



Proposal for:

Medicaid Managed Care Rate Setting / Program Administration

CRFP 0511 BMS2700000001

Presented to:



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

Technical Proposal

September 9, 2026

Presented by:

A handwritten signature in blue ink that reads "Russell H. Ackerman".

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

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



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September 9, 2026

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

RE: Medicaid Managed Care Rate Setting / Program Administration I CRFP BMS2700000001

Dear Ms. Hustead:

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

Through our work with West Virginia from 2018 to 2022, Guidehouse demonstrated our ability to provide the State with integrated actuarial, financial, and policy support. We delivered these services under a single vendor structure, creating one point of contact for the full scope and reducing the contract coordination challenges that can arise when multiple vendors are involved. Our prior work also helped improve MCO transparency and rebuild trust between the agency and the plans after a challenging period in the State-MCO relationship. We have a strong history of working with BMS to keep contractors and the State focused on high-impact priorities, and we would be honored to return to support this important work.

Under our prior 2018–2022 contract, BMS leadership consistently praised Guidehouse’s performance on services that closely align with this RFP. After the prime contract was fully novated to Guidehouse in 2020, our team performed all related services directly. BMS staff and leaders regularly noted that this was the only period in the last decade when the agency experienced a truly seamless approach to managed care oversight and actuarial services. That integrated model supported a successful and transparent partnership between BMS and Guidehouse and strengthened the relationship between BMS and the MCOs. Our work also helped implement the State’s SUD waiver, support the transition of Mountain Health Promise to managed care, and begin the actuarial oversight needed to better align WVCHIP with the MHT and MHP capitation rate development processes.

We present to you our proposal for your consideration, which includes members of our team who were previously highly successful in supporting these same services to the full satisfaction of BMS, including Russ Ackerman, Sterling Felsted, Melanie Bell, Kory Wolf, Liz Barabas, and Dustin Schmidt. We also include others who are recognized as national experts throughout the Medicaid industry, including Lance Robertson, Christina Koster, Charles (Charlie) Smith, and Coy Jones.

This Proposal will be used by the parties to finalize the terms and is intended for informational purposes only. This Proposal does not constitute a contract to perform services and neither party has committed to any of the terms described herein.



We would be pleased to review and discuss this Proposal with you in more detail to best meet all of your needs and expectations toward executing a contract. Please contact Russ Ackerman at (480) 318-9390 or russ.ackerman@guidehouse.com with questions, for additional information or discussion of next steps.

Sincerely,

A handwritten signature in blue ink that reads "Russell H. Ackerman". The signature is fluid and cursive, with the first name "Russell" being the most prominent.

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

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Executive Summary

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

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

Addressing Pressing Health Issues with Innovative Solutions and Execution

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

We understand that the RFP requirements should be addressed in the context of the current and future healthcare landscape and support BMS' mission, values, and priorities. The number of issues that BMS must consider simultaneously and sequentially (constant regulatory change) can sometimes seem infinite – from basic blocking and tackling of member enrollment and provider payment to the latest hot topics such as the opioid crisis, the future of rural and critical access hospitals, and fraud, waste, and abuse.

As we execute the requirements of this RFP and support BMS throughout the contract term, we will provide strategic guidance and practical support to help BMS address emerging challenges and maximize the value of its managed care program. Through our prior work supporting West Virginia Medicaid programs, Guidehouse developed a strong understanding of BMS' goals, operating environment, and program priorities. We look forward to leveraging that experience to provide thoughtful, responsive support and help BMS achieve its current and future objectives.

Your Guidehouse Team: A "One-Firm" Resource

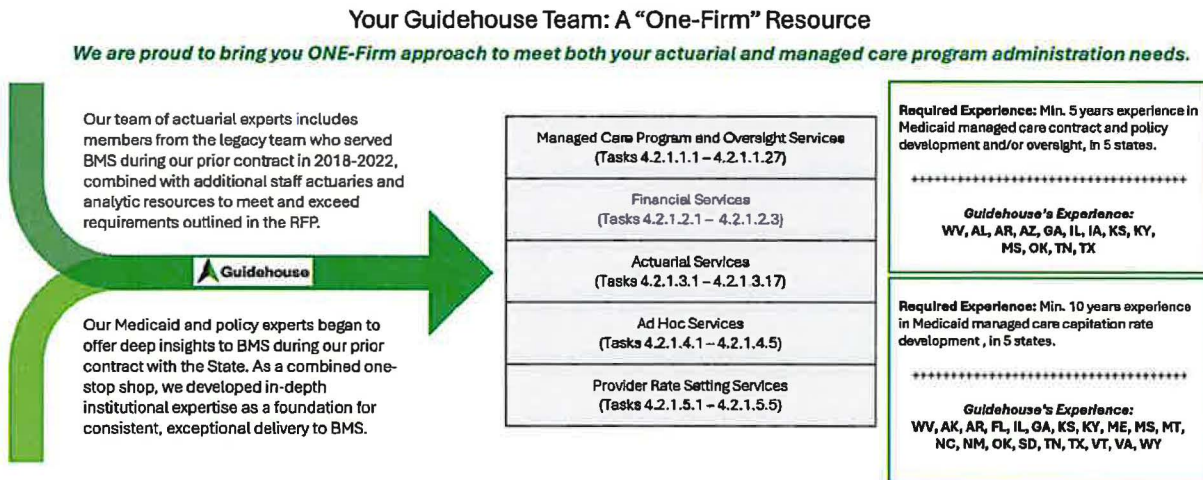
Guidehouse brings a deep understanding of West Virginia Medicaid and the unique needs of BMS, informed by our prior experience supporting the agency. **We are one of the few truly full-service Medicaid consulting firms that house both program and policy support alongside our highly reliable and robust actuarial practice, without requiring subcontracting arrangements.**

Unlike firms that rely on subcontractors or separate affiliates to provide key functions, Guidehouse offers both Medicaid program and policy expertise alongside a highly experienced actuarial practice within one coordinated team. This integrated model promotes consistent communication, streamlined decision making, and efficient execution across all aspects of managed care oversight and operations.

The result for BMS is lower transition risk, less vendor coordination burden, stronger day-to-day oversight, and faster access to the actuarial, policy, pharmacy, financial, and analytics expertise

needed to make timely decisions for MHT and MHP to help BMS address ongoing program requirements and emerging priorities.

Figure1. Guidehouse One-Firm Approach

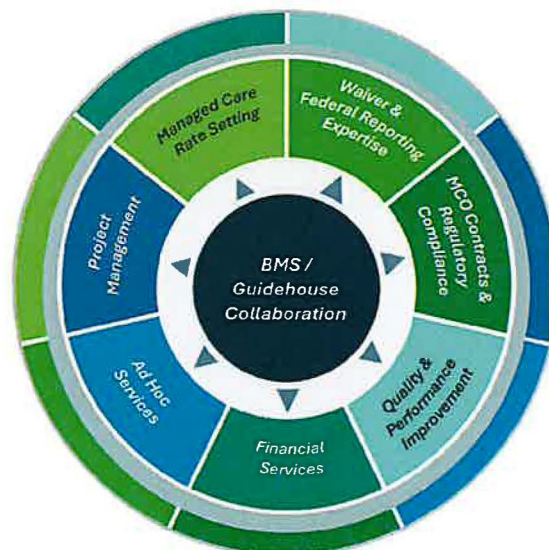


Guidehouse Offers Continuity Along with a Fresh Perspective

Guidehouse offers proven delivery of the requested services, supported by strategic insight and direct West Virginia experience. During our prior contract with BMS, we quickly assumed responsibility for MHT, MHP, and WVCHIP program administration and actuarial tasks. BMS described the transition to Guidehouse actuarial services as smooth and seamless, with virtually no disruption to the State or the Managed Care Organizations (MCOs). We understand BMS's managed care program history, team structure, operating environment, and MCO strengths and challenges. We can continue helping BMS navigate sensitive issues while bringing national best practices through one integrated actuarial, finance, and policy team.

In our prior contract, we helped BMS with:

- **Project management:** We developed and maintained detailed work and operations plans to meet BMS' increasingly complex needs due to MHT and MHP program changes.
- **Managed care rate setting:** Our collaborative and nationally-informed approach, especially with the complexity of COVID-19 challenges, helped BMS meet Centers for Medicare & Medicaid Services (CMS) requirements and achieve value from the MHT and MHP programs, while also providing appropriate actuarial support for your WVCHIP program that had been requested because of our high levels of expertise.



- **Waiver and Federal Reporting expertise:** Our thorough and expedient approach put BMS on a smooth path to CMS approval. Guidehouse's federal reporting and actuarial teams' course-corrected 1115 waiver reporting to enable a forward path of compliance and improved processes and successfully negotiated changes with CMS.
- **MCO contracts and regulatory compliance:** We conducted a comprehensive compliance review in 2020 to assess MCOs adherence to contractual and Federal requirements, establishing a foundation for subsequent performance improvement efforts. Guidehouse also developed contract enhancements related to care coordination, reporting requirements, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and marketing to strengthen oversight and support improved member outcomes and experiences across MHT and MHP.
- **Quality and performance improvement:** We supported BMS in updating its quality strategy to better reflect program goals, priorities, and stakeholder expectations. We also worked with BMS to enhance and streamline MCO reporting to support more effective performance monitoring and operational improvement.
- **Financial Services:** We provided BMS financial support for Managed Care Medical Loss Ratio (MLR), rate and reimbursement studies, budgeting, forecasting, waiver oversight, Directed Payment Programs (DPPs), payment reviews, tax settlements, audits, and reporting. We implemented transparent methods, validated data, and provided audit-ready documentation to support BMS decision making.
- **Ad hoc services:** We served as a responsive resource to BMS on a wide range of emerging issues, legislative inquiries, policy initiatives, budget-related analyses, and programmatic priorities. This support included topics ranging from pharmacy high-risk pools to Drug Free Moms and Babies, often under compressed deadlines and evolving circumstances.

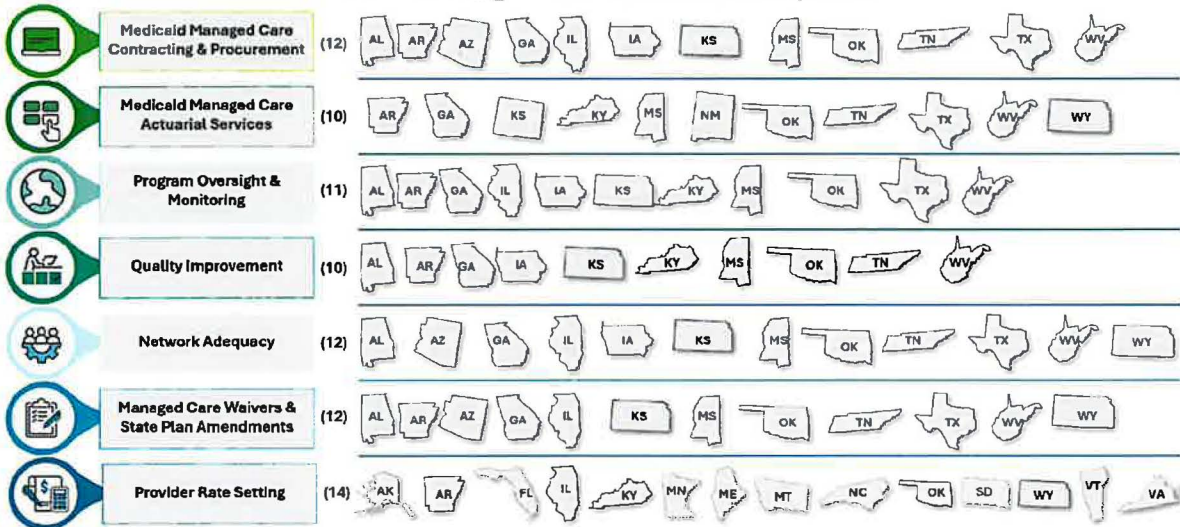
Our team is prepared to build on the support previously provided to BMS by bringing additional capabilities, enhanced tools, and insights informed by our work with Medicaid programs across the country. We are confident that our experience and continually evolving approaches can help BMS strengthen and enhance the MHT, MHP, and WVCHIP programs while continuing to meet critical regulatory, operational, and compliance requirements.

Guidehouse Brings a National Medicaid Perspective

Guidehouse is a national firm backed by a long history supporting states, Federal agencies, and commercial payers with similar tasks, bringing together our prior experience supporting West Virginia Medicaid with insights and leading practices from Medicaid programs across the country.

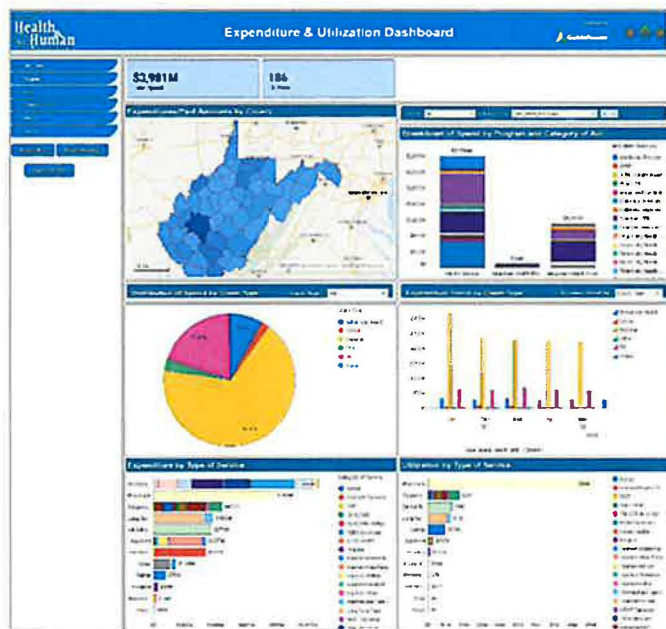
The figure below illustrates the breadth of Guidehouse's Medicaid managed care experience, including more than a decade of actuarial support for Medicaid managed care programs and extensive experience supporting managed care contracts, quality initiatives, waiver activities, program oversight, and provider reimbursement across multiple states.

Guidehouse Brings A National Medicaid Perspective



In this figure, our Medicaid managed care actuarial services includes direct actuarial capitation rate setting for six of the ten listed states over the last ten years: West Virginia, Georgia, Kansas, Kentucky, Oklahoma, and Tennessee. Our Medicaid managed care actuarial work in Arkansas, Mississippi, New Mexico, Texas, and Wyoming include actuarial review of other firms' managed care rate methodologies and results, analyses assessing considerations of implementing managed care programs, and trend development exercises.

Guidehouse has a wide array of tools available to BMS, some of which are familiar to the State from our prior work, and others that have been developed and enhanced through continued investments in our digital, analytics, and data visualization capabilities. Examples of these tools are included in appropriate sections of this proposal. These capabilities can provide BMS with enhanced access to data and interactive analytic tools that support deeper program monitoring and decision making. BMS can drill down to compare data across MHT, MHP, WVCHIP, and fee-for-service (FFS) populations by county, region, category of aid (COA), and other key dimensions on a variety of performance and utilization metrics. Automated reporting and visualization capabilities help reduce manual data processing, accelerate identification of potential issues, and allow State staff to focus on interpretation, oversight, and decision making.



Guidehouse brings a suite of proven project management and program oversight tools that have been refined through our work supporting Medicaid agencies nationwide. These include implementation and readiness review trackers, issue and risk management logs, action item and decision trackers, compliance monitoring tools, and project reporting templates designed to promote transparency, accountability, and timely decision making. These tools provide BMS with clear visibility into project status, risks, deliverables, and performance, while supporting efficient coordination across BMS staff, MCOs, and other stakeholders.

Further, in other states Guidehouse has heavily invested in data visualization and drill down tools and has provided key State staff with access to these tools. For example, in Tennessee, our actuarial team reviews quarterly data drill-downs using R and Power BI. The actuarial team leads presentations on findings of key cost and utilization drivers with drill-downs by rate cell, COA, region, category of service (COS), etc. These analyses also support experience studies and provide early visibility into developing cost and utilization trends.

Your Guidehouse Team Meets and Exceeds All Required Staffing Requirements

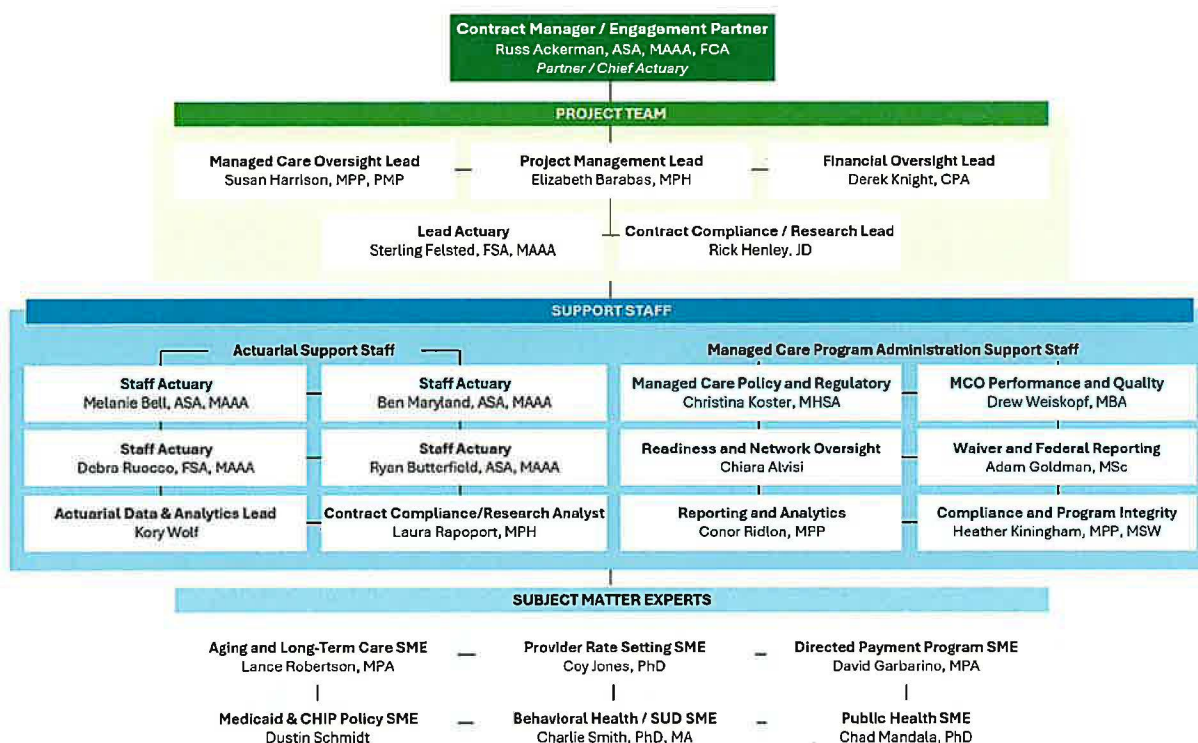
Guidehouse has assembled a team that not only meets all staffing requirements identified in the RFP but also brings a unique combination of prior West Virginia Medicaid experience, national managed care expertise, actuarial leadership, and specialized policy knowledge. Our proposed team includes several individuals who previously supported BMS and are familiar with the State's managed care programs, organizational priorities, and operating environment, complemented by experts who have supported Medicaid agencies across the country.

Guidehouse is committed to maintaining a strong partnership with BMS through a combination of onsite and remote support. Our actuarial, policy, and program management teams will work closely with BMS staff throughout the contract period, with regular in person engagement in Charleston to facilitate collaboration, responsiveness, and effective project execution.

Our proposed team includes nationally recognized leaders in actuarial services, managed care oversight, Medicaid policy, quality improvement, financial analysis, project management, aging and long-term services and supports, and behavioral health. Team members include Russ Ackerman, Derek Knight, Christina Koster, Liz Barabas, Lance Robertson, and Dr. Charlie Smith, whose collective experience spans state Medicaid programs, Federal health agencies, managed care oversight, quality initiatives, and healthcare financing. Together, they provide the multidisciplinary expertise necessary to support the full scope of services contemplated under this contract.

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

Figure 2. Guidehouse Team Structure and High-Level Qualifications



Guidehouse has assembled an integrated team designed specifically to meet the full scope of actuarial and managed care program administration services required under this contract.

Under the leadership and oversight of our **Lead Actuary, Sterling Felsted**, our actuarial team including Melanie Bell, Debra Ruocco, Ben Maryland, and Ryan Butterfield, will provide the actuarial analyses, rate development support, financial modeling, certifications, and other actuarial deliverables required by BMS. Each of our actuaries identified above is an ASA or FSA and MAAA certified and has more than 5 years of rate setting experience in Medicaid or Medicaid and CHIP managed care or other insurance pricing.

Complementing our actuarial team is a dedicated managed care program administration team responsible for project management, contract oversight, policy analysis, quality improvement, regulatory compliance, waiver support, program monitoring, and stakeholder engagement activities. Together, these teams provide BMS with a coordinated approach that integrates actuarial, operational, financial, and policy expertise across all contract requirements.

To further support BMS's evolving priorities, Guidehouse's core project team is supplemented by a broad network of subject matter experts with experience in Medicaid managed care, behavioral health, long-term services and supports, aging services, provider reimbursement, data analytics, and Federal Medicaid policy. This structure allows Guidehouse to quickly provide specialized expertise when needed while maintaining continuity and accountability through a stable project leadership team.

Detailed professional resumes can be found in Appendix B.

1.0 Engagement Approach (§4.2)

Project Goals / Objectives (§4.2.1.)

Compliance Statement | Guidehouse meets and exceeds all requirements as set forth in Section 4.2 of this RFP.

Managed Care Program Administration (§4.2.1.1.)

§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).

Within the first 30 calendar days, Guidehouse will establish the management framework for overseeing contract activities, monitoring MCO performance, and tracking compliance obligations. During the first 10 days, we will inventory current MHT and MHP contracts, waivers, CMS submissions, MCO reporting requirements, open compliance items, recurring activities, and established BMS deadlines. We will identify the BMS and Guidehouse owner, required inputs, dependencies, review points, and due date for each activity.

We will translate this inventory into an Operations Plan and detailed work plan that covers every Managed Care Oversight requirement. The plan will show milestones, responsible parties, decision points, MCO dependencies, BMS review periods, and escalation paths. For performance targets, incentives, penalties, program changes, and MLR oversight, we will document the current approach, identify decisions BMS needs to make, and develop options supported by performance data and Federal requirements. We will also develop a master compliance and reporting calendar that incorporates contractual, state, and federal reporting requirements and key program milestones.

We will review the draft plan with BMS before the 30-day deadline and incorporate feedback. After approval, we will maintain them as active management tools, with regular status updates, a rolling look-ahead, and an issue and decision log. Guidehouse successfully used this approach during our prior engagement with BMS to support ongoing program administration, compliance monitoring, and managed care oversight activities.

Figure 3. Sample Section of a West Virginia BMS Operations Plan

Operations Plan - Program and Policy West Virginia Bureau for Medical Services Last Updated: 08/XX/20XX Proprietary and Confidential, solely for discussion between Guidehouse and West Virginia Bureau for Medical Services.								
Task #	Task	Dependency	Target Date	Adjusted Target Dates	Reason for New Target	Completion Date	% of Task Completed	Notes
A	1815(b) Waiver Development, Review and Analysis							
A.1	Sections A and B Program Description and Monitoring Plan (note: if no changes are made to Section A or B during a renewal the existing section can carry over.)							
A.1.a	Review current waiver and compile recommended changes and questions (Note: consider needed changes based on 2025 Final Managed Care Rule)		1/15/2026			1/15/2026	Complete	No significant recommendations were found. A.1.b or c not needed
A.1.b	Review recommendations as a group and determine if changes are needed / approved		1/22/2026				Complete	Step not needed
A.1.c	Review recommendations with BMS for approval		1/25/2026				Complete	Step not needed
A.1.d	Draft preprint revisions		3/1/2026			3/1/2026	Complete	MHT - Sent on 3/1/XX, MHP expected 3/2.
A.1.e	Review preprint revisions as a group		3/8/2026				Complete	
A.1.f	Revised based on group feedback		3/12/2026				Complete	
A.1.g	Approve Section A and B drafts		3/15/2026				Complete	
A.2	Sections C: Monitoring Results							
A.2.a	Identify data request for Internal GH reporting team, BMS and MCOs		1/19/2026			1/19/2026	Complete	
A.2.b	Send out data requests		1/22/2026			1/19/2026	Complete	
A.2.c	Respond to data requests		2/2/2026	2/5/2026		2/5/2026	Complete	
A.2.d	Complete monitoring results from MCOs and identify findings	Data Receipt from MCOs and BMS	2/2/2026	2/26/2026	Delayed due to timing of data received from BMS		Complete	Minor follow ups still outstanding on 3/1 with anticipated completion by 3/8
A.2.e	Complete Section C preprint		3/1/2026			3/2/2026	Complete	MHT - Sent on 3/1/XX, MHP expected 3/2.
A.2.f	Review Section C draft		3/8/2026				Complete	
A.2.g	Revise Section C draft based on BMS feedback		3/12/2026				Complete	
A.2.h	Approve Section C draft		3/15/2026				Complete	
A.3	Section D: Cost-Effectiveness							
A.3.a	Complete Appendices D1-7		1/29/2026	3/26/2026	Delay due to outstanding CMS questions		Complete	
A.3.b	Complete Section D preprint summary		2/12/2026	3/26/2026			Complete	
A.3.c	Review Section D and Appendices D1-7		2/17/2026	3/29/2026			Complete	
A.3.d	Approve Section D and Appendices D1-7		2/19/2026	3/30/2026			Complete	
B	Policy Analysis							
B.1	Policy Impact analyses and support as requested by BMS		Ongoing				On Track	Examples of recent deliverables include SDoH research and pharmacy high risk pool policy analyses.
B.2	Revise analyses as needed, based on future releases or revisions of information		TBD				Not Started	
B.3	Ongoing monitoring of federal regulations for program impact		Ongoing				On Track	
B.4	Assist with implementation of adopted strategies		TBD				Not Started	

§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.

Managed care contracts must evolve as Federal requirements, West Virginia policy, program operations, and performance expectations change. Guidehouse will maintain the MHT and MHP contracts through a structured annual contract management and amendment process, similar to the approach we successfully used during our prior engagement supporting BMS.

Guidehouse recognizes that West Virginia's MCO contracting and procurement approach has evolved overtime. We will begin by confirming the current statutory authority, BMS contracting procedures, applicable Purchasing Division requirements, contract templates, approval pathways, and roles and responsibilities for MHT and MHP. Our work products and recommendations will be tailored to the process in effect at the time of the activity and updated as BMS policies, legislation, CMS requirements, or program operations change.

Our approach will recognize the distinct statutory and operational context of each program. For MHT, this includes BMS's current statutory authority to administer mainstream MCO contracting outside the Purchasing Division's standard procurement requirements. For MHP, this includes the specialized-population procurement pathway, applicable Purchasing Division requirements, the current agreement's renewal options, and the need to coordinate future re-procurement and transition planning with BMS, the Purchasing Division, CMS, the MCO, and child welfare stakeholders.

Gather and Prioritize Potential Contract Changes

At least 120 calendar days before each applicable annual contract implementation or renewal date, Guidehouse will solicit proposed contract changes from BMS and the MCOs and begin an independent review of Federal and state requirements, CMS guidance, waiver changes, monitoring findings, audit results, MCO reporting trends, network adequacy reviews, quality performance results, and operational issues identified during the contract year. We will structure this process around the state fiscal year and annual contract renewal cycle, while also maintaining a process for mid-year amendments when operational, policy, regulatory, or compliance needs require them.

We will compile all proposed changes into a centralized contract tracking tool and categorize them by topic area, including compliance, quality, reporting, network adequacy, care coordination, EPSDT, program integrity, member experience, waiver requirements, and financial oversight. We will also identify whether each change requires contract amendment, annual renewal documentation, MCO response, formal procurement action, CMS review or approval, state legal review, or implementation through policy or operational guidance.

Conduct Policy, Operational, and Compliance Review

Guidehouse will maintain a contract requirements crosswalk that identifies the source of each material requirement, its location within the MHT and MHP contracts, and associated reporting, monitoring, or oversight requirements. Using this crosswalk, we will evaluate each proposed revision for consistency with Federal regulations, West Virginia policy, waiver requirements, and existing contract provisions.

For each proposed change, we will assess operational, policy, financial, actuarial, compliance, and implementation impacts and identify any necessary system, reporting, staffing, or process changes required of BMS or the MCOs.

Develop Contract Revisions and Decision Support Materials

Guidehouse will prepare draft contract language, redlines, issue papers, and supporting analyses for BMS review. For material revisions, we will document the rationale for the change, available policy options, implementation considerations, potential risks, and anticipated



Proven Results in Managed Care Contract Updates

Guidehouse is currently working with Oklahoma Medicaid to prepare for its next managed care procurement, planned for go-live in 2030. We are holding listening sessions with State staff to identify opportunities to refine procurement and contract requirements. We are also developing surveys to solicit stakeholder feedback from beneficiaries, providers, and other stakeholders.

We will apply lessons from this work to West Virginia while tailoring all methods, tools, timelines, and decision processes to BMS's current statutory and administrative framework.

impacts on program operations and oversight activities. This approach enables BMS to evaluate changes in the context of broader program goals rather than reviewing contract language in isolation.

Facilitate Review and Comment Resolution

After BMS identifies preferred revisions, Guidehouse will coordinate review activities with BMS and the MCOs, manage comment resolution meetings, maintain version control, and document discussion outcomes and decisions. All comments, decisions, and action items will be tracked through a centralized contract management log to support transparency and accountability throughout the amendment process.

Finalize Amendments and Support Implementation

Following approval of contract revisions, Guidehouse will prepare final contract amendments and implementation materials and assist BMS with communicating changes to the MCOs. We will update compliance monitoring tools, reporting requirements, contract crosswalks, training materials, and oversight processes as necessary to support implementation.

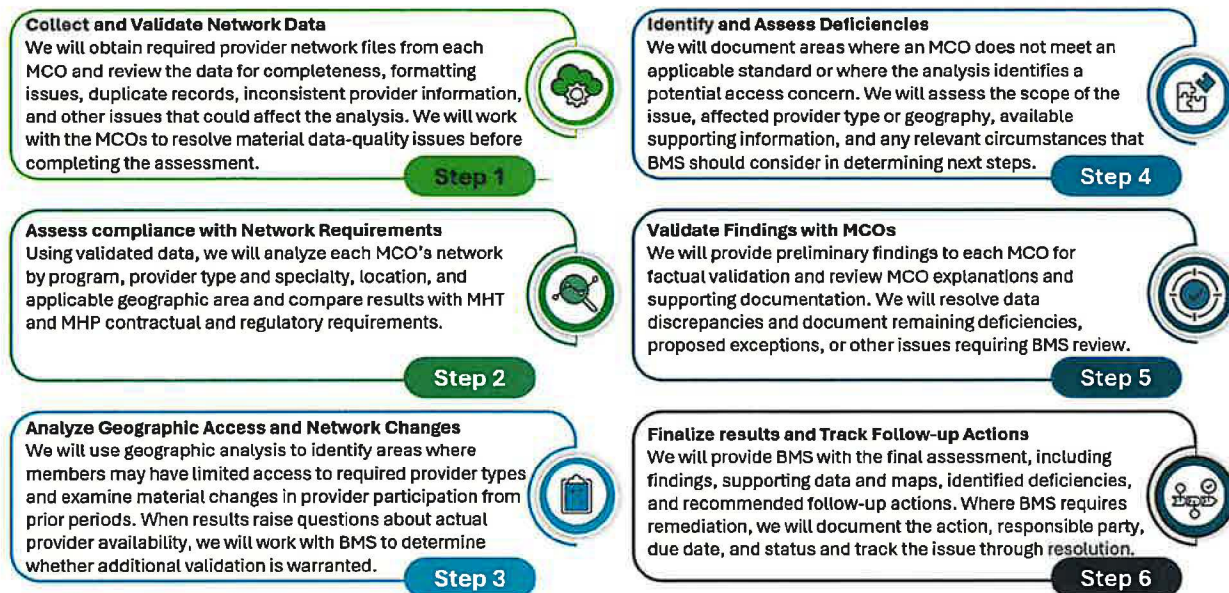
As part of this work, we will incorporate applicable provisions of the 2024 Medicaid Managed Care Access, Finance, and Quality Final Rule as implementation dates become effective, along with any other relevant Federal and state laws, regulations, and guidance. We will also monitor implementation of contract changes throughout the year and identify any additional revisions needed to address emerging operational, compliance, or programmatic priorities.

§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.

Guidehouse will use a repeatable annual process to assess network adequacy for both MHT and MHP, moving from planning and data validation through access analysis, MCO review, and follow-up on identified deficiencies. We will work with BMS to confirm the assessment methodology and obtain the Agency's written approval before implementation. Sixty calendar days before implementation, we will submit a preliminary milestone-based timeline that accounts for data collection, validation, analysis, MCO review, issue resolution, BMS review, and completion of the assessment by October 1. We will update the timeline with BMS if external factors affect planned activities or dependencies.

Thirty calendar days before implementation, Guidehouse will lead the required network adequacy kickoff meeting with BMS and the MCOs. We will review the approved methodology, provider file specifications, applicable MHT and MHP network standards, measures, deadlines, validation rules, roles and responsibilities, and expectations for addressing data issues and preliminary findings.

The annual assessment will follow six steps:



Guidehouse brings direct experience performing network adequacy analysis for BMS. During our prior West Virginia managed care oversight engagement, we analyzed MCO provider networks across counties and provider types, assessed performance against MHT and MHP contractual standards, and supported BMS in evaluating identified deficiencies and potential exceptions. We will build on that experience through a repeatable annual process that integrates provider file validation, geographic access analysis, MCO review, and remediation tracking.

We will also update the methodology as Federal access requirements become applicable. For rating periods beginning on or after July 9, 2026, CMS requirements add network monitoring and provider payment analysis requirements to the Federal managed care access framework, with additional appointment wait-time and secret-shopper requirements phasing in later. We will incorporate applicable requirements into the annual methodology, data requests, timeline, and assessment process.

§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.

Establish the Reporting Framework

Guidehouse will develop the annual MCO performance and compliance report as the culmination of monitoring performed throughout the State fiscal year rather than begin the analytical process after June 30. At the beginning of each reporting cycle, we will establish a source-to-report crosswalk covering the required topics, including enrollment, covered services, financial performance and cost savings, quality measures, MLR, program integrity, improvement activities, program goals, and MCO compliance with contractual obligations. For each element, we will

identify the source, reporting period, responsible reviewer, validation approach, and any related MCO or federal reporting requirement.

Conduct Ongoing Monitoring and Validation

Throughout the year, Guidehouse will use quarterly and monthly MCO reporting, dashboard results, network analyses, quality monitoring, financial reviews, compliance findings, and other available program information to develop the evidence base for the annual report. We will identify missing or inconsistent data, unexplained changes, differences across MCOs, and unresolved findings as they arise so those issues can be addressed before year-end. This continuous monitoring approach reduces year-end reconciliation efforts and improves the accuracy and completeness of the final report.

Leverage Established BMS Reporting Processes

Guidehouse brings direct experience establishing this type of reporting foundation for BMS. During our prior engagement, we helped develop BMS's Managed Care HealthCheck Reporting Guide, which established consistent monthly and quarterly reporting requirements across operational, network, utilization, financial, access, and program integrity domains. The reporting framework included defined reporting periods, due dates, data definitions, formulas, and MCO certification requirements, creating structured inputs that BMS could use for contract monitoring and broader program assessment. The prior guide included reporting on provider networks, claims processing, utilization and unit cost, MLR and administrative costs, out-of-network utilization, member access, and program integrity, many of the same areas that inform the annual performance assessment.

Analyze Program Performance and Contract Compliance

Following the June 30 reporting period close, we will reconcile final information, confirm that reporting periods and populations are aligned, analyze trends and material differences across MCOs, and identify the most significant findings for BMS. Where information from multiple data sources appears inconsistent, we will investigate and resolve discrepancies or clearly document limitations before incorporating the information into the report.

In addition to summarizing performance results, Guidehouse will assess compliance with key contractual obligations, identify areas where MCO performance met or failed to meet requirements, summarize corrective actions and improvement activities completed during the reporting year, and highlight unresolved compliance concerns requiring future monitoring.

Develop Findings, Recommendations, and Program Insights

The annual report will distinguish between reported results and Guidehouse's assessment of what those results mean for BMS. We will identify significant trends, areas of strong or improving performance, persistent or emerging risks, unresolved contractual issues, and improvement strategies implemented during the year. Where appropriate, findings will be supported by comparisons across MCOs, comparisons to prior reporting periods, and assessment of progress toward BMS program goals and objectives.

