Large Group rate development.



# June Chu, ASA, MAAA

Associate Actuary, Milliman

## ROLE: STAFF ACTUARY

- ✓ Five years of experience with Medicaid managed care rate setting.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

June is an actuary with Milliman's Seattle Health Practice. Since joining Milliman in 2021, her experience includes assisting state Medicaid agencies, Department of Veterans Affairs, and commercial clients in a range of projects. She has supported state Medicaid agencies in Washington and West Virginia in the development of Medicaid managed care capitation rates and Incurred But Not Paid (IBNP).

## EDUCATION

M.S., Finance, University of Utah, 2013  
M.S., Mathematics, University of Utah, 2010  
B.S., Mathematics, University of Utah, 2009

## EXPERIENCE

5 years of professional experience, including:

- **Medicaid managed care rate setting:**
  - Washington Apple Health (2021-Present).
  - West Virginia Mountain Health Trust (2022-Present).
- **Other experience:**
  - Reserving and Pricing for commercial insurer and third party administrator (2015-2021).
  - Department of Veterans Affairs (2021-Present).
  - IBNP for commercial clients (2021-Present).
  - Benchmarking analysis for commercial clients (2021-Present).
  - Statement of Actuarial Opinions (2021-Present).
  - Health cost guidelines updates (2022-Present).
  - The Centers for Medicare & Medicaid Services Virtual Research Data Center fee-for-service Medicare data analysis for commercial clients (2023-Present).
  - Indian Health authorization cost model development (2025-Present).

## RELEVANT WORK EXPERIENCE

### Milliman (2021-Present), Associate Actuary

- **State of West Virginia: Mountain Health Trust (Medicaid) Managed Care**
  - IBNP.
- **State of Washington: Apple Health (Medicaid) Managed Care**
  - Revenue data processing and validation, IBNP, trend analysis, rate settings for service-based enhancement programs.

### Cigna (2019-2021), Actuarial Analyst

- Reserving and rate settings.

### National Health Insurance Company (2015-2019), Actuarial Advanced Analyst

- Reserving and data processing.

# Tyler Edwards, ASA, MAAA

Associate Actuary, Milliman

## ROLE: STAFF ACTUARY

- ✓ More than five years of experience developing Medicaid capitation rates and fiscal analyses.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Tyler is an associate actuary with Milliman's Seattle Health practice. He joined the firm in 2024 and has more than five years of experience in healthcare consulting. Tyler has experience in rate development across the healthcare spectrum, including Medicaid rate setting, Medicaid plan support, and value-based care benchmarking. Tyler has supported state Medicaid agencies in core areas of the capitation rate development process.

## EDUCATION

B.S., Mathematics, *magna cum laude*, Brigham Young University, 2020

## EXPERIENCE

5 years of healthcare consulting experience

## RELEVANT WORK EXPERIENCE

### Milliman (2024-Present), Associate Actuary

- **State of Utah, Department of Health and Human Services (2024-Present)**
  - Development of Medicaid capitation rates for expansion populations.
  - Emerging experience review.
- **Various California Health Plans (2024-Present)**
  - Medi-Cal rate review and support.
  - Rebasing for provider capitation arrangements and other provider contracting support.
  - Pro forma projections and financial support.
- **State of Idaho, Department of Health and Welfare (2025-Present)**
  - Development of Medicaid capitation rates for Non-Emergency Medical Transportation managed care program.
- **State of Washington, Health Care Authority (2024-2025)**
  - State directed payment managed care organization compliance.
  - Health plan data requests.

### Milliman (2021-2024), Associate II

- **State of California, Department of Healthcare Services (2021-2024)**
  - Development of California's \$50+ billion Medicaid capitation and delivery case rates for Temporary Assistance for Needy Families, aged/disabled, expansion, non-citizen, and dual eligible populations.
  - Non-benefit load development and research.
  - Health plan audits.
  - Efficiency adjustments.
  - Dental capitation rate development.
  - Duals demonstration.
  - Dual Eligible Special Needs Plan rate setting for Medicaid benefits.
  - In-Lieu of Service analysis.
  - Procurement research and analysis.

# Elias Kehr, ASA, MAAA

## Associate Actuary, Milliman

### ROLE: STAFF ACTUARY

- ✓ Eight years of experience with Medicaid Managed Care rate setting.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Elias Kehr is an Associate Actuary with Milliman's Seattle Health practice. He joined the firm in 2018. Elias has eight years of actuarial consulting experience, including multiple years of expertise in Medicaid managed care rate setting and Medicare Advantage bids.