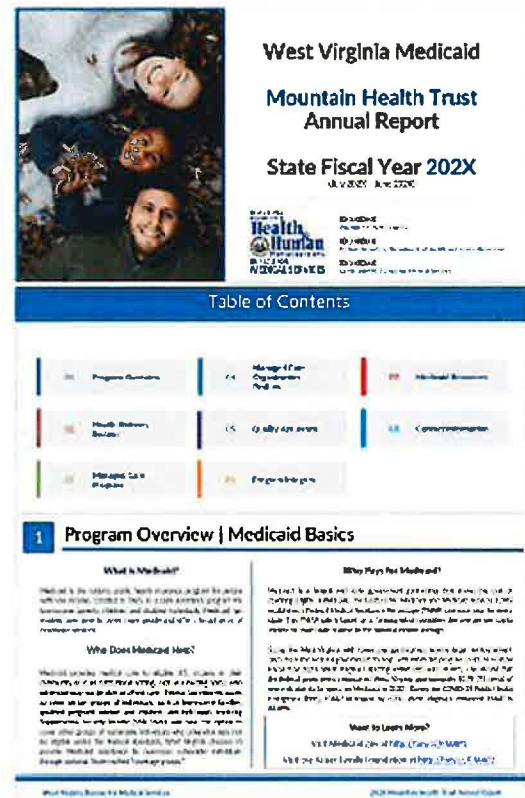
The report will also summarize key drivers of program performance, notable changes in enrollment or utilization, quality outcomes, MLR results, program integrity activities, and opportunities for further improvement in managed care program administration and oversight.

Complete Drafting, Review, and Final Submission

We will prepare the report through a structured drafting and review process that allows sufficient time for Guidehouse subject matter expert review, BMS review, factual validation, and revision before the required 90-calendar-day deadline. Where annual BMS and federal reporting requirements use common data, we will use a consistent, validated source to reduce duplicative reconciliation efforts and improve consistency across submissions.

Support Future Program Improvement

Guidehouse previously supported BMS with quarterly dashboard reporting, MCO follow-up on areas of concern, and analyses used for program and legislative discussions. We will build on that experience to provide an annual report that serves not only as a retrospective summary, but also as a management and decision-making tool that helps BMS establish future monitoring priorities, identify emerging risks, evaluate the effectiveness of improvement initiatives, and guide program enhancements for the coming year.



\$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:

Guidehouse will configure and host a dashboard to support BMS decision making and oversight. We will collaborate with BMS to confirm users, data sources, update frequencies, required drill-downs, file transfer processes, and priority dashboard views. We will then establish a consistent data and document structure so utilization, cost, MCO reporting, policies and procedures, quality, network, contractual, and compliance information can be accessed through a common monitoring environment rather than maintained across separate spreadsheets, folders, and tracking tools.

The dashboard will provide BMS with both analytical views and program compliance views. Analytical views will allow authorized users to examine utilization, cost, quality, and performance information by program (e.g., MHT, MHP), MCO, service category, geography, population, and member, as supported by the underlying data. Where practical, Guidehouse will automate data validation, refreshes, notifications, and status updates while retaining the underlying source documentation so BMS can trace dashboard results and compliance findings back to the information submitted by the MCOs.

Table 5. Technical Compliance Commitments

RFP Requirement	Guidehouse Commitment
Vendor-hosted dashboard	Guidehouse will configure and host the dashboard environment on behalf of BMS.
Simultaneous user access	Supports concurrent access for up to ten BMS users as required by the RFP.
Windows 11 compatibility	Accessible through standard web browsers compatible with Windows 11 environments.
Microsoft 365 compatibility	Designed to support integration with files and workflows commonly used within Microsoft 365 environments.
Google Workspace compatibility	Accessible through Google Chrome and compatible with Google Workspace-supported environments.
Configurable settings	Measures, thresholds, filters, dashboards, user views, and alerts may be configured based on BMS priorities.
Member-level analysis	Authorized users can drill from summary views to detailed member-level information when supported by available source data and user permissions.
Compliance tracking	Supports tracking of MCO submissions, policies and procedures, contract requirements, quality measures, network adequacy reviews, readiness activities, grievances, and appeals.

Guidehouse will implement role-based access controls that limit users to authorized data and functions. User authentication, access management, and data protections will be implemented consistent with applicable State security requirements, HIPAA requirements, and contractual obligations. Member-level information will only be available to authorized users and protected through appropriate administrative, technical, and physical safeguards.

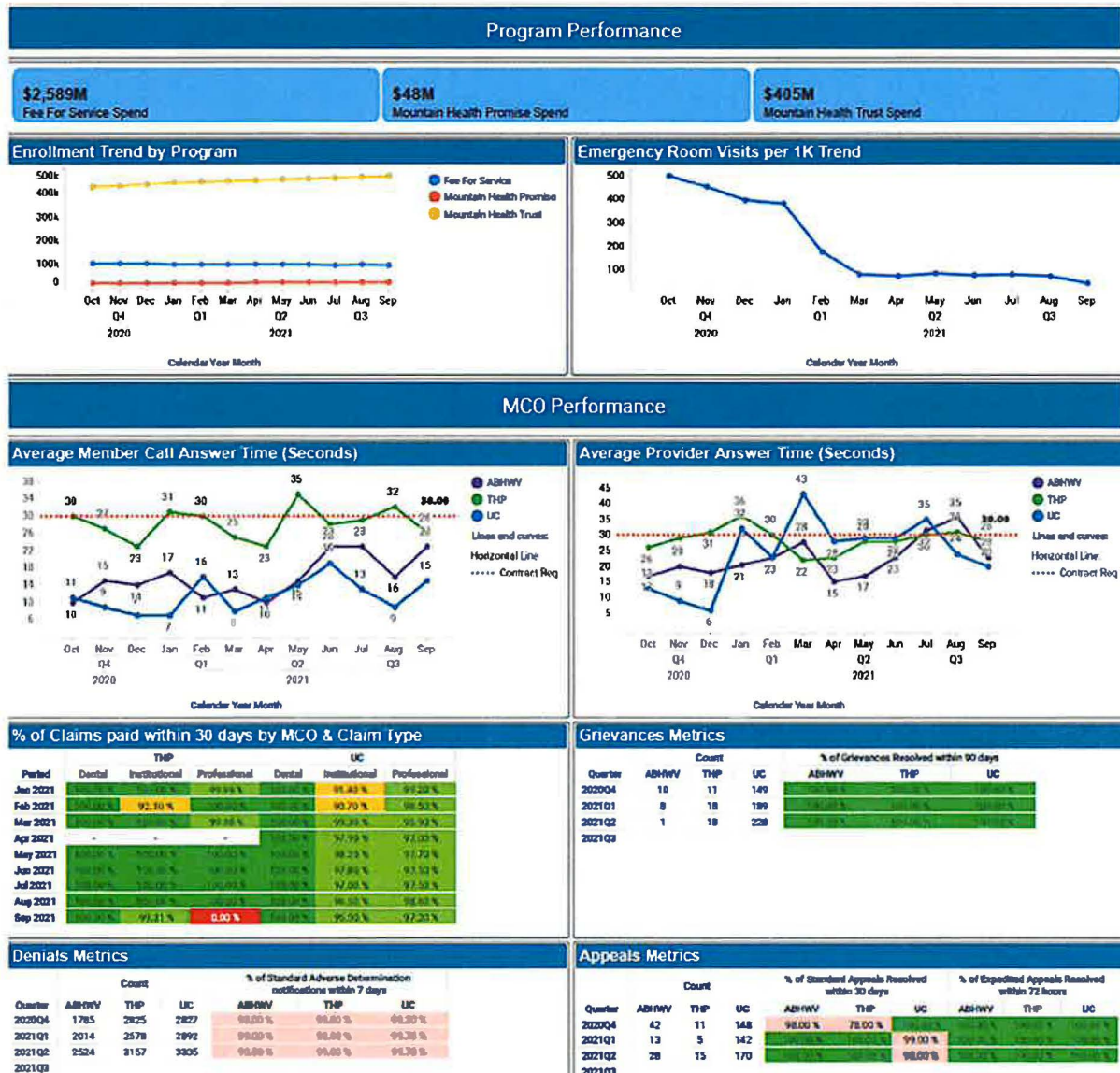
Figure 4 provides a view of that prior dashboard and demonstrates the foundation of our experience supporting BMS with interactive managed care monitoring. For this engagement, we will build on and advance that approach by incorporating more robust analytical capabilities, automated monitoring features, and integrated repositories and tracking for MCO deliverables, policies and procedures, and contract and amendment requirements.



Proven BMS Performance Oversight Experience

Guidehouse brings direct experience developing this type of capability for BMS. In 2021, while under contract with BMS, we designed and developed a web-based dashboard to support MCO compliance and performance oversight.

Figure 4. West Virginia MCO Dashboard Developed by Guidehouse



The dashboard will be configurable so BMS can refine measures, views, filters, thresholds, and monitoring priorities as the managed care program evolves. Guidehouse will work with BMS to organize dashboard content into intuitive functional views, such as MCO compliance, quality, network, utilization and cost, grievances and appeals, and contract requirements, with the ability to move from summary indicators to the supporting detail.

Across the required dashboard components described below, Guidehouse will apply a consistent set of monitoring capabilities, including summary-to-detail navigation, configurable filters, status and exception tracking, document traceability, historical and version tracking, and role-based access. These common capabilities will allow BMS to move from high-level program monitoring to the underlying MCO submission, document, measure, or finding requiring attention.

§4.2.1.1.5.1. All deliverables submitted by the MCOs under the Managed Care contract.

Guidehouse will establish a centralized MCO deliverable inventory and tracking function that allows BMS to monitor what each MCO is required to submit, when submissions are due, whether they have been received, and where they are in the State's review process. The tracker will capture, as applicable, the MCO, deliverable or report name, associated contractual or reporting requirement, reporting period and frequency, due date, date received, completeness or validation status, assigned reviewer, review status, findings, follow-up actions, and final disposition.

The dashboard will provide both a portfolio-level view of MCO reporting compliance and drill down to individual submissions. Users will be able to filter information by MCO, functional area, reporting period, or status and quickly identify upcoming, overdue, missing, incomplete, or unresolved submissions. Where appropriate, Guidehouse will configure status indicators and notifications to support proactive follow-up on submission and review deadlines.

Guidehouse will also maintain the underlying submitted files and associated review information so BMS has a traceable history of each submission, including its review status, findings, required follow-up, and resolution.

§4.2.1.1.5.2. MCO policies and procedures.

The dashboard will maintain an organized inventory of required MCO policies and procedures by MCO and functional area. For each policy or procedure, Guidehouse will capture key information such as document title, applicable requirement, effective date, submission or revision date, version, review status, assigned reviewer, identified findings, required revisions, follow-up actions, and approval or closure status.

Rather than operating only as a document repository, this structure allows BMS to monitor the currency and compliance status of MCO policies. BMS users will be able to identify policies that are missing, outdated, under review, superseded, or associated with unresolved findings. Where an MCO submits a revised policy, the dashboard will preserve the document history so BMS can understand what changed and maintain a clear audit trail.

Guidehouse will organize policies and procedures using consistent metadata and naming conventions so users can search or filter by MCO, functional area, requirement, effective period, or review status.

§4.2.1.1.5.3 Contract and amendment language, including version history.

Guidehouse will establish a contract requirements and amendment register that provides BMS with a single point of reference for current and prior MCO contract language. The register will capture the applicable contract section, requirement topic, MCO or program applicability, effective date, amendment number, current language, prior version or superseded language, and related implementation or monitoring actions.

This capability will allow BMS to trace how requirements change overtime and connect those changes to downstream monitoring activities. For example, when an amendment modifies an MCO reporting obligation, performance standard, network requirement, or other contractual obligation, BMS will be able to identify the effective requirement and associate it with the applicable MCO deliverable, policy, monitoring activity, or compliance finding.

The dashboard will maintain version history and effective date information so users can distinguish between current requirements and requirements that applied during an earlier reporting period.

This will reduce reliance on manual comparison of contract versions and provide a stronger record for ongoing contract administration and compliance monitoring.

§4.2.1.1.5.4 MCO quality metrics and report card information.

Guidehouse will configure quality and report card views that allow BMS to monitor MCO performance overtime and compare results across plans. For each measure, the dashboard can display the applicable reporting period, MCO result, target or benchmark, prior-period performance, trend, and performance status.

Users will be able to filter and compare measures by MCO, measure domain, population, reporting period, and other available dimensions. Dashboard views will highlight sustained improvement, declining performance, variation across MCOs, and measures that warrant additional review or intervention. Where BMS establishes performance thresholds or report card scoring methodologies, Guidehouse can incorporate those thresholds into dashboard indicators and summary views.

§4.2.1.1.5.5 Network adequacy documents and readiness review materials.

Guidehouse will maintain network adequacy and readiness review submissions together with the findings and remediation activities generated through BMS review. The dashboard will track applicable submission periods, receipt and review status, identified deficiencies, MCO responses, remediation actions, due dates, and closure status.

Where supported by the underlying data, dashboard views will connect submitted network information with geographic, provider type, or provider-level analyses so BMS can quickly identify areas in which an MCO is not meeting an applicable standard or where performance is changing overtime. Readiness findings can similarly be retained as historical baseline information and linked to subsequent monitoring to show whether identified issues have been resolved or have reemerged during ongoing operations.

Guidehouse previously developed network monitoring dashboard views for BMS as part of our prior West Virginia engagement. Figure 5 shows a 2021 dashboard view that illustrates the foundation of our network monitoring approach. For this engagement, we will build on that experience with more advanced drill-downs, integrated document tracking, and stronger linkage between network findings, remediation activities, and ongoing compliance monitoring.

Figure 5. Prior West Virginia MCO Network Monitoring Dashboard



§4.2.1.1.5.6 Grievances and appeals.

Guidehouse will configure grievance and appeal views that enable BMS to monitor volumes, categories, dispositions, and timeliness across MCOs and reporting periods. Available filters and drill-downs may include MCO, appeal or grievance type, category, reporting period, disposition, resolution timeframe, and other information available through MCO submissions.

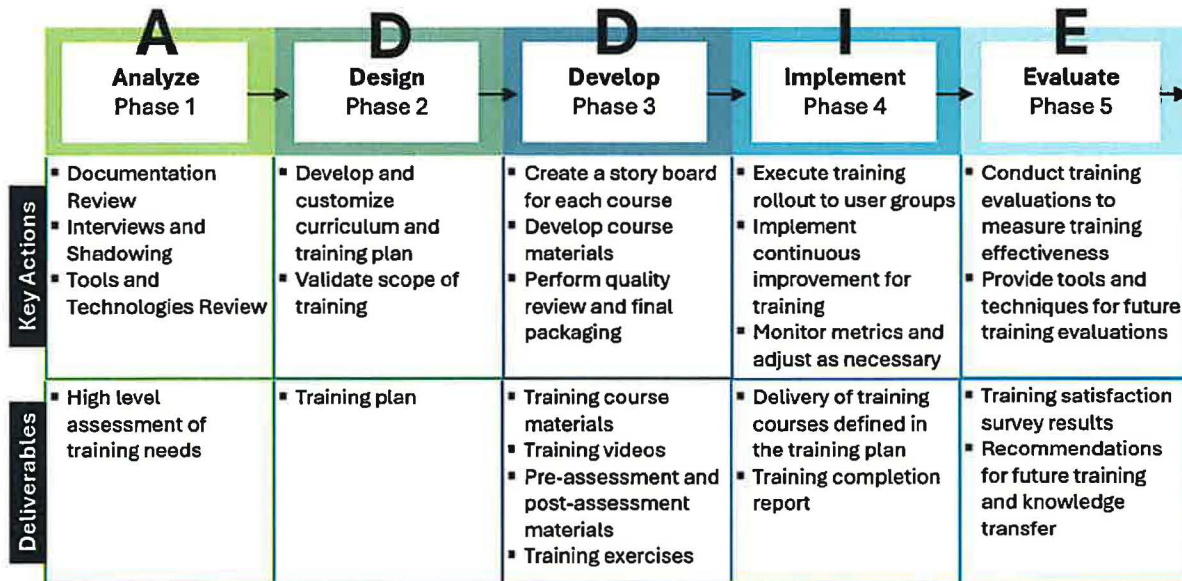
The dashboard will allow BMS to identify material changes, recurring categories, timeliness concerns, and differences across MCOs. Guidehouse will work with BMS to establish appropriate indicators or thresholds for follow-up and will assess grievance and appeal trends alongside related quality, access, network, utilization, or operational information when patterns may indicate a broader program issue.

This structure will also preserve the relationship between reported performance and any resulting monitoring activity, allowing BMS to document questions, findings, MCO responses, and follow-up actions in connection with significant trends.

\$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.

Guidehouse will provide practical, role-based training that helps BMS staff build and maintain the knowledge needed to oversee the MHT and MHP programs. We will use our proven ADDIE training approach – Analyze, Design, Develop, Implement, and Evaluate – scaled to BMS’s needs and existing managed care processes.

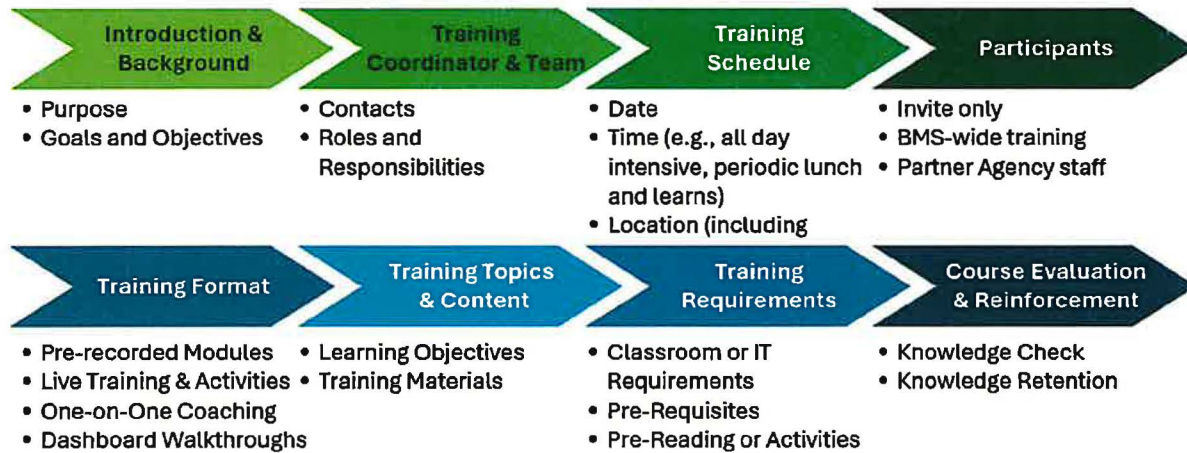
Figure 6. ADDIE Training Approach



At the start of the engagement, we will work with BMS to identify staff roles, existing knowledge, priority training needs, and available materials. We will use those findings to develop a training plan that identifies the audience, learning objectives, topics, delivery method, and schedule. Training topics will align with the work BMS staff perform and may include MCO contract requirements, MCO reporting and dashboard use, network adequacy, readiness reviews, quality and EPSDT monitoring, MLR, program integrity, waivers, and federal reporting.

We will use a mix of live and virtual training, demonstrations, working sessions, job aids, and targeted coaching based on the topic and audience. Training will use West Virginia examples and MCO oversight activities where appropriate so staff can apply the material directly to their work. We will also use knowledge checks, participant feedback, and recurring technical assistance questions to identify topics that require clarification or additional training.

Figure 7. Example Guidehouse Managed Care Training Plan



Guidehouse has applied this approach to Medicaid managed care training in other states. For example, for Oklahoma's SoonerSelect program, we developed role-specific managed care monitoring and compliance training, coordinated a virtual training program completed by nearly 600 agency staff, and supplemented formal training with coaching, office hours, knowledge checks, and reusable training materials.

We will maintain the required training manual as an operational resource, not simply a record of completed training. The manual will document key MCO oversight activities, applicable requirements, roles and responsibilities, review steps, escalation points, and supporting tools. Where applicable, it will link staff to related Standard Operating Procedures (SOPs), templates, job aids, reporting instructions, and dashboard guidance.

We will update the manual and related training materials when material changes occur in MCO contracts, waivers, Federal or State requirements, reporting processes, or BMS procedures. We will also provide reusable materials that support onboarding and knowledge transfer as BMS staff responsibilities change overtime.



Proven Managed Care Training Results

For Oklahoma's SoonerSelect program, Guidehouse developed role-based managed care monitoring and compliance training that :

Nearly 600
agency staff
attended

95%+
participation

The program increased staff understanding of managed care concepts, MCO operations, compliance requirements, and oversight responsibilities through training, coaching, office hours, knowledge checks, and reusable learning resources.

"The training strengthened staff understanding of how MCOs operate and highlighted the critical role of state oversight and compliance monitoring."

~ Deputy Medicaid Director

\$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.

Guidehouse will support MLR audits, incurred but not reported (IBNR), and risk adjustment activities. At the beginning of each annual or recurring review cycle, we will conduct an MCO kickoff to confirm reporting periods, populations, data requirements, definitions, submission dates, certification expectations, validation procedures, and the process for resolving questions or discrepancies. Our managed care, financial, data, and actuarial staff will work from common source information so financial oversight, rate development, and MCO reporting remain aligned.

Medical Loss Ratio

Guidehouse has direct experience supporting state agencies in MLR compliance. We will develop a template that will promote consistency, CMS MLR compliance, and ease of review. MLR submissions will be reviewed individually and in aggregate to monitor the MLR of the WV Medicaid program. MCO MLR submissions for both MHT and MHP programs will be reviewed for:

- Completeness, internal consistency, and compliance with applicable reporting requirements.
- Changes from prior submissions, including significant discrepancies or restatements, will be reviewed and reconciled before submissions are formally accepted.
- Emerging experience to inform rating and budget decisions.
- Changes in IBNR assumptions between reports will be used to evaluate the reasonableness of individual MCO IBNR assumptions and their impact on total incurred claim costs.



Proven Success Supporting BMS MLR Compliance

Building on **direct BMS experience**, Guidehouse will deliver standardized MLR reporting templates, detailed submission guidance, and MCO training to promote consistent, timely, and complete reporting. Previously, Guidehouse **developed BMS's Managed Care HealthCheck Reporting Guide**. This required quarterly Medicaid-specific revenue and expense reporting, established performance thresholds, and clearly distinguished quarterly monitoring requirements from annual MLR reporting. We will leverage this proven approach while aligning the process with current federal and BMS requirements.

IBNR

IBNR is an intrinsic part of rate development. Because of the lag between when claims are incurred and when they are paid, IBNR is a critical input to provide an accurate view of claims experience. In addition to developing IBNR to apply to encounter claims during the normal course of rate setting, Guidehouse also has previous experience developing IBNR for BMS's FFS Medicaid. For our IBNR analyses, Guidehouse actuaries will review historical medical and prescription drug claim data, summarized by incurred and paid dates.

- We will use development method (Chain Ladder method) to project ultimate claim costs and estimate IBNR.
- Loss Triangles will be evaluated at the COA level, distinguishing Expansion vs Non-expansion to account for the different mix of services between populations, acknowledging that the mix of services within a COS may complete at different rates.
- Loss Triangles will be evaluated at the COS level, acknowledging that Inpatient, Outpatient, Prescription drug, and Physician claims all complete at different rates.
- Outlier analysis will be performed to account for claims and payments that differ from the pattern present in the lag triangles that may skew IBNR results.
- We will evaluate the reasonableness of final results based on historical information and knowledge about the West Virginia Medicaid program.

Risk Adjustment

To conduct capitation risk adjustment analysis, we will build on our previous experience performing risk adjustment of the MHT program. We will develop and refine risk adjustment methodology scenarios as needed for the different populations. We will then analyze, test and communicate additional scenario results to BMS for decision.

We will begin by reviewing data completeness, population assignments, methodology, model inputs, material changes from prior cycles, and resulting plan-level impacts. We will identify anomalies or unexpected changes, assess whether differences are driven by population mix, data quality, coding, methodology, or other factors, and document the implications for BMS.

In order to remain revenue neutral and achieve state objectives related to risk adjustment, it is important to apply actuarial models to assess and reassess:

- When and how previously determined approaches will be applied and implemented
- Base data criteria
- The application of prospective factors
- Frequency of updates to risk scores
- Addressing risk adjustment of new managed care enrollment
- Enrollment churn and movement between MCOs

Guidehouse will assist BMS in adjusting to appropriate timeliness and expectations, including:

- Modeling potential impacts to State and MCO cash flows
- Enabling adherence to applicable actuarial standards
- Inclusion of methodology in rate certifications and MCO contracts
- Continuous monitoring of results for accuracy and consistency

In addition, we will also participate in ongoing communication of results and respond to questions from BMS, CMS, and MCOs.

Managed Care Waiver Oversight

Guidehouse will maintain a requirements matrix connecting MHT and MHP waiver authorities to MCO contract provisions, reporting obligations, performance measures, CMS commitments, responsible parties, and due dates. This will allow BMS to see not only what each waiver authorizes, but how the requirement is operationalized and monitored through the managed care program.

When a waiver is amended, renewed, or expanded, we will identify resulting changes to MCO contracts, rates, reporting, systems, quality measures, provider requirements, member communications, and readiness activities and incorporate those actions into the managed care work plan. Guidehouse previously supported BMS with both managed care waivers and associated MCO oversight and will use that knowledge to connect Federal authority, financial oversight, and day-to-day managed care operations.

§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.

Establish a Waiver Oversight Framework

Guidehouse will coordinate Children with Serious Emotional Disorder (CSED) waiver oversight with BMS, including MHP monitoring, so BMS can clearly evaluate how waiver requirements are being implemented through the managed care delivery system. At the outset of the engagement, we will develop a CSED oversight matrix that identifies applicable waiver requirements, MCO responsibilities, State responsibilities, required data sources, performance measures, reporting frequency, responsible reviewers, and supporting documentation. We will also establish a waiver monitoring calendar that aligns waiver reporting, MHT and MHP oversight activities, quality reviews, and Federal submission requirements.

Monitor Waiver Operations and Performance

Our reviews will focus on the areas supported by the approved waiver and BMS requirements, including service access and utilization, care coordination and person-centered planning, provider capacity, health and welfare monitoring, grievances and appeals, quality performance, and compliance with waiver-specific requirements. We will reconcile waiver reporting with relevant MHP submissions, identify inconsistencies or performance concerns, and track MCO or program follow-up activities through resolution.

To support proactive oversight, we will review trends in enrollment, service utilization, provider network capacity, timeliness of service delivery, critical incidents, appeals, and quality measures throughout the year. We will identify emerging risks, operational challenges, and areas requiring corrective action before they become significant compliance concerns.

Support Waiver Reporting, Compliance, and CMS Interactions

Guidehouse will assist BMS in meeting all ongoing waiver reporting and documentation requirements by developing reporting calendars, monitoring submission deadlines, validating supporting data, and reviewing draft materials prior to submission. We will support BMS in responding to CMS requests for information, preparing supplemental analyses, documenting operational changes, and evaluating the potential programmatic impact of waiver modifications and renewals.

Where waiver findings overlap with managed care oversight activities, we will coordinate reporting and compliance monitoring efforts to reduce duplication and provide BMS with a more complete view of program performance.

Monitor Regulatory and Policy Changes

We will maintain an applicability tracker for Federal requirements affecting CSED and other 1915(c) waivers, including the 2024 Medicaid Access, Finance, and Quality Final Rule and subsequent CMS guidance. We will identify applicable provisions affecting person-centered service planning, incident management, access monitoring, Home and Community-Based Services (HCBS) quality measurement, reporting requirements, and public transparency. We will track implementation deadlines and emerging Federal guidance and assess resulting changes needed to BMS oversight processes, MHP requirements, reporting systems, quality monitoring activities, and waiver operations.

Align Quality Monitoring and Continuous Improvement Activities

Guidehouse will align waiver oversight activities with applicable CMS HCBS quality measures, State quality strategies, and managed care performance monitoring activities wherever feasible. Using common measures and data sources across waiver and managed care oversight efforts will reduce duplication, improve consistency, and allow BMS to evaluate waiver performance within the broader context of managed care program operations.

In addition to monitoring compliance, we will help BMS identify opportunities to strengthen program effectiveness, improve beneficiary access and outcomes, enhance provider participation, and support continuous quality improvement activities. Findings from waiver monitoring activities will be incorporated into broader managed care oversight discussions, quality strategy updates, contract management activities, and annual program assessments.

§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.

Guidehouse will support BMS through the full waiver development lifecycle – from defining the program change and Federal authority through application development, public review, CMS approval, and implementation. Figure 8 summarizes our approach.

Figure 8. Guidehouse Approach to Waiver Development



At the start of each waiver action, we will meet with BMS program, managed care, quality, financial, actuarial, and other affected staff to define the objectives, proposed program changes, populations and services affected, required Federal authority, key decisions, and target submission date. We will translate these decisions into a waiver development work plan that identifies required application components, supporting data and analyses, responsible parties, BMS review points, public notice requirements, and CMS milestones.

Our team will then:

1. **Assess the current authority and proposed changes.** We will review the existing waiver, Special Terms and Conditions where applicable, MCO contracts, State Plan provisions, quality requirements, prior CMS correspondence, program performance information, and relevant Federal requirements. We will identify provisions that should continue, change, or be added and flag issues that may require early discussion with CMS.
2. **Develop the waiver application and supporting analyses.** We will coordinate policy, program, quality, financial, and actuarial inputs and draft the application in sections so BMS can review decisions as the document develops. Where a proposed change would benefit from early Federal feedback, we can develop a concept document or issue paper for discussion with CMS before BMS completes the formal application.
3. **Align the waiver and quality strategy.** We will identify the quality goals, measures, MCO requirements, monitoring activities, and improvement strategies affected by the waiver. Rather than develop the quality strategy separately, we will connect waiver objectives to measurable outcomes and the mechanisms BMS will use to monitor performance. During our prior work with BMS, Guidehouse reframed the State's quality goals and objectives, streamlined the MHT, MHP, and WVCHIP quality strategies into a comprehensive managed care quality strategy, and addressed CMS comments.
4. **Support public review and CMS approval.** We will prepare required public notice and hearing materials, organize and assess comments, revise the application as appropriate, and document responses. Following submission, we will maintain a CMS questions and decisions log, prepare responses and supporting analyses, participate in CMS discussions, and revise waiver materials based on BMS direction and CMS feedback.
5. **Translate approval into operations.** Following CMS approval, we will identify resulting changes to MCO contracts, reporting, quality measures, systems, provider requirements, member communications, financial processes, and BMS oversight activities and incorporate those actions into the managed care work plan.



**Proven BMS Waiver
Expertise**

Guidehouse has successfully supported BMS and other state Medicaid agencies across 1115, 1915(b), and 1915(c) waiver authorities, including leading BMS's MHT and MHP 1915(b) waiver renewals. This direct experience enables us to streamline waiver development, accelerate stakeholder alignment, and produce clear, compliant submissions aligned with Federal expectations.

§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.

Develop Correspondence and Supporting Analyses

Guidehouse will help BMS develop clear, accurate, and timely correspondence for waiver and other managed care matters and will manage each communication through resolution. Our support will extend beyond drafting letters to include the supporting research, data, analyses, briefing materials, and follow-up needed for productive engagement with CMS and other Federal entities.

For each request, we will first confirm the issue BMS needs to address, intended recipient, applicable Federal authority, due date, and supporting information needed. We will review the controlling statutory and regulatory authority, CMS guidance and submission requirements, prior correspondence, MCO requirements, program data, and other source materials before drafting the response. Depending on the issue, this may include Sections 1115 and 1915(b) or 1915(c) of the Social Security Act, applicable requirements under 42 CFR Parts 431, 438, and 441, the terms and conditions of BMS's approved waivers and demonstrations, and applicable CMS waiver application instructions and technical guidance. We will bring in actuarial, financial, clinical, quality, or other subject matter staff when the issue requires their review.

Prepare Waiver and Managed Care Communications

Depending on the need, we will develop materials such as waiver applications and amendments, concept papers, formal letters, responses to CMS questions and requests for additional information, public notices, responses to public comments, meeting agendas, briefing materials, talking points, and supporting analyses. Guidehouse has produced this range of materials for other state Medicaid agencies.

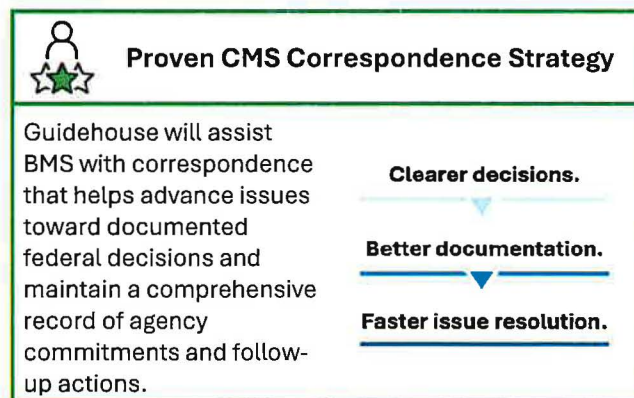
Conduct Structured Review and Quality Assurance

We will use a structured review process before BMS transmits material externally. The project team will validate facts and citations, the appropriate subject matter expert will review technical content, and project leadership will confirm that the document directly addresses the Federal request and remains consistent with other BMS submissions. BMS will retain final review and approval.

Track Federal Correspondence and Resulting Commitments

We will also maintain a Federal correspondence and commitments log that records the communication, due date, status, CMS questions, BMS decisions, follow-up actions, responsible party, and related waiver or program requirement. This is particularly important when a CMS response creates a new implementation obligation. Rather than close the item when the letter is sent, we will carry resulting commitments into the applicable waiver, MCO contract, reporting calendar, work plan, or oversight activity.

For complex issues, we will help BMS prepare for discussions with CMS by developing concise briefing materials that identify the issue, BMS's position, supporting evidence, anticipated questions, and decisions needed. Following the meeting, we will document decisions and outstanding items and incorporate them into the correspondence tracker. This approach builds on Guidehouse's experience facilitating recurring CMS discussions and using open-question trackers to keep unresolved waiver decisions visible until resolution.



\$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.

Guidehouse will evaluate waiver programs against their intended objectives and use program, operational, financial, quality, and stakeholder information to identify practical opportunities to improve effectiveness and efficiency. Our approach will examine both what the waiver requires and how BMS, MCOs, providers, and other parties operationalize those requirements.

We will begin each analysis by defining the program question with BMS and establishing the baseline against which we will evaluate performance. Depending on the waiver and issue, the baseline may include approved waiver authorities and requirements, enrollment, service utilization, expenditures, quality measures, access and provider capacity, member experience, MCO performance, administrative processes, and prior findings or corrective actions.

We will conduct the analysis through four connected activities:

1. **Review program design and Federal requirements.** We will assess the approved waiver and related Federal requirements to identify the program's objectives, populations, services, performance expectations, reporting requirements, and State commitments. We will examine whether current policies and processes align with those requirements and identify areas where program design may create unnecessary complexity or administrative burden.

2. **Assess program operations and performance.** We will analyze available quantitative data and review policies, procedures, reports, workflows, contracts, and other program documentation. We will look for variation across MCOs, populations, services, regions, or time periods; recurring compliance or operational issues; process steps that create delays or duplication; and areas where performance differs from BMS goals. Where the data does not support a conclusion, we will identify the limitation rather than infer a finding.

3. **Identify root causes and obtain operational perspectives.** When an analysis identifies a performance or process issue, we will examine the factors contributing to it before recommending a solution. As appropriate, we will obtain input from BMS staff, MCOs, providers, members, advocates, or other stakeholders to distinguish policy or program design issues from implementation challenges.
4. **Develop and prioritize recommendations.** For each material finding, we will identify the supporting evidence, root cause, recommended action, expected benefit, implementation considerations, Federal authority or approval implications, affected parties, and measures



Proven Results in Waiver Redesign

Kentucky used Guidehouse recommendations to advance part or all of nine waiver modernization initiatives. Through a comprehensive evaluation of six 1915(c) waivers, Guidehouse combined program and waiver reviews with extensive stakeholder engagement, including **40 focus groups across 10 cities with nearly 500 participants**. Our recommendations addressed payment methodologies, waiver administration, service consistency, care planning, participant direction, case management, training, and oversight, resulting in improvements that strengthened consistency across waiver programs and alignment with federal and state requirements.

BMS can use to evaluate results. Where multiple approaches are available, we will compare the options and help BMS prioritize recommendations based on expected impact, feasibility, cost, risk, and implementation effort.

Guidehouse has used this approach in large waiver redesign efforts. For Kentucky, we evaluated six 1915(c) waivers by reviewing program administration and waiver content and conducting extensive stakeholder engagement, including 40 focus groups in 10 cities with nearly 500 participants. The resulting recommendations addressed payment methodology, standardization of waiver services and administration, care planning and budgeting, participant direction, case management, training and oversight, and stakeholder engagement. Kentucky proceeded with part or all of nine post assessment recommendations and redesigned Federal and State requirements for greater consistency across programs.

Our analysis for West Virginia will conclude with an implementation-oriented roadmap rather than a list of observations. For recommendations BMS elects to pursue, we will identify the policy, waiver, contract, financial, systems, reporting, training, and monitoring actions needed to move the recommendation into practice and establish measures BMS can use to determine whether the change produced the intended result.

§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.

Guidehouse will support BMS with the ongoing administration, implementation, federal reporting, and analysis of the 1115 Continuum of Care waiver. Our approach will focus on translating the demonstration's Federal requirements into day-to-day BMS and MCO operations and giving BMS a clear view of implementation progress, performance, and Federal commitments, consistent with Section 1115 of the Social Security Act, 42 CFR §§431.420 and 431.424, and the demonstration's CMS approved Special Terms and Conditions (STCs).

Most recently, CMS approved West Virginia's updated Substance Use Disorder (SUD) Implementation Plan and Health IT Plan in March 2026, establishing additional requirements and activities that BMS must carry forward as it implements the current demonstration. Under our prior contract with BMS, Guidehouse helped BMS develop and support the SUD component that formed the foundation of the demonstration's behavioral health continuum of care. We will now help BMS operationalize the requirements of the current demonstration and approved implementation plans through MCO requirements, monitoring, analysis, and federal reporting.

We will:

1. **Manage demonstration requirements and deadlines.** We will maintain a crosswalk of the STCs, approved implementation plans and protocols, monitoring requirements, evaluation activities, budget neutrality requirements, CMS correspondence, and Federal deliverables. For each requirement, we will identify the BMS and MCO responsibilities, source data, reporting period, internal review date, and CMS deadline. We will incorporate these activities into the broader managed care reporting calendar rather than manage the demonstration as a separate reporting process. The current STCs include specific requirements for monitoring, budget neutrality, evaluation, and scheduled State deliverables.

2. **Support implementation through the MCOs.** We will map demonstration requirements and newly authorized services to the applicable MCO contract provisions, operational processes, provider requirements, reporting, systems, quality measures, and member communications. We will work with BMS to identify gaps between Federal requirements and current MCO processes and develop the contract, reporting, or operational changes needed to address them. This will be particularly important as BMS continues implementing services authorized under the current demonstration. BMS's implementation plan identifies activities such as policy development, Medicaid Management Information Systems (MMIS) changes, MCO and provider communications, provider capacity building, and MCO training for new services.
3. **Manage federal reporting and performance analysis.** We will collect and validate required information from BMS, MCOs, and other available sources before incorporating it into Federal reports. We will manage applicable STC reporting requirements, including quarterly and annual monitoring reports, expenditure reporting, budget neutrality reporting, and evaluation-related deliverables, and maintain the supporting data and analyses needed for each submission. We will analyze performance against demonstration goals and prior reporting periods, investigate material changes or data inconsistencies, and provide BMS with concise explanations of findings. Our program, data, quality, financial, and actuarial staff will coordinate where reporting requires multiple inputs so that narrative, performance, and financial information use consistent populations, periods, and assumptions.
4. **Monitor implementation and address performance issues.** We will track implementation milestones, MCO deliverables, performance measures, identified risks, and corrective actions. When results indicate an access, quality, utilization, provider capacity, operational, or compliance concern, we will work with BMS to identify the cause, determine whether MCO action is required, and track the response through resolution.
5. **Support ongoing CMS engagement.** Consistent with the Federal correspondence approach described in 4.2.1.1.10, Guidehouse will support required CMS reporting, questions, meetings, and follow-up related to the 1115 demonstration. We will track resulting Federal commitments and incorporate any required contract, reporting, systems, provider, member communication, financial, or oversight changes into the applicable implementation activities and managed care work plan.



**Proven Support for BMS
Demonstration Success**

Direct BMS experience accelerates implementation and supports federal compliance. Through our prior work on West Virginia's Continuum of Care demonstration, Guidehouse supported 1115 reporting, financial projections, program analysis, and CMS discussions. We will leverage this experience to help BMS manage demonstration requirements, advance remaining initiatives, and use demonstration results to guide ongoing improvements.

§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).

Similar to the highly successful work Guidehouse performed under our prior contract with BMS, we will help you move policy issues from **research to decision to implementation**. We will use a consistent policy impact analysis process while tailoring the depth and timing of each analysis to the significance of the issue and the decision BMS needs to make.

Define the Policy Question

We will begin by confirming the issue, BMS's objectives, affected programs and populations, decision needed, and timeframe. Analyses may address Federal or State policy changes, legislation, waiver or State Plan changes, budget actions, BMS initiatives, or emerging managed care issues. We will identify the BMS functions and Guidehouse subject matter experts needed so policy, managed care, financial, actuarial, quality, clinical, systems, and operational implications are considered together.

Assess Requirements and the Current State

We will review applicable Federal and State authorities, CMS guidance, BMS policies, waivers and State Plan provisions, and MHT and MHP contract requirements. Where applicable, we will also provide support for WVCHIP. We will combine this regulatory review with relevant program information, which may include enrollment, claims and encounters, utilization, provider data, quality measures, MCO reports, financial information, and prior analyses. When useful, we will also examine how peer Medicaid programs have addressed comparable issues.

Analyze Options and Impacts

We will identify viable policy options and assess their implications for BMS. Depending on the issue, our analysis may address:

- Members, benefits, access, and quality
- MCO contracts, operations, reporting, and readiness
- Providers and reimbursement
- State and MCO systems and data
- BMS staffing and administrative processes
- Costs, savings, rates, and Federal financial participation
- Waivers, State Plan, or other Federal approvals
- Implementation timing, dependencies, and risks



Proven Federal Policy and CMS Approval Success

States receive practical guidance that turns federal policy changes into approved program solutions. In Delaware, Guidehouse evaluated the impact of new federal requirements affecting provider taxes and State Directed Payments, supported CMS engagement strategies, and guided program updates and preprint development. This support contributed to CMS approval of Delaware's 2025 and 2026 State Directed Payment preprints.

We will distinguish confirmed requirements from assumptions or unresolved Federal guidance and identify data limitations that could affect the conclusions.

Support BMS Decision Making

We will translate the analysis into a decision-ready product appropriate to the issue, such as an options memorandum, program impact assessment, regulatory crosswalk, executive presentation, or briefing. We will clearly identify options, tradeoffs, risks, implementation considerations, and recommended next steps. When a decision requires input across BMS functions, we will develop the materials, facilitate working sessions, document decisions, and track unresolved questions.

Move the Decision into Implementation

Once BMS selects an approach, we will develop a work plan that identifies the actions, owners, dependencies, and milestones required to implement it. Depending on the policy, actions may include MCO contract amendments, waiver or State Plan submissions, rate or financial analyses, systems changes, revised reporting, policies and procedures, provider or member communications, training, and CMS engagement.

Monitor and Evaluate Results

We will identify measures that allow BMS to determine whether the policy is producing its intended result. We will monitor available program, MCO, financial, quality, and operational information, identify emerging issues, and recommend adjustments when implementation results or subsequent policy changes warrant them.

\$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.

Update Analyses as State and Federal Requirements Evolve

Guidehouse will structure recurring analyses so they can be efficiently revised when State or Federal data, guidance, policy, or reporting requirements change. For material analyses, we will maintain a source and assumptions register identifying the data version, regulatory or policy source, methodology, key assumptions, and date of analysis. When new information is released, we will identify affected analyses and deliverables, confirm the revision timeframe with BMS, update the applicable inputs, rerun the analysis, and provide a concise change summary explaining how and why the results differ from the prior version.

Oversee MCO Reporting and Reporting Compliance

For MCO reporting oversight, Guidehouse will maintain reporting requirements, definitions, validation rules, submission schedules, and issue tracking consistent with applicable Federal



Proven Federal and State Policy Monitoring

For Alabama Medicaid, Guidehouse screened 1,000+ bills during the 2026 legislative session to pinpoint the policy changes that required agency action. This disciplined approach helps Medicaid agencies focus on the policies that affect operations, compliance, funding, and program strategy.

requirements and BMS expectations. Material changes in federal reporting requirements will be incorporated into the reporting inventory, templates, calendar, and MCO instructions so changes are implemented consistently across MCOs.

Maintain Separate Medicaid and WVCHIP MLR Oversight Processes

For MLR oversight, we will maintain separate MHT, MHP, and WVCHIP reporting processes, data definitions, validation checks, issue logs, and supporting workpapers. We will reconcile MCO submissions to available financial, capitation, encounter, and rate development information; investigate material variances; and document MCO explanations, and resolution. Additional BMS-requested MLR analyses will be incorporated into this same review framework so results remain consistent with the underlying MLR reporting and work papers. We will also track evolving Federal MLR requirements and reporting guidance and incorporate those changes into the MLR review process as needed.

This approach will connect directly with the financial oversight process described in §4.2.1.1.7 and the Federal regulatory monitoring process described in §4.2.1.1.15, allowing BMS to move quickly from a new requirement or revised source to updated analysis and implementation.

§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.

Guidehouse already maintains an active Federal regulatory monitoring process to identify and assess Federal policy, regulatory, and guidance changes affecting state Medicaid programs. We will bring this existing capability to BMS from the start of the engagement and establish a West Virginia-specific process to translate relevant Federal changes into BMS impacts and actions. This approach will support BMS in identifying changes early, distinguishing material requirements from informational updates, and understanding the impact on West Virginia Medicaid and WVCHIP.

Figure 9. Guidehouse’s CMS Policy and Guidance Tracking Tool

CMS Policy & Guidance Tracking Tool				
Type	Topic	Document Title	Release Date	Guidehouse Analysis
				Key Points
Toolkit	Fraud, Waste, and Abuse	Applied Behavior Analysis Toolkit	8/4/2026	1) Purpose: CMS designed the toolkit to help state Medicaid and CHIP agencies make Applied Behavior Analysis (ABA) coverage, payment, oversight, and program-integrity decisions for beneficiaries with autism spectrum disorder (ASD). CMS’s principal concern is rapidly growing utilization and spending combined with fraud, waste, and abuse risk. 2) Toolkit checklists: The toolkit includes checklists covering clinical standards, policy and coverage, payment approaches, provider requirements, utilization management, fraud prevention, and suggested practices. 3) ABA coverage: CMS does not require ABA (ABA is one treatment modality for ASD) for children under age 21 with ASD, but does require states to provide medically necessary ASD services under EPSDT. 4) ABA hours: The toolkit says there is no consensus on a fixed number of ABA hours; higher intensity should not be authorized by default
Toolkit	Eligibility	State Implementation Tool: Section 71109 of the Working Families Tax Cut (WFTC) Legislation	7/31/2026	1) Purpose: The toolkit is meant to help states implement new federal Medicaid eligibility and funding requirements for noncitizens by outlining required actions needed to ensure accurate eligibility determination and proper FFP claiming by October 1, 2026. 2) Checklist action items: a) Complete redeterminations for all potentially affected beneficiaries b) Update state applications, eligibility determination logic, and verification logic to ensure accurate eligibility determinations and proper claiming of FFP c) Provide communication to individuals and other state agencies and partners regarding eligibility changes d) Update T-MSIS enrollment data submissions to accurately report who is an FFP-eligible noncitizen in Medicaid and CHIP and, in Medicaid, who is eligible for emergency Medicaid only. CMS is updating the T-MSIS Data Guide to ensure accurate reporting of FFP-eligible noncitizens.

Monitor Authoritative Federal Sources

Through our existing Federal monitoring process, we routinely monitor sources that can create or modify BMS state Medicaid and CHIP requirements, including CMS regulations and proposed rules, Federal Register notices, State Medicaid Director letters, CMS informational bulletins, Medicaid and CHIP managed care guidance, waiver guidance, reporting instructions, and other relevant CMS and Health and Human Services (HHS) releases. We will also monitor implementation guidance associated with major enacted legislation that affects Medicaid and CHIP. This existing surveillance provides the starting point for identifying Federal developments that warrant West Virginia-specific review.

Log and Triage New Requirements

For BMS, we will establish and maintain a West Virginia regulatory tracker that records the source, publication date, effective or applicability date, affected program areas, responsible BMS functions, status, and required actions. As Federal developments are identified through our existing monitoring process, we will screen them for applicability to West Virginia to determine whether each item is informational or requires further analysis. For material changes, we will immediately identify the BMS and Guidehouse subject matter experts needed for the assessment.

Assess West Virginia Program Impacts

For each material change, we will trace the requirement to the affected West Virginia programs and operating processes. Depending on the change, we will assess impacts to MHT, MHP, WVCHIP, waivers, eligibility and enrollment, covered services, MCO contracts, providers, rates and financing, quality, network adequacy, systems, data, reporting, member communications, and BMS oversight activities. We will identify both the Federal requirement and areas where CMS permits State flexibility.

Provide an Actionable Impact Analysis within 30 Calendar Days

For each Federal change requiring analysis, we will provide BMS with a concise analysis within 30 calendar days of notification that identifies:

- Federal change and controlling authority
- Effective and implementation dates
- Affected BMS programs and populations
- Operational, contractual, financial, systems, reporting, and policy impacts
- State decisions or Federal clarification needed
- Recommended actions and responsible parties
- Key implementation dates and dependencies

For significant changes, we will supplement the written analysis with an executive briefing or working session so BMS leadership and affected program areas can quickly align on the response.

Track Requirements Through Implementation

We will not close a regulatory item when the impact analysis is delivered. Once BMS determines its response, we will convert required actions into the appropriate work plan and track them through completion. This may include revisions to MCO contracts or reporting, waiver or State Plan actions,

rate analyses, system changes, policies and procedures, training, or provider and member communications. We will update the regulatory tracker as CMS releases additional guidance or changes an implementation date.

Guidehouse applies this disciplined monitoring process with other state Medicaid agencies, including Alabama Medicaid, where our team tracks Federal policy developments and state legislative activity. We will bring the same focused screening approach to BMS, helping staff quickly identify Federal changes that require action while filtering out the broader volume of Federal healthcare activity.

§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.

Guidehouse will use a consistent, risk-based readiness review framework to assess new MCOs, new populations entering managed care, major program changes, and targeted areas of concern for existing MCOs. The framework will provide BMS with a repeatable methodology while allowing the depth of each review to be tailored to the nature and level of risk involved. Guidehouse will support this work with several materials that we created alongside BMS that contributed to successful MCO monitoring for both MHP and MHT.

At the outset of each review, Guidehouse will confirm the scope, timeline, applicable requirements, responsible parties, and BMS subject matter experts who should participate. For new MCO go-live reviews, we will structure activities to support completion within the required four-month period and, where applicable, at least 90 days before the MCO's planned operational start date, consistent with Federal readiness review requirements. For new populations, major changes, or existing MCOs, we will focus the review on affected functions and related dependencies.

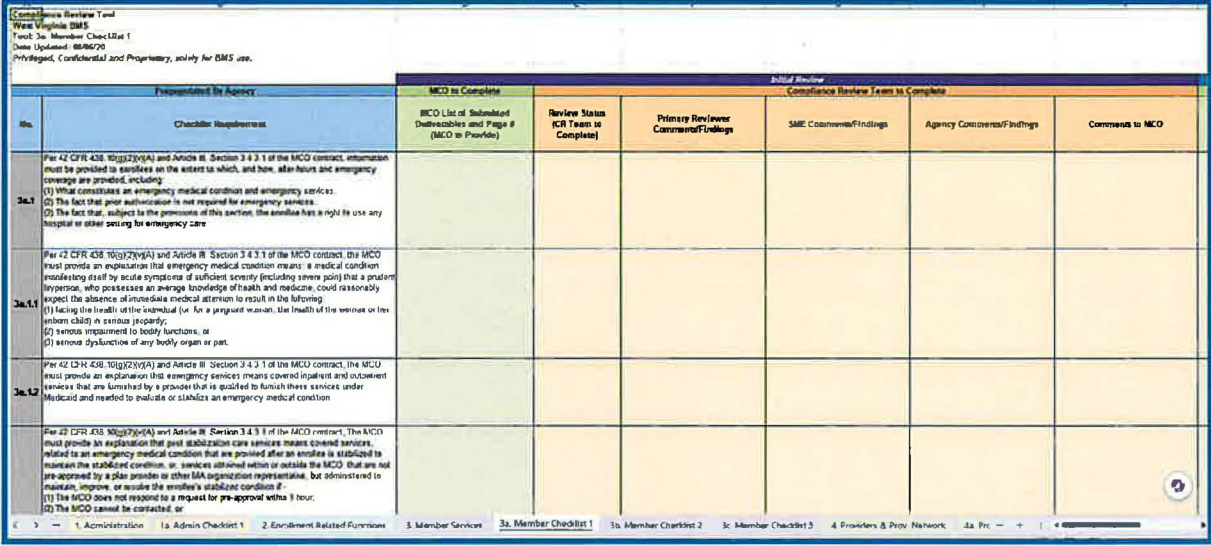
Develop the Readiness Review Tool

Guidehouse will translate applicable federal and State requirements, waiver provisions, managed care contract requirements, CMS readiness expectations, and other applicable standards into a structured readiness review tool. The tool will serve as the central source for documenting requirements, required evidence, review status, findings, MCO responses, remediation, and final disposition.

The review will address functional areas such as governance and staffing; member services; provider networks; claims and encounters; care management and quality; grievances and appeals; program integrity; finance; reporting; systems and interfaces; and training. For each requirement, the tool will identify the applicable authority, expected evidence, review type, priority or risk level, finding, responsible party, remediation due date, and closure status.

Guidehouse will also establish evidence submission instructions, naming conventions, deadlines, and review waves so documentation is received and reviewed in a consistent manner.

Figure 9. Sample Section of a West Virginia BMS Readiness Review Tool



Conduct Structured Desk Reviews

Desk review will serve as the primary mechanism for assessing MCO readiness documentation. Guidehouse will organize reviewers by functional area so evidence is assessed by team members with relevant operational, clinical, financial, network, systems, or compliance expertise.

Before reviews begin, we will align reviewers on evidence expectations and criteria for determining whether requirements are complete, incomplete, or require additional validation. During the review, we will assess not only whether documentation was submitted, but whether it demonstrates that required policies, processes, systems, staffing, and controls are sufficiently developed to support compliant operations.

Where evidence is incomplete or unclear, Guidehouse will document the issue, request clarification or supplemental information, and track subsequent submissions through final disposition.

Validate High-Risk or Unclear Area

Where desk review alone does not provide sufficient assurance, Guidehouse will use interviews, demonstrations, testing, scenario walkthroughs, or onsite review to validate readiness. These activities may include staff interviews, system demonstrations, test transactions or file exchanges, and targeted reviews of processes that require direct observation.

Validation activities will be driven by the desk review findings and level of risk rather than conducted as a separate, duplicative exercise. Results will be incorporated into the same readiness review tool to maintain a consolidated record of readiness.

Manage Findings and Remediation

Guidehouse will document each finding with the underlying requirement, evidence reviewed, nature of the gap, level of risk, responsible party, required remediation, and due date. Findings will be prioritized based on potential impact to member access, quality, financial integrity, regulatory compliance, operational continuity, or successful implementation.

Where remediation is required, Guidehouse will work with BMS to establish corrective actions and expected closure evidence. We will review revised submissions, validate remediation as appropriate, and update readiness status when sufficient evidence demonstrates that the issue has been resolved. Items requiring post go-live monitoring will be clearly documented with an accountable owner and timeline.

Figure 10. Readiness Assessment Status – “Stop Light” Dashboard

#	Tool Name	MCO 1			MCO 2			MCO 3			MCO 4			MCO 5		
		C	NC	S	C	NC	S	C	NC	S	C	NC	S	C	NC	S
1	Administration	100%	100%	Green	14%	0%	Red	43%	50%	Red	57%	0%	Red	43%	0%	Red
2	Enrollment Related Functions	100%	100%	Green	25%	22%	Red	100%	100%	Green	88%	78%	Yellow	100%	78%	Green
3	Member Services	67%	85%	Yellow	47%	30%	Red	47%	80%	Yellow	67%	75%	Yellow	47%	90%	Yellow
4	Providers and Provider Network	0%	33%	Red	0%	33%	Red	0%	33%	Red	0%	67%	Red	0%	33%	Red
5	Coverage	67%	82%	Yellow	83%	82%	Yellow	75%	91%	Yellow	33%	73%	Red	75%	91%	Yellow
6	Quality and Performance Improvement	100%	100%	Green	100%	100%	Green	100%	100%	Green	100%	100%	Green	100%	100%	Green
7	Utilization Management	100%	100%	Green	0%	57%	Red	100%	100%	Green	100%	86%	Green	100%	100%	Green
8	Care Coordination	46%	86%	Yellow	32%	47%	Red	75%	62%	Red	46%	76%	Yellow	46%	59%	Red
9	Grievance, Appeal and Fair Hearing Process	57%	75%	Yellow	57%	58%	Red	86%	58%	Red	14%	67%	Red	0%	67%	Red
10	Program Integrity	79%	70%	Red	43%	52%	Red	50%	67%	Red	79%	70%	Red	79%	96%	Yellow
11	Encounter Data	50%	64%	Red	58%	79%	Yellow	50%	75%	Yellow	83%	89%	Yellow	33%	75%	Yellow
12	Systems	0%	100%	Yellow	100%	100%	Green	100%	100%	Green	100%	100%	Green	100%	100%	Green
13	Finance	57%	100%	Yellow	57%	60%	Red	57%	60%	Red	57%	60%	Red	57%	60%	Red
14	Long Term Services and Supports	100%	100%	Green	100%	33%	Red	100%	33%	Red	100%	33%	Red	100%	33%	Red
15	General Terms and Conditions	67%	92%	Yellow	56%	85%	Yellow	56%	85%	Yellow	56%	85%	Yellow	56%	85%	Yellow

Status	Status Description
Green	Completion of both 100% of critical requirements and 75% or more of non-critical requirements in a functional area
Red	Any functional area with unmet critical requirements regardless of percent completion of non-critical elements
Yellow	Any functional area with both less than 75% completion of non-critical elements and 100% achievement of critical elements

Maintain Visibility Throughout the Review

Guidehouse will manage the readiness review schedule against key milestones for evidence submission, desk review, clarification, validation, remediation, rereview, and final readiness determination. Throughout the four-month review period, we will maintain a status view showing progress by MCO, functional area, and readiness requirement.

Regular updates to BMS will identify completed activities, outstanding requirements, critical findings, remediation progress, upcoming deadlines, and risks to timely completion. For reviews involving multiple MCOs, Guidehouse will also identify cross-cutting issues that may reflect State or program-level dependencies rather than individual MCO deficiencies.

Apply the Framework to Existing MCOs and New Populations

For targeted reviews of the four existing MCOs, Guidehouse will apply the same core methodology while scaling the review to the issue or change being evaluated. For example, adding a new managed care population may require focused review of enrollment, member communications, network adequacy, care management, utilization management, provider training, systems configuration, and continuity-of-care processes.

This scalable approach gives BMS a consistent framework for both initial and ongoing readiness reviews without creating unnecessary administrative burden when a full review is not warranted.

Final Readiness Determination and Reporting

At the conclusion of each review, Guidehouse will synthesize findings across functional areas and provide BMS with a clear assessment of readiness, including unresolved items, residual risks, and recommended postimplementation monitoring.

Within 30 calendar days following completion of the readiness review, Guidehouse will prepare the detailed findings report and completed CMS readiness review tool. The report will summarize the scope and methodology, readiness status by functional area, significant findings, corrective actions, outstanding items, and any recommended follow-up.

Guidehouse has applied this progression – readiness tool development, desk review, targeted validation, corrective action, retesting, and final readiness determination – in multiple state Medicaid programs including Alabama, Georgia, Iowa, Mississippi, and Oklahoma. In Oklahoma, for example, **Guidehouse developed tailored readiness tools, conducted multiple rounds of desk review across approximately 1,300 requirements, developed corrective action processes and trackers, and supported final reporting to CMS.**

§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.

Validate Provider Network Data

Each quarter, Guidehouse will obtain standardized network data from each MCO and first test the files for completeness, consistency, duplicate records, valid specialties and locations, and other data quality issues that could distort the analysis. We will return material data issues to the MCO for correction before drawing conclusions.

Build on Prior West Virginia Network Oversight Experience

Guidehouse brings direct experience performing this work for BMS. Under our prior West Virginia managed care oversight engagement, BMS leadership and staff praised the clarity and transparency of our provider network adequacy analyses across West Virginia counties and provider types. We evaluated compliance with MHT and MHP contractual network standards and supported BMS in assessing deficiencies and potential exceptions. Our prior BMS reporting framework also tracked quarterly provider additions and terminations, primary care provider panel availability, members affected by provider losses, and whether network changes materially affected an MCO's ability to meet BMS access standards. We will build on that experience with a standardized quarterly process that gives BMS earlier visibility into network changes and emerging access risks.



Proven BMS Network Oversight Experience

Guidehouse provided BMS with actionable network adequacy reporting and provider access monitoring across MHT and MHP programs, including compliance reviews, provider change tracking, member impact analysis, and early identification of emerging access risks.

Analyze Network Adequacy and Access Trends

Using validated files, we will compare each MCO's network with applicable program standards and analyze changes from the prior quarter. We will examine provider distribution by specialty and geography, network gains and losses, areas with limited provider availability, and differences across

MCOs. Cross-MCO comparisons will help distinguish broader provider-supply limitations from MCO-specific network gaps or contracting opportunities. We will pay particular attention to rural areas and provider types where small changes in participation may materially affect access.

In addition to compliance with network adequacy standards, we will analyze provider turnover, specialty-specific access trends, geographic coverage patterns, and emerging risks that could affect member access to care. Where available, we will incorporate provider panel status, network growth and contraction trends, and indicators of network stability to support proactive oversight.

Report Findings and Support Corrective Action

Guidehouse will use visual scorecards and geographic analyses to help BMS quickly distinguish compliant networks from areas requiring further review and drill down by MCO, provider type, specialty, and geography. Figure 11 illustrates the type of network adequacy analysis Guidehouse uses to convert detailed provider network data into actionable monitoring information.

Figure 11. Sample Network Adequacy Summary Scorecard

		County Name																							
CMS Specialty (group)	CMS Specialty	AMELIA	BRUNSWICK	CAROLINE	CHARLES CITY	CHESTERFIELD	COLONIAL HEIGHTS CITY	DINWIDDIE	ESSEX	GOOCHLAND	GREENSVILLE	HANOVER	HENRICO	HOPEWELL CITY	KING AND QUEEN	KING WILLIAM	LOUISA	NEW KENT	PETERSBURG CITY	POWHATAN	PRINCE GEORGE	RICHMOND CITY	SURRY	SUSSEX	
Primary Care	Pediatrics	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
	Primary Care	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
Medical Specialties	Cardiology	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
	Gastroenterology	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
	Infectious Diseases	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
	Neurology	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
	Pulmonology	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
Surgical Specialties	Cardiothoracic Sur.	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
	General Surgery	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
	Gynecology, OB/GYN	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
Other Specia..	Psychiatry	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	

For each quarter, we will give BMS an exceptions report that identifies the requirement, finding, affected geography or population, trend, MCO explanation, and recommended follow-up. Unresolved findings will move into the compliance tracking process.

Similar to our work in other states, this quarterly process will provide a consistent foundation for annual access assessments and network adequacy reporting. Results from quarterly network monitoring will feed directly into annual network adequacy assessments and provider mapping activities, reducing duplication and providing BMS with a continuously updated view of network performance.

§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.

Maintain a Standardized Provider Mapping Process

Guidehouse will maintain a reusable provider data and geospatial analysis process so BMS can receive MCO-specific provider reports and maps within 10 calendar days of request without rebuilding the underlying analysis for each request. We will use standardized processes for validating, classifying, geocoding, and analyzing provider files and tailor individual outputs to the question BMS needs answered.

 Proven Network Adequacy Analytics	
Alabama Department of Mental Health Guidehouse used its Network Adequacy tool to assess access to SUD treatments statewide. We conducted provider mapping by level of care to identify service gaps and understand where targeted strategies could strengthen the continuum of care.	Benefit for BMS This approach provides BMS with earlier visibility into network changes, access challenges, and potential compliance risks through: ✓ Geographic Mapping ✓ Provider-Level Analysis ✓ Time-and-Distance Assessment ✓ Access Gaps Identification

For each request, Guidehouse will confirm the applicable MCO, program, provider types or specialties, geographic area, reporting period, and desired output. We will review provider records for completeness, duplicate or inconsistent records, valid locations, specialty classifications, and other material data issues before producing the analysis. Where data quality limits the conclusions that can be drawn, we will clearly identify those limitations.

Develop MCO-Specific Reports and Geographic Analyses

Depending on the request, reports and maps may show provider, clinic, hospital, or other facility locations; provider distribution by specialty; concentration or scarcity of providers by county or service area; differences across MCO networks; provider additions and losses; and areas warranting further network review. Maps will be paired with supporting tables so BMS can see both the geographic pattern and the underlying provider information.

Support Rapid-Turnaround and Consistent Reporting

Because the underlying data preparation and geospatial methods will be standardized, most requests will involve applying established filters and analytical views rather than rebuilding the analysis. This approach will support delivery within the required 10-calendar-day timeframe and allow BMS to compare results across MCOs, provider types, specialties, and geographic areas.

Build on Prior West Virginia Experience

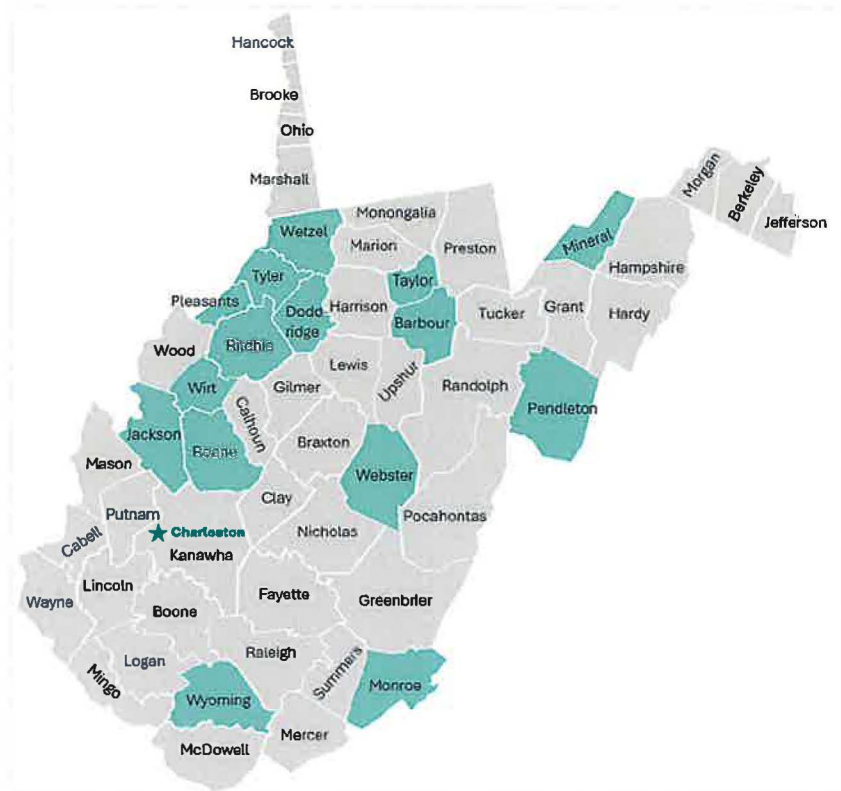
Guidehouse brings direct experience working with these data for BMS. Our prior BMS reporting framework captured provider specialty and location, additions and deletions, primary care provider panel status, members affected by provider losses, and whether network changes materially affected compliance with access standards. We will build on that foundation with more flexible MCO-specific mapping and rapid-

 Proven BMS MCO-Specific Reports Geographic Analysis
Guidehouse's prior BMS reporting framework tracked provider additions and terminations, primary care provider panel status, impacted members, specialty coverage, and compliance with access standards.

turnaround geographic analyses that allow BMS to move from a statewide or MCO-level view to the provider type, specialty, county, or service area driving the result.

Figure12. Provider Specialty Map for West Virginia Previously Created by Guidehouse

Map of WV Counties Where No MCO Net OB/GYN Requirements



§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.

Guidehouse will build one master reporting calendar that combines requirements from the MHT and MHP contracts, Exhibit C, managed care waivers, State requirements, CMS reporting, quality activities, and recurring BMS oversight processes. For every submission, the calendar will identify the requirement, MCO or State owner, reporting period, source data, contractual due date, internal review date, reviewer, submission method, dependencies, and completion status.

We will work backward from external deadlines to establish earlier dates for MCO submission, validation, analysis, BMS review, correction, and final submission. Automated reminders and status indicators will identify upcoming, late, or unresolved items. We will review the calendar regularly with BMS and update it when contracts, waivers, or regulations change.

Guidehouse brings direct experience establishing and administering BMS's managed care reporting framework. During our prior engagement, we helped develop BMS's Managed Care HealthCheck Reporting Guide, which consolidated monthly and quarterly MCO reporting requirements,

submission schedules, file specifications, data definitions, formulas, and reporting instructions into a common operational resource. The Guide established consistent reporting periods and due dates and required MCO certification of submitted data and disclosure of known data limitations. We will build on this prior foundation to develop a more integrated reporting calendar that connects each requirement not only to its due date, but also to validation, BMS review, follow-up, federal reporting dependencies, and compliance status.

 Guidehouse West Virginia Department of Health and Human Resources Bureau for Medical Services Mountain Health Trust (MHT) Program Managed Care HealthCheck Reporting Guide for Monthly and Quarterly Report Submissions	Reporting Requirement		Timeframe			
			Monthly	Quarterly	Annually	Other
Quarterly Reporting						
Enrollment and Membership				✓		
Provider Network Status				✓		
Claims Processing				✓		
Experience Summary				✓		
Lag Tables				✓		
Summary of Claims Paid Outside Encounter Data & Sub-Capitation Arrangements				✓		
Member and Provider Services Functions				✓		
Statement of Revenue and Expenses				✓		
Out-of-Network Utilization				✓		
Member Access to Care				✓		
Quality Reporting						
Written Description of PIPs and Results					✓	
PIP Progress Report				✓		
HEDIS					✓	
CAPI Annual Evaluation Report Including Status and Results					✓	
CAPI CAP						✓
CAHPS Enrollee Survey Analysis, Action Plan and Evaluation					✓	
Accreditation Review Report						✓
Encounter Data			✓			
Adult and Child Core Quality Measures					✓	
Provider Reporting						

§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.html> <https://dhbr.wv.gov/bms/Members/Managed%20Care/Pages/default.aspx>.

Building on the regulatory monitoring and impact analysis process described in 4.2.1.1.15, Guidehouse will maintain a compliance inventory that documents how each applicable federal and State Medicaid and WVCHIP requirement is implemented and evidenced through BMS's managed care program. We will map applicable requirements under 42 CFR Part 438 for Medicaid managed care and 42 CFR Part 457 for WVCHIP, along with BMS contracts, waivers, policies, and other State requirements, to the activities and documentation used to demonstrate compliance.

We will assign each requirement an owner and review frequency and update the inventory when Federal or State policy changes. Regular reviews will identify requirements that need a contract amendment, new MCO report, revised procedure, additional monitoring activity, or other action. We will track those actions through completion and retain supporting evidence.

When regulatory monitoring identifies a new or changed requirement, we will update the compliance inventory and carry required actions into the applicable contract, waiver, reporting, policy, training, or oversight process. We will account for phased implementation of the 2024 Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule and subsequent CMS guidance, as well as applicable Medicaid and CHIP changes under Public Law 119-21. Guidehouse

used a similar compliance-focused approach when it reviewed Federal managed care requirements and updated MHT and MHP contracts during its prior BMS engagement.

§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.

Establish an EPSDT Monitoring Framework

Guidehouse will conduct quarterly EPSDT monitoring using MCO submissions and available claims and encounter data to assess performance and compliance with MHT and MHP contract requirements. We will establish an EPSDT requirements crosswalk that identifies the applicable population, requirement or measure, data source, reporting period, MCO obligation, and BMS review criteria.

Validate Data and Analyze EPSDT Performance

Each quarter, we will review MCO submissions for completeness and consistency and use available claims, encounter, enrollment, and other program data to validate results and investigate material discrepancies. We will analyze BMS required EPSDT measures and service-use patterns by MCO and, where supported by the data, by age group, geography, and other relevant populations. We will trend results overtime, compare performance across MCOs, and identify patterns that may indicate access, care coordination, provider, data quality, or other performance concerns.

Track Compliance and Improvement Activities

We will maintain a compliance tracker that connects identified findings to MCO explanations, required actions, responsible parties, and resolution dates. We will discuss material findings with each MCO, identify contributing factors, and monitor corrective or improvement actions in subsequent reporting periods to determine whether performance improves.

Prepare Federal and State Reports

For federal and State reporting, we will use validated information from the quarterly monitoring process and clearly distinguish Medicaid and WVCHIP when separate analysis is required. Reports will summarize performance and compliance findings, trends, improvement activities, and practical recommendations to improve the efficiency, effectiveness, coordination, or quality of EPSDT services. We will work with BMS to establish the report format and submission standards.

In addition to reporting results, we will identify opportunities to improve EPSDT service delivery, coordination across providers, member outreach and engagement, and compliance with contractual and Federal requirements.