### EDUCATION

B.S., Mathematics, *summa cum laude*, Eastern Mennonite University, 2013

### EXPERIENCE

8 years of actuarial experience, including:

- **Medicaid managed care rate setting:**
  - Hawai'i (2018-Present).
  - Nevada (2018-2019).
  - Utah (2018-Present).
  - West Virginia (2022-Present).
- **Other experience:**
  - Medicare Advantage bid development (2018-Present).
  - Public Employees Benefits Board of Washington (2019-Present).
  - Department of Veterans Affairs (2018-2023).

### RELEVANT WORK EXPERIENCE

#### Milliman, Inc (2018-Present), Actuarial Analyst and Associate Actuary

- **State of West Virginia**
  - Risk adjustment, acuity analyses, and other rate development activities.
- **State of Utah**
  - Children's Health Insurance Program and mental health managed care.
  - Trend analysis, rate development, Incurred But Not Paid, risk adjustment, data management, project management.
- **State of Hawai'i**
  - Data management, risk adjustment, financial reconciliation, other analyses.
  - Alternative payment model development.
- **Public Employees Benefits Board**
  - Data processing and management, rate development, other analyses.



# Celena Jo Robinson, ASA, MAAA

Associate Actuary, Milliman

## ROLE: STAFF ACTUARY

- ✓ Nine years of experience with Medicaid actuarial work in health plans, insurance, and consulting.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Celena is an experienced actuary with nine years of experience in Medicaid actuarial services across health plans, insurance, and consulting. Prior to joining Milliman's Seattle Health Practice in 2024, Celena worked at Guidehouse, a global consulting firm, where she led the development of Medicaid capitation rates and provided strategic advisory services. At Centene, a multinational healthcare company, she developed actuarial analysis and co-certified specialty care rates.

## EDUCATION

B.S., Mathematics and Economics, University of California, San Diego, 2015

## EXPERIENCE

9 years of professional actuarial experience, including:

- **Medicaid rate setting and analysis:**
  - Oklahoma (2021-2024).
  - West Virginia (2024-Present).
  - Washington (2025-Present).
  - Idaho (2025-Present).

## RELEVANT WORK EXPERIENCE

### Milliman (2024-Present), Associate Actuary

- **State of West Virginia, Department of Health and Welfare**
  - Development of Medicaid managed care capitation rates for Mountain Health Trust.
- **State of Idaho, Department of Health and Welfare**
  - Development of Medicaid managed care capitation rates for behavioral health services.
- **State of Washington, Health Care Authority**
  - Development of Medicaid managed care capitation rates for foster care population.
  - Development of behavioral health case rates for the Wraparound with Intensive Services and New Journeys programs.

### Guidehouse (2021-2024), Managerial Consultant

- **State of West Virginia, Medicaid Program**
  - Lead analyst in developing capitation rates for Medicaid program.
- **State of Oklahoma, Medicaid Program**
  - Lead developer and project manager for Medicaid capitation rate setting with a projected \$3 billion annual premium (2021-2024).
  - Co-certifying actuary for Children's Specialty Medicaid capitation rates.
  - Led the development of Non-Emergency Medical Transportation capitation rate setting.

### Centene (2017-2021), Senior Actuarial Analyst

# Joshua Welsh, ASA, MAAA

Associate Actuary, Milliman

## ROLE: STAFF ACTUARY

- ✓ Seven years of Medicaid managed care rate setting.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Joshua is an Associate Actuary with Milliman's Seattle Health Practice. Since joining Milliman in 2019, he has worked with state Medicaid agencies, performing capitation rate setting, experience studies, and modeled rate adjustments among other projects. Additional experience includes Incurred But Not Paid development, risk score projections, and Medicare Advantage bids.

## EDUCATION

M.S., Mathematics, Western Washington University, 2019  
B.S., Mathematics, Western Washington University, 2017

## EXPERIENCE

7 years of professional experience, including:

- **Medicaid managed care rate setting:**
  - Hawai'i Quest Integration (2019-2022).
  - Washington Apple Health (2020-Present).
  - West Virginia Mountain Health Trust (2024-Present).
- **Other experience:**
  - Budget Forecast Development for Idaho Department of Health and Welfare (2024-2025).
  - Medicare Advantage Bid Development (2019-2021).
  - Department of Veterans Affairs (2019-2021).