Proven EPSDT Oversight Experience

Guidehouse helped BMS strengthen EPSDT oversight by enhancing EPSDT-related requirements within the MHT and MHP managed care contracts and incorporating EPSDT measures into BMS's broader MCO monitoring framework.

Our team reviewed EPSDT contractual requirements and identified opportunities to strengthen MCO accountability through standardized reporting and performance reviews that improved visibility into compliance and program performance.

§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.

For each ad hoc request, Guidehouse will first confirm the question BMS needs answered, the decision the analysis will support, available data, required comparison, expected output, and deadline. We will document those elements in the approved scope of work so the analysis remains focused.

When comparing managed care and FFS, we will align time periods, populations, covered services, and data definitions before calculating differences and identify limitations where the delivery systems or populations are not directly comparable. We will identify important limitations where the delivery systems or populations are not directly comparable. Depending on the question, our analysis may compare:

- Cost and financial performance, including per member per month (PMPM) costs, service category spending, and cost trends
- Utilization and service patterns, including changes in the volume, mix, and setting of services
- Access and provider participation, including differences in provider availability and service access
- Quality and outcomes, using applicable measures and available program data
- Program operations, including areas where managed care practices may improve efficiency, coordination, or member experience

We will tailor the measures and level of analysis to the question BMS needs answered rather than apply the same comparison to every request.

Our final product will lead with the finding and implications for BMS, followed by the supporting analysis, assumptions, and limitations. We will provide underlying tables or workbooks when useful so BMS can trace the result and reuse the analysis. Guidehouse's prior BMS work included numerous rapid-turnaround policy, financial, program, and legislative 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.

Guidehouse brings direct experience supporting BMS in this capacity, including legislative research, policy analysis, budget support, and rapid-turnaround responses to complex stakeholder and oversight requests. We will use the following process for time-sensitive requests:

- **Intake and clarify the request.** We will confirm the question BMS needs answered, requesting audience, due date, required level of detail, source information, deliverable format, and mutually agreed upon timeframe.

- **Assign the right expertise.** We will match the request to the appropriate program, data, regulatory, financial, actuarial, clinical, or other subject matter experts and establish roles and internal milestones based on the agreed schedule.
- **Analyze the issue.** We will use the appropriate methodology for the request:
- **Data:** Validate source, reporting period, population, definitions, and assumptions.
- **Policy and regulatory:** Trace conclusions to the applicable Federal or State authority and identify areas where guidance remains unclear.
- **Budget and fiscal:** Align program, enrollment, utilization, and actuarial assumptions so policy and financial analyses use a common baseline.
- **Program and operational:** Assess impacts to members, providers, MCOs, program operations, and implementation as applicable.
- **Develop and quality review the response.** We will translate the analysis into the requested product, such as a briefing, fact sheet, policy or fiscal analysis, presentation, or supporting tables, and conduct a senior-level review for accuracy, consistency, and clarity before delivery to BMS.
- **Deliver, document, and reuse.** We will provide the final product within the agreed timeframe, retain the underlying analysis and source documentation, and incorporate reusable work products into our knowledge base so BMS can obtain consistent answers.

§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-managed-care-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.

Guidehouse will work with BMS Quality and Managed Care staff to develop and maintain a comprehensive quality assessment and performance improvement strategy for MHT, MHP, and WVCHIP that aligns program goals, MCO accountability, quality measurement, and improvement activities with applicable CMS requirements. Our approach will align with the managed care quality assessment and performance improvement requirements at 42 CFR §438.330 and State Managed Care Quality Strategy requirements at 42 CFR §438.340, including the corresponding CHIP requirements incorporated



Proven Quality Strategy Experience

Guidehouse worked with BMS to unify multiple managed care quality strategies into a comprehensive Quality Strategy that aligned program goals, addressed CMS feedback, and connected quality performance targets with payment initiatives.

Drawing on our prior work with BMS, we will help translate quality goals into measurable performance monitoring, stakeholder-driven improvements, and actionable program enhancements.

through 42 CFR §457.1240. We will also use applicable CMS Quality Strategy and External Quality Review guidance to inform the approach.

Assess the Current Quality Program

We will begin by reviewing BMS's current quality strategy and quality-related requirements across MCO contracts, waivers, CMS guidance, External Quality Review (EQR) findings, performance improvement projects, quality measures, network and access monitoring, member experience, and other BMS quality activities. We will assess how these activities work together across the CMS managed care quality cycle, quality strategy, quality assessment and performance improvement, and EQR, rather than review them as separate compliance activities. We will map these activities to applicable Federal requirements and identify gaps, duplication, or opportunities to better align measures and monitoring across programs.

Develop an actionable quality strategy. Working with BMS, we will establish or refine measurable quality goals and objectives and connect each objective to the measures, targets, MCO requirements, monitoring activities, and improvement actions BMS will use to assess progress. For each priority measure, we will establish a baseline using the most appropriate available historical data and set performance targets informed by BMS goals, Federal requirements, applicable benchmarks, prior performance, and opportunities for improvement. Where appropriate, we will establish interim milestones to measure progress toward longer-term targets. We will help BMS select a focused set of measures that provides a meaningful view of quality and appropriateness of care rather than relying on reporting volume alone.

Engage MCOs, Enrollees, Advocates, and Other Collaborators

We will support BMS in obtaining structured input from MCOs and other collaborators identified by the Agency, including enrollees and advocates. We will develop meeting materials, present relevant performance information in an understandable format, facilitate discussions, and document recommendations. We will use this input alongside quantitative performance information to identify quality priorities and potential improvement strategies.

Monitor performance and Move Findings into Action

We will establish a regular process for reviewing quality results, EQR findings, MCO performance, improvement projects, and other available information. We will compare results against established baselines, targets, and prior-period performance to identify improvement, persistent gaps, and meaningful variation across MCOs or populations. When results identify a quality or appropriateness of care concern, we will help BMS assess contributing factors and develop options for action. Depending on the finding, recommendations may include establishing or revising an MCO performance improvement project, adjusting performance targets, focusing MCO corrective action on an identified population or service, strengthening provider or member outreach, revising contract or reporting requirements, or conducting a targeted analysis to better understand the



Proven Quality Strategy Experience

Alabama Medicaid engaged Guidehouse to update its ACHN Quality Strategy. We reviewed quality measures, performance initiatives, program goals, and other related quality activities to assess alignment and identify opportunities for improvement. Our work is helping the Agency strengthen performance measurement, align quality activities with CMS expectations, and create a more actionable framework for monitoring and improving program performance.

cause of the performance gap. We will help BMS evaluate the options based on expected impact, feasibility, and available evidence; establish responsibility and timelines for selected actions; and monitor subsequent results to determine whether performance improves.

Maintain and Annually Update the Strategy

Each year, we will provide BMS with a quality strategy update plan that identifies the federal and State requirements to review, analyses to complete, collaborator engagement activities, MCO and BMS input needed, proposed updates, review and approval milestones, and required CMS activities. We will document changes and their rationale so BMS can trace how performance results, Federal requirements, and collaborator input shaped each update.

§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.

Guidehouse will evaluate program expansion options through a staged process that allows BMS to understand the policy, financial, operational, legal, and implementation implications of an expansion before committing to a course of action. We will tailor the depth of each assessment to the size and complexity of the proposed change, whether BMS is considering adding a population or service, expanding managed care responsibility, modifying benefits, or integrating an existing program into MHT or MHP.

Define the Expansion and Establish the Baseline

We will first confirm the population, service, or program change under consideration, the objective BMS wants to achieve, and the decision that must be made. We will establish a current state baseline using available enrollment, utilization, expenditure, quality, access, provider, operational, and program information so options can be assessed against the same starting point.

Assess Policy and Federal Authority

Guidehouse will identify the federal and State authorities required to implement the expansion and determine whether changes are needed to an existing waiver, State Plan, MCO contract, quality strategy, or other governing document. We will identify legal and regulatory constraints, implementation dependencies, required Federal approvals, and areas in which BMS has program design flexibility.

Evaluate Program and Delivery System Impacts

We will assess how each option affects members, benefits, provider networks, care coordination, MCO operations, staffing, systems and interfaces, data and reporting, quality measures, member and provider communications, and BMS oversight. Where an expansion affects a new or high-need population, we will specifically assess continuity-of-care, provider capacity, transition risks, and MCO readiness requirements.

Analyze Financial Impacts

Our program and actuarial teams will coordinate to estimate expected costs, savings, or shifts in spending where the available data support a defensible estimate. We will identify assumptions and uncertainty and assess potential implications for managed care rates, State expenditures, Federal financial participation, administrative costs, and other affected funding streams.

Compare Options and Support BMS Decision Making

Guidehouse will present BMS with a concise options analysis identifying the benefits, risks, fiscal implications, policy considerations, operational complexity, dependencies, legal or Federal constraints, and unresolved questions associated with each alternative. Where appropriate, we will recommend sequencing or a phased approach that allows BMS to address the highest-risk dependencies before implementation.

Translate the Selected Option into Implementation

Once BMS selects an approach, Guidehouse will develop an implementation work plan identifying required Federal approvals, contract amendments, rate activities, systems changes, MCO and provider readiness, reporting and dashboard changes, quality measures, communications, training, member transition activities, and postimplementation monitoring. We will assign owners, dependencies, milestones, decision points, and escalation paths and track implementation issues through resolution.

Prior to implementation, we will use the readiness framework described in §4.2.1.1.16 to validate the MCO and program functions most affected by the expansion. Following implementation, we will identify early monitoring indicators so BMS can determine whether the expansion is operating as intended and quickly address access, quality, utilization, financial, or operational concerns.

Guidehouse brings direct West Virginia experience with program expansion and managed care transformation. During our prior work with BMS, we supported managed care expansion to behavioral health and Supplemental Security Income (SSI) populations, as well as the integration of waiver, foster care, and institutes for mental disease (IMD) services. For example, during West Virginia's foster care transition to managed care, Guidehouse identified opportunities that reduced projected capitation costs by approximately 10% while maintaining access to care and supporting the State's program goals. This combination of actuarial, policy, operational, and managed care expertise allows us to help BMS move expansion concepts from evaluation and Federal approval through implementation and long-term oversight, while identifying opportunities to improve outcomes, strengthen program performance, and maximize the value of State and federal Medicaid dollars.

§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.

Guidehouse will establish a structured MCO reporting process that gives BMS consistent, reliable information for contract monitoring and program decision making. Per the RFP's mention of Exhibit C, we will use the RFP's Exhibit C as the starting point and maintain an MCO reporting inventory that identifies each report's purpose, due date, population, data source, review criteria, complexity level, responsible reviewer, and relationship to other BMS and federal reporting requirements. We will maintain separate Medicaid and WVCHIP reporting where required.

Develop Clear, Standardized Reporting Templates

We will create or refine MCO reporting templates with defined data elements, calculation methodologies, reporting periods, population definitions, instructions, and required explanations for material variances. Where practical, we will incorporate validation checks and standardized fields that allow BMS to compare results across MCOs and reporting periods and roll information into program-wide analyses. We will also maintain reporting instructions and version control so MCOs and BMS reviewers work from current requirements.



Proven Integrated MCO Oversight

Beyond report review, Guidehouse connects insights across financial performance, utilization, quality, EPSDT, network adequacy, grievances, and other key indicators to identify emerging risks and focus BMS oversight where it matters most.

Apply a Risk-Based Review Process

We will classify reports based on the expertise and level of review required. Routine reports will undergo defined completeness, compliance, and trend checks. High-complexity reports will receive deeper review by the appropriate Guidehouse clinical, actuarial, financial, data, or program subject matter experts. We will adjust the level of review when data trends, legislative or regulatory changes, prior findings, or emerging program risks warrant greater scrutiny, consistent with BMS's authority to elevate or demote report complexity.

For high-complexity reports, we will test internal consistency, compare results with prior periods and available independent data sources, evaluate material variances, and identify unusual clinical, utilization, or financial patterns. Where reports contribute to program-wide modeling or comprehensive BMS reports, we will also validate definitions and assumptions across MCOs before aggregating the information so differences in MCO reporting do not distort State level conclusions.

Move Findings from Analysis to Action

We will document material anomalies and compliance concerns in an issue tracker that identifies the finding, supporting evidence, MCO explanation, required follow-up, responsible party, due date, and resolution. We will look across reports when appropriate – for example, determining whether a financial variance corresponds with a change in enrollment or utilization, or whether an EPSDT or quality concern is also reflected in network, grievance, or encounter data. This cross-report analysis will help BMS distinguish isolated reporting issues from broader program performance concerns.

Use Monthly MCO Meetings to Resolve Issues and Improve Performance

We will conduct an individual meeting with each MCO every month to review submitted reports and dashboard findings, including the Cash Disbursement Journal, EPSDT results, and other priority or high-risk items. Before each meeting, we will identify material findings and questions requiring MCO explanation or action. Following the meeting, we will document decisions, corrective or improvement actions, responsible parties, and deadlines and monitor open items through resolution.

Provide BMS with Decision-Ready Reporting

We will synthesize findings across MCO reports into concise Agency reports and dashboard views that highlight significant trends, MCO variation, emerging risks, unresolved compliance issues, and recommended actions. Rather than repeat information already contained in MCO submissions, these products will focus BMS leadership on what changed, why it matters, and what action may be needed.

Guidehouse brings direct experience designing and administering MCO reporting for BMS. During our prior West Virginia engagement, we helped develop BMS's Managed Care HealthCheck Reporting Guide and supporting templates, which standardized MCO report purposes, submission frequencies and deadlines, definitions, data elements, formulas, and reporting instructions across key operational, financial, network, utilization, and program integrity areas. We will build on that foundation by updating reporting requirements for BMS's current programs and linking MCO submissions more directly to validation, cross-report analysis, dashboard monitoring, findings, and follow-up actions.

Managed Care Reporting Guide for BMS Previously Developed by Guidehouse



West Virginia Department of Health and Human Resources
Bureau for Medical Services
Mountain Health Trust (MHT) Program

Managed Care HealthCheck Reporting Guide for Monthly
and Quarterly Report Submissions



§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.

Establish a Risk-Based Compliance Monitoring Framework

Guidehouse will establish a joint monitoring process with the West Virginia Office of Program Integrity (OPI) that connects MCO compliance plans with actual MCO program integrity activities and results. At the beginning of each annual cycle, we will review MCO compliance plans, prior findings, referrals, claims issues, recoveries or overpayments reported to BMS, and other available risk information to identify priority monitoring areas.

Using this information, we will develop a risk-based monitoring plan that aligns oversight activities with identified compliance risks, Federal requirements, contract provisions, and BMS program priorities.

Monitor Compliance Activities and Corrective Actions

We will track activities such as compliance plan updates, validation of selected claims or payment issues, MCO identification and correction of errors, referrals to BMS or the Medicaid Fraud Control Unit, and required remediation. We will document findings, responsible parties, due dates, corrective actions, and closure evidence in a common action log.

We will also monitor the effectiveness of corrective actions to determine whether identified issues have been fully resolved or require additional follow-up.

Support Collaboration Between OPI and the MCOs

Regular coordination meetings with OPI and the MCOs will focus on specific risks, findings, corrective actions, and unresolved compliance issues rather than status reporting alone. Guidehouse will facilitate information sharing, track action items, and help make sure that program integrity concerns are consistently incorporated into MCO compliance activities and oversight processes.

When compliance concerns affect multiple MCOs or indicate broader operational risks, Guidehouse will work with OPI and BMS to identify common root causes and opportunities for systemwide improvements.



Proven Program Integrity and Reporting Oversight

West Virginia strengthened MCO program integrity oversight through Guidehouse-developed reporting and monitoring processes for fraud, waste, and abuse activities. Our framework tracked investigations, referrals, provider actions, overpayments, recoveries, prepayment reviews, and case outcomes, providing BMS with greater visibility into MCO performance, corrective actions, and emerging program integrity risks.

Incorporate Strategic Planning and Emerging Compliance Priorities

Guidehouse will support annual MCO compliance plan training and use findings from oversight activities to recommend changes to MCO requirements, BMS procedures, compliance monitoring approaches, and future oversight priorities.

As part of this process, we will monitor emerging Federal and state compliance priorities and incorporate them into risk assessments and oversight activities as appropriate. This may include

areas such as program integrity reporting, behavioral health oversight, mental health parity requirements, fraud, waste, and abuse prevention, and other evolving compliance expectations affecting Medicaid managed care programs.

Build on Prior West Virginia Program Integrity Experience

During our prior BMS engagement, Guidehouse helped establish detailed MCO program integrity reporting that captured investigations and referrals, provider actions, overpayments, recoveries, prepayment activities, case status, outcomes, and related follow-up. We will use that experience as a starting point for coordinating with OPI while updating the monitoring framework to reflect current BMS priorities, MCO compliance plans, Federal requirements, and emerging program integrity risks.

Financial Services (§4.2.1.2.)

§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.

Guidehouse will provide BMS with an integrated actuarial and financial services methodology that combines Medicaid financial analysis, rate setting expertise, reimbursement policy knowledge, implementation support, and clear decision support for state leadership.

Our prior West Virginia experience gives us a practical understanding of BMS's program structure, waiver authorities, reimbursement environment, and need for analyses that are technically sound, transparent, and usable for state decision making.

Financial Services Area	Guidehouse Activities	Benefit to BMS
MLR review and audit	Review templates, reconcile reported values, test reasonableness, and document findings.	Supports compliance, transparency, and stronger oversight of MCO financial reporting.
Rate and reimbursement studies	Analyze rates, benchmarks, fiscal impacts, provider payment methods, and Federal approval pathways.	Helps BMS compare options, understand tradeoffs, and defend recommended approaches.
Legislative and policy support	Develop fiscal estimates, policy option summaries, assumptions, and briefing materials.	Enables timely, defensible responses to legislative and leadership requests.
Budget and forecasting	Model enrollment, utilization, acuity, Federal Medical Assistance Percentage (FMAP), state/Federal share, and expenditure scenarios.	Gives BMS a clearer view of budget pressure, funding impacts, and emerging financial risks.

Our methodology is intentionally flexible because BMS's needs may vary across managed care, FFS, waiver, supplemental payment, budget, and policy workstreams. For each task, Guidehouse

will confirm the purpose of the analysis, the decision it must support, the required level of documentation, and the intended audience before developing the data request, validation approach, analytic model, quality review steps, and deliverable format.

Explainable by Design

Guidehouse will break complex financial calculations into clear components, document the purpose and impact of each adjustment, and provide summaries BMS can use with technical and nontechnical audiences. This is especially important for MLR review, waiver financial projections, reimbursement updates, legislative fiscal requests, and CMS-facing materials. Guidehouse is experienced in presenting complex technical concepts in a strait forward way to a range of stakeholder backgrounds.

Integrated Financial Services Methodology

MLR Template Review and Audit

Guidehouse will review MCO-submitted MLR templates for completeness, internal consistency, mathematical accuracy, and alignment with applicable Federal and state reporting requirements. We will assess reported revenue, claims, nonclaims costs, quality improvement expenses, taxes and fees, credibility adjustments, exclusions, and other components required by BMS.

- *Template completeness and accuracy:* Verify required fields, formulas, crosswalks, and supporting schedules.
- *Financial reconciliation:* Reconcile amounts to capitation payments, encounter and claims summaries, financial statements, and other documentation provided by BMS or MCOs.
- *Reasonableness testing:* Compare current results to prior years, rate assumptions, enrollment trends, utilization changes, and known policy or benefit changes.
- *Findings and documentation:* Prepare an issue log, recommended follow-up questions, review documentation, and a concise findings summary for BMS leadership.

Rate Studies and Reimbursement Support

Guidehouse will conduct and help BMS evaluate, design, update, and explain Medicaid reimbursement approaches using a comprehensive rate study process that connects payment policy, provider economics, access considerations, program goals, fiscal impact, Federal authority, and implementation feasibility. Our support will cover recurring rate maintenance and targeted reimbursement studies for provider types or services identified by BMS, including institutional, noninstitutional, waiver, managed care, supplemental payment, and FFS reimbursement arrangements.

1. Define the rate study question and scope.

- Confirm the affected provider types, services, policy objectives, rate period, implementation timeline, statutory or regulatory requirements, available data, fiscal constraints, stakeholder considerations, and BMS decision points.
- Develop a rate study work plan that identifies data requests, validation steps, analytic milestones, stakeholder activities, draft and final deliverables, and implementation dependencies.

- Identify whether the reimbursement change may require State Plan Amendments (SPA), waiver amendments, managed care contract changes, system configuration, provider communications, CMS review, or postimplementation monitoring.
- 2. Collect and validate data.**
- Use existing BMS, MCO, fiscal agent, cost report, claims, encounter, enrollment, provider, and payment data where available to minimize additional asks of BMS, providers, and MCOs.
 - Develop clear templates, instructions, validation rules, and review procedures when provider cost, wage, staffing, utilization, or service information is needed.
 - Test data for completeness, reasonableness, internal consistency, outliers, duplicate records, service definition differences, and reconciliation to available financial or claims sources before using the information to develop rates or recommendations.
- 3. Develop reimbursement methodology options.**
- Analyze provider rate adequacy, fee schedule updates, cost-based methodologies, acuity adjustment options, resource-based relative value approaches, case-mix or level-of-care adjustments, provider class-specific methodologies, quality or performance components, transition policies, and phase-in options.
 - Compare Medicaid reimbursement to Medicare, peer Medicaid programs, available market information, cost report data, claims experience, encounter data, or other benchmarks where appropriate.
 - Document the policy rationale, calculation methodology, source data, assumptions, rate components, trend factors, inflation or wage inputs, utilization adjustments, acuity considerations, provider tax or supplemental payment interactions, Federal financial participation, and implementation steps for each option.
- 4. Analyze fiscal, provider, and access impacts.**
- Model projected fiscal impacts by provider type, service category, population, geography, managed care cohort, waiver authority, and funding source.
 - Prepare current-versus-proposed payment comparisons, provider-level impact summaries, service mix analyses, rural or access-sensitive provider impacts, managed care and FFS interaction analyses, and sensitivity testing around utilization, trend, staffing, wage, or cost assumptions.
 - Help BMS distinguish intended policy effects from unintended consequences and identify mitigation options when proposed changes produce material variation across providers, services, populations, or regions.
- 5. Support stakeholder, CMS, and implementation activities.**
- Work with BMS to define the right mix of stakeholder workgroups, advisory sessions, interviews, written comments, and public presentations for each rate study.
 - Support onsite provider sessions, regional meetings, site visits, and workgroups to improve participation and identify operational issues affecting reimbursement, access, staffing, and service delivery.

- Prepare plain language summaries, methodology documents, fiscal exhibits, FAQs, presentations, and responses to stakeholder, provider, CMS, legislative, and payer questions.
- Facilitate provider and payer meetings to explain methodologies, gather feedback, identify implementation concerns, and document items requiring BMS review or decision making.
- Develop targeted surveys on costs, staffing, wages, service delivery, access constraints, billing practices, and implementation readiness, using clear instructions, definitions, and validation checks.
- Improve survey participation and data reliability through communications, webinars, office hours, reminders, follow-up with incomplete submissions, and response validation.
- Summarize stakeholder and survey findings for BMS decisions, reimbursement models, fiscal analyses, CMS documentation, provider communications, and implementation planning.
- Translate selected reimbursement approaches into rate files, system updates, provider notices, MCO or fiscal agent instructions, reporting changes, and monitoring steps.
- Maintain feedback, survey, Q&A, decision, and follow-up logs showing how stakeholder input was considered and how it informed final recommendations.
- Maintain a clear record of source data, methodology, assumptions, calculations, adjustments, review steps, BMS decisions, unresolved limitations, and version history.
- Draft documentation that supports future updates, CMS review, legislative questions, provider inquiries, implementation monitoring, and audit support.

6. Maintain documentation and audit trail.

- Maintain a clear record of source data, methodology, assumptions, calculations, adjustments, review steps, BMS decisions, unresolved limitations, and version history.
- Use version-controlled workpapers and decision logs so BMS can trace the rate from source data through final recommendation.
- Prepare documentation that supports future updates, CMS review, legislative questions, provider inquiries, implementation monitoring, and audit support.

Federal Review Alignment

When an analysis involves directed payments, state plan rates, waiver services, or other reimbursement mechanisms requiring Federal review, Guidehouse will connect the financial model to the applicable approval pathway. This may include supporting exhibits, payment methodology documentation, CMS-facing narratives, and analysis of consistency with access, quality, economy, efficiency, and budget objectives.

Legislative Planning and Policy Support

Guidehouse will translate technical Medicaid financial analyses into clear fiscal estimates, policy option summaries, and briefing materials. This support may include reviewing proposed legislation or budget language, estimating state and federal fund impacts, identifying operational and timing

considerations, assessing interactions with managed care rates or provider reimbursement methodologies, and preparing concise materials for BMS leadership.

For each legislative or policy scenario, we will document the analytic question, assumptions, affected populations or providers, data limitations, implementation dependencies, and fiscal ranges. We will also identify where additional policy decisions are needed before final estimates can be completed.

Budget Support and Financial Forecasting

Guidehouse will develop budget projections, fiscal impact estimates, and scenario models that reflect Medicaid program costs, enrollment trends, utilization, acuity, FMAP assumptions, provider reimbursement changes, managed care rate impacts, and state policy decisions. We will distinguish gross expenditures, state share, Federal share, one-time impacts, recurring impacts, and timing differences that may affect appropriations or cash flow.

Data Validation, Quality Assurance, and Documentation

For each financial services assignment, Guidehouse will develop targeted data requests that reflect the purpose of the analysis and minimize burden on BMS and its partners. Potential data sources may include managed care financial templates, MLR submissions, capitation rate files, encounter and claims data, enrollment and eligibility files, provider cost reports, supplemental payment records, SPA and waiver materials, appropriations data, FMAP assumptions, budget schedules, and legislative proposals. We will work with BMS to confirm source systems, file layouts, data owners, submission timing, and secure transfer protocols.

Guidehouse will perform reasonableness checks, completeness reviews, reconciliation tests, and trend analyses before relying on data for financial modeling, audit conclusions, budget estimates, or reimbursement recommendations. We will document data limitations, follow-up questions, adjustments, accepted assumptions, version history, and quality review steps so BMS can trace results from source data through final recommendations.

Deliverables, Implementation Support, and Ongoing Advisory Services

Audience-Specific Deliverables

Guidehouse will tailor deliverables to the audience and purpose. Technical users will receive workbooks, assumptions documentation, reconciliation exhibits, and audit workpapers. Executive and legislative audiences will receive concise summaries that describe the issue, assumptions, fiscal impact, policy tradeoffs, risks, and recommended next steps. CMS-facing materials will emphasize transparency, regulatory alignment, and reproducibility.

Potential Deliverables

Guidehouse will work with BMS to define the format, level of detail, review process, and delivery schedule for each assignment. Deliverables may include:

- *Oversight and audit tools:* MLR review findings, audit workpapers, issue logs, and assumptions logs.

Quality Performance Manual



- *Rate and reimbursement tools:* rate study reports, reimbursement comparison models, provider impact analyses, and fiscal impact analyses.
- *Budget tools:* budget forecasts, expenditure monitoring models, scenario analyses, and state/Federal share summaries.
- *Communication materials:* legislative fiscal notes, executive summaries, policy option summaries, CMS exhibits, and presentation materials.

Monitoring Tools

Where recurring monitoring is useful, Guidehouse will develop dashboard-ready exhibits or reporting templates that allow BMS to track results overtime by program, population, provider type, MCO, service category, region, waiver authority, or funding source. These tools may display enrollment, expenditures, PMPM trends, utilization patterns, MLR maturation, waiver spending, reimbursement variation, state and federal share, and actual-to-expected results.

Stakeholder and CMS Support

Guidehouse will help BMS communicate results to MCOs, providers, legislative staff, CMS, and other stakeholders, as requested. This may include agendas, plain language issue summaries, methodology walkthroughs, decision logs, meeting notes, follow-up trackers, and responses to technical questions.

For reimbursement initiatives that require Federal approval or technical documentation, Guidehouse will help BMS develop the materials needed to support review and implementation. This may include SPA support, waiver financial exhibits, directed payment preprints, rate development documentation, provider impact analyses, and responses to CMS questions. We will connect the financial model to the policy narrative so that assumptions, funding sources, provider classes, payment methodologies, and implementation timelines are clearly documented.

We will also help BMS evaluate implementation feasibility before finalizing reimbursement recommendations. This includes identifying operational steps, data dependencies, system changes, MCO or provider reporting needs, timing considerations, and risks that could affect implementation. Where appropriate, we will prepare implementation checklists, review calendars, and response trackers so BMS can manage approvals and next steps efficiently.

Guidehouse will support BMS in monitoring financial results and refreshing analyses as new data, Federal guidance, legislative direction, enrollment trends, acuity shifts, utilization patterns, or provider reimbursement changes emerge. For recurring workstreams, we will establish update cycles, review thresholds, and supporting documentation so BMS can identify material changes early and determine whether additional analysis or corrective action is needed.



Proven Value Delivered to BMS

This approach gives BMS structured financial oversight, defensible documentation, clearer budget projections, faster responses to legislative and CMS inquiries, and effective management of financial and policy risks throughout the contract period.

Risk Management and Advisory Support

Guidehouse will help BMS identify issues that may affect budget neutrality, state share, Federal claiming, rate adequacy, provider access, CMS approval, or legislative decision making. We will provide practical recommendations, alternative scenarios, and documentation that allows BMS to respond to time-sensitive questions while maintaining a consistent analytic record.

\$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 health care and/or payment provision rules, regulations, laws, or codes.

Guidehouse will help BMS verify that payments and reimbursements affected by Affordable Care Act (ACA)-related requirements, HR1, CMS rules, state legislation, budget directives, and other Federal or state health care and payment provisions are calculated, applied, reported, and reconciled accurately. For example, we will review compliance with proposed Medicaid managed care state-directed payment and FFS targeted practitioner payment requirements, including proposed limits on certain non-grandfathered directed payments. Our approach connects each Federal or state requirement to the related payment methodology, allowing BMS to identify overpayments, underpayments, timing issues, duplicate payments, unsupported adjustments, and inconsistencies before they create compliance, budget, provider, or CMS concerns.

1. Identify the payment or reimbursement change.

- Confirm the ACA, Federal, state plan, waiver, contract, budget, provider payment, or other related provision being reviewed.
- Identify the effective date, affected populations, provider types, MCOs, services, payment systems, funding sources, and implementation assumptions.
- Define the review period, source data, expected outputs, required documentation, and BMS decision points.

2. Map requirements to the payment methodology.

- Develop a regulatory and policy crosswalk that connects the applicable authority to the reimbursement methodology or payment component being reviewed.
- Review whether capitation rates, fee schedules, supplemental payments, directed payments, passthrough payment transitions, risk adjustment, acuity adjustments, provider taxes, quality payments, and other reimbursement components were implemented consistent with approved requirements.
- Separate confirmed requirements from assumptions, unresolved policy decisions, pending CMS guidance, or state implementation choices.

3. Test payment logic and system implementation.

- Recalculate selected payments and test rate tables, fee schedules, eligibility criteria, provider classifications, payment parameters, and system configuration assumptions.
- Confirm that policy or payment changes were applied to the correct populations, providers, services, programs, and time periods.

- Identify calculation errors, unsupported adjustments, timing issues, duplicate payments, excluded services, or inconsistent treatment across payment systems or programs.

4. Reconcile payments to source data and financial records.

- Reconcile payments to capitation rate files, claims and encounter data, provider payment records, MCO financial submissions, budget schedules, State Plan or waiver exhibits, and Federal claiming records.
- Compare actual payments to expected payments and identify material variances by provider, service, population, MCO, geography, program, or funding source.
- Document data limitations, reconciliation differences, follow-up questions, and items requiring BMS or external party resolution.

5. Conduct variance and source analysis.

- Determine whether payment differences are driven by data quality issues, coding changes, timing differences, methodology changes, provider classification issues, systems configuration, policy interpretation, or implementation errors.
- Quantify overpayments, underpayments, state share, Federal share, budget, claiming, and provider impact implications where data support a defensible estimate.
- Prioritize findings based on fiscal impact, compliance risk, operational complexity, stakeholder sensitivity, and urgency.

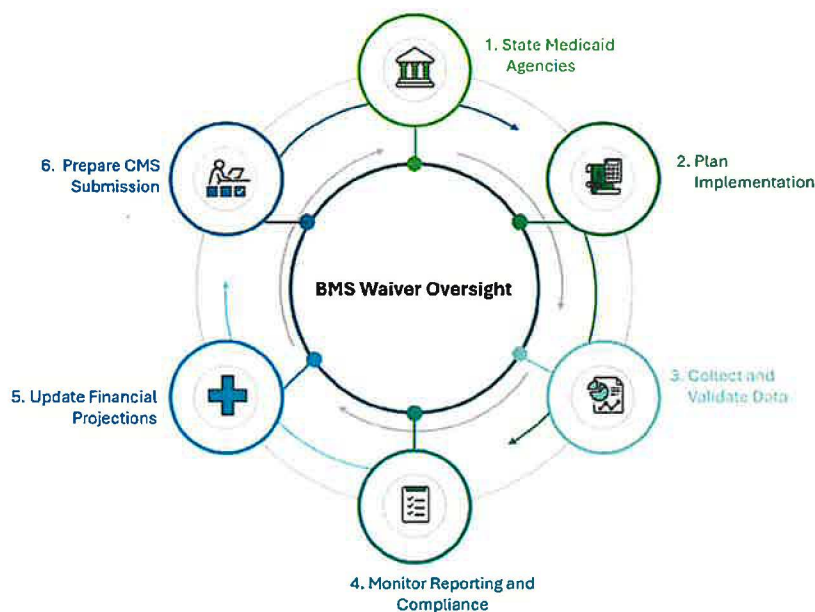
6. Support corrective action, documentation, and monitoring.

- Prepare findings summaries, audit-ready workpapers, fiscal impact exhibits, issue logs, recommended corrective actions, and response materials for BMS review.
- Assist BMS with MCO, provider, CMS, legislative, fiscal agent, or internal leadership communications when payment accuracy findings require explanation or follow-up.
- Establish monitoring steps to confirm corrections were implemented and to prevent recurrence in future payment cycles, system updates, rate changes, or reimbursement methodology updates.

§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.

Guidehouse will help BMS oversee waiver implementation, reporting, and financial projections for 1915(b), 1915(c), 1115(a), and related waiver or State Plan authorities. Our approach draws on our prior West Virginia experience supporting BMS with waiver cost effectiveness documentation, 1915(c) waiver development, 1115(a) waiver and SPA submissions, policy consulting, finance review, and recommendations.

Figure13. Waiver Oversight



Area of Support	Guidehouse Activities	Benefit to BMS
Implementation	Maintain waiver workplans, milestone trackers, readiness checklists, and issue logs.	Creates a practical view of what must happen, who owns it, and when decisions are needed.
Reporting	Identify source data, owners, validation steps, due dates, and review cycles for required waiver reports.	Reduces last-minute reporting risk and supports consistent responses to CMS questions.
Financial and budget projections	Model enrollment, utilization, service mix, rates, trend, acuity, FMAP, waiver slots, and state/Federal share.	Helps BMS understand cost drivers, budget pressure, and waiver financial performance.
Governance	Maintain dashboards, issue logs, decision logs, risk registers, and submission trackers.	Provides leadership visibility into implementation status, reporting readiness, financial performance, and upcoming decisions.
CMS submissions	Prepare or review financial exhibits, narratives, amendments, renewals, and responses to CMS requests.	Improves consistency across the policy narrative, financial story, and implementation plan.

Implementation Support

Guidehouse will establish waiver-specific workplans that translate approved waiver commitments into practical implementation tasks. These workplans may address eligibility and enrollment rules, waiver requirements, enrollment processes, service authorization requirements, provider qualifications, MCO and contractor responsibilities, quality reporting, system configuration needs, claims and encounter coding, financial claiming, and communication with providers and stakeholders.

Reporting Support

Guidehouse will help BMS move from operational preparation to a repeatable reporting process. We will identify the source data, conduct validation checks, implement reconciliation steps, and review timelines for each required report or exhibit, including quarterly and annual waiver reports, budget neutrality or cost effectiveness demonstrations, quality and access measures, utilization reporting, enrollment and slot reporting, corrective action tracking, and responses to CMS requests.

We will coordinate waiver reporting activities with managed care oversight, CSED waiver monitoring, 1115 reporting requirements, quality strategy activities, and other BMS reporting processes to maintain consistency across submissions and reduce duplicative effort.

Financial Projection and Budget Support

Guidehouse will develop models that align waiver policy assumptions with enrollment, utilization, unit cost, service mix, trend, acuity, provider rates, waiver slots, and Federal match assumptions. We will compare actual waiver experience to approved projections and identify whether variances stem from enrollment growth, participant need, authorization patterns, provider capacity, claims lag, rate updates, or policy changes.

Where appropriate, we will develop baseline, high, and low scenarios to help BMS evaluate potential expenditure ranges, state share requirements, Federal claiming impacts, and budget timing. We will distinguish recurring versus one-time impacts, gross versus net state share costs, timing effects, and budget neutrality or cost effectiveness implications.