## RELEVANT WORK EXPERIENCE

### Milliman (2019-Present), Associate Actuary

- **State of West Virginia, Mountain Health Trust (Medicaid) Managed Care**
  - Custom risk weight methodology for risk adjustment, modeling acuity adjustments, and certified community behavioral health clinic program change modeling for rates.
- **State of Hawai'i, Quest Integration (Medicaid) Managed Care**
  - Data processing and validation, sub-capitation encounter proxy pricing, trend analysis, and rate development.
- **State of Washington, Apple Health (Medicaid) Managed Care**
  - Rx trend analysis, behavioral health-related program changes, sub-capitation encounter proxy pricing, and behavioral health trend analysis.
  - Data acquisition and management, behavioral health rate development, presentations, and certification.
- **State of Idaho, Department of Health and Welfare (Medicaid)**
  - Medicaid budget forecasting which included, among other items, trend analysis, data reconciliation, and membership projections.

# Menko Ypma, ASA, MAAA

Associate Actuary, Milliman

## ROLE: STAFF ACTUARY

- ✓ Seven years of experience with Medicaid managed care rate setting.
- ✓ Associate of the Society of Actuaries (ASA).
- ✓ Member of the American Academy of Actuaries (MAAA).

Menko is an actuary with Milliman's Seattle Health Practice. Since joining Milliman in 2019, his experience includes assisting state Medicaid agencies, Medicare Advantage carriers, and commercial clients in a range of projects. He has supported state Medicaid agencies in Washington, Idaho, and West Virginia in the development of Medicaid managed care capitation rates.

## EDUCATION

B.S., Bioengineering, University of Washington, 2015

## EXPERIENCE

7 years of professional experience, including:

- **Medicaid managed care rate setting:**
  - Washington Apple Health (2019-Present).
  - Washington Program of All-Inclusive Care for the Elderly (PACE) (2022-Present).
  - Idaho Medicare Medicaid Coordinated Plan and Idaho Medicaid Plus (2019-Present).
  - West Virginia Mountain Health Trust (2023-Present).
- **Other experience:**
  - Medicare Advantage bid development (2019-Present).
  - Idaho Health Connections Value Care Program support (2019-Present).
  - Washington Cascade Select Public Option support (2023-Present).

## RELEVANT WORK EXPERIENCE

### Milliman (2019-Present), Associate Actuary

- **State of West Virginia: Mountain Health Trust (Medicaid) Managed Care**
  - Data processing and validation, Incurred But Not Paid, non-benefit expense analysis, rate development, and certification.
- **State of Washington: Apple Health (Medicaid) Managed Care**
  - Data processing and validation, non-system payment analysis, trend analysis, acuity analysis, program changes, waiver support, rate development and certification, and budget forecast support.
- **State of Washington: PACE (Medicaid Long-Term Care) Managed Care**
  - Data processing and validation, trend analysis, program changes, rate development, and certification.
- **State of Idaho: Idaho Medicare Medicaid Coordinated Plan and Idaho Medicaid Plus (Medicaid Duals)**
  - Data processing and validation, trend analysis, program changes, acuity and membership projections, retrospective settlements, rate development, and certification.



## Appendix D: Certifications and Degrees

Myers & Stauffer



### Firm & CPA Verification

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|                                                     |
|-----------------------------------------------------|
| Board Members & Staff                               |
| Meeting Agendas and Minutes                         |
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| Accountancy Law and Board Rules                     |
| Freedom of Information Act                          |
| WVBOA Budget                                        |
| Privacy Policy                                      |
| Feedback                                            |
| Employment Opportunities                            |
| Verification                                        |
| Firm & CPA Verification                             |
| Request CPA Verification: Login                     |

#### Firm License Information

**Firm Name** MYERS AND STAUFFER LC  
**Address** 700 W 47TH ST STE 1100  
**City** KANSAS CITY  
**State** MO  
**Zip** 64112  
**County** OUTOFSTATE  
**Permit Number** F0188  
**Effective Date** 07/01/2026  
**Current Status** Active  
**Expiration Date** 06/30/2027

#### Authorization to Perform Attest/Compilation Services

Active 06/30/2027

Jerry Dubberly, PharmD, MBA - Principal (Partner), Myers & Stauffer



### Confirmation of Degree

|                                                  |                                             |
|--------------------------------------------------|---------------------------------------------|
| COD: UNIVERSITY OF ARKANSAS, College of Pharmacy |                                             |
| <b>Name While Attending School:</b>              | Jerry Dubberly                              |
| <b>School Name:</b>                              | UNIVERSITY OF ARKANSAS, College of Pharmacy |
| <b>School Address:</b>                           | LITTLE ROCK, AR                             |
| <b>School Type:</b>                              | UNIVERSITY                                  |
| <b>Information Provided By:</b>                  | UNIVERSITY OF ARKANSAS, College of Pharmacy |
| <b>Department/Title:</b>                         | Automated Verification Service              |
| <b>Phone Number:</b>                             | 501-686-6499                                |
| <b>Verification Obtained By:</b>                 | FAX                                         |
| <b>Verification Verified By:</b>                 | NOT PROVIDED                                |

| < Applicant Info > |                        | < Respondent Info > |
|--------------------|------------------------|---------------------|
| (not provided)     | <b>Start Date</b>      | 06/1999             |
| 2005               | <b>End Date</b>        | 12/22/2005          |
| 2005               | <b>Graduation Year</b> | (verified)          |
| Doctor of Pharmacy | <b>Degree Received</b> | (verified)          |

Is this school accredited by a nationally recognized accrediting agency?

Yes

| COD - UNIVERSITY OF TENNESSEE AT CHATTANOOGA |                                        |
|----------------------------------------------|----------------------------------------|
| Name While Attending School:                 | Jerry Dubberly                         |
| School Name:                                 | UNIVERSITY OF TENNESSEE AT CHATTANOOGA |
| School Address:                              | CHATTANOOGA, TN                        |
| School Type:                                 | UNIVERSITY                             |
| Information Provided By:                     | UNIVERSITY OF TENNESSEE AT CHATTANOOGA |
| Department/Title:                            | Automated Verification Service         |
| Verification Obtained By:                    | VERIFICATION SERVICE                   |
| Verification Verified By:                    | NOT PROVIDED                           |

| < Applicant Info >                |                 | < Respondent Info >                                                                              |
|-----------------------------------|-----------------|--------------------------------------------------------------------------------------------------|
| (not provided)                    | Start Date      | See Comments                                                                                     |
| 1995                              | End Date        | 12/17/1995                                                                                       |
| 1995                              | Graduation Year | (verified)                                                                                       |
| Master of Business Administration | Degree Received | MASTER OF BUSINESS ADMINISTRATION; MAJOR(S)- BUSINESS ADMINISTRATION; HEALTH SERVICES MANAGEMENT |

| COD - UNIVERSITY OF GEORGIA  |                                |
|------------------------------|--------------------------------|
| Name While Attending School: | Jerry Dubberly                 |
| School Name:                 | UNIVERSITY OF GEORGIA          |
| School Address:              | ATHENS, GA                     |
| School Type:                 | UNIVERSITY                     |
| Information Provided By:     | UNIVERSITY OF GEORGIA          |
| Department/Title:            | Automated Verification Service |
| Verification Obtained By:    | VERIFICATION SERVICE           |
| Verification Verified By:    | NOT PROVIDED                   |

| < Applicant Info >              |                 | < Respondent Info > |
|---------------------------------|-----------------|---------------------|
| (not provided)                  | Start Date      | 09/19/1985          |
| 1990                            | End Date        | 03/22/1990          |
| 1990                            | Graduation Year | (verified)          |
| Bachelor of Science in Pharmacy | Degree Received | (verified)          |

Terri Branning - Senior Manager, Myers & Stauffer



| COD - EMORY UNIVERSITY       |                                |
|------------------------------|--------------------------------|
| Name While Attending School: | Terri Branning                 |
| School Name:                 | EMORY UNIVERSITY               |
| School Address:              | ATLANTA, GA                    |
| School Type:                 | UNIVERSITY                     |
| Information Provided By:     | EMORY UNIVERSITY               |
| Department/Title:            | Automated Verification Service |
| Phone Number:                | 404-727-6123                   |
| Verification Obtained By:    | VERIFICATION SERVICE           |
| Verification Verified By:    | VERIFICATION SERVICE           |

| < Applicant Info >             |                 | < Respondent Info >                               |
|--------------------------------|-----------------|---------------------------------------------------|
| (not provided)                 | Start Date      | 09/15/1977                                        |
| (not provided)                 | End Date        | 08/18/1979                                        |
| (not provided)                 | Graduation Year | 1979                                              |
| Bachelor of Science in Nursing | Degree Received | BACHELOR OF SCIENCE IN NURSING; MAJOR(S)- NURSING |

Is this school accredited by a nationally recognized accrediting agency?