Governance and Decision Support

Guidehouse will maintain governance tools that connect implementation activities, reporting obligations, financial performance, and key decision points. These tools may include waiver dashboards, issue logs, decision logs, risk registers, assumptions inventories, readiness checklists, and CMS submission trackers. Together, these resources provide BMS leadership with a consolidated view of waiver status, upcoming deadlines, implementation risks, financial performance, and policy decisions requiring action.

Two Levels of Documentation

For each waiver deliverable, Guidehouse will prepare both technical support and a clear decision-ready summary. Technical materials will document source data, methodology, calculations, assumptions, version history, and quality review steps. Summary materials will explain the key issue, fiscal impact, operational implications, CMS considerations, risks, and recommended next steps in plain language.

Amendment and Renewal Support

Guidehouse will help BMS prepare coordinated waiver submission packages that align policy objectives, operational design, financial projections, implementation assumptions,



Proven Value Delivered to BMS

Integrated Governance ♦ Earlier Risk Identification ♦ Better Decision-Making

Guidehouse connects waiver implementation, CMS reporting, financial performance, compliance obligations, and policy planning within a single governance framework. This integrated approach helps BMS identify emerging risks earlier, improve federal readiness, support budget development, maintain a clear audit trail, and make informed decisions regarding future waiver operations and investments.

quality monitoring strategies, and responses to anticipated CMS review questions. We will also track CMS questions, requests for additional information, negotiation points, required follow-up actions, and implementation commitments through approval and operationalization.

Core Deliverables

Guidehouse will develop practical tools and deliverables designed to support ongoing waiver oversight, financial monitoring, federal reporting, and executive decision making.

Potential deliverables include:

- *Governance tools:* waiver management calendars, issue logs, decision logs, readiness checklists, and CMS submission trackers.
- *Financial tools:* budget neutrality or cost effectiveness workbooks, waiver slot and enrollment projection models, state and federal share forecasts, and variance analyses.
- *Reporting tools:* reporting matrices, utilization dashboards, quality and access tracking, and CMS response logs.
- *Briefing materials:* executive summaries, amendment and renewal exhibits, stakeholder summaries, and leadership briefing materials.

Actuarial services (§4.2.1.3)

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.

Guidehouse will develop, set, review, and certify actuarially sound capitation rates for both the MHT and MHP programs, including populations served through Medicaid and WVCHIP. Our approach reflects more than a decade of experience supporting BMS rate setting, actuarial analyses, certification, risk adjustment, financial oversight, and managed care policy initiatives across both programs. We recognize that MHT and MHP have distinct populations, program objectives, risk profiles, and operational considerations. Our methodology is specifically designed to address those differences.

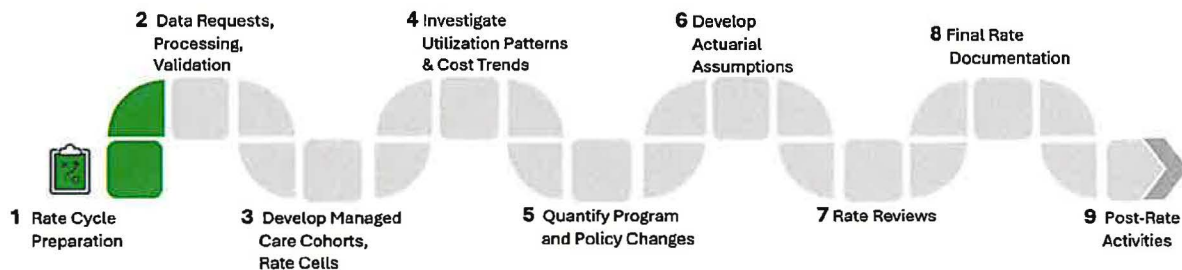
Our methodology maintains consistency with CMS actuarial soundness requirements and BMS policy goals, including full compliance with 42 CFR § 438.4, any applicable newer CMS regulations, CMS' Medicaid Managed Care Rate Development Guide, all Actuarial Standards of Practice (ASOPs), and at any point they are applicable in our processes, American Institute of Certified Public Accountant (AICPA) standards for designing and performing review procedures.

Our BMS-Aligned Rate Cycle with Clear Decision Points

We structure rate development around defined decision points so BMS approves each major element before rates are finalized. This cadence satisfies West Virginia's requirement for periodic meetings to discuss parameters, methodology, and emerging results during each cycle.



Rate Development Activities



1. Rate Cycle Preparation

We begin each rate cycle with an early planning discussion with BMS (and, as desired, MCOs) to confirm timeline requirements and identify items that may be expected to materially affect the rate cycle, such as accelerated rate needs for the new comprehensive managed care procurement, evolving CMS guidance, high-cost drug risk mitigation strategies, state-directed payment arrangements, claims data maturity, or new benefits/populations.

If desired, as we have in past years consulting to BMS, we would like to share our ‘rate setting 101’ presentation with state staff to help all gain alignment in terms of roles, expectations, processes, and common rate development practices.

We work with BMS to determine the most appropriate data sources (encounter, FFS, financial reports, and supplemental plan data), define the base period and runout approach, and confirm the rate cell structure (including West Virginia-specific geography and eligibility distinctions).

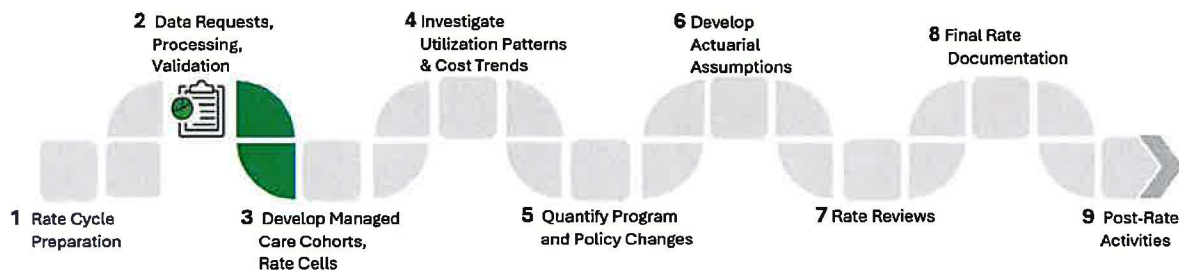
We document these items in a living “*program change and issue tracker*” so changes are captured once and carried consistently through the model and documentation.

During initiation, Guidehouse will conduct separate planning discussions for MHT and MHP to identify program-specific changes that may affect capitation rates. For MHT, this includes changes affecting Temporary Assistance for Needy Families (TANF), SSI, ACA Expansion, WVCHIP, and other managed care populations, while MHP discussions focus on foster care, adoption assistance, kinship care, legal guardianship, and Children with Serious Emotional Disorder Waiver (CSEDW) members. Special consideration will be given to population transitions, behavioral health initiatives, high-cost members, and emerging child welfare policies that may affect MHP utilization and expenditures.

Prior to beginning annual rate development activities, Guidehouse will facilitate a formal MCO Rate Setting Kickoff Meeting on behalf of BMS. Separate discussion tracks will be established for MHT and MHP as appropriate. The kickoff meeting will:

- Review the rate development timeline and milestones
- Explain data submission requirements and validation schedules
- Discuss anticipated program and policy changes
- Review risk adjustment methodology and reconciliation processes
- Identify known operational issues affecting encounter data quality
- Establish communication protocols and recurring working sessions
- Outline opportunities for MCO review and feedback throughout the rate cycle

Throughout development, Guidehouse will facilitate recurring technical meetings with participating MCOs to discuss data validation results, emerging utilization trends, policy impacts, rate assumptions, and draft rate findings. Meeting materials, action logs, and decision documentation will be maintained and shared with BMS to enable transparency and consistency across the rate setting process.



2. Data Requests, Processing, and Validation

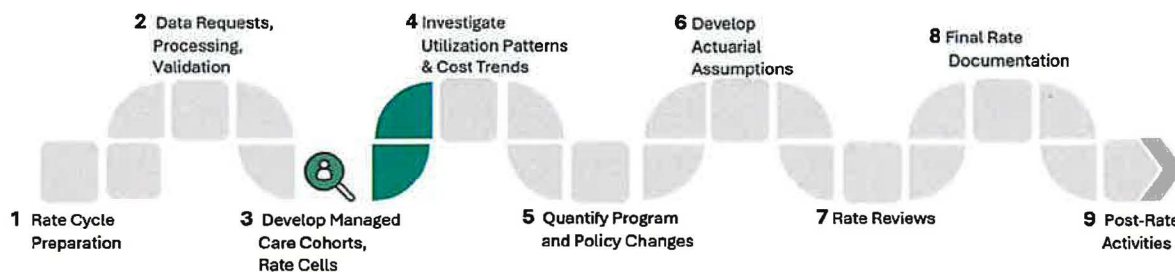
Guidehouse will request, receive, and process all readily available State data required (and supplemental data where appropriate) to develop actuarially sound capitation rates, including BMS provided utilization and enrollment data as well as managed care plan financial and supplemental files needed to validate experience and support assumption development. We have extensive experience receiving and managing large, multi year Medicaid claims and encounter datasets through State sponsored secure file transfer (SFTP) solutions, and we can also provide a Guidehouse managed secure transfer option if preferred by BMS.

Our actuarial and data teams work together throughout the intake and processing phase. While our data specialists manage the mechanics of loading and structuring the data, our actuaries remain closely involved so that data validation is focused not only on technical completeness, but also on rate-setting relevance.

We use layered validation so issues are identified early, minimizing disruption and rework later in the cycle:

- Processing-stage (early warning) validation
 - Record counts and expected volume checks (claim lines, member months, time period coverage)
 - Required field completeness and format checks (presence, ranges, date logic)
 - Duplicate/overlap detection and basic internal consistency checks
- Actuarial reasonableness validation
 - PMPM and utilization reasonableness by major COS and population
 - Enrollment/exposure reconciliation to cohort/rate cell assignment logic
 - Outlier scans (high-cost claimants, service spikes) and unusual service distribution flags
 - Preliminary reconciliation to available financial summaries where appropriate

When anomalies are identified, we review them with BMS to confirm whether they represent true experience or data artifacts and document the resolution approach (correction, exclusion, alternative treatment, or limitation disclosures). This documentation is carried forward into the rate development narrative so BMS can confidently explain data decisions during CMS review and stakeholder questions.



3. Develop Managed Care Cohorts

Guidehouse will develop managed care cohorts using parameters required by BMS, including age, gender, category of eligibility, level-of-care, benefits, and geographic location. We will analyze PMPM costs over several time periods split by the above categories and make this available for BMS's review, along with recommendations for cohorts / aid categories and rate cell mapping early to confirm that the structure is both actuarially credible and operationally feasible (often establishing new rate cell structures in state IT systems takes a while). This is most critical during the first year of setting capitation rates but is useful to review periodically thereafter. As actuaries, we must attest that rate cells do not cross-subsidize each other.

Particular attention will be given to maintaining actuarially credible rate cells within both MHT and MHP. For MHT, this includes evaluating eligibility categories such as TANF, SSI, Expansion, and WVCHIP populations, while MHP analyses will focus on foster care-related populations and other specialized child-serving groups. We will evaluate whether emerging experience warrants refinement of existing cohort structures while maintaining operational feasibility within BMS enrollment systems and MCO reporting processes. BMS will receive a clear base-data summary and rate cell mapping for review before assumption setting begins.



4. Investigate Utilization Patterns and Cost Trends

Step 4 is intentionally distinct from Step 2: Step 2 establishes that the data are trustworthy; Step 4 uses that trusted data to identify the cost and utilization dynamics that will drive the rate build.

Guidehouse will identify medical service utilization patterns by COS and develop medical and administrative cost profiles for cohorts and major lines of business, consistent with the RFP requirements. We explicitly separate utilization and unit cost trends so BMS can distinguish what is changing and why.

As part of these efforts, Guidehouse will prepare data dashboards so we and BMS can visualize these patterns and delve deeper into the underlying causes (dashboarding is described in more detail in subsequent pages). As significant patterns are identified, we work with BMS' deep knowledge of your program and population to best estimate how utilization and cost trends are expected to change going forward. We also highlight implications for access and rural delivery.

As part of this analysis, we perform explicit **base-data normalization** to align historical experience to the rating period. This includes benefit alignment, exclusion of non-covered services per BMS' managed care design, and reconciliation of known structural changes so the base is representative of the future contract period.

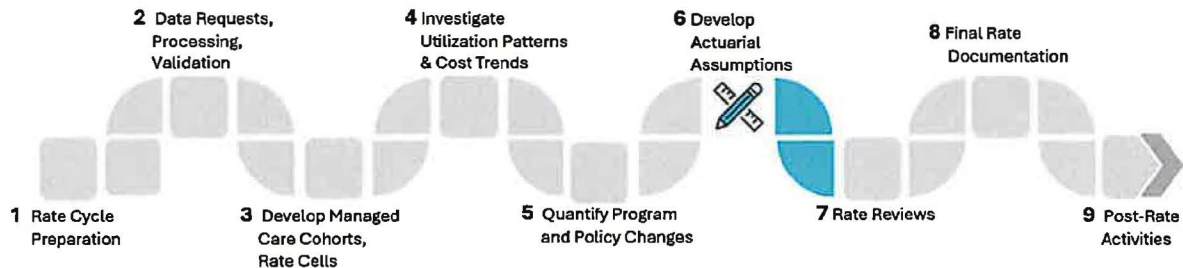
Because utilization patterns differ substantially between MHT and MHP populations, Guidehouse will complete separate trend analyses for each program. MHT evaluations will focus on traditional managed care drivers such as inpatient utilization, outpatient services, pharmacy costs, chronic condition prevalence, and expansion population experience. MHP analyses will place additional emphasis on behavioral health services, residential treatment utilization, community-based services, trauma-informed care initiatives, and the impact of child welfare placement changes on healthcare utilization.



5. Quantify Program and Policy Changes (including State-Directed Payments)

Guidehouse will analyze programmatic changes and state/Federal policy changes effective for the rating period and develop adjustment factors to apply to existing/pending rate cells. Program and

policy changes are identified, quantified, and documented individually, with impacts reviewed and approved by BMS as each change is completed. We will review projected impacts with BMS as they become available, going through the assumptions, methodology and impact to confirm our approach and the final results align with the intended purpose of the program change. This prevents double counting (or missing) impacts across the rate build and helps BMS defend rate movements in a way stakeholders can follow, especially the MCOs.



6. Develop and Review Assumptions with BMS (trend, non-benefit, risk mitigation)

Guidehouse has extensive experience supporting BMS' historical risk mitigation initiatives, including revenue neutral risk adjustment methodologies used within the MHT program. We will evaluate existing and proposed risk mitigation strategies for both MHT and MHP populations, assess financial impacts on participating MCOs, and prepare recommendations designed to promote actuarial soundness while minimizing unintended incentives and preserving program stability.

We will develop the full set of actuarial assumptions required to calculate actuarially sound capitation rate cells consistent with CMS checklist expectations and managed care rules. This includes assumptions that directly correspond to plan financial analysis, risk mitigation and settlements (as applicable/approved), parity, and network adequacy reporting verification.

- *Trend and projection assumptions:* prospective trends, split by utilization and unit cost, set by service category and cohort, supported by historic diagnostics and reasonableness review.
- *Non-benefit loads and plan financial considerations:* review administrative/non-benefit cost information (and other plan financial data relevant to rate development) to set reasonable, supportable loads. Note that in the first year we rely on external metrics and take MCO expectations into consideration.
- *Risk mitigation evaluation and settlements:* assess risk mitigation approaches BMS elects to use (for high-cost drugs as well as to stabilize plan performance in early years) and model related settlements where applicable and approved, confirming consistency with the broader rate build.

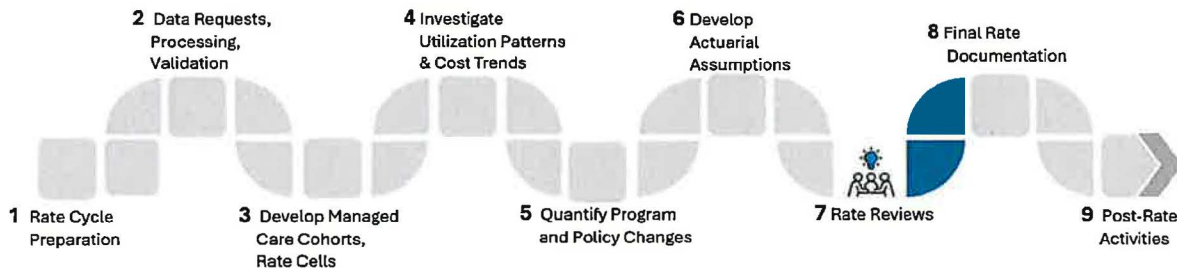


Proven Collaborative Decision-Making Approach

Guidehouse works alongside BMS through shared decision-making, using recurring working sessions, advance materials, and clear decision logs to align on results and next steps. This approach reduces rework, minimizes late-cycle surprises, and equips BMS to clearly communicate key decisions and rate drivers to CMS, MCOs, and policymakers.

- *Rate parity*: analyze applicability and incorporate parity adjustments transparently as directed.
- *Network adequacy reporting*: verify the accuracy and internal consistency of MCO network adequacy reporting to inform rates, particularly where access constraints may affect utilization or unit cost patterns.

Assumption recommendations are presented to BMS with rationale and clear impact summaries so BMS can make informed decisions before rates are finalized.

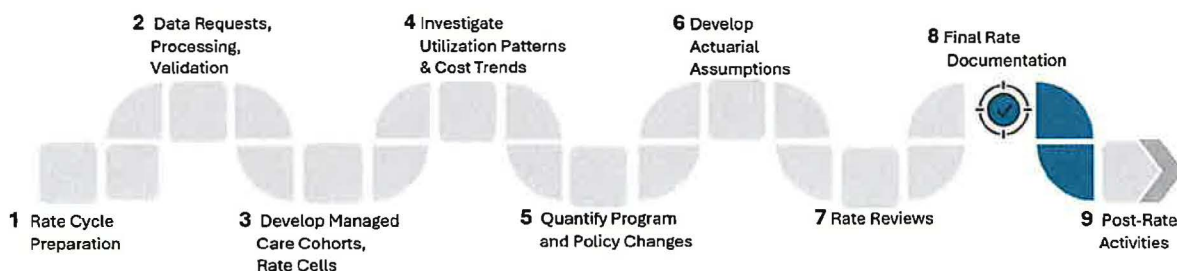


7. Rate Reviews

Once all assumptions are individually presented and understood, the rates as a whole are reviewed with BMS to confirm the final results are in alignment with expectations. Assumptions can then be tweaked if the full picture context reveals disparity, double counting, or other inequities. As the RPF mentions rate parity, we'll point out that we do review the applicability of parity requirements as directed by BMS and incorporate any parity adjustments transparently within the rate build, including documentation of impact and interactions with other components. This is most applicable in the first-rate cycles when transitioning from FFS to managed care.

Draft rate packages that support BMS-approved rates are then prepared and submitted to the MCOs. These include explanations of all material rate assumptions for each program as well as high-level rate comparisons so the MCOs understand how the rates were developed as well as where they are landing in aggregate. With BMS approval, Guidehouse then leads a rates meeting to go through the rate development materials with the MCOs to address any questions.

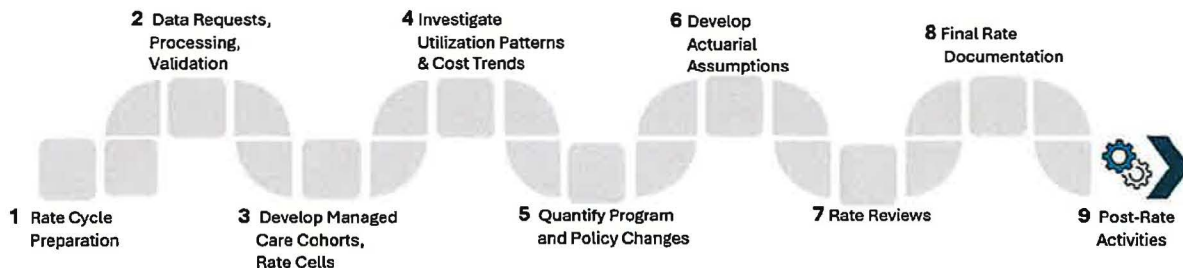
In cases where the actuaries and BMS agree that a change to the rates is warranted following MCO feedback, Guidehouse makes the adjustments quickly and presents that adjusted rates once more to BMS.



8. Deliver Draft Rates, Finalize Certification, and Support CMS Review

BMS requires draft rates on a timeline that supports final certification (including advance delivery expectations), and Guidehouse will meet BMS' required milestones. We provide BMS with a draft rate package that includes a plain-language walkthrough and a structured list of open items, so feedback can be incorporated efficiently. Final deliverables include a rate book with side-by-side comparisons to FFS costs (in the first-rate cycles) and to prior rates (in subsequent). Also, a "rate build-up" exhibit showing the dollar, PMPM, and percentage impacts of each step, specifically designed to help BMS explain results internally and externally.

We also prepare CMS-ready documentation, including a Rate Development Guide crosswalk/index to streamline review, and we support BMS in responding to CMS questions through to approval. In the rare instance where CMS questions are not fully resolved through email documentation, we stand ready to interact with CMS directly on calls, preparing exhibits as needed.



9. Post Rate Activities

In addition to the activities outlined above that help directly develop capitation rates, Guidehouse remains actively engaged to support BMS' ongoing rate oversight responsibilities and to respond to emerging experience. The following activities are generally important to incorporate throughout the year:

- *Actual-to-Expected Testing.* Throughout the year, Guidehouse will continue to monitor experience separately for MHT and MHP populations, providing BMS with actual-to-expected analyses, emerging trend reports, and assessments of developing cost pressures. Results will support future rate cycle planning, legislative reporting requirements, MCO oversight activities, and annual MHT and MHP program reporting obligations.

Periodically, we review the actual PMPM costs by rate cell and produce 'actual-to-expected' comparisons to identify where differences persist. In doing so, we often rely on our own proprietary IBNR estimates to overcome pessimistic MCO reporting.

- *Mid-Year Rate Amendments.* Generally, policies, regulations, fee schedule changes, and any number of additional actions will cause the need for adjustments to be made to the capitation rates. These adjustments are completed within the same framework as other deliverables, where we review the program change with BMS and agree upon an approach and expected impacts. We review the individual impacts and final rates also with BMS and work to present the revisions to external parties, especially the MCOs. *We note that the importance of making it clear to the MCOs (and other stakeholders, such as legislators) that better- or worse-than-expected experience is alone NOT sufficient justification for adjusting the rates.*

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

Guidehouse will develop high, mid, and low capitation rate ranges for the MHT and MHP programs to provide BMS with a clear understanding of how key assumptions may affect final capitation rates. Rather than presenting a single rate outcome early in the process, we develop a range of reasonable actuarial scenarios that allow BMS to evaluate uncertainty, assess financial risk, and make informed policy decisions prior to final rate certification.

Our approach recognizes that rates for MHT, WVCHIP, and MHP are influenced by multiple factors, including utilization trends, unit cost changes, enrollment shifts, behavioral health service needs, provider reimbursement changes, state-directed payments, pharmacy costs, and emerging programmatic initiatives. Each of these factors may create uncertainty within the rating period, and our scenario-based methodology is designed to quantify those potential impacts.



1. **Establish Baseline Rate Development.** Guidehouse first develops a baseline actuarial rate model using the most current and credible data available, including encounter data, enrollment information, financial reports, supplemental MCO submissions, and BMS operational guidance. The baseline serves as the midpoint scenario and reflects our best estimate of expected experience during the rating period.
2. **Identify Key Rate Drivers.** We identify the assumptions most likely to influence capitation rates for each program. Examples may include:
 - Medical and behavioral health utilization trends
 - Unit cost inflation
 - Pharmacy cost growth
 - High-cost claimant experience
 - Foster care and CSEDW population changes within MHP
 - Expansion, SSI, TANF, and WVCHIP experience within MHT
 - State DPP impacts
 - Administrative cost assumptions
 - Risk adjustment and risk mitigation parameters
 - Policy or benefit changes effective during the rating period
 - Each assumption is reviewed with BMS to confirm relevance and materiality.
3. **Develop Scenario Ranges.** Guidehouse develops high, mid, and low scenarios by varying key assumptions within actuarially reasonable ranges. These scenarios are not arbitrary

adjustments but are based on historical experience, observed variability, emerging trends, program-specific considerations, and professional actuarial judgment.

4. **Present Results Through Interactive Review Sessions.** Guidehouse reviews preliminary rate ranges with BMS through working sessions designed for both technical and nontechnical audiences. These sessions focus on:

- Drivers of differences between scenarios
- Key assumptions and supporting rationale
- Potential operational or policy implications
- Financial impacts on State and federal expenditures
- Potential effects on MCO solvency and program stability

Our objective is to make sure that BMS leadership fully understands not only the projected rates but also the factors driving those rates.

5. **Refine and Narrow Ranges as Information Emerges.** As additional information becomes available during the rate development process, Guidehouse continuously refines rates ranges. Data validation findings, updated enrollment projections, finalized program changes, MCO feedback, and CMS guidance may all contribute to narrowing uncertainty and increasing confidence in the final actuarial estimates.

By the time final rates are submitted for certification, BMS will have a clear understanding of how the selected rates compare to alternative scenarios and the rationale supporting the final recommendation.

6. **Supporting BMS Decision Making.** Our high, mid, and low rate range methodology provides BMS with a structured framework for evaluating risk, testing assumptions, and assessing the financial implications of policy decisions before rates are finalized. This process promotes transparency, supports informed decision making, and helps make sure that final MHT and MHP capitation rates are actuarially sound, defensible, and aligned with BMS' programmatic and fiscal objectives.

Our methodology maintains consistency with CMS actuarial soundness requirements and BMS policy goals, including full compliance with 42 CFR § 438.4, any applicable newer CMS regulations, CMS' Medicaid Managed Care Rate Development Guide, all ASOPs, and at any point they are applicable in our processes, AICPA standards for designing and performing review procedures.

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.*

Guidehouse has extensive experience developing managed care capitation rates in environments where differences in member acuity, demographic mix, geographic distribution, provider access, program participation, and enrollment patterns create varying levels of risk across participating health plans. If BMS elects to implement MCO-specific rates within the MHT and/or MHP programs, Guidehouse will develop a transparent, actuarially sound risk stratification methodology that appropriately compensates each MCO for the risk characteristics of the members it serves while maintaining compliance with CMS managed care regulations and actuarial soundness requirements.

Our approach is designed to make sure rate differences reflect measurable differences in member risk and expected costs rather than rewarding or penalizing plans based solely on historical performance.

1. Evaluate Program-Specific Feasibility and Objectives

Before implementing MCO-specific rates, Guidehouse will work with BMS to assess the appropriateness of risk-stratified rates within both MHT and MHP.

For MHT, we will evaluate factors such as:

- Difference in enrollment composition across MCOs
- Variations in SSI, Expansion, TANF, and WVCHIP populations
- Geographic enrollment concentration
- Chronic condition prevalence
- Behavioral health acuity
- High-cost claimant concentration
- Provider network composition

For MHP, we will evaluate unique characteristics of the foster care and child welfare populations, including:

- Foster care placement status
- Kinship care participation
- Adoption assistance members
- Legal guardianship populations
- Children with CSEDW enrollment
- Behavioral health and residential treatment utilization patterns
- Population volatility resulting from placement changes and reunification activities

This assessment allows BMS to determine whether risk-stratified MCO-specific rates would improve payment accuracy and program stability.

2. Develop Risk Stratification Methodology

Guidehouse will analyze available enrollment, encounter, financial, and supplemental data to identify measurable risk factors that materially influence expected costs. Potential risk stratification factors include:

- Age and gender
- Eligibility category
- Geographic location
- Behavioral health status
- Chronic disease burden
- Disability status

- Foster care and child welfare status
- Historical utilization patterns
- Pharmacy risk indicators
- Social and environmental factors included within approved methodologies

The resulting framework may leverage demographic risk adjustment, diagnostic risk adjustment, pharmacy-based models, or other actuarially appropriate approaches based on data quality, credibility, and BMS program goals.

3. Analyze MCO Risk Profiles

Guidehouse will calculate and compare risk profiles across participating MCOs to identify material differences in expected costs.

Within MHT, we will assess whether individual plans enroll members with significantly different levels of medical complexity, behavioral health needs, disability prevalence, rural access challenges, or pharmacy utilization.

Within MHP, particular attention will be paid to differences in child welfare populations, serious emotional disturbance prevalence, residential treatment utilization, and other characteristics that may significantly affect expected expenditures.

The objective is to determine whether observed cost differences are attributable to member risk rather than operational performance.

4. Develop MCO-specific Adjustments

After completing the risk analysis, Guidehouse will develop plan-specific adjustment factors that appropriately reflect differences in expected risk.

- Adjustments may be developed:
 - Across an entire MCO
 - By eligibility cohort
 - By rate cell
 - By geographic service area
 - By specialized populations

All methodologies, assumptions, data sources, and calculations will be documented in sufficient detail to support BMS review, MCO stakeholder discussions, and CMS rate certification requirements.

5. Evaluate Program Stability and Financial Impacts

Because risk adjustment methodologies can materially affect plan revenues, Guidehouse will model the financial impact of proposed MCO-specific rates under multiple scenarios.

- These analyses may include:
- Comparison of current and proposed payment levels
- MCO revenue impacts

- State and federal funding impacts
- Sensitivity testing
- Multi-year transition considerations
- Interaction with existing risk mitigation programs

For MHT, Guidehouse will specifically evaluate how MCO-specific rates interact with existing or future risk adjustment and risk mitigation strategies to avoid duplicative adjustments or unintended financial incentives.

Our methodology maintains consistency with CMS actuarial soundness requirements and BMS policy goals, including full compliance with 42 CFR § 438.4, any applicable newer CMS regulations, CMS' Medicaid Managed Care Rate Development Guide, all ASOPs, and at any point they are applicable in our processes, AICPA standards for designing and performing review procedures.

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.

Guidehouse understands that developing actuarially sound capitation rates is only one component of a successful managed care program. Equally important is verifying that BMS leadership, program staff, MCOs, CMS, and other stakeholders understand the methodology, assumptions, and financial implications underlying rate development decisions.

Our team supports BMS throughout the entire MHT and MHP rate setting lifecycle by participating in working sessions, executive briefings, technical discussions, MCO meetings, legislative discussions, and CMS engagement activities as requested. Because Guidehouse has supported West Virginia's managed care programs across multiple rate cycles, we understand the importance of translating complex actuarial concepts into practical information that can be used for policy and operational decision making.

For every major rate development milestone, we prepare clear and defensible supporting documentation tailored to the audience and purpose. Deliverables may include executive presentations, actuarial memoranda, rate workbooks, financial models, scenario analyses, certification exhibits, MCO briefing materials, and CMS supporting documentation. Throughout the process, we maintain version-controlled workpapers and transparent documentation so BMS staff can understand how decisions were made and how assumptions evolved over the course of the rate development cycle.

Our goal is not simply to deliver actuarial products, but to serve as an extension of the BMS team by verifying decision-makers have the information necessary to confidently manage and communicate changes affecting both MHT and MHP.

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.

The Guidehouse actuarial team includes dedicated data professionals with many years of experience with intaking, processing, and cleaning Medicaid data from multiple state agencies. Guidehouse's data team will request claims and enrollment data extracts from each of the Medicaid MCOs. This data will be aggregated at a COA and COS level. The aggregated data will then be compared to the state's encounter data to confirm the accuracy of the data before its used in rate development.

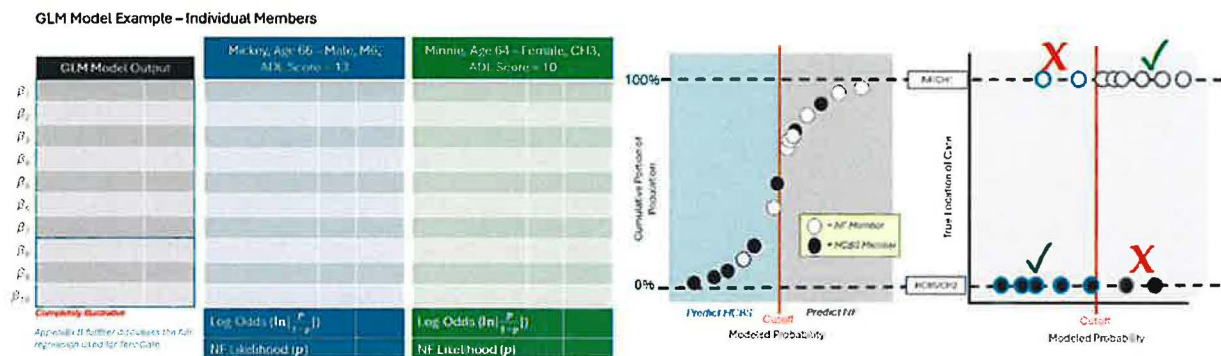
Guidehouse will work with the State to investigate and resolve any discrepancies. We will hold at least weekly check-in meetings with BMS to provide data validation status updates and gather feedback on State priorities and data nuances. We value collaboration with our State clients and understand that issues may arise between scheduled meetings. Our team will remain available by phone, text, or email and can meet in person as needed, recognizing that face-to-face discussions can improve communication, strengthen working relationships, and surface additional information.

Once the data is validated, Guidehouse actuaries will analyze the data at a COS and COA to identify trends and anomalies. Exhibits showing this data will be developed and shared with the state for review and discussion during weekly meetings.

States often have regularly scheduled fee schedule increases, the impact of which can be observed in historical data. If these impacts are observable in the states data, some efficiencies may be gained by avoiding individual program changes for each fee schedule change and rather acknowledging that impacts of these changes will be captured in trend.

Guidehouse actuaries have developed an innovative way to risk adjust the Long-Term Services and Supports (LTSS) population. The adjustment uses activities of daily living, member demographic data, enrollment history, and historical medical data to classify LTSS individuals into risk categories by evaluating their expected location of services (nursing facility, HCBS) rather than their expected costs. Rates are then risk adjusted based on the expected proportion of members residing in nursing facilities (NF) vs those receiving HCBS services. This effectively removes the incentive for MCOs to direct members to NF when HCBS services may be more appropriate and vice-versa.

Figure 14. GLM Model Example



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.

Guidehouse believes that transparency is fundamental to effective actuarial and programmatic support. BMS should not only receive the final results of an analysis but also have access to the data, methodologies, assumptions, calculations, and supporting documentation necessary to understand how those results were developed. Throughout the engagement, Guidehouse will provide reports, calculations, workpapers, databases, datasets, and supporting documentation in formats specified by BMS and appropriate for the intended use of the information.

We recognize that different stakeholders require information in different formats. BMS leadership may require executive summaries and presentation materials, while program staff, financial staff, auditors, and technical personnel may require detailed supporting calculations and data files. Guidehouse will work with BMS to establish preferred formats for recurring deliverables and will adapt deliverables as Agency needs evolve over the course of the contract.

Depending on the request, deliverables may include:

- Excel-based actuarial models and rate workbooks
- Financial projection models
- Rate development exhibits
- CMS submission support materials
- Databases and structured data extracts
- Data dictionaries and file layouts
- Encounter and eligibility analysis files
- Trend and utilization reports
- Actuarial memoranda
- Technical documentation
- Executive briefings and presentations
- Legislative and stakeholder briefing materials

All deliverables will be provided in a mutually agreed upon format that is appropriate for the complexity and intended use of the information.

In providing these deliverables, our methodology maintains consistency with CMS actuarial soundness requirements and BMS policy goals, including full compliance with 42 CFR § 438.4, any applicable newer CMS regulations, CMS' Medicaid Managed Care Rate Development Guide, all ASOPs, and at any point they are applicable in our processes, AICPA standards for designing and performing review procedures.

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.

Guidehouse understands that reimbursement methodologies often evolve over many years in response to changing program requirements, legislative actions, Federal guidance, provider needs, and operational considerations. As a result, payment methodologies that are appropriate when developed may become increasingly difficult to administer, explain, or reconcile across programs as the environment changes. While some variation in reimbursement approaches is both expected and appropriate, BMS benefits from periodically evaluating where greater consistency and alignment can improve transparency, administrative efficiency, and financial oversight.

Guidehouse will facilitate a structured workgroup process involving BMS leadership, program staff, fiscal staff, policy personnel, and other stakeholders identified by the Agency. Working sessions will be scheduled collaboratively with BMS and may be conducted virtually or in person based on Agency preference.

The workgroup process will focus on:

- Establishing a common understanding of existing rate setting methodologies and payment structures
- Identifying key drivers of variability across programs
- Documenting historical decisions and program-specific requirements that influence reimbursement approaches
- Evaluating whether differences in methodologies reflect intentional policy choices, operational constraints, regulatory requirements, or legacy practices
- Prioritizing areas where consistency could improve program administration or financial management



Proven Experience Supporting Rate Uniformity

Guidehouse will support BMS in convening a Rate Uniformity Workgroup and reviewing reimbursement methodologies across Medicaid managed care, WVCHIP, and other identified programs. The review will identify opportunities to standardize key rate-setting components, strengthen governance, reduce inconsistencies, and enhance the overall framework while preserving program-specific approaches where appropriate.