Yes

## Hannah Lawrence, MPH - Health Care Manager, Myers &amp; Stauffer

**Hannah Rae Lawrence**

Complete Report

Social Security Number:

DOB:

Request #: HA-081826-2Z5C7

Prepared By:

HireRight, LLC

14002 E. 21<sup>st</sup> Street Suite 1200

Tulsa, OK 74134

Phone: 866-521-6995

Fax: 877-797-3442

[customerservice@hireright.com](mailto:customerservice@hireright.com)

Requested By:

|                          | <u>Information Provided</u>            | <u>Information Verified</u>            |
|--------------------------|----------------------------------------|----------------------------------------|
| School:                  | Indiana University                     | Indiana University Bloomington         |
| Dates Attended:          | Aug 2005 - May 2012                    | Jan 10, 2005 - Jul 27, 2012            |
| Degree/Diploma Received: | graduated, degree received             | yes                                    |
| Degree /Hours Completed: | Bachelors                              | BACHELOR OF SCIENCE IN PUBLIC HEALTH   |
| Date Degree Received:    | May 2012                               | Aug 31, 2012                           |
| Major /Area of Study:    | Community Health                       | MAJOR: COMMUNITY HEALTH, PUBLIC HEALTH |
|                          |                                        |                                        |
| School:                  | University of South Carolina           | University of South Carolina           |
| Dates Attended:          | Aug 2013 - Dec 2014                    | Aug 16, 2013 - Dec 31, 2014            |
| Degree/Diploma Received: | graduated, degree received             | yes                                    |
| Degree /Hours Completed: | Masters                                | MASTER OF PUBLIC HEALTH                |
| Date Degree Received:    | Dec 2014                               | Dec 15, 2014                           |
| Major /Area of Study:    | Health Services, Policy and Management | HLTH SERVICES POLICY AND MGMT          |

## Robert Rhoton, CPA - Senior Manager, Myers &amp; Stauffer



Home &gt; CPA Licensure Services &gt; Online Services

**CPA Details****Name**

Name: Robert Donald Rhoton

**Address Information**

City, State, ZIP code:

RICHMOND VA 23222

County:

Richmond City

Country:

United States

**License Information**

License #: 53478

Profession: Accountancy

Type: Certified Public Accountant

Status: Active

Issued: 1/25/2024

Expiration: 6/30/2027





## Confirmation of Degree

| COD - RANDOLPH-MACON COLLEGE |                                |
|------------------------------|--------------------------------|
| Name While Attending School: | Robert Rheton                  |
| School Name:                 | RANDOLPH-MACON COLLEGE         |
| School Address:              | ASHLAND, VA                    |
| School Type:                 | UNIVERSITY                     |
| Information Provided By:     | RANDOLPH-MACON COLLEGE         |
| Department/Title:            | Automated Verification Service |
| Phone Number:                | 804-752-7200                   |
| Verification Obtained By:    | VERIFICATION SERVICE           |
| Verification Verified By:    | NAME AND SSN                   |

| < Applicant Info >                                    |                 | < Respondent Info > |                                                             |
|-------------------------------------------------------|-----------------|---------------------|-------------------------------------------------------------|
|                                                       | Start Date      |                     | 09/06/2010                                                  |
| 05 / 2014                                             | End Date        |                     | 05/23/2014                                                  |
| 2014                                                  | Graduation Year |                     | (verified)                                                  |
| Bachelor of Arts in Accounting and Economics/Business | Degree Received |                     | BACHELOR OF ARTS; MAJOR(S)- ACCOUNTING ; ECONOMICS/BUSINESS |

Is this school accredited by a nationally recognized accrediting agency?

Yes

Gail Moriarty, JD - Health Care Consultant, Myers &amp; Stauffer

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\*For complete disciplinary history please see our new research site.

**Look Up An Attorney**

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| Name                                                      | Status | Multipractice Insurance | Location     | Public Discipline |
|-----------------------------------------------------------|--------|-------------------------|--------------|-------------------|
| <a href="#">Gail Catherine Moriarty</a><br>(317) 846-9521 | Active | No                      | Indianapolis | None              |

Myers and Stauffer  
900 East 96th Street, Suite 200  
Indianapolis, Indiana 46240

Admitted to the Mass. Bar  
Nov 15, 2024

Board of Bar Overseers Number  
716080

Not applicable because:  
1) I practice law as a government lawyer or a military lawyer, or 2) I am employed as in-house counsel and do not represent clients outside that capacity, or 3) I am registered under inactive status or retired status.

Employment Opportunities | Volunteer Opportunities | Calendar | FAQs

1 Beacon St., 10th Floor, Boston, Massachusetts 02108 | (617) 726-8700 | webmaster@massbbo.org

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Received: **Gall C Moriarity** Submitted: **Gall Catherine Moriarity**

Complete Report

Social Security Number: [REDACTED]

DOB: [REDACTED]

Prepared By:

HireRight, LLC

14002 E. 21<sup>st</sup>

Street Suite 1200

Tulsa, OK 74134

PHONE: 866-521-

6995

FAX: 877-797-3442

[customerservice@hireright.com](mailto:customerservice@hireright.com)

Request #: TB-061224-HU326

Requested By:

|                          | <u>Information Provided</u>         | <u>Information Verified</u> |
|--------------------------|-------------------------------------|-----------------------------|
| School:                  | Suffolk University                  | Suffolk University          |
| Dates Attended:          | Sep 2021 - May 2024                 | Data not available          |
| Degree/Diploma Received: | graduated, degree received          | yes                         |
| Degree /Hours Completed: | Doctorate                           | JURIS DOCTOR                |
| Date Degree Received:    | May 2024                            | May 19, 2024                |
| Major /Area of Study:    | Law                                 | LAW                         |
|                          | <u>Information Provided</u>         | <u>Information Verified</u> |
| School:                  | University of Dayton                | University of Dayton        |
| Dates Attended:          | Aug 2012 - May 2016                 | Aug 22, 2012 - May 6, 2016  |
| Degree/Diploma Received: | graduated, degree received          | yes                         |
| Degree /Hours Completed: | Bachelors                           | BACHELOR OF ARTS            |
| Date Degree Received:    | May 2016                            | May 7, 2016                 |
| Major /Area of Study:    | Psychology and Human Rights Studies | Psychology                  |

Nancy Kim, PMP, MPH - Senior Manager, Myers & Stauffer



### Confirmation of Degree

| COD - NORTHWESTERN UNIVERSITY |                                |
|-------------------------------|--------------------------------|
| Name While Attending School:  | Nancy Kwon                     |
| School Name:                  | NORTHWESTERN UNIVERSITY        |
| School Address:               | Evanston, IL                   |
| School Type:                  | UNIVERSITY                     |
| Information Provided By:      | NORTHWESTERN UNIVERSITY        |
| Department/Title:             | Automated Verification Service |
| Verification Obtained By:     | VERIFICATION SERVICE           |
| Verification Verified By:     | VERIFICATION SERVICE           |

| < Applicant Info >     |                                    | < Respondent Info >                                   |
|------------------------|------------------------------------|-------------------------------------------------------|
| 09 / 2002              | Start Date                         | 09/25/2002                                            |
| 06 / 2006              | End Date                           | 06/09/2006                                            |
| 2006                   | Graduation Year                    | 06/16/2006                                            |
| Bachelor's: Nancy Kwon | Degree/Diploma Pursued or Obtained | BS EDUCATION & SOCIAL POLICY; MAJOR(S)- SOCIAL POLICY |

| COD - YALE UNIVERSITY        |                  |
|------------------------------|------------------|
| Name While Attending School: | Nancy Kwon       |
| School Name:                 | Yale University  |
| School Address:              | New Haven, CT    |
| School Type:                 | UNIVERSITY       |
| Information Provided By:     | L. Marra         |
| Department/Title:            | Registrar's Aide |
| Phone Number:                | 203-785-6260     |
| Verification Obtained By:    | FAX              |
| Verification Verified By:    | NAME AND SSN     |

| < Applicant Info >   |                                    | < Respondent Info >                             |
|----------------------|------------------------------------|-------------------------------------------------|
| 08 / 2007            | Start Date                         | (verified)                                      |
| 05 / 2009            | End Date                           | 05/25/2009                                      |
| 2009                 | Graduation Year                    | (verified)                                      |
| Master's: Nancy Kwon | Degree/Diploma Pursued or Obtained | Master of Public Health; Major in Health Policy |