Guidehouse will maintain issue logs, decision documentation, and meeting summaries throughout the process to promote transparency and continuity across discussions.

Throughout the workgroup, our team will conduct a detailed inventory and comparative assessment of rate methodologies currently administered by BMS. Depending on Agency priorities, this review may include managed care payment methodologies within MHT and MHP, WVCHIP reimbursement structures, FFS methodologies, directed payment initiatives, supplemental payment programs, and other reimbursement approaches identified by BMS.

The assessment will examine areas such as:

- Cost base development methodologies
- Trend development practices
- Assumption governance and documentation
- Data sources used for payment calculations
- Rate update processes
- Risk adjustment approaches
- Provider payment methodologies
- Directed payment methodologies
- Quality incentive structures
- Financial monitoring and reconciliation practices

Throughout the review, Guidehouse will distinguish between differences that are appropriate because of program design and differences that may be creating unnecessary administrative complexity or inconsistent reimbursement outcomes.

Drawing upon our experience supporting Medicaid agencies nationwide, Guidehouse will identify opportunities to improve consistency while preserving the flexibility needed to address unique program requirements.

Potential areas for alignment may include:

- Standardized data validation processes
- Common actuarial assumptions and documentation standards
- Consistent trend development methodologies
- Uniform financial reporting practices
- Shared governance and approval processes
- Standardized rate update schedules
- Consistent approaches to monitoring and reconciliation

Where opportunities for uniformity exist, Guidehouse will evaluate the operational, financial, and policy implications of implementation and help BMS determine whether the benefits justify the required effort and change management activities.

Guidehouse views this effort as more than a review of reimbursement methodologies. It is an opportunity to strengthen governance, improve transparency, reduce administrative burden, and create greater consistency across the processes used to support MHT, MHP, WVCHIP, and other BMS-administered programs. By combining our knowledge of West Virginia's managed care programs with lessons learned from Medicaid agencies across the country, we will help BMS identify opportunities to simplify rate administration, enhance stakeholder understanding, and support a more sustainable and consistent rate setting framework for the future.

Our review methodologies are established to maintain consistency with all requirements and BMS policy goals, including all relevant ASOPs, and where applicable, AICPA standards for designing and performing review procedures.

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.

Guidehouse actuaries are qualified to develop actuarially sound capitation rates. Rates are developed prospectively at least once per fiscal year.

- If there are new state or Federal program changes that have a significant impact on the capitation rates, Guidehouse actuaries will develop mid-year rate adjustments at the state's request to account for these changes.
- We will also develop supplemental templates for the MCOs to complete. These templates will be used to monitor emerging experience for each of the MCOs and the program as a whole and make appropriate adjustments to the rates, when necessary.
- Our actuaries will supply and sign rate certifications to submit to CMS attesting that the original fiscal year capitation rates and all subsequent amendments are actuarially sound.

Our capitation update methodology is established to maintain adherence to all CMS actuarial soundness requirements and BMS policy goals, including full compliance with 42 CFR § 438.4, any applicable newer CMS regulations, CMS' Medicaid Managed Care Rate Development Guide, all ASOPs, and at any point they are applicable in our processes, AICPA standards for designing and performing review procedures.

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.

Guidehouse understands the BMS desire to maintain continuity at the start and end of the engagement. Providing a smooth transition is incumbent upon all parties involved so BMS and its stakeholders are not adversely impacted, and services and operations are not interrupted. Guidehouse has procedures in place to safeguard a seamless transition and uninterrupted service throughout the transition to or from the State at the start or end of the contract.

We will plan and perform end of contract turnover and disengagement activities including transition planning to confirm a seamless operational transition under the BMS' facilitation in the event of required contract transition. The Guidehouse team will work with the State to complete end of contract turnover tasks and transition project responsibilities in a timely and effective manner. At

the end of the contract period, Guidehouse is committed to working cooperatively with BMS to develop and successfully implement a plan to turn over all data, methodologies, documentation, and ongoing projects via Department of Human Services (DHS) to the succeeding contractor organization, vendor, or firm.

From Guidehouse's perspective, the benefits of a smooth transition plan are multi-faceted whether we are taking over a project or transitioning work to BMS for transfer to another vendor. The successful transition of duties and responsibilities will be critical at the end of this engagement. As such, it is imperative that a robust transition plan is developed and implemented to provide a seamless transition of our work to BMS.

Our transition plan will outline various aspects of the monitoring and compliance transition, including the Guidehouse transition organization, roles and responsibilities, objectives, operation, milestones, and timeline. Implementing this transition plan will enable independent management of activities upon the conclusion of this contract.

Guidehouse will work with BMS to develop a detailed End of Contract Turnover Plan that will be developed and delivered to the State at least 90 days prior to the scheduled termination date of the contract (or at any time if requested by the DHS). Guidehouse is accustomed to developing and completing End of Contract Turnover Plans as it is an essential step in project management process.

Guidehouse will complete the transition activities necessary to transfer all data, methodologies, documentation, workpapers, tools, status trackers, and ongoing project responsibilities to BMS and/or the succeeding vendor at least sixty (60) calendar days before the contract end date.

Guidehouse will develop and implement a transition strategy and plan that meets the requirements of BMS in a manner designed to decrease disruption. That plan will reflect the circumstances and status of the engagement at the time of transition. Figure 15 provides an outline of elements that would be included in an End of Contract Turnover Plan. As part of a Transition Strategy, a turnover plan is naturally designed for a smooth transition from the implementation phase to the operational phase.

Transition Strategy

Our transition strategy, as shown in **Figure 15**, focuses on decreasing disruption to ongoing operations while providing a seamless transfer of responsibilities and knowledge.

Figure 15. Guidehouse's Transition Strategy



Guidehouse's universal transition approach provides immediate value by enabling a seamless, efficient takeover of the prior actuaries' work without interrupting business as usual or disrupting the State's managed care oversight activities. Should Guidehouse be awarded, we will begin with a structured knowledge transfer process that inventories all active rate development workstreams, certification schedules, data sources, models, assumptions, documentation, CMS submission materials, outstanding questions, and recurring reporting obligations. Our experienced Medicaid actuarial team will rapidly validate existing work products, confirm key decision points with State staff, and establish clear continuity protocols so critical activities continue on schedule while we assume responsibility. Because our team has deep experience supporting large, complex Medicaid managed care programs and interacting with CMS on behalf of state agencies, we can quickly identify risks, preserve institutional knowledge, maintain stakeholder confidence, and keep rate setting, risk adjustment, encounter data review, financial monitoring, and managed care oversight functions moving forward without delay. This disciplined transition plan minimizes burden on BMS staff, accelerates onboarding, and positions BMS to benefit from both uninterrupted operational support and Guidehouse's fresh perspective on opportunities to improve efficiency, transparency, and program oversight.

At the beginning of our prior contract to West Virginia for actuarial services, BMS previously experienced Guidehouse's extraordinarily smooth transitions from your prior actuaries to our Guidehouse actuarial team. BMS considered the smoothest that your staff and leadership had ever experienced. Guidehouse was praised by both BMS and the MCOs for the ease of transition to our actuarial team and systems.

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.

Guidehouse understands that actuarially sound rate development begins with reliable data. The quality of capitation rates for MHT and MHP is directly dependent on the completeness, accuracy, and consistency of encounter, claims, and eligibility information received from the State's fiscal agent, MCOs, and other program data sources. Our approach emphasizes ongoing coordination with BMS, the fiscal agent, and participating MCOs to make sure rate development is based on the most accurate and credible information available.

We will work closely with BMS and the State's fiscal agent throughout the year to establish a shared understanding of available data sources, reporting schedules, submission timelines, known limitations, planned system changes that could affect rate development activities. This coordination allows potential data issues to be identified and addressed early, reducing the likelihood of downstream impacts on actuarial analyses and rate certification activities.

Through recurring data review sessions and technical meetings, we will assess the readiness of encounter, eligibility, enrollment, financial, and supplemental data needed to support MHT and MHP rate development. Where appropriate, we will coordinate directly with MCOs and the fiscal agent to investigate anomalies, reconcile differences, and validate reported results.

When it comes to eligibility and enrollment data validation, eligibility data often present unique challenges because enrollment files continue to evolve after the initial reporting period closes.

Retroactive eligibility determinations, eligibility category changes, enrollment corrections, and delayed processing can affect both member month counts and rate cell assignment.

Guidehouse routinely evaluates these timing differences and develops normalization methodologies to make sure the historical experience is representative of the populations expected to be covered during the rating period.

Our review includes:

- Member month reconciliation across eligibility files and rate setting extracts
- Retroactive eligibility analysis
- Eligibility category transition analysis
- Rate cell assignment validation
- Enrollment trend and seasonality analysis
- Reconciliation to financial and operational reporting sources

Where material differences are identified, we quantify the impact and determine whether adjustments are warranted to improve the accuracy of the experience period used for rate development.

Encounter data frequently mature overtime as claims are adjudicated, adjusted, voided, and resubmitted by providers and MCOs. The completeness of encounter information can vary by source, provider type, service category, and reporting period. Certain services may have longer adjudication cycles than others, while some provider types historically experience delayed submission patterns.

Guidehouse recognizes that relying solely on raw encounter data at a point in time can produce distortions within trend analyses and base period experience. Accordingly, we perform formal claims completion and encounter maturity analyses to evaluate the degree to which experience data are fully developed.

Our approach includes:

- Historical lag studies by service category
- Encounter completion factor development
- Reporting pattern analysis by MCO
- Paid-versus-incurred reconciliation
- Service date versus payment date analysis
- Comparison of encounter data to financial reporting and MLR submissions
- Review of high-cost claims and catastrophic cases

Where encounter data are determined to be immature or incomplete, Guidehouse develops actuarially appropriate completion factors and normalization adjustments to estimate fully developed costs and utilization. These adjustments are documented and reviewed with BMS prior to incorporation into the rate development process.

Our methodology for validating and reconciling data used for developing capitation rates maintains consistency with CMS actuarial soundness requirements and BMS policy goals, including full compliance with 42 CFR § 438.4, any applicable newer CMS regulations, CMS' Medicaid Managed Care Rate Development Guide, all ASOPs, and where applicable in this process, AICPA standards for designing and performing review procedures.

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.

Guidehouse understands that successful state and federal reporting depends on more than simply compiling information from existing systems. Reports such as the CMS-64, CMS-21, CMS-37, managed care financial reports, waiver reports, legislative reports, and other Federal and state reporting requirements frequently rely on data originating from multiple sources that are maintained independently across the Medicaid enterprise. Financial data, eligibility information, encounter records, enrollment files, managed care reports, and provider payment information are often housed within separate systems managed by fiscal agents, data warehouses, MCOs, and state program areas. A critical component of reporting integrity and timely submissions is validating that these disparate data sources are complete, accurate, and reconciled before reporting.

Guidehouse has extensive experience supporting Medicaid agencies with the development, validation, and review of complex Federal and state reporting requirements. Our team understands the challenges associated with assembling reporting data from multiple operational systems and the importance of establishing repeatable validation processes that identify data discrepancies before reports are finalized and submitted.

Coordinated Approach with Fiscal Agents and Data Partners

Guidehouse will work collaboratively with BMS, the State's fiscal agent, data warehouse vendors, MCOs, and other reporting stakeholders to establish a common understanding of reporting requirements, data sources, submission schedules, and validation responsibilities.

For each reporting requirement, we will identify:

- Required source systems and data owners
- Reporting timelines and submission deadlines
- Data dependencies and reconciliation points
- Known limitations or historical reporting challenges
- Opportunities to improve reporting efficiency and accuracy

This approach enables reporting issues to be identified early and reduces the risk of late-cycle reporting revisions.

Validation and Reconciliation of Reporting Data

Because reporting information is frequently derived from multiple systems, Guidehouse performs extensive validation and reconciliation activities before reports are finalized. Depending on the reporting requirement, these activities may include:

- Reconciliation of eligibility and enrollment data to reported member month counts

- Verification of managed care expenditures and payment information
- Comparison of encounter-based reporting against financial reporting sources
- Validation of managed care and WVCHIP reporting elements
- Crosswalks between fiscal agent data and enterprise data warehouse reporting
- Reconciliation of federal reporting totals to supporting source systems
- Identification of missing, incomplete, or inconsistent reporting elements

Our objective is to identify discrepancies before reports are submitted, allowing BMS sufficient time to investigate, resolve, and document any necessary adjustments.

Strengthening Reporting Completeness and Accuracy

Guidehouse recognizes that the quality of reporting is directly tied to the quality of the underlying data. Throughout the engagement, we will help BMS strengthen reporting processes by identifying recurring reconciliation issues, data gaps, reporting inefficiencies, and opportunities for improved data governance.

When inconsistencies are identified, Guidehouse will work directly with the fiscal agent, data warehouse teams, MCOs, and BMS staff to determine root causes, assess reporting impacts, and develop practical corrective actions. We will document findings and recommendations in a manner that supports both current reporting needs and future process improvement efforts.

Supporting Timely Submission of Reports

Federal and state reporting requirements often operate on compressed timelines, making proactive coordination essential. Guidehouse will maintain ongoing communication with reporting partners, track reporting dependencies, and monitor the status of required data submissions to make sure BMS receives complete and validated information in time to meet reporting deadlines.

Our role is not simply to review completed reports, but to help BMS establish a reliable reporting framework that improves consistency, reduces reconciliation effort, and supports timely submission of accurate information to state and federal stakeholders.

Guidehouse brings extensive experience supporting Medicaid financial and programmatic reporting efforts across state agencies, including reporting processes that require coordination among fiscal agents, enterprise data warehouses, MCOs, and state program staff. By combining rigorous data validation, proactive stakeholder coordination, and deep familiarity with Medicaid reporting requirements, we help BMS confirm that reports used for state and federal reporting are complete, accurate, supportable, and delivered on time. This approach strengthens confidence in the underlying data and helps reduce the risk of reporting discrepancies, audit findings, and reporting delays.

Our methodology maintains consistency with CMS requirements and BMS policy goals, including full compliance with all applicable ASOPs, and at any point they are applicable in our processes, AICPA standards for designing and performing review procedures.

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.

High-quality encounter and claims data are the foundation for managed care oversight, actuarially sound rate development, federal reporting, and financial monitoring. For MHT and MHP, each actuarial analysis depends on the completeness, accuracy, timeliness, and credibility of the underlying data. Guidehouse understands that Medicaid data rarely reside in one system. They often originate from multiple organizations with different reporting schedules, data structures, and maturity levels. We use a disciplined process to gather, process, validate, reconcile, and analyze managed care encounter and claims data. We also work closely with BMS, the State's fiscal agent, data warehouse vendors, and MCOs to resolve data quality issues before they affect rate development, federal reporting, financial forecasting, or program decisions.

Our team begins by identifying and cataloging all data sources necessary to support MHT and MHP rate development, financial analysis, reporting, forecasting, and managed care oversight activities. We recognize that the data used for actuarial analysis frequently originates from multiple systems and organizations, including MCO encounter submissions, eligibility systems, fiscal agent reporting, enterprise data warehouses, pharmacy benefit administrators, behavioral health administrators, waiver programs, and other specialized service providers. While each source may be accurate within its own environment, meaningful differences often exist in timing, coding practices, eligibility determinations, reporting logic, and data completeness. Our role is to integrate these disparate data sources into a comprehensive and reliable analytical framework that supports defensible decision making.

Guidehouse will work closely with BMS and its data partners to make sure all relevant data sources are incorporated into the analytical process and appropriately aligned. We perform reconciliation and validation activities across systems to confirm consistency among eligibility, enrollment, encounter, financial, and utilization information. Particular attention is given to services that are carved out of managed care because these services frequently reside outside traditional encounter reporting systems and often require separate extraction, reconciliation, and validation efforts before they can be incorporated into actuarial analyses.

Depending upon program design, carved out services may include pharmacy benefits, behavioral health services, waiver services, long-term care programs, nonemergency transportation, and other specialized benefits. Although these services may not be included directly within managed care capitation rates, they frequently influence utilization patterns, care delivery models, future rate development decisions, and broader



Proven Value Delivered to BMS

West Virginia's pharmacy carve-out analyses provided Guidehouse with firsthand experience integrating carved-out program data into managed care financial and operational evaluations. Our work assessed pharmacy utilization, expenditure trends, federal funding impacts, and capitation rate implications while addressing challenges related to eligibility attribution, reporting timelines, service definitions, claims completion, and financial reconciliation. We will apply these lessons learned to future analyses involving pharmacy, behavioral health, waiver services, transportation, and other carved-out programs affecting MHT, MHP, and WVCHIP.

managed care program strategy. As a result, we believe it is essential that BMS maintain a complete picture of member experience across both managed care and carved out delivery systems.

For carved out services, Guidehouse evaluates:

- Utilization patterns and service demand
- Historical and emerging cost trends
- Population-specific impacts
- Service integration opportunities
- Potential managed care carve-in implications
- Financial and operational interactions with MHT and MHP
- Data quality, completeness, and reporting consistency

Where carved out services are maintained within separate systems or administered by external vendors, Guidehouse reconciles those data to managed care enrollment, eligibility, encounter, and financial information to make sure analyses accurately reflect total member experience and program expenditures. This process helps identify potential data gaps, duplicate reporting, timing differences, population attribution issues, and other discrepancies that could affect actuarial analyses, financial reporting, or future rate development activities.

Beyond basic reconciliation, Guidehouse applies advanced validation techniques through our Encounter Data Validation Toolkit and related analytic tools to identify anomalies, incomplete reporting, outlier utilization patterns, and emerging data quality concerns. Our team routinely evaluates encounter completeness, reporting lags, service category consistency, eligibility alignment, and financial reconciliation across multiple data sources. Findings are communicated through actionable reports and dashboards that allow BMS, MCOs, and other stakeholders to address issues proactively.

This integrated approach provides BMS with a complete understanding of the relationship among managed care expenditures, carved out services, utilization patterns, and future rate development considerations. By combining encounter data, eligibility information, financial reports, and carved out service data into a unified analytic framework, Guidehouse helps BMS evaluate policy alternatives, support federal reporting requirements, quantify fiscal impacts, and make informed decisions regarding the future direction of MHT, MHP, and WVCHIP programs.

Our methodology maintains consistency with CMS requirements and BMS policy goals, including full compliance with any applicable CMS regulations, CMS' Medicaid Managed Care Rate Development Guide, all applicable ASOPs, and where applicable, AICPA standards for designing and performing review procedures.

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.

DPPs have become one of the most important tools available to Medicaid agencies seeking to strengthen provider networks, improve access to care, address workforce challenges, support rural health systems, and advance quality outcomes within managed care programs. Guidehouse understands that successful DPPs require more than actuarial calculations. They require alignment

among policy objectives, provider financing strategies, managed care operations, quality improvement goals, and CMS expectations.

Guidehouse brings extensive experience supporting Medicaid agencies with the design, development, approval, implementation, certification, and ongoing monitoring of DPPs and supplemental payment initiatives. Our team has helped states develop and implement complex provider financing strategies, including more than **\$1.5 billion in directed payment arrangements** in Georgia, to strengthen provider capacity, improve access to care, and support long-term program sustainability. Starting in 2024, we developed and implemented a new physician supplemental directed payment in **Virginia** uniquely financed through third party Inter governmental Transfers from Public Entities. That program required navigating the recent changes to 438.6c as a result of the caps placed on Average Commercial Rate (ACR) defined Upper Payment Limit (UPL) payments. We will bring those lessons learned and leading practices to BMS as it evaluates current and future opportunities within MHT, MHP, and WVCHIP.

Rather than beginning with a payment methodology, Guidehouse starts by understanding the policy and programmatic objectives BMS is seeking to achieve. Whether the goal is improving rural healthcare access, strengthening behavioral health capacity, stabilizing critical provider types, supporting workforce investments, advancing value-based purchasing, or improving quality performance, we develop payment approaches designed to align financial incentives with measurable outcomes.

Guidehouse will develop actuarially sound payment methodologies by evaluating provider utilization, reimbursement adequacy, encounter experience, enrollment trends, network adequacy findings, quality performance metrics, and provider financial sustainability. Our analyses quantify the expected impacts on providers, MCOs, State expenditures, Federal funding, and member access so BMS can make informed decisions before implementation. Because payment programs frequently affect multiple stakeholders differently, we evaluate alternative approaches and present BMS with the operational, financial, and policy implications of each option before recommendations are finalized.

Once a preferred approach is identified, Guidehouse will support development of all required CMS documentation, including preprints, supporting actuarial analyses, financial exhibits, monitoring plans, evaluation frameworks, and quality strategies. Our team understands that CMS increasingly expects a clear connection between payment methodologies and measurable program outcomes. Accordingly, we will work with BMS to establish meaningful performance expectations, identify monitoring metrics, and develop quality strategies that demonstrate how payment investments support improved access, quality, health outcomes, and provider sustainability.

Guidehouse remains engaged well beyond CMS approval. We assist agencies with implementation planning, MCO contract modifications, provider education, financial monitoring, annual preprint updates, quality reporting, program evaluations, and future program refinements. As Federal requirements and market conditions evolve, we help agencies adjust payment methodologies, evaluate program performance, and demonstrate value through measurable outcomes.

Our objective is to help BMS develop sustainable payment strategies that strengthen provider participation, improve member access to care, support rural and specialty services, and advance the long-term goals of West Virginia's Medicaid programs. By combining actuarial expertise with deep Medicaid policy, operational, and managed care experience, Guidehouse helps agencies move DPPs from concept to CMS approval, implementation, monitoring, and continuous

improvement while maintaining compliance with Federal requirements and supporting the strategic priorities of the State.

Our methodology maintains full compliance with applicable CMS regulations, CMS' Medicaid Managed Care Rate Development Guide pertaining to Directed Payments, all relevant ASOPs, and at any point they are applicable in our processes, AICPA standards for designing and performing review procedures.

During our prior contract with BMS, Guidehouse became intimately familiar with and fully supported all aspects of West Virginia's DPPs. Of note, each year BMS provides the expected total DPP payment amounts to be included in the rate certification. In the past, the rate certifications did not include discussion of the allocation and payments to providers. As a result, BMS required actuarial support to determine the DPP payments according to the methodology approved by BMS. Our support included the comparison and validation of utilization data and the calculation the hospital-specific payments by MCO along with provider deliverables. We worked closely with those providers to identify NPIs associated with their hospitals. We also developed a quarterly calculation and payment with a year-end report to CMS on the actual amount of DPP payments. As part of this work, we drafted preprints for CMS and responded to CMS questions. Our work directly supported CMS approvals of BMS's DPPs.



Proven Directed Payment Program Experience

Guidehouse provided actuarial, financial, and reporting support for West Virginia's Directed Payment Programs, including provider payment calculations, CMS submissions, and ongoing payment monitoring.

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.

Medicaid programs are continually evolving in response to Federal requirements, state policy decisions, economic conditions, healthcare market changes, and emerging member needs. As a result, BMS frequently evaluates programmatic changes that may affect utilization, expenditures, enrollment, provider participation, and overall program performance. Guidehouse understands the importance of quantifying these impacts before implementation so that decisions can be made with a clear understanding of potential fiscal, operational, and programmatic consequences.

Guidehouse will provide actuarial analysis and valuation support for proposed changes affecting MHT, MHP, WVCHIP, and other BMS-administered programs. Our analyses are designed not only to estimate costs and savings but also to identify key drivers, assumptions, risks, and implementation considerations that may influence actual program experience.

Examples of programmatic changes we frequently evaluate include:

- Transitioning populations from FFS to managed care
- Movement of populations between delivery systems
- Benefit expansions or reductions
- Carve-in and carve-out initiatives
- Payment methodology changes

- DPPs
- Waiver initiatives
- Eligibility changes
- Provider reimbursement modifications
- Care management and value-based purchasing initiatives

For each proposed change, Guidehouse develops a baseline projection representing expected future experience in the absence of the proposed policy change. We then model the anticipated impacts of the program modification using available data, actuarial techniques, and subject matter expertise. Analyses consider both direct financial effects and secondary impacts on utilization, provider behavior, enrollment patterns, and managed care rates.

Where uncertainty exists, Guidehouse develops alternative scenarios and sensitivity analyses to help BMS understand the range of potential outcomes. Results are presented in a transparent and actionable manner, enabling Agency leadership to make informed decisions regarding implementation timing, funding implications, operational readiness, and program sustainability.

Our goal is to provide BMS with more than a fiscal estimate. We provide the analytic foundation necessary to understand how policy decisions may affect the Medicaid program, participating MCOs, providers, and members over both the short and long-term.

Our methodology for performing actuarial analysis and valuation of costs/savings established by implementing programmatic changes, including transitioning populations from FFS to managed care or alternate coverage options, maintains consistency with CMS actuarial soundness requirements and BMS policy goals, including full compliance with 42 CFR § 438.4, any applicable newer CMS regulations, CMS' Medicaid Managed Care Rate Development Guide, all ASOPs, and at any point they are applicable in our processes, AICPA standards for designing and performing review procedures.

As part of our prior contract, Guidehouse worked closely with BMS to identify and incorporate programmatic changes into rate development. Because BMS does implement several changes throughout the year, Guidehouse developed a Program Changes Tracker to identify and determine timelines and next steps for each change, which helped keep our team and BMS on time and confirmed that we included all relevant changes. We ultimately included all program changes in our rate development and communicated impacts through MCO presentations.

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.

Guidehouse recognizes the importance of transparency and accountability in the administration of professional services contracts. We maintain detailed project accounting and billing practices that provide clients with a clear understanding of the services performed, resources utilized, and costs incurred throughout the engagement.

Each invoice submitted to BMS will be accompanied by a detailed billing report that documents hours billed by individual staff member and staffing classification. Billing reports will provide sufficient detail to allow BMS to understand who performed the work, the level of staff assigned, and the amount of effort associated with specific project activities.

At a minimum, billing reports will include:

- Staff member name
- Staffing position or labor category
- Billing period
- Hours worked
- Applicable billing rate
- Total charges



Proven Operational Continuity Experience

Guidehouse's prior experience supporting BMS enables a seamless transition from contract start-up through ongoing operations. Our team is already familiar with BMS invoicing requirements, and previously used invoice templates remain available within our systems, supporting efficient implementation, continuity, and alignment with Guidehouse billing processes.

Upon request, Guidehouse can also provide supplemental narrative descriptions summarizing major activities performed during the billing period. Our objective is to make sure BMS has complete visibility into project staffing and resource utilization while minimizing administrative burden associated with invoice review and approval.

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.

Guidehouse understands the critical role WVCHIP plays in providing healthcare coverage to West Virginia's children and the importance of maintaining long-term program sustainability. Because funding levels, enrollment patterns, healthcare costs, and Federal requirements continue to evolve, BMS benefits from forward-looking financial projections that provide early visibility into potential fiscal pressures and funding needs.

To support ongoing program oversight, Guidehouse will prepare quarterly financial forecasts covering the current fiscal year and six future fiscal years. These forecasts will be designed to provide BMS leadership with a comprehensive view of expected program revenues, expenditures, reserve levels, and overall fiscal stability.

Our forecasting methodology incorporates multiple data sources, including:

- Historical enrollment experience
- Membership trends
- Utilization patterns
- Medical and pharmacy cost trends
- Capitation payment requirements

- Administrative expenses
- Federal funding assumptions
- State funding assumptions
- Legislative and regulatory changes
- Economic and demographic considerations

Because WVCHIP participates within the broader MHT managed care environment, our analyses will also consider how changes in managed care rates, enrollment shifts, provider reimbursement levels, and program policy decisions may affect future program expenditures.

An important component of each quarterly forecast is the development of updated IBNR estimates. Guidehouse has extensive experience developing Medicaid and CHIP IBNR estimates and understands that accurate reserve development is critical to assessing true financial position and funding adequacy. We will review emerging claims experience, reporting patterns, and payment lags to make sure IBNR estimates remain current and support sound financial decision making.

Forecast results will be summarized through executive briefings, written reports, and supporting financial exhibits that clearly communicate key drivers, emerging risks, and potential funding considerations. These reports will help BMS monitor program stability, support budget planning activities, evaluate policy alternatives, and prepare requests for additional state or Federal funding when necessary.

Our approach and methodology for producing quarterly reports on expected total program revenues and expenditures for WVCHIP will be consistent with CMS requirements and BMS policy goals, including full compliance with all relevant ASOPs, and where applicable in our processes, AICPA standards for designing and performing review procedures.

During our prior contract, Guidehouse was asked to review WVCHIP efforts that were at that time being performed by another firm. We did so regularly to achieve BMS expectations regarding the program. We have full understanding of the operations and financial needs regarding WVCHIP as it has now been integrated into the rest of BMS' managed care framework.

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.

Guidehouse understands that maintaining WVCHIP's financial integrity requires ongoing evaluation of both projected expenditures and available funding resources. As part of our financial oversight and forecasting support, Guidehouse will annually assess the program's financial position and provide BMS leadership with an independent actuarial evaluation of funding sufficiency.

Using the most current enrollment projections, claims experience, expenditure forecasts, administrative cost estimates, revenue projections, and updated IBNR calculations, Guidehouse will evaluate whether projected program and administrative expenditures are expected to remain within the statutory funding threshold established for WVCHIP.

Our review will incorporate:

- Current fiscal year experience
- Updated enrollment forecasts

- Medical and pharmacy trends
- Administrative expenses
- Federal funding projections
- State funding projections
- Reserve requirements
- IBNR estimates
- Known legislative and regulatory changes

Upon completion of the analysis, Guidehouse will provide the Director with a formal actuarial assurance letter documenting our methodology, assumptions, findings, and conclusions regarding the program's compliance with the requirement that total program and administrative expenditures, including IBNR, do not exceed ninety percent (90%) of available funding.

The annual assurance process serves as both a compliance activity and an important financial management tool. By providing an independent actuarial assessment of program sustainability, Guidehouse helps BMS identify emerging funding risks early, support informed budget decisions, and maintain confidence in the long-term financial stability of WVCHIP.

Our approach and plan for providing the requested letter to the Director regarding assurance of program and administrative costs, including IBNR, will comply with applicable ASOPs, and where applicable, AICPA standards for designing and performing review procedures.

Ad Hoc Services (§4.2.1.4)

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.

Guidehouse will provide BMS with a responsive, integrated model for additional consultation, actuarial services, and other requested work. As a full-service consultancy, Guidehouse offers BMS a one-stop shop that brings together credentialed actuaries, data analytics professionals, Medicaid policy consultants, managed care specialists, waiver and evaluation experts, clinical and quality professionals, program integrity advisors, and technology resources through one coordinated team. This integrated structure allows BMS to access the right expertise quickly without managing disconnected vendors or workstreams.

Upon receipt of an ad hoc request, Guidehouse's Engagement Partner will confirm the objective, policy or operational context, requested timeline, data needs, assumptions, stakeholders, and preferred work product format. We will then assign the appropriate in-house lead based on the nature of the request, including actuarial and rate setting support, encounter and eligibility analytics, program and policy analysis, waiver and demonstration support, fiscal modeling, CMS response support, or other technical assistance. Our team will use established data processes, analytic models, review protocols, and West Virginia-specific knowledge to provide responses that are technically sound, timely, practical, and aligned with Agency priorities.

BMS may recall Guidehouse's prior experience performing for BMS the highest quality, expedited ad hoc services in an extraordinarily successful manner to meet and exceed all expectations as pertains to several highly visible, and often highly complex needs that BMS has had in the past. Please note that during our prior contract with BMS, our past successes to full State satisfaction

pertaining to both reactive and proactive work performed during the COVID-19 pandemic and in relation to your SUD waiver development activities that Guidehouse was asked to support for BMS on an ad hoc basis. Other examples of our highly successful coordination of ad hoc work we performed for BMS under the prior contract (some of which is now identified in sections above and no longer would be considered ad hoc) include:

- Medicaid Fee Schedule Analysis and Development
- Actuarial Input for Annual Report
- Pharmacy Carve-out Analysis
- 1915(b) Cost Effectiveness Support as Needed
- 1115 SUD Budget Neutrality
- Serious Emotional Disorder (SED) Waiver Actuarial Analysis
- MHP HCBS and Waiver Support
- Risk corridors during the Public Health Emergency
- Recommendations/feedback to state on Final Rule changes including regarding rate ranges
- T1019 (within COVID rate efforts)
- PT/OT/ST (within COVID rate efforts)
- Coordinating with M&S on implementing +10M for WV hospitals (within COVID rate efforts)
- Review of Agreed Upon Procedures documents for prior authorizations
- High-cost drugs analytics
- SB546 provider lists and operations plans
- DPP strategic planning including % of Medicare pricing approaches for preprints

Our support for all of these previous ad hoc activities were thoughtfully considered via continual ongoing transparent communication, where our Guidehouse team would gather the requests mentioned by BMS, we would discuss the need for each item and what would be required to perform the work and then determining together the resources and level of effort that would be required. Our dynamic and transparent approach would follow this same structure that BMS was very appreciative of during our prior contract.

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.

For each ad hoc request, Guidehouse will prepare a clear Statement of Work for Agency review and approval before beginning work, unless otherwise directed by BMS. The Statement of Work will define the request, proposed approach, anticipated deliverables, project assumptions, data needs, key tasks, estimated timeline, number of project hours, resources to be used, and associated cost. This process gives BMS transparency into the level of effort, staffing plan, and expected work products before authorizing the assignment.

Guidehouse will tailor each Statement of Work to the urgency and complexity of the request. For routine or recurring requests, we will leverage existing templates, models, and quality review procedures to support efficient delivery. For urgent legislative, CMS, budget, or leadership inquiries, we will identify the minimum data, assumptions, and senior resources needed to provide a reliable response within the required timeframe. For complex or multi-phase assignments, the Statement of Work will include milestones, review points, responsible team members, and decision points so BMS can monitor progress and adjust direction as needed.

Similar to our prior experience with BMS from 2018-2022 providing appropriate statements of work that included all of the necessary detail for effectively conducting the projects, Russ Ackerman as Guidehouse's Engagement Partner and your Contract Manager, will remain accountable for responsiveness, quality, and client satisfaction, while the designated task lead will manage day-to-day execution. Our Project Manager, Liz Barabas, will coordinate any additional in-house resources, orient them to the request, and maintain close communication to preserve continuity. This disciplined approach allows Guidehouse to scale staffing up or down as needed while maintaining cost effectiveness, project efficiency, and consistent quality.

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.*

Guidehouse will assist with programmatic activities across other agencies and divisions by applying an interdisciplinary methodology that connects actuarial analysis with Medicaid policy, operations, finance, quality, waiver, program integrity, public health, and technology expertise. Given our extensive experience with BMS and our work with other states, we recognize the dynamic nature of state Medicaid programs. Program priorities continually evolve in response to stakeholder needs, state and federal objectives, legislative mandates, CMS expectations, and leadership changes. Guidehouse's one-stop, integrated

Health team allows BMS to access surge staffing and technical specialists as needs change, rather than coordinating disconnected vendors or workstreams.

Our collaborative approach will extend to BMS divisions or other agencies, (or BMS vendors that may play a role in activities required under this scope of work). Guidehouse will meet with these divisions as needed, or on an ongoing basis when coordination needs are more substantial or activities overlap. This approach promotes consistency in assumptions, communication, work product quality, and alignment with statewide Medicaid objectives.

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.*

Guidehouse will conduct research and recommend approaches in chronic care and disease management, pharmacy, eligibility and coverage, quality improvement, rural health, and other



**Proven Multi-Agency
Collaboration**

Guidehouse has demonstrated trusted cross-functional collaboration through its work with BMS, TennCare, and other Medicaid agencies. Known for our availability, responsiveness, and ability to engage effectively with leadership, staff, and MCOs, our team uses a transparent, practical, and solutions-oriented approach to resolve complex issues, answer difficult questions and support effective program operations.

areas requested by BMS using a structured, multidisciplinary methodology. Our in-house experts will combine national Medicaid experience, actuarial and financial modeling, policy and regulatory research, clinical and quality expertise, waiver and delivery system knowledge, and data analytics



Proven Rural Health Experience

Guidehouse supported a state in creating a Governor-created Rural Health Care Task Force that improved the health and health outcomes of persons in rural areas. The Task Force was divided into three work groups including access to care, social determinants of health, and workforce development. Guidehouse assisted with developing Task Force and workgroup meeting materials, conducted an environmental scan to identify gaps, informing Task Force meeting materials and final report findings, and delivering project execution support.

to develop recommendations that are evidence-informed, operationally realistic, and tailored to BMS's program environment. This expertise is demonstrated throughout our response, including our work supporting BMS with SUD waiver development, Drug Free Moms and Babies, pharmacy high-risk pool and carve-out analyses, EPSDT and quality strategy improvements, MCO contract and reporting enhancements, waiver and State Plan-related policy analyses, network adequacy and rural provider mapping. These examples show BMS that Guidehouse can pair disciplined research with deployable subject matter experts who understand Medicaid chronic disease priorities, pharmacy cost and utilization drivers, eligibility and coverage impacts, quality measurement, access challenges, and rural health needs.