Annie Hallum, FSA, MAAA - Principal and Consulting Actuary, Milliman

### The Actuarial Directory

Anne Pankow Hallum

FSA MAAA



Designations

MAAA 2012  
FSA 2013

SOA CPD attestation status

Compliant(2023-2024)  
Compliant(2024-2025)



## Justin C. Birrell, FSA, MAAA - Principal and Consulting Actuary, Milliman

## The Actuarial Directory

Justin Crayton Birrell

FSA MAAA



## Designations

MAAA 2007

FSA 2010

## SOA CPD attestation status

Compliant(2024-2025)

Compliant(2023-2024)

## Shelly S. Brandel, FSA, MAAA - Principal and Consulting Actuary, Milliman

## The Actuarial Directory

Shelly S Brandel

FSA MAAA



## Designations

MAAA 1999

FSA 2001

## SOA CPD attestation status

Compliant(2024-2025)

Compliant(2023-2024)

## Davis Burge, FSA, MAAA - Principal and Consulting Actuary, Milliman

### The Actuarial Directory

Davis Burge

FSA MAAA



#### Designations

MAAA 2014

FSA 2016

#### SOA CPD attestation status

Compliant(2023-2024)

Compliant(2024-2025)

## Nick Johnson, FSA, MAAA - Principal and Consulting Actuary, Milliman

### The Actuarial Directory

Nicholas Joseph Johnson

FSA MAAA

Principal & Consulting Actuary

Milliman Inc

1301 5th Ave Ste 3800

Seattle

Washington 98101-2605

United States

Email nick.johnson@milliman.com

Fax +1(206) 3401380

Tel +1(206)504-5941



#### Designations

MAAA 2012

FSA 2014

#### SOA CPD attestation status

Compliant(2023-2024)

Compliant(2024-2025)

Rachel Kullman, FSA, MAAA - Principal and Consulting Actuary, Milliman

The Actuarial Directory

Rachel Kullman

FSA MAAA



Designations

MAAA 2015  
FSA 2017

SOA CPD attestation status

Compliant(2024-2025)  
Compliant(2023-2024)

Stacy Albrecht, FSA, MAAA- Consulting Actuary, Milliman

The Actuarial Directory

Stacy Hannah Albrecht

FSA MAAA



Designations

MAAA 2017  
FSA 2022

SOA CPD attestation status

Compliant(2023-2024)  
Compliant(2024-2025)



## Nick Gipe, ASA, MAAA - Consulting Actuary, Milliman

| The Actuarial Directory                                                           |                            |
|-----------------------------------------------------------------------------------|----------------------------|
| Nicholas B Gipe<br>ASA MAAA                                                       |                            |
|  |                            |
| Designations                                                                      | SOA CPD attestation status |
| MAAA 2018                                                                         | Compliant(2024-2025)       |
| ASA 2018                                                                          | Compliant(2023-2024)       |

## Victoria Boon, FSA, MAAA - Actuary, Milliman

| The Actuarial Directory                                                             |                            |
|-------------------------------------------------------------------------------------|----------------------------|
| Victoria Mei Kay Boon<br>FSA MAAA                                                   |                            |
|  |                            |
| Designations                                                                        | SOA CPD attestation status |
| MAAA 2019                                                                           | Compliant(2023-2024)       |
| FSA 2026                                                                            | Non-compliant(2024-2025)   |

## Vincent Dang, ASA, MAAA - Associate Actuary, Milliman

| The Actuarial Directory                                                           |                            |
|-----------------------------------------------------------------------------------|----------------------------|
| Vincent Tieu Dang<br>ASA MAAA                                                     |                            |
|  |                            |
| Designations                                                                      | SOA CPD attestation status |
| ASA 2018                                                                          | Compliant(2024-2025)       |
| MAAA 2019                                                                         | Compliant(2023-2024)       |

## Stacey Hagensen, FSA, MAAA - Consulting Actuary, Milliman

| The Actuarial Directory                                                             |                            |
|-------------------------------------------------------------------------------------|----------------------------|
| Stacey Hagensen<br>FSA MAAA                                                         |                            |
|  |                            |
| Designations                                                                        | SOA CPD attestation status |
| MAAA 2018                                                                           | Compliant(2024-2025)       |
| FSA 2022                                                                            | Compliant(2023-2024)       |

## Kimberly Lake, ASA, MAAA - Consulting Actuary, Milliman

The Actuarial Directory

Kimberly A Lake  
ASA MAAA



|              |                            |
|--------------|----------------------------|
| Designations | SOA CPD attestation status |
| ASA 2018     | Compliant(2023-2024)       |
| MAAA 2019    | Compliant(2024-2025)       |

## Lu Miao, FSA, MAAA - Actuary, Milliman

The Actuarial Directory

Lu Miao  
FSA MAAA



|              |                            |
|--------------|----------------------------|
| Designations | SOA CPD attestation status |
| MAAA 2019    | Compliant(2023-2024)       |
| FSA 2023     | Compliant(2024-2025)       |



## Steven Rounsley, FSA, MAAA - Actuary, Milliman

| The Actuarial Directory                                                           |                            |
|-----------------------------------------------------------------------------------|----------------------------|
| Steven R Rounsley<br>FSA MAAA                                                     |                            |
|  |                            |
| Designations                                                                      | SOA CPD attestation status |
| MAAA 2019                                                                         | Compliant(2024-2025)       |
| FSA 2021                                                                          | Compliant(2023-2024)       |

## Brian Schatzel, FSA, MAAA - Actuary, Milliman

| The Actuarial Directory                                                             |                            |
|-------------------------------------------------------------------------------------|----------------------------|
| Brian Schatzel<br>FSA MAAA                                                          |                            |
|  |                            |
| Designations                                                                        | SOA CPD attestation status |
| MAAA 2022                                                                           | Compliant(2024-2025)       |
|                                                                                     | Compliant(2023-2024)       |

## Logan Blank, ASA, MAAA -Associate Actuary, Milliman

| The Actuarial Directory                                                            |                            |
|------------------------------------------------------------------------------------|----------------------------|
| Logan Blank<br>ASA MAAA                                                            |                            |
|  |                            |
| Designations                                                                       | SOA CPD attestation status |
| ASA 2020                                                                           | Compliant(2024-2025)       |
| MAAA 2020                                                                          | Compliant(2023-2024)       |

## June Chu, ASA, MAAA - Associate Actuary, Milliman

| The Actuarial Directory |                            |
|-------------------------|----------------------------|
| Yunhye Chu<br>ASA MAAA  |                            |
| Designations            | SOA CPD attestation status |
| ASA 2021                | Compliant(2023-2024)       |
| MAAA 2023               | Compliant(2024-2025)       |

## Tyler Edwards, ASA, MAAA - Associate Actuary, Milliman

| The Actuarial Directory                                                            |                                                                                     |
|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| <p><b>Tyler S Edwards</b><br/>ASA MAAA</p>                                         |                                                                                     |
| <p>Email     <b>tedwardskc@gmail.com</b><br/>Tel        <b>+1(475)333-1737</b></p> |   |
| <p>Designations<br/>MAAA 2024<br/>ASA 2024</p>                                     | <p>SOA CPD attestation status<br/>Compliant(2024-2025)<br/>Compliant(2023-2024)</p> |

## Elias Kehr, ASA, MAAA - Associate Actuary, Milliman

| The Actuarial Directory                                                              |                                                                                     |
|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| <p><b>Elias Kehr</b><br/>ASA MAAA</p>                                                |                                                                                     |
|  |                                                                                     |
| <p>Designations<br/>ASA 2022<br/>MAAA 2022</p>                                       | <p>SOA CPD attestation status<br/>Compliant(2024-2025)<br/>Compliant(2023-2024)</p> |



## Celena Jo Robinson, ASA, MAAA - Associate Actuary, Milliman

### The Actuarial Directory

Celena Jo Robinson

ASA MAAA

Email celenarobinson@ymail.com

Tel +1(760)509-5505



#### Designations

ASA 2021

MAAA 2022

#### SOA CPD attestation status

Compliant(2024-2025)

Compliant(2023-2024)

## Joshua Welsh, ASA, MAAA - Associate Actuary, Milliman

### The Actuarial Directory

Joshua M Welsh

ASA MAAA



#### Designations

MAAA 2023

ASA 2023

#### SOA CPD attestation status

Compliant(2023-2024)

Compliant(2024-2025)

## Menko Ypma, ASA, MAAA - Associate Actuary, Milliman

The Actuarial Directory

Menko Ypma

ASA MAAA



Designations

MAAA 2023  
ASA 2023

SOA CPD attestation status

Compliant(2024-2025)  
Compliant(2023-2024)