Our research approach will begin with a clear definition of the policy question, target population, available data, stakeholder considerations, Federal and state requirements, and intended use of the recommendation. Guidehouse will then draw on internal expertise and relevant national experience to assess options, identify leading practices, evaluate fiscal and operational implications, and recommend practical approaches that BMS can use for decision making. Where appropriate, our recommendations may include implementation considerations, performance measures, stakeholder engagement strategies, CMS considerations, data and reporting needs, and potential risks or tradeoffs. This one-stop-shop model allows BMS to obtain integrated recommendations that balance actuarial soundness, policy feasibility, program goals, and operational execution.

For all ad hoc requests, Guidehouse will identify and assign teams based on the specific project scope, timing, deliverables, expected outcomes, and required technical expertise or credentials. As new needs are identified, our Engagement Partner and Project Manager will coordinate with dedicated healthcare resource managers to confirm the right mix of staff. Guidehouse has staffed thousands of large and small projects over its decades-long history, often requiring a broad range of expertise, including actuaries, managed care experts, physicians, nurses, pharmacists, behavioral health professionals, social workers, coding professionals, CPAs, statisticians, policy analysts, data analysts, CMS-certified grants officers, MBAs, PMPs, LEAN and Six Sigma trained professionals, public policy experts, and public health professionals. This depth allows Guidehouse to bring the right in-house specialists to BMS quickly while maintaining continuity, quality, and accountability through our project management practices and tools, including TruePMO™.

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.

Guidehouse has no conflicts of interest for the services requested in this RFP, nor conflicts via contract with any stakeholders in West Virginia as we are not performing any work for any West Virginia MCO nor health care providers in West Virginia.

Conflict Mitigation Plan

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

Conflict Mitigation Strategies

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

Ethical Screen (Ethical Wall)

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

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

- No member of TEAM A will discuss or otherwise share information relating to their engagement with any member of TEAM B and vice-versa.
- No member of TEAM A may share secretarial coverage with any member of TEAM B.
- Guidehouse's IT network and network servers will provide appropriate segregation and security between the files maintained by TEAM A and TEAM B to the extent deemed advisable.
- Active case files kept at employees' desks or in offices will be clearly marked as confidential.

- To the extent necessary, Guidehouse can physically secure a team's workspace requiring special access rights.
- These restrictions will continue until all engagements are concluded. Each member of TEAM A and TEAM B by his / her signature acknowledges these restrictions and agrees to uphold them.
- Should Guidehouse determine that there is the potential for a conflict of interest, we will immediately engage the State, discuss the issue and collectively determine the most appropriate course of action to remediate/mitigate.

Provider Rate Setting Services (§4.2.1.5)

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-medicaid-plan>, the CHIP state plan, which can be found at: <https://chip.wv.gov/rmedia/38021/download?inline> and the Agency Provider Manual, which can be found at: <https://bms.wv.gov/providers/policy-manuals>.

Guidehouse will provide BMS with an integrated financial services approach that combines Medicaid financial analysis, rate setting expertise, reimbursement policy knowledge, waiver and federal reporting support, and implementation assistance. Our methodology is designed to help BMS develop technically sound, transparent analyses, rate and reimbursement studies, legislative and budget support, financial projections, directed payment programs, provider payment reviews, MCO tax settlements, and waiver support, across the range of state plan provider types.

Guidehouse leads the field for public payers in the areas of provider rate development, payment system design, cost reporting, and analysis for institutional and noninstitutional providers, program evaluation, healthcare reform, the development and financing of consumer-directed services and managed care systems. Our consultants provide assistance in virtually all areas of healthcare policy and reimbursement, including the following:

- Analysis, development, implementation, updating, and evaluation of a wide range of reimbursement systems
- Analysis of large MMIS paid claims datasets and cost reports for rate analysis and rate setting, payment accuracy assessment, identifying reimbursement-related issues and impacts, support program monitoring, and litigation support
- Leading practices and other research regarding Medicare and other state Medicaid reimbursement systems for institutional and non-institutional providers
- Design, implementation, and evaluation of Medicaid supplemental payment programs for hospitals, NF, physician, and ambulance services. This includes the use of provider taxes, Disproportionate Share Hospital (DSH), intergovernmental transfer, and certified public expenditure (CPE) funding
- Cost finding, review of cost report surveys and other cost data submissions, and cost report design, development, and implementation for disability and other HCBS programs, residential treatment centers, and local education agency-provided school-based services for Medicaid payment rate development

- Training state personnel and providers on new policies, regulations or technical calculations related to changes in reimbursement systems
- Evaluation of service delivery models and coverage expansions including:
 - Selective contracting and managed care
 - Expansions of Medicaid and Children's Health Insurance Program (CHIP) coverage, including 1115 Federal waiver evaluations and cost analyses
 - Evaluation of managed care 1115 waiver programs
 - HCBS waiver programs
 - Family planning waiver programs
 - EQR and independent assessments of waiver programs

We also assist with the implementation of new service delivery models such as:

- Home- and Community-Based Waiver Services
- Alternative payment models
- Value-based payment models
- Managed care
- ACOs and Patient Centered Medical Homes (PCMH)/Medical Home models
- Expansions of public programs to parents of Medicaid and CHIP, children, and other populations
- PACE waiver programs
- School-Based Services Medicaid reimbursement for Local Education Agencies



Proven Reimbursement System Experience

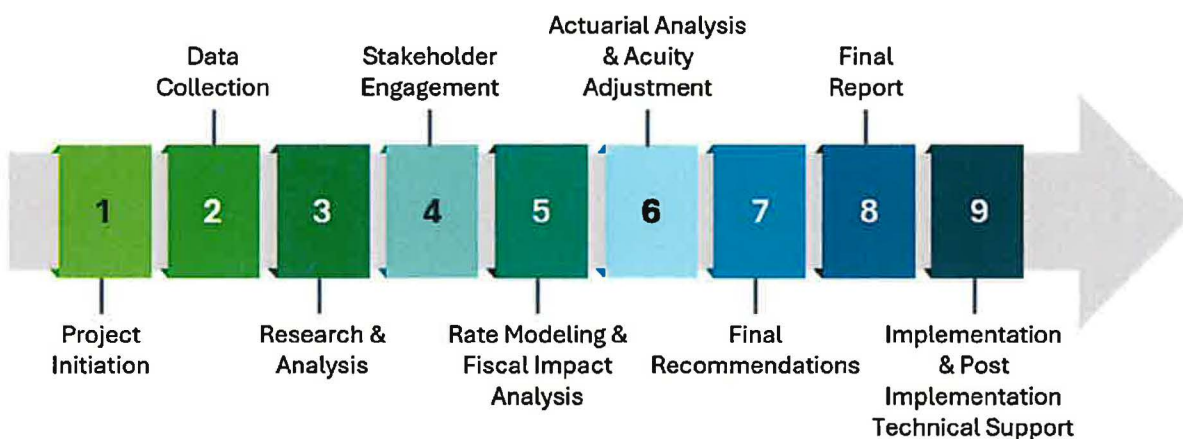
- Inpatient hospital services using the severity-based Medicare Diagnosis Related Groups (DRGs) and All-Patient Refined DRGs, and those that preceded severity-based models, including the Centers for Medicare and Medicaid Services DRGs and All-Patient DRGs
- Outpatient services using prospective payment systems involving Medicare's Ambulatory Payment Classifications and Integrated Outpatient Code Editor, and other bundled approaches, such as Enhanced Ambulatory Patient Groups including the recently released version 4.0
- Nursing facility reimbursement systems, including the Patient-Driven Payment Model as well as older resource groupers and patient classification systems, such as Resource Utilization Groups
- Supplemental hospital, physician, ambulance, and nursing home payment programs involving DSH and inter-governmental transfer financing mechanisms and provider assessments and Directed Payments
- Physician and other practitioner services, including both Resource-Based Relative Value Scale systems and other fee schedule approaches
- Psychiatric residential treatment facilities, outpatient residential treatment centers and community mental health and substance abuse centers
- Behavioral health services, including mental health and substance abuse services, delivered through traditional community behavioral health clinics as well as Certified Community Behavioral Health Clinics

General Rate Study Approach

Guidehouse understands that BMS is requesting a broad range of rate development activities, spanning multiple divisions and programs, service populations, care settings, Medicaid authorities, and funding sources. Each of these services features its own rate setting methodologies and source data sets, and rate recommendations will need to be attuned to the specific policies and regulations of different financing authorities. Understanding the substantial methodological differences between institutional and community reimbursement and the fact that each of these services involves distinct methods for capturing and representing costs, Guidehouse proposes approaches for harnessing available data sources such as cost reports and public data sources, as well as the development of provider cost and wage surveys, for collecting the data needed as the foundation for rate development in each of these different settings.

Tasks 1-9 below encompass the end-to-end support we will provide for the evaluation, development, and implementation of rate setting methodologies. While each major service category is likely to require its own unique work steps and methodological procedures, the schedule of tasks described below broadly captures our management plan for each of the services under review as well as their characteristic deliverables. Of note, throughout the entirety of this contract, Guidehouse's Project Manager will work closely with BMS to follow through on project management requirements and maintain oversight of our team. Through our ongoing status meetings, we will continue to keep BMS apprised of our progress and bring issues for discussion to the team's attention.

Figure 16. End-to-End Support Tasks



Task 1: Project Initiation

We will hit the ground running after rate study authorization so that we can develop a thorough and robust, detailed work plan within the first month of the engagement. Guidehouse's initial priority will be to review service specifications including definitions, delivery models, and existing rate models, and then use that understanding and analysis to discuss our proposed approach with BMS and make refinements during kick off meeting discussions. The kickoff meeting will be followed by introductory meetings with any other stakeholders deemed appropriate by BMS. The kickoff meeting will also provide an ideal opportunity to discuss desired changes or planned redesigns to the service array and rate setting methodologies. As part of the kickoff meeting Guidehouse also plans to initiate a formal data request to BMS, identifying the range of required and optional data elements to be used in the rate analysis, including specifications for Medicaid claims and other large data sets.

Task 2: Data Collection

Our primary tasks in rate analysis and development include the collection of rate setting information, the review and analysis of cost information, the development of conceptual rate models, and the creation of recommendations for rates. States may not regularly collect the full array of service delivery and financial data needed to develop a sound reimbursement methodology. In these cases, the task of rate setting requires development of a comprehensive provider cost and wage survey that can be used to determine rate adequacy and establish reimbursement levels sufficient to support high-quality services. On the other hand, many services already have well-established cost reporting standards and processes, especially for hospitals and NF. States may require residential treatment facilities (e.g., private residential treatment facilities [PRTFs]) or community providers to submit cost reports or standardized cost forms on a recurring basis based on audited financials. From the information gathered during the kickoff process, Guidehouse will determine the appropriate approach to collect data for each service and provider type.

Provider Cost and Wage Survey Design and Administration

Provider surveys are often the tool of choice to collect the necessary data required for rate development. Our team has developed and executed provider cost and wage surveys in dozens of



Proven Value Delivered to BMS

National Experience ♦ West Virginia-Specific Design.

Guidehouse brings an extensive library of cost surveys developed across multiple states to draw from. We will tailor survey content to reflect West Virginia's provider landscape, program priorities, and data needs, reducing development time while improving the relevance and quality of collected data.

states, including providers of behavioral health services, LTSS, and transportation. We understand what to do and what not to do to confirm success in survey execution. We propose to kick off this process with a collaborative discussion with BMS about service definitions to allow us to fully understand service requirements, activities, staff requirements, etc., for all services to be included in the survey, which will inform decisions about what data is necessary to collect. Based on this discussion, we will be prepared to develop a Provider Cost and Wage Survey and instructions, administer the survey, verify responses with providers and finally, conduct analyses of the survey data.

The large variety of services and providers may warrant creating simplified and customized surveys or distinct survey forms catered to the special nature of particular

services and to capture unique cost characteristics of the services. Where commonalities exist in service provision or costs, we would advise using a broader common template form survey to alleviate administrative burden or eliminate redundancies.

Normally, the data informing these assumptions can only come from asking providers, and this is likely the case for many services delivered in West Virginia, whose unique demographic and geographic features may contribute to costs that are significantly different than states dominated by large, metropolitan areas. Moreover, the cost of not asking the right questions is high, with an equal risk of under-reimbursing or over reimbursing providers and the impacts to the Medicaid budget.

Nonmedical Transportation is an example of a service for which states often value a separate survey for basic data collection on service models and alternatives, to understand how providers cover transportation, especially when multiple transportation options exist in an area. Although transportation possesses many of the same features as other services, staffing costs for the drivers, administration costs, vehicle and maintenance costs, rate setting for transportation often demands the development of cost assumptions for travel time and equipment use that are not comparable to other services.

As part of the survey administrative process, we will work with BMS to determine whether it is advisable to administer surveys to the entire community or to create representative, stratified samples of providers to complete the cost and wage survey. At minimum, “representativeness” should satisfy the following criteria for capturing the characteristics of West Virginia’s provider communities:

Figure 17. Minimum Provider Characteristic Criteria

 Diversity in Providers	 Diversity in Service Offerings	 Diversity in Geography	 Diversity in Client Resource Needs
Diversity in the size of providers will help us make sure that recommendations can be generalizable across provider agencies regardless of size or, when applicable, targeted to large or smaller providers who may incur distinct costs. Similarly, diversity in types of providers will help us ensure representation from both Tribal Health Organizations and other providers.	Providers that participate in the rate study, in the aggregate, offer services that span all service areas under review.	Geographic diversity helps representation across states whether in the more urban or rural regions of the state. The geographic distinctions may help capture common differences in the regions including the cost of transportation, the availability of a sufficient provider pool, the cost of living, and other components that impact the rates or rate setting process.	Providers that serve clients of varied needs will ensure that individuals with complex needs are also represented. Existing assessment or evaluation scales used by BMS to identify severity of client needs or behavioral conditions may be used as a frame of reference. This may also account for providers that serve clients of all age groups that have distinct challenges.

Provider Cost and Wage Survey Analysis

Once providers return completed surveys, Guidehouse will “scrub” the cost and wage data by conducting “outlier” and other reasonableness and completeness checks and follow-up with providers as necessary. Using our complete database of provider survey responses, we will analyze the results of the survey. After validating survey data and adjusting for our analysis, we will summarize the data and calculate the average parameter values needed to support or construct the service rates, by provider for each service code. We will calculate various statistical metrics, such as weighted and unweighted average, median, and outlier thresholds across all providers for each service category.

Additionally, to support consistent analyses across all submitted surveys, we may analyze and statistically adjust the survey data to make valid comparisons among different providers, participants, and services. For instance, we may use special functions for certain data features, including adjustments for unequal item weighting, unequal weight by entity (e.g., sampling weight), and stratifying data reported. For example, we can consider approaches to analyze data in the creation of statewide benchmarks based on true average, weighted average, and median values. Where weighted averages account for the influence of large providers on the marketplace, median values are more suitable in cases where there are wide swings in labor costs among providers. Provider survey data can also have missing responses. Depending on the proportion of responses for which values are missing and the intent of the analysis, we may either follow-up with providers for further clarification or choose to impute for missing values before using the data to derive insights for rate setting purposes.

Facility and Provider Cost Report

A significant part of setting rate development for many of the state plan provider types is cost reporting and analysis as state agencies work to implement reimbursement methodologies based on timely and meaningful provider cost data. Cost information is also valuable for rate setting activities for other providers such as hospitals and NF. Accurate Medicare and Medicaid hospital cost report data is invaluable to understanding provider characteristics, utilization, and reimbursement information on an annual basis.

We will draw from our experience working with a variety of private and public clients to design and execute provider cost reports for FQHCs, Rural Health Clinics, Certified Community Behavioral Health Centers (CCBHCs), hospitals, and other provider types. We have performed independent

reviews of Medicaid expenditures, policies, to provide reports on cost reporting practices and other issues, including cost surveys, hospital and nursing facility reimbursement, financial review, and utilization analysis; Medicaid expenditure trends; budget and forecasting process; administration of the Medicaid program; and data management.

Guidehouse also has conducted many projects requiring the analysis of large Medicaid paid claims datasets and cost reports for rate setting, payment accuracy, and litigation support. Part of our work has included using integrated provider Healthcare Cost Report Information System (HCRIS) cost data to estimate provider costs on an individual claim basis to enable calculating provider margins by service type. In addition, Guidehouse has extensive experience building Medicare claims data sets with SAS® including using a variety of files including HCRIS cost reports. Each of these activities are designed for one outcome. Guidehouse uses this facility information to determine the cost of providing Medicaid services for individual claims. As deemed applicable and necessary, we will conduct similar analysis in West Virginia.

We have also often used annual provider cost reports collected by states to analyze program support and administrative costs (e.g., supplies, transportation, agency operating costs, maintenance costs, etc.) for common HCBS waiver services including, but not limited to, residential homes, days, employment, and employment services. If BMS collects cost reports, we can analyze the data to assess how the information may assist in rate development.

Public and Proprietary Data Analysis

We know that provider-reported cost data does not always constitute the best benchmark for future rate setting, especially when the data results are influenced by deficiencies in the current system. Depressed reimbursement may contribute to lower reported wage costs than the true labor costs needed to sustain valuable long-term staff recruitment and retention. By contrast, higher reported wage costs may reflect service delivery inefficiencies that should not be enshrined in future rates. There are a few reasons why the rate development process should include additional sets of objectives, publicly reported data benchmarks from other industries in West Virginia, as well as peer states and nationwide indices.

We will make sure that the rate development process includes additional sets of objectives, publicly reported data benchmarks from other industries in West Virginia, as well as peer states and nationwide indices.

Claim and Encounter Data Analysis

Guidehouse's proposed team has significant experience working with MMIS for state Medicaid programs across the country. This experience includes working with the business processes associated with eligibility updates and usage, claims auditing and payment, encounter data and claims data processing and using that data for rate setting, pharmacy point of service processing, drug rebate processing, MCO enrollment processing and reporting, use of the Data Warehouse, surveillance/utilization review, fiscal management and federal reporting.

Our staff have assisted states and participated in work groups that have developed both the initial and changes to



Proven Claim and Encounter Analysis

Guidehouse has a wealth of experience analyzing Medicaid claims data. Every rate setting analysis that we perform requires us to develop detailed data requests and customized data analysis and reporting to support the analysis of millions of Medicaid claims records.

business requirements and design specifications, the testing of the MMIS with the initial configuration and changes to confirm compliance with business requirements and design specifications, the use the MMIS data warehouse for analytic purposes (using both corporate reports and ad hoc queries), and overall management of the MMIS contractually and operationally.

As part of our experience working with MMIS systems, we have in-depth knowledge of:

- Standard file layouts for institutional and non-institutional claims data on the header and line-item level.
- Appropriate ways to combine header and detail claims data for analytical purposes.
- Common pit falls of using MMIS data. For example, if there are multiple fields of units (i.e., reported units versus reimbursed units), assess which field is most appropriate for the desired analysis.
- Evaluating the completeness of available data. The existence of a particular field in an MMIS system does not mean, for example, that the field is consistently reported or that the MMIS system retains all of the information submitted by providers. Prior to using data from a state's MMIS system, our consultants review the values reported in the fields required for analysis and assess if the data provided is sufficient to perform the analysis appropriately.

Task 3: Research and Analysis Activities

Following project initiation, the project team will conduct additional data analysis as needed to obtain information related to the development of the rate methodologies. This task will run concurrently with gathering data from BMS and the service providers. Guidehouse will also facilitate a discussion with BMS that reviews each service to understand some key components critical to rate setting. During this discussion, we will also want to gather information regarding service requirements or definitions where there have been issues raised by providers or BMS staff, or by CMS as part of the regulatory process.

The sections below outline the analysis that will be conducted with the data gathered in Task 2 as well as additional resources that will support the rate development process. We will present the results of our research and any recommendations as part of our presentation of rate models. We will also advise and discuss with BMS any research and findings during our periodic status meetings, so we can determine if any follow-up work is needed prior to modeling the rates.

Task 4: Stakeholder Engagement

For HCBS and other community-based services, Guidehouse recommends developing at least one Rate Workgroup that would serve as an advisory group for each service category to tailor discussions to the populations served by the providers. There may be alternative ways of classifying Rate Workgroups based on specific groups of services and targeted populations across service categories. For examples, the LTSS service category can be divided into distinct groups for services provided to aged and disabled, intellectual and / or developmental disability, mental illness populations across all waivers, state plans, and institutional services. For consumer-directed services in all applicable service categories, we propose a distinct group to allow a customized process to collect data and set rates that may vary from provider agency-managed services. We are aware that consumer-directed services are typically managed by fiscal management provider intermediaries or agencies that serve as a liaison between the state and the clients, and the

approach to gathering information on this service will differ from the other services depending on the existing policies, systems, and processes within the State.

Focus Groups and Other Advisory Groups

Beyond the Rate Workgroups, Guidehouse suggests conducting focus groups with workers, members and their families, and advocacy communities. Guidehouse will further discuss with BMS to determine whether, how, and when to engage these communities in the rate study work. Depending on need, we may also recommend up to two Public Comment sessions that can serve as a capstone to the formal sessions that would allow all stakeholders, including government representatives, an opportunity to express thoughts, ideas and concerns about the finalized and recommended rates, and rate study findings and recommendations. We also suggest conducting public comment sessions at the end of a rate study, and prior to proceeding with legislative funding requests or implementation actions.

Contingent on BMS's interest, we can work with the State to organize the meetings, post agendas, and send out invites to engage one or more of the proposed advisory group(s).

Task 5: Rate Modeling and Fiscal Impact Analysis

Guidehouse will leverage data collected and analyzed to support the development of the draft rate models for each of service. We will work with BMS to discuss rate methodology options and potential changes from the current methodology. Once we have initial decisions regarding the rate model input options, we will develop draft rate models to review with BMS. Once our team has developed the draft rate models, we will facilitate a discussion with BMS to discuss data inputs, model formulas, and options available to BMS to develop the rates within the proposed construct. These models will vary depending on the desired rate methodology approach approved by BMS. We will review the draft rate models and input value options with BMS in detail to determine whether the resulting rates are reasonable. The sections below highlight methodologies and examples associated with the modeling of rates for common service categories.

5.1. Behavioral Health Rate Modeling

We have experience with designing and implementing adult and children residential treatment facilities including PRTF cost reports, creating rate methodologies and calculating rates (e.g., per diem rates) for both in state and out of state facilities, and interpreting Federal and state guidance and regulations. Our cost reports provide a structured framework for capturing the cost of PRTF services, including direct patient care, facility operations, and administrative overhead. This enables the State to allocate resources effectively and implement reimbursement policies that reflect the unique needs of populations served. Furthermore, our cost reporting methodology serves as a mechanism for promoting transparency, accountability, and regulatory compliance. By accurately documenting costs, the State can evaluate the costs of services and advocate for policies and appropriations that support continued access to essential adult and youth psychiatric services. For instance, PRTF costs present several unique challenges due to the specialized nature of the facilities and the complexities inherent in their operations such as fluctuating patient census, varying lengths of stay, and specialized treatment modalities for youth with a variety of acuity levels. Another unique challenge is that most PRTFs operate schools to continue youth education. In-house education costs are not reimbursable by Medicaid and need to be separated from PRTF allowable costs. When analyzing PRTF costs, we pay special attention to the data to allocate costs appropriately among direct patient care expenses, indirect overhead costs, and nonallowable costs

(such as education-related costs). This involves utilizing standardized methodologies for cost allocation and adhering to state specific policies and guidelines for cost reporting and rate setting.

Provider cost and wage surveys combined with public benchmarks can be leveraged to create independent rate build ups for community behavioral health services. We are sensitive to behavioral health services potentially requiring specific licensure requirements for staff, decreased billable time adjusters to account for additional charting, high prevalence of no shows and the combination of extensive travel when the service takes place in the community. In addition, many behavioral health services require team-based structures that demand additional considerations related to cost when developing rates. It is important to not only utilize provider costs because they are reflective of the current system that supports wages dependent on the rates. As an example, mental health-related services require varying licensure levels to provide services, individuals with these licensure levels are challenging to recruit and retain which has resulted in larger-than-average increases in salaries. These same specifics need to be considered when evaluating Applied Behavior Analysis, with an even larger emphasis on the costs needed to retain and recruit staff in a labor category where this specialty is challenging to find.

We use a similar rate development method for Certified CCBHCs, in which we provide specific guidance to providers around accounting for direct costs and allocating indirect costs. For CCBHCs, we also perform a detailed review of visits, particularly for states transitioning to this provider type, as the prospective rate requires a per day or per month accounting of encounters that many FFS providers have not previously used.

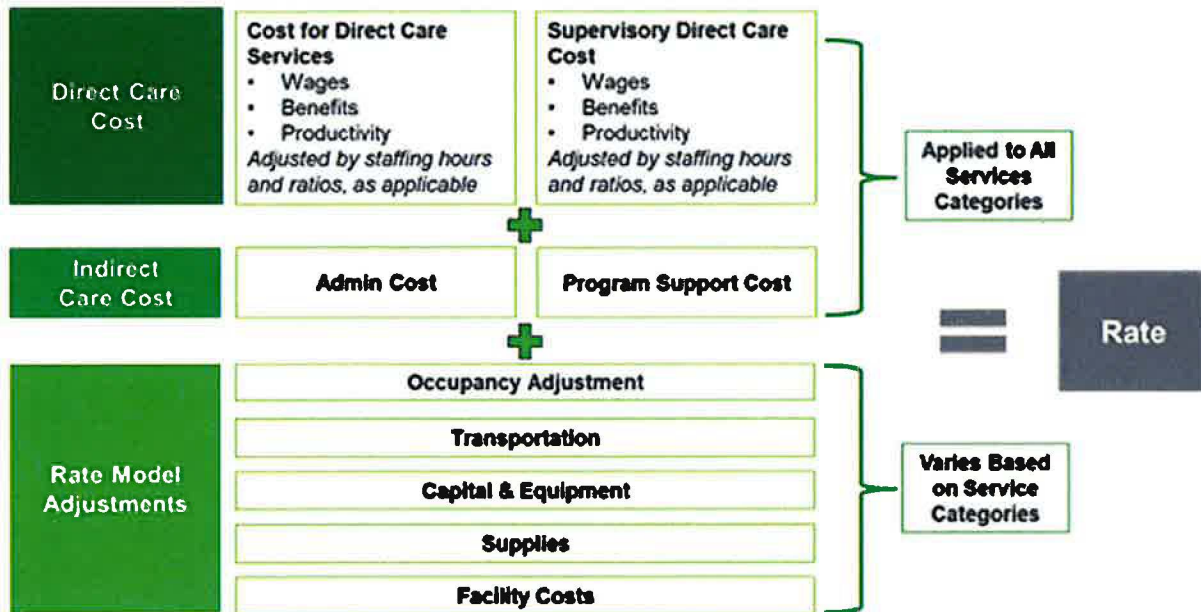
Crisis stabilization and programs are critical services in the behavioral healthcare continuum. We not only have the experience to incorporate the appropriate cost components to build rates, but we are also cognizant of relevant policies and procedures such as SAMHSA's crisis guidelines. It is important that crisis services are built to address the needs of diverse populations. We will work with the state to understand the best structure to your crisis program and can provide thoughtful contributions related to the interaction of less than 24-hour services, 24-hour overnight crisis program and the intersection of mobile crisis if desired.

In addition to costs, Guidehouse always reviews revenue and is familiar with major sources of Federal, state, and other funds that make up revenues. Examples of types of revenues we commonly see on general ledgers and cost reports are Medical Assistance – Title XIX, Foster Care IV-E, State and county general funds, USDA National School Lunch Program, and Public-School funds. These revenue sources are important to consider and incorporate into rate setting to avoid duplication of funds for services.

5.2. LTSS Rate Modeling

An independent rate build-up approach is commonly used by states to develop rates for HCBS services such as personal care, respite, adult day health, employment support, residential habilitation and community integration. Guidehouse has a customizable approach to rate development where we categorize the data from the cost surveys to develop statewide standardized benchmarks for various wage categories. These benchmarks include the weighted and unweighted mean and median values, with and without outliers or other statistical metrics related to the reported data along with administrative, program and other support costs. For services that require tiers based on level-of-care, geographic differences or other variables, our team can provide statistical approaches to support these various levels and determining their costs.

Figure 18. Rate Model for Independent Rate Build-Up Approach



This figure provides a general outline of an independent rate build-up model. The rate starts as a cost build-up model, based on direct care costs that include staff compensation which is adjusted by productivity where applicable. The model then adds indirect costs, such as administrative overhead and general program support costs. Other types of costs, such as transportation or capital and equipment costs, will vary depending on the specific characteristics of each service.

Rate modeling based on provider-reported cost assumptions may not always be advisable or feasible, and we will work with BMS to provide defensible, alternative benchmarks in cases where providers' historical cost data, are out of date due to accelerated wage growth for direct care staff, anticipated changes in minimum wage laws, or where service redesign and policy priorities may warrant resource use assumptions dictated by factors other than the historical costs of providing a service. We have assisted multiple state clients with factoring the effects of minimum wage and downstream solutions into our rate models to address wage compression that occurs for more experienced staff and managers.

5.3. FQHCs Rate Modeling

When setting encounter-based rates for FQHCs, our primary tasks include analysis of cost reports to capture relevant cost and utilization data, supporting providers to complete the cost reports, collecting, reviewing, and analyzing the cost information, developing a rate model, and calculating rate recommendations. Guidehouse has extensive experience working with cost data and we have designed and executed many providers cost reports. Our experience in developing and implementing cost reports for state clients allows us to gather information quickly and accurately to review cost reports and data requests that capture relevant cost and utilization data. The information we gain in these cost reports allows us to examine the costs of services and develop of provider rates. The majority of FQHC services have similar cost profiles that are driven largely by staff compensation costs, with only minor differences in the types of costs to be collected to model the encounter rate. While some FQHCs might offer additional services, such as dental care, it is typically feasible to develop a one-size-fits-all cost report that can be distributed to every provider

without unnecessary complication in survey questions or responses. At the State's discretion, these cost reports can typically be used to accommodate future FQHC rate evaluation requests due to changes in scope of service.

For the cost reports that we develop and review, Guidehouse has multiple methods to confirm that information is correct, valid, comparable, and reasonable. One method is to compare the cost report data against publicly available FQHC cost data. For example, CMS publishes FQHC cost data quarterly through the HCRIS Dataset – Freestanding FQHC's. A second method is to request "as settled" CMS FQHC cost reports from Medicare intermediaries and / or directly from the facilities. In West Virginia, we will consider these methods help to validate the information that providers may report in cost surveys and confirm that the reported costs are reasonable.

5.4. Nursing Facilities

Among the fundamental decisions to make when designing a per diem-based NF payment method is whether the per diems will be facility-specific or standardized across facilities, as well as the extent to which rates will be individualized to a facility's residents. Generally, when using facility-specific rates, the rates are calculated based on facility-specific costs. In addition, facility-specific rates are generally determined prepayment-based on costs submitted in historical cost reports and then adjusted post payment after cost reports have been submitted and audited for the timeframe the services were rendered.

Along with the standard cost calculations to derive facility-specific direct and non-direct care base rates, Guidehouse will conduct an analysis of payment-to-cost coverage. We will compare anticipated rates to the average cost per day adjusted for a facility's Medicaid Case-Mix Index adjusted for cost growth. For each NF, we will analyze the rates separately, to calculate payment-to-cost ratios. For each facility, we will also multiply estimated rates described above for each year by the NF's adjusted Medicaid days to estimate total payments. We will multiply each NF's average cost per day, adjusted for the facility's Medicaid CMI and adjusted for cost growth) by the facility's adjusted Medicaid days to estimate total costs. We will also use the total payments and total costs to calculate weighted average payment-to-cost ratios.

In many states, facilities are classified into various peer groupings and are subject to different reimbursement ceilings or other limitations, both to reduce and contain cost variation among facilities and to promote specific program goals. Depending on the groupings preferred by the BMS, we may group NF and analyze costs into one of four quartiles based on the facility's resulting payment-to-cost ratio for purposes of further analysis. NF with the highest payment-to-cost ratios will be categorized into Quartile one, while those with the lowest payment-to-cost ratios will be categorized into Quartile four. We will then analyze some of the common characteristics of the NF in the aggregate and for each Quartile, including:

- **Facility Occupancy Rates.** This statistic is generally indicative of whether the rate setting system appropriately "rewards" facilities with higher occupancies, understanding that the payment system is designed, in part, to reward higher occupancy. Higher occupancy may be indicative of efficiency, although we also understand that there are many other factors beyond occupancy that should be considered when efficiency in the delivery of care.
- **Medicaid Percentage.** This statistic is generally indicative of whether the rate setting system appropriately "rewards" facilities with higher Medicaid percentages.

- *Cost Per Day Values.* This statistic is generally indicative of whether the rate setting system appropriately “rewards” facilities with lower CMI-adjusted cost per day values, which may be another indicator of relative efficiency.
- *Pay-to-Cost Ratios.* We will also analyze the aggregate pay-to-cost ratios by Quartile, and the number of facilities with pay-to-cost ratios, that exceed 100%.

Guidehouse is conversant with all of the major techniques for reimbursing provider capital costs, and we can serve as a trusted collaborator in advising BMS on the merits of one approach over another. We have frequently assisted Medicaid agencies in surveying other states to determine leading methodologies for reimbursing NF capital costs, as well as subtle differences in the “Fair Rental Value System” (FRVS) or traditional cost accounting methods used in various states. Calculation of the fair property value for this per diem component can be performed in a variety of ways including appraised property values, value of capitalized tangible assets, and estimate of construction costs.

5.5. Professional Services Rate Modeling

Guidehouse has worked with several states in the past to develop and implement Resource-Based Relative Value Scale (RBRVS) systems for their Medicaid programs. We frequently have used relative value principles in calculating and operationalizing physician UPL supplemental payment programs as well. Although the Medicare Physician Fee Schedule and its RVU-based approach establishes a strong methodological standard for other public and commercial insurance programs, we understand from our work with state Medicaid as well as Workers’ Compensation programs that the populations these programs serve have their own needs and access challenges distinct from Medicare priorities. Our detailed understanding of RBRVS mechanics, give us the expertise to develop insightful recommendations for adjusting fee schedules to better support services and providers of particular importance to Medicaid, including primary care and OBGYN physicians. We are well positioned to extend our experiences from other states and work with BMS to set rates for Professional Services.

Fiscal Impact Analysis

Following final decisions on the rate models and model inputs, we will conduct fiscal simulation modeling that will allow us to understand the fiscal impacts of the changes to consumers and their individual budgets, the providers, and the State. The project team will conduct a fiscal impact calculation for the proposed rate changes resulting from the rate models at both the provider and state level. We will discuss the results with BMS identifying any potential budget neutrality issues associated with the proposed rate changes.

Although our approach to rate development is based on cost, as it is in most Medicaid rate setting, we understand that there are a wide range of factors other than cost-adequacy that must be considered to implement a viable, sustainable rate structure. This is especially true when working within the rules of a Waiver authority. Aside from the “budget neutrality” requirements specific to Medicaid waivers, state budgets need to keep overall waiver expenditures flat, or to modify rates equitably based on still-undetermined legislative appropriation. We frequently hear these concerns in our engagements, and West Virginia can be confident that Guidehouse is able to call on a wide range of solutions for addressing the resource needs of providers, even under strict budget constraints. Standard in our analysis of fiscal impact is an analysis of impacts on specific providers and provider interest groups. We understand that even when rates are “generally” adequate, or good for providers “on average,” that there may be crucial service lines, geographic areas, or

provider types where access to services may be under threat, prompting an additional review of the rate recommendations and a keener understanding of potential rate impacts on existing provider networks.

Task 6: Actuarial Analysis and Acuity Adjustment

Guidehouse's actuaries provide assistance to our state clients year-round to provide actuarially sound rates and produce regular and ad hoc actuarial analyses. For example, we are often called on by our state clients to produce financial impact estimates of proposed legislative changes, often within compressed timeframes. In all our work, we adhere to evolving CMS guidelines, Federal and state regulations, and applicable actuarial standards and practices. The result of this commitment to excellence is showcased by the fact that CMS has never rejected any of our many actuarial certifications. In fact, our actuarial team has a history of reviewing and/or correcting other actuarial firms' assumptions and rates.

Our actuaries have a long history of expertise in this area with multiple risk adjustment software packages and procedures, having assisted states in (a) performing annual (or more frequent) risk adjustment calculations and preparing documentation to support the premium adjustment calculations, (b) initiating new risk adjustment processes to Medicaid programs that were not being risk adjusted prior, which often involves assisting states in selecting risk adjustment options that best meet the needs and goals of their program, transparency preferences, etc., (c) performing regular reviews of existing risk adjustment processes to reestablish their appropriateness and making changes as needed, and (d) developing new 'risk adjustment' processes to aid State objectives. An example of the last item is that in Tennessee, our actuaries developed a method of performing a 'site of service' adjustment to effectively 'risk adjust' their blended Nursing Facility / HCBS rates in its LTSS program.

We are also knowledgeable when it comes to the different approaches for tying assessment data to reimbursement. Our project team has worked on every phase of this rate adjustment process, from advising states on the most appropriate assessment instrument to adopt for their needs, to measuring reliability for using the assessment, to conducting time studies to understand the correlation between assessment score and resource use, to developing tiering frameworks to translate differences in scores into appropriate variances in reimbursement level. We have worked with Illinois and South Dakota to use the Inventory for Client and Agency Planning tool as part of setting residential service rates. In Virginia, we have worked with Mayo-Portland Adaptability Inventory for tiering service rates for brain injury populations. For NF, Guidehouse would consider a variety of system options, comparing recent Federal movement to newer data collection and grouper classification variations; older federally driven options which most commonly includes the resource utilization groups-based systems used in many states, or a modified version of status quo in West Virginia. Our experience in states like Illinois shows where multiple tools have been adopted to the broader assessment processes, and how potential weaknesses in one tool can be supplemented with strengths in another tool to enhance reimbursement. We are also constantly monitoring CMS guidelines related creating standardized assessment tools to align with national efforts to create exchangeable data across Medicare and Medicaid programs.

Depending on BMS's current assessment framework and intention to incorporate acuity-based adjustments, we will be available to suggest additional analyses of the assessment data that may be of interest to the State. We will work to analyze current assessment data to group populations into appropriate rate tiers to project the expected utilization and fiscal impact of updated rates for each tier.

Task 7: Final Recommendations

Based on the rate study process and results, Guidehouse will identify rate recommendations and policy considerations highlighted for BMS to consider as it navigates the adoption and implementation of our proposed benchmark rates for the programs under review. Contingent on BMS's requirements, we will offer recommendations related to service rate structures, individual service rates, service arrays, and implementation considerations. We will review service coding and billing rules, especially considering significant changes to service design, as well as changes to service authorizations or budget ceilings required by changes in service definition or rate modifications, as part of our rate recommendations. In response to the request in the RFP to allow for regular reviews, maintenance, and updates to reflect changes in costs, Guidehouse will also offer considerations for a regular process of administrative rate reviews indexed to inflation or other economic indicators. We will consult with BMS on the need for these recommendations and will be able to identify potential options if desired. Guidehouse will also consider input provided by stakeholders throughout the rate development process in arriving at these recommendations for BMS. Guidehouse can offer guidance with prioritization of our rate and policy recommendations for implementation to help steer investments by BMS in the most sensible, efficient, and quality-oriented manner as possible.

Task 8: Final Report

The Guidehouse team has extensive experience developing comprehensive reports for submission to different branches of state government, including state Legislatures and Governor's Offices. We understand that our rate study reports will potentially be viewed by BMS's upper-level administration, legislative officials, and executive staff. At BMS request, we will prepare a draft final report outline for review and approval by BMS. We will work to follow BMS's format for similar reports that have previously been submitted to governmental stakeholders and the wider public. A high-level outline of the final report may include an executive summary, background information on the purpose and goals of the rate study, methodology and findings, rate model recommendations, fiscal impact analysis, summary of stakeholder engagement process, and other conclusions and recommendations. After the outline is approved by BMS, we will draft the entire report, relying on the many documents that we have developed along the way to memorialize the rate setting process, decisions, and final recommendations. We will submit a draft report with BMS and ask for comments and feedback. We will prepare and deliver the final report and appendices, incorporating BMS feedback.

Task 9: Implementation and Post implementation Technical Support

After delivery of the final report, we will collaborate with BMS to provide active technical assistance and ongoing support. We understand that the rate development process also requires more responsive and interactive forms of communication and coordination with the stakeholders needed for successful implementation. Guidehouse will collaborate with BMS in developing implementation plans and auxiliary analyses of rate impacts for key stakeholders including CMS, as a part of the implementation process. In Task 4, we propose public comment meetings that can also be conducted as part of the implementation phase. We will be available to present recommendations and answer stakeholder questions. Examples of technical support activities:

- *Application Amendments.* To effectuate changes resulting from the rate study the state must comply with all state and federal reporting requirements. We can apply our experiences in rate setting for state plans, waivers, and institutional services across the

country to work closely with BMS to track and respond to formal and informal public comments, draft clear and responsive language for state and federal documentation and applications. For example, we can assist the State with drafting waiver amendment language for Appendices I and J for 1915(c) waivers, field questions from CMS, and anticipate the level of documentation needed to secure waiver approval. Similarly, we can work with BMS to draft SPA for PRTF and other services in scope. After the updated applications are approved by CMS, BMS will develop fee schedules that will include a complete listing of fees for individual services that can be published and used for reimbursing providers and Tribal Health Organizations.

- **Billing Validations and Trainings.** Changes in the rates will require updated billing processes including existing regulations. The changes may also have impacts on providers' claims practices and monitoring processes internal to BMS. We will advise BMS on revisiting billing validation processes including prepayment and post payment reviews that are designed to make sure providers' billing for waiver services meets essential tests to maintain program and financial accountability. Lastly, training in billing requirements and recommended practices for newly structured services may benefit BMS staff, providers, and West Virginia contractors serve as reference material. We will work with BMS to identify other topics that can be considered for training.

Select Detailed Rate Setting Methodologies

Following is a detailed discussion of Guidehouse rate setting approach for Hospitals and then for Skilled Nursing Facilities/ICFs. These two example provider types highlight Guidehouse' experience and knowledge in setting rates and some of the applicable considerations.

Hospital Rate Setting

Guidehouse has extensive experience working with multiple states in the conceptualization and development of hospital rate setting methodologies for a variety of state plan institutional programs for both an FFS and managed care environment.



Proven Medicaid Hospital Rate-Setting Expertise

Guidehouse has significant experience in the design, development, implementation and evaluation of FFS prospective payment systems and rate setting for Medicaid hospital programs in the States of **Wisconsin, Illinois, Nebraska, Virginia, and Wyoming.**

For all of these engagements, we have assisted our clients with the conceptual design process and selection of appropriate models, analyzed cost and claims data, developed cost estimates, performed rate and other rate component calculations, developed comprehensive payment simulation models, conducted coding validation and assisted with policy development. Our transparent approach to rate development means that we work closely with our clients to present the impact that policy decisions have on proposed rates. Through discussions and deeper analysis, we can align rates to what our experts and our client's experts consider appropriate for the population.

As part of our work in the a forementioned projects, we evaluated and provided assistance to states to confirm that rates are appropriate for the populations covered and that the rates are appropriate for the services furnished by these hospitals. As a starting point, the Solventum relative All Patient Refined Diagnosis Related Group (APR-DRG) weights used for inpatient services are national

standards from studies designed to demonstrate that the weights are based on the relative resource utilization. Also, during our payment simulation model process, we:

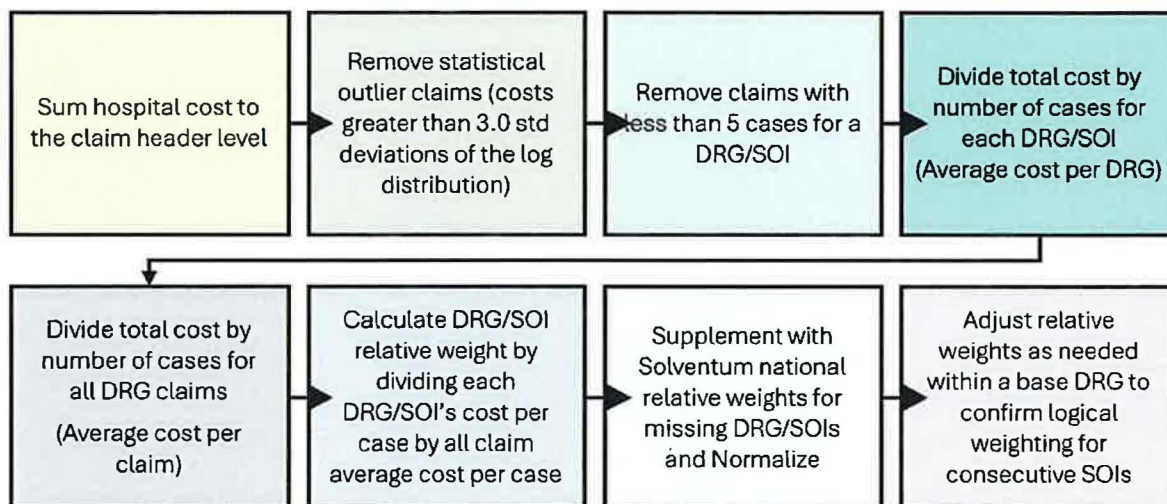
1. **Develop analysis by service line.** To identify how the proposed methodology affects hospitals within services lines where Medicaid represents a significant proportion of the total market. These service lines typically include:
 - a. Behavioral health
 - b. Normal newborn services
 - c. Neonatal services
 - d. Obstetrical service
 - e. Pediatric services
 - f. Psychiatric services
2. **Prepare analysis by hospital, hospital system, and by individual MCOs, if applicable.** This process allows the State to assess if payment levels support hospitals and other providers appropriately across the state.
3. **Apply service.** Specific policy adjustments, if necessary, to base rates and / or per diem rates. This process allows the State to fulfill its policy objectives related to certain populations.
4. **Formulate analysis of cost coverage.** This will include cost coverage with and without supplemental payments. While Federal rules under Section 1902(a)(30)(A) of the Social Security Act require State to set rates to be "consistent with efficiency, economy, and quality of care", there is no requirement for reimbursing all providers at cost, we want to establish reasonable reimbursement that will align with the Federal requirement of providing access. Cost coverage models also allow our state clients to respond to queries from hospitals and state legislators regarding the appropriate level of reimbursement of services.

Guidehouse is positioned to meet the needs required by having assisted with the development, implementation, and periodic updates of APR–DRG and Enhanced Ambulatory Patient Group (EAPG) pricing methods for many state Medicaid agencies. Guidehouse has various staff members that are knowledgeable with APR–DRG and EAPG grouper schedules and settings that allow them to effectively communicate changes and the impacts of grouper changes. Guidehouse staff work with fiscal agents and software developers to assist states through implementation in their MMIS. We also have a direct relationship with Solventum whereby we provide assistance in establishing grouping and pricing software solutions that comply with state reimbursement policies.

As an example, Guidehouse assists **Wyoming Medicaid** with updates to its EAPG outpatient reimbursement program. We then collaborate with Solventum to create pricing schedules and confirm settings within their standalone grouping software (for example claim edits specific to outpatient reimbursement of Wyoming critical access hospitals) to confirm that the software correctly prices outpatient claims. Along with our support work for **Wyoming Medicaid**, we have assisted with MMIS implementation of payment method changes in **Virginia** as well as supporting these states with their periodic hospital rebasing efforts.

For Virginia Medicaid, Guidehouse was tasked with developing state – specific APR–DRG weights. This task required identification of eligible claims (outliers excluded from rate setting based on a statistical formula), the average cost per DRG, and the average cost for all claims.

Figure 19. State Specific DRG Weight Development Process



Hospital Rate Setting Approach

As an initial step in any hospital rate setting engagement, Guidehouse will review the State’s current inpatient payment parameter requirements, as approved in the State Plan, with our understanding of the rate calculation as follows:

- Most recently available DRG grouper, updated on an annual basis.
- Solventum national relative weights normalized for consistency to historical West Virginia experience.
- Standardized DRG base rates, with adjustments for wage index, labor portion, and GME costs.
- High-cost outlier payments, with fixed-loss threshold and marginal cost factor differentiated by provider type.
- Policy adjusters to increase payments for certain populations, providers, and / or services to align with the policy goals of the State.

West Virginia Medicaid’s inpatient rates may require the development of per diem rates as well as DRG rates. Proposed steps for updating the current inpatient DRG payment system are described in the following subtasks:

1. **Project initiation and planning.** Meet with State staff to confirm the inpatient rate setting project scope and confirm the timing of the various tasks.
2. **Prepare inpatient hospital paid claims data set.** Develop an analytical dataset for inpatient analyses and modeling, based on the three most recent years of complete and fully adjudicated Medicaid inpatient paid claims data. Building this dataset involves downloading inpatient data to the Guidehouse server, “scrubbing” the data (i.e., removing duplicate records, assigning DRG classifications to claims and identifying whether claims

are paid under the DRG payment system or are DRG-exempt). This will also include data validation steps to compare the three-year dataset to historical data trends to validate that the dataset is complete, and the data provided is accurate. Control totals and claims experience trending will be provided to the State in these initial stages of preparing the claims dataset. This initial step to prepare and validate the paid claims data is necessary before moving forward in our analysis and will require agreement from BMS that the data are complete.

3. **Extract Medicare cost report data from HCRIS data set.** Extract from the CMS HCRIS dataset the most recently available Medicare cost report for each West Virginia Medicaid hospital for the following calculations:
 - a. Calculate, for each cost center for each hospital, per diems for routine cost centers and cost-to-charge ratios (CCRs) for ancillary cost centers and organ acquisition cost centers. The CCRs will be “fully loaded,” including overhead costs, operating costs, capital costs and direct medical education costs.
 - b. Calculate, for each hospital, the capital cost portion percentage, based on the ratio of total capital costs to total allowed costs.
 - c. Calculate for each hospital the direct medical education cost portion percentage, based on the ratio of total direct medical education costs to total allowed costs.
 - d. Calculate Cost Grouped CCRs and Cost Grouped per diems that group together like-cost centers, such as Cost Centers 66, 67, and 68 (physical therapy, occupational therapy, and speech pathology). These cost groups create a level comparison between providers because some providers will designate only one of these cost centers on their Cost Report to represent multiple types of services.
4. **Calculate Medicaid claim costs, including operating, capital and direct medical education.** Calculate the cost of each Medicaid paid claim in the analytical dataset using a detailed approach based on Medicare’s detailed cost apportionment methodology. To estimate the costs of each claim detail line we will multiply either the days for each revenue code by the appropriate routine cost center or the charges for each revenue code by the appropriate, ancillary, or organ acquisition CCRs using a statewide standardized crosswalk that is based on Medicare crosswalk methodology. We will then calculate separately for each claim the operating cost, capital cost and direct medical education cost components.
5. **Obtain Medicare rate data.** Obtain various Medicare rate components from the CMS website and the Federal Register, including:
 - a. West Virginia hospital wage index factors, per the CMS Final Occupational Mix Factor by Provider file. Out of State providers receive the wage index factor directly from the file. For non– inpatient prospective payment system hospitals, such as children’s providers, use an average wage index, weighted by payment percentage, of all hospitals in the county where the hospital is physically located.
 - b. Base rate labor portion percentages.
 - c. Provider Cost-to-Charge Ratios, per the Public Use Provider File. For non– inpatient prospective payment system hospitals, use an aggregate calculation of Medicaid costs divided by Medicaid charges.

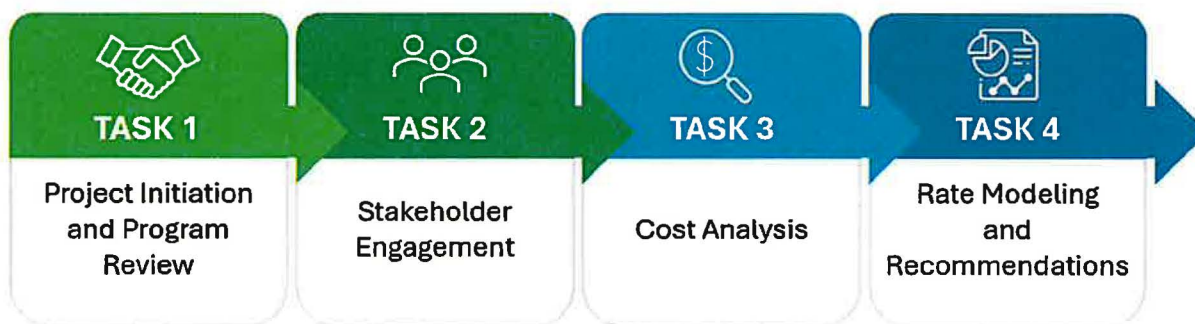
6. **Determine relative weights.** In other states, we have seen individual relative weights vary overtime due to changes in resource utilization within the DRGs while typically remaining relatively stable overall. We often recommend the inclusion of a normalization factor to prevent a large change in payments instead of a large rate change. In such cases, we calculate a normalization factor for DRG relative weights using one year of inpatient hospital paid claims data as follows:
 - a. Calculate the case-mix (average weight) of the DRG version from the prior rate year for this set of claims experience.
 - b. Calculate the case-mix of the DRG version from the upcoming rate year for the same set of claims experience.
 - c. Divide the older case-mix by the new unadjusted case-mix to determine an initial normalization factor.
 - d. Review and analyze anomalies and incongruities in the resulting weights in the light of the prior year's weights.
 - e. Discuss with the agency the proposed normalization factor to apply to the relative weights based on the outcome review.
 - f. Apply weight normalization factor to all DRGs.
7. **Calculate DRG base rates – general acute hospitals.** We calculate DRG base rates for general acute hospitals (excluding Critical Access Hospitals) as follows:
 - a. Determine the “statewide base rate” using an inflation factor based on the inpatient prospective payment system Hospital CMS Market Basket cost factor to inflate the prior year’s base rate forward one year.
 - b. Adjust the labor portion of the standard DRG group rate for hospital wage index. Wage indices will be based on hospital wage data published by CMS. For hospitals not published in the public use file, wage indices will be based on a weighted average of other wage indices in the same geographic county as each nonpublished provider. The weighted average will be based on average payments.
 - c. Calculate capital cost rate components based on the average Medicaid capital cost per discharge using one year of inpatient claims data, adjusted for case-mix. Determine the capital cost portion of total Medicaid costs by applying the capital cost portion percentage, capped at eight percent. Inflate the adjusted capital costs to the rate year based on changes in CMS input price index levels.
 - d. Calculate direct medical education rate components based on the average Medicaid direct medical education cost per discharge using one year of inpatient claims data, adjusted for case-mix. Determine the direct medical education cost portion of total Medicaid costs by applying the direct medical education cost portion percentage. Inflate adjusted direct medical education costs to the rate year based on changes in CMS market basket price index levels.

8. **Calculate DRG base rates – critical access hospitals.** Guidehouse calculates DRG base rates for CAHs as follows:
 - a. Using one year of CAH inpatient claims data, summarized by CAH Medicaid inflated allowable costs for each provider-based on the prior detail costing methodology.
 - b. Calculate a CCR for each provider by dividing the total costs by the total claim charges.
 - c. Back into a base rate for each provider that will result in the total estimated payments equaling cost, including base and outlier payments using simulated SAS models to determine the base rate to the nearest cent.
9. **Validate all hospital rates.** All hospital rates will go through at least two additional levels of review prior to presentation to BMS.
 - a. Use prior year exhibits for comparison to determine whether new rates pass a reasonability test
 - b. Provide detailed explanation for all rate changes
10. **Prepare summary report documenting the system development process.** Develop a summary report that documents the State's rebased DRG payment system and assist with Federal approval.

Long-Term Care Institutional Rate Setting

Guidehouse's approach to long-term care rate setting depends on the setting (skilled nursing facility vs. ICF) as well as which grouper system or other acuity-adjustment framework has been implemented by the State. Generalizing from these setting-specific variations in rate methodology, our approach follows a standard outline, with project work plans and deliverables are organized across four broad tasks. These tasks are:

Figure 21. Project Work Plan and Deliverable Tasks



Task 1: Project Initiation and Program Review

Task 1 includes the fundamental tasks related to project initiation, finalization of work plan and project communication protocols, and the development of the cost, acuity, and quality data for later analysis. This dataset is used for cost analysis and financial modeling across all nursing facility providers covered under this task order. Task 1 tasks are described in detail below.

- **Project Initiation.** In this task we commence project initiation and finalize the project work plan. We form protocols for establishing regular progress reports and provide analytical tools used during the project. At project initiation we work with BMS to refine and finalize

the project work plan, project timeline, and deliverables described in our proposal. The final project work plan provides our client with a concise overview and describe the expected process for the project.

- **Program Review.** We familiarize ourselves with the details of the State's current program, including an in-depth review of reimbursement methodology and participating providers. Guidehouse uses the review to identify recent reimbursement trends along with any specific financial or quality concerns of the client. Our Program Review focuses on system features such as overall patterns of expenditure and identification of all per diem payment components. Guidehouse examines any current reimbursement ceilings, targets, or other limitations, as well as rate add-ons, property components, and the role of quality assessments in reimbursement.
- **Data Collection.** This section describes the data that Guidehouse obtains from the State Agency and from other outside sources, for the purpose of reimbursement evaluation.

We summarize below many of the data types we find useful for analysis and rate evaluation. We describe, by type of data, how that data generally will be used to support Guidehouse's analyses and reporting.

- *Cost Report Data (and Other Proxy Cost Data), Rate Calculation Models and Rate Tables.* Generally, these data will be used to determine the costs of services being provided and make comparisons to those services to the rates being paid for services. Note that these data must also be considered in conjunction with case-mix and service level information, and indices used to inflate costs from the reporting periods to the time period for which rates are being evaluated and analyzed.
- *Case-Mix Data.* We use case-mix data to help us understand changes in client acuity overtime, which will be a component of our comparisons of costs and rates described above. We will use case-mix data to help apportion total facility costs to Medicaid clients.
- *Inflation Data.* Consumer Price Index data published by CMS for West Virginia are used to inflate historical cost (or proxy cost) of providing services to the SFY for which rates are being evaluated.
- *Provider Capacity and Utilization Data.* Provider capacity and utilization data, which include the number of providers of services, licensed bed capacity, total provider utilization, Medicaid utilization, occupancy metrics, facility closure information, and provider Medicaid contracting status, are used to analyze trends in access to care. These data are used to understand trends in unused capacity, changes in provider capacity overtime and the use of such capacity by clients eligible for Medicaid services.
- *Provider Location Data:* If access to care proves to be a significant quality or rate adequacy concern, we can use provider location data as part of our analyses. With the provider capacity and utilization data described above, we use location data to understand unused capacity, and the use of capacity by Medicaid clients on a regional or county basis. We use location data to prepare maps that graphically show provider capacity and utilization at the county level.

- *Citations, Inspections, Certifications, and De-Certifications.* We use these data to help us better understand trends in the quality of care being provided by nursing facility providers.
- **Requirements Gathering.** A key task in inaugurating the rate evaluation and design process will be to understand in detail the current needs of BMS and its long-term care providers and consumers. This entails the identification of any potential changes in scope for the population whose care is reimbursed under the current system, rate components requiring adjustment or other modification, or the development of additional policies or rate augmentations.

When updating or designing a new payment method, one of the decision points to consider is whether or not there are specific providers, recipients, or services that are sufficiently unique to merit exclusion from the proposed payment method. If so, they can be carved out of the method and either given another payment method or held under their current payment method. Carving providers, recipients, and / or services out of the payment method can increase overall complexity for the State but may be worthwhile to provide access to healthcare services.

In contrast to hospital services, the nature of long-term care services provided to long-stay Medicaid recipients on a daily basis is relatively homogeneous. However, there are some facilities that provide specialty care, such as those who service children, or veterans, or populations with unique care needs, such as those with severe behavior challenges or traumatic injury. Guidehouse will work with BMS to review these specialty care needs and determine whether current reimbursement policy adequately addresses the cost of care for these groups.

Other unique project requirements could include assisting BMS with Performance Based Contracting policy design and implementation, monitoring and modification; reevaluation of existing institutional bed need; new waiver implementation and monitoring assistance; access and network capacity gap analysis (both long-term care and LTSS) and other germane projects. Other project requirements may involve analyzing issues involving industry growth / contraction, development of value-based purchasing options including pay-for-value and outcomes, as well as analysis that helps address litigation results and consent decree mandates.

Task 2: Stakeholder Engagement

Task 2 includes developing the appropriate forums for communicating with external stakeholders to gather important financial, policy, and service delivery information regarding system operations, as well as reporting project status to promote transparency in execution of the project. Task 2 tasks are described in detail below.

Stakeholder Interviews, Focus Groups, and Public Meetings, Developing a Medicaid payment method requires balancing a variety of tradeoffs and competing priorities among stakeholders. Payment methods have an impact on nursing facility residents, staff, medical providers, taxpayers, Medicaid MCOs, and program administrators, each with their own perspective on what makes a payment method successful. To identify and balance the priorities of these different stakeholders, Guidehouse will work with BMS to establish a series of stakeholder interviews to solicit needed information, convene focus groups as needed to discuss key elements of the methodology, and public meeting to communicate progress and results.

Task 3: Cost Analysis

Task 3 includes the fundamental tasks related to cost analysis, including the examination of facilities' varying direct, non direct, and capital costs, as well as the State's acuity adjustment framework and its effectiveness in promoting efficient, effective care. Task 3 tasks are described in detail below.

- **Direct and Non-Direct Care Cost Analysis.** In this section, we describe our approach to conducting an analysis of payments under the current Medicaid payment methodology in relation to the allowable costs incurred by facilities for serving Medicaid-eligible residents.

Among the fundamental decisions to make when designing a per diem based payment method is whether the per diems will be facility-specific or standardized across facilities, as well as the extent to which rates will be individualized to a facility's residents. Generally, when using facility-specific rates, the rates are calculated based on facility-specific costs. In addition, facility-specific rates are generally determined prepayment-based on costs submitted in historical cost reports and then adjusted post payment after cost reports have been submitted and audited for the time frame the services were rendered.

Facility-specific cost-based per diems may have a positive influence on access to care as long as the percentage of cost covered is reasonable. However, this rate calculation method increases the financial risk to the State, and as evidenced by the wide range of rates under the current system, results in significantly different reimbursement amounts for similar services provided at different facilities. In addition, this method is not always well-aligned with maintaining incentives for NF to be cost-effective. And while the current method may be consistent with improving the quality of care provided, it assumes that providers with higher costs are more likely to be providing higher quality care. To test this assumption, Guidehouse typically conducts a preliminary analysis that compares the costs incurred by providers to available quality scores to determine whether the connection between high-cost and high-quality is consistent.

Along with the standard cost calculations to derive facility-specific direct and non direct care base rates, Guidehouse will conduct an analysis of payment-to-cost coverage. We will compare anticipated rates to the average cost per day adjusted for a facility's Medicaid CMI, adjusted for cost growth. For each facility, we will analyze the rates separately, to calculate payment-to-cost ratios. For each facility, we will also multiply estimated rates described above for each year by the nursing facility's adjusted Medicaid days to estimate total payments. We will multiply each facility's average cost per day (adjusted for the facility's Medicaid CMI and adjusted for cost growth) by the facility's adjusted Medicaid days to estimate total costs. We will also use the total payments and total costs to calculate weighted average payment-to-cost ratios.

In many states, facilities are classified into various peer groupings and are subject to different reimbursement ceilings or other limitations, both to decrease and contain cost variation among facilities and to promote specific program goals. Depending on the groupings preferred by the agency, we group facilities and analyze costs into one of four quartiles based on the facility's resulting payment-to-cost ratio for purposes of further analysis. Facilities with the highest payment-to-cost ratios will be categorized into Quartile 1, while those with the lowest payment-to-cost ratios will be categorized into

Quartile 4. We will then analyze some of the common characteristics of the NF in the aggregate and for each Quartile, including:

- *Facility Occupancy Rates.* This statistic is generally indicative of whether the rate setting system appropriately “rewards” facilities with higher occupancies, understanding that the payment system is designed, in part, to reward higher occupancy. Higher occupancy may be indicative of efficiency, although we also understand that there are many other factors beyond occupancy that should be considered when efficiency in the delivery of care.
- *Medicaid Percentage.* This statistic is generally indicative of whether the rate setting system appropriately “rewards” facilities with higher Medicaid percentages.
- *Cost Per Day Values.* This statistic is generally indicative of whether the rate setting system appropriately “rewards” facilities with lower CMI-adjusted cost per day values, which may be another indicator of relative efficiency.
- *Pay-to-Cost Ratios.* We will also analyze the aggregate pay-to-cost ratios by Quartile, and the number of facilities with pay-to-cost ratios, that exceed 100%.
- **Acuity Adjustment.** Measurement of resident acuity is used by some payers to adjust nursing facility rates to reflect differences in the nurse staffing needs for Medicaid residents among providers (i.e., adjust a standardized base rate for differences in acuity). Medicaid agencies that perform this type of rate adjustment primarily use average facility acuity scores to adjust the direct or resident care rate component, rather than the entire rate. In most cases, the direct care rate component is computed by multiplying the direct care standardized rate by the applicable Medicaid case-mix (average acuity) for each facility.

Acuity adjustments are typically intended to increase payment for facilities that, on average, care for residents with more complex healthcare needs and reduce payment for facilities that care for residents with less complex healthcare needs. In theory, this allows payment to more accurately align with expected costs of providing nursing care, based on an assumption that facilities caring for residents with more complex healthcare needs are providing higher levels of staffing and thus incurring higher levels of direct care cost.

Our experience with nursing facility acuity adjustment in other states includes the full range of reimbursement evaluation and design, spanning relatively minor adjustments and requirements for rebasing, to more fundamental investigation of alternative acuity designs and assessment tools. Guidehouse notes that West Virginia has already moved to a patient driven payment model-based system, but in the event that the Department is looking for a more comprehensive evaluation of its acuity adjustment system, Guidehouse can recommend an appropriate approach for further investigation.

- **Capital Cost Analysis.** Common in nursing facility and ICF payment systems is a component calculated to reimburse providers for their facility-related property or capital costs. Many Medicaid agencies calculate the property rates using a method referred to as a “Fair Rental Value System” (FRVS), which estimates the fair rental rate as a proxy for the value of the facility, independent of type of ownership or rental arrangements. The FRVS method can be contrasted to another very common approach, which relies on the reasonable and necessary cost of property expenses and places a greater reliance on accounting values for those expenses.

Guidehouse is conversant with all of the major techniques for reimbursing provider capital costs, and we can serve as a trusted partner in advising BMS on the merits of one approach over another. We have frequently assisted Medicaid agencies in surveying other states to determine dominant methodologies for reimbursing facility capital costs, as well as subtle differences in the FRVS or traditional cost accounting methods used in various states.

Generally, a property cost-based approach is considered a less equitable approach than an FRVS model because the property-related expenses reimbursed under a cost-based approach may bear no relationship to the actual cost of doing business. As an example, depreciation expense, which is a significant element of cost-based property reimbursement, is an accounting amortization of historical book value of property that could have been purchased many years ago, where there is no actual cash outlay today. Also, such depreciation does not include any expense related to the land upon which a building sits (because the value of land is not expected to diminish overtime). Further, the book value of a building is based on the historical cost – an amount that may have been established many years ago, depending on the provider, and may no longer reflect today's value. Finally, financing costs (mortgage interest expense, closing costs, etc.) can vary significantly by provider depending on financing decisions made many years ago, when the capital markets were significantly different than they are today.

The primary advantage of the FRVS approach is that it recognizes the value of a nursing facility property in today's dollars using a standardized approach that takes into account the age and size of the facility. It then establishes a reasonable rate of return for the operator based on that value.

Calculation of the fair rental value for this per diem component can be performed in a variety of ways including:

- Appraised property values
- Value of capitalized tangible assets
- Estimate of construction costs

Calculation of appraised property values allows for detailed facility-specific information. It also may be more accurate than reliance on self-reported information as long as the appraisals are completed by a single or small number of independent vendors. However, use of appraised property values is more time-consuming and costly in comparison to other options.

Valuing capitalized tangible assets is a very complex method and is open for significant interpretation of allowable assets and asset value. On the other hand, estimate of construction costs utilizes easily accessible and annually updated values for cost per square foot. These values are adjusted slightly based on region of the State and are multiplied by total facility square feet to determine facility value. This method also requires inclusion of the value of land and the value of equipment. All of these methods also require recognition of depreciation and require a determination of the amount of total value to be reimbursed annually, which is referred to as the "Fair Rental Rate."

In the event that BMS has specific interests in reviewing this aspect of a payment methodology, Guidehouse is conversant in a variety of alternatives and is in a position to help the Department objectively consider potential reimbursement alternatives based on

information available in provider cost reports and current capital cost levels as a proportion of total costs.

- **Quality Incentive Development.** One significant opportunity while designing a new payment system for facility reimbursement is the ability to introduce or refine a quality incentive program as an element of the overall reimbursement model. If quality incentives are of interest to BMS for any of its long-term care settings, we would recommend incorporating discussion and planning for a quality incentive program with stakeholders early in the design process, with the goal of receiving wide support for a strong quality incentive within the prospective payment system, so long as the incentive is constructed in a manner that:
 - Includes evidence-based quality indicators that demonstrably impact care outcomes and quality of life for nursing home residents
 - Does not significantly drive administrative burden for NF by adding new measures that would require additional tracking and reporting above and beyond current reporting required by CMS
 - Rewards top-performing providers, while allowing some opportunity for providers with significant improvement to benefit from a quality incentive payment as well

When working with states to consider what measures to include in a quality incentive program, Guidehouse deliberately chooses quality standards that we believe drive quality of care and quality of life for residents. Our model incorporates measures that “hinge” the quality standards expected of facilities to quality measures for the statewide long-term care programs. We believe coordinating quality standards across the long-term care continuum will drive increased coordination and continuity-of-care as long-term care consumers transition across the continuum of care. Our recommended quality measures draw from preexisting measures that facilities are already tracking and reporting on in some form or fashion to CMS, thereby reducing any additional administrative burden.

Task 4: Rate Modeling and Recommendations

Task 4 includes the fundamental tasks related to the synthesis of rate recommendations, including modeling of potential quality incentives into rate development. Task 4 tasks are described in detail as follows.

- **Per Diem Component and Rate Modeling.** After analyzing each major cost center, Guidehouse will consider modeling rates as a whole, including calculated rate components for direct nursing, other care-related components, administration and operating and capital costs, and incorporation of payment rate incentives.

Our team will support system design decisions through research and analysis that we present iteratively in various issue papers. We will identify and discuss numerous system design alternatives and related advantages and disadvantages in the papers for alignment of cost components into rate cost components, methods for adjusting nursing components for relative acuity, selection of update factors to measure inflation, payment for therapy and other ancillary services and others.

- **Fiscal Impact Analysis.** As a final step in the process of rate evaluation and design, we will incorporate any proposed changes resulting from our cost analysis into a revised rate model

that will be analyzed for cost coverage and overall fiscal impact. This final synthesis frequently involves determination of revised peer groupings; calculated rate components for direct nursing, other care-related components, administration and operating and capital costs; the inclusion of payment rate incentives; and computer modeling to determine various scenarios of fiscal impact for the different payment system options, both on the Medicaid program as a whole, and on the nursing facility providers.

Task 5: Report of Recommendations

Task 5 includes the fundamental tasks related to the synthesis of rate recommendations, including modeling of potential quality incentives into rate development. Task 5 tasks are described in detail as follows.

- **Final Rate Recommendations and Reporting.** We create reimbursement recommendations and rebasing reports documenting rebasing calculations, analyses, and findings. We will submit a final report for BMS that describes in detail the modeling, calculations, and findings for all included NF and their respective per diem rates. This report will also document model summaries and rate calculations described in previous tasks.

4.2.1.5.2. Other tasks include, but are not limited to:

4.2.1.5.3. Meeting with payers and providers to review payment policies.

Guidehouse understands the value of transparency with stakeholders both internal and external and creating an opportunity to collect input from a wide range of audiences. This effort starts with working with BMS to identify the appropriate stakeholders.

With the stakeholders identified, Guidehouse works with BMS to identify specific areas to share or seek input from the groups. We establish a meeting cadence, usually set at major milestones of the rate development or Audit process. We recommend meeting prior to the start of work to outline the process, conducting periodic check-ins during execution to keep stakeholders informed, and concluding with a final meeting to present results and gather feedback.

Below is a stakeholder engagement process that we will be customizable for each engagement:



Confirm Provider Participants

To make sure the right voices are heard, we will work closely with BMS to identify providers and provider associations that should be involved in the initial engagement. This may include hospitals, physician groups, behavioral health providers, and other entities impacted by the proposed payment policies. In our experience, engaging key provider stakeholders early allows for a unified vision, streamlined communication, and cohesive planning before broader implementation.

Plan the Engagement Session

Guidehouse will collaborate with BMS to plan the sessions and align on the goals, such as introducing rate development process, or audit findings. Discussions will focus on aligning expectations, identifying potential challenges, and presenting the pathway forward. Depending on BMS's preferences, the type of stakeholders, and the nature of the information being shared, the sessions may be structured as either:

- A collaborative meeting designed to incorporate real-time provider feedback and foster open dialogue, or
- A webinar-style presentation focused on delivering BMS updates, with opportunities for providers to submit feedback afterward through structured channels.

We propose hosting these sessions virtually to accommodate providers' schedules and geographic dispersion, facilitating maximum participation. Our team will manage all technology to deliver a seamless, user-friendly experience as well as developing accompanying materials including a presentation deck with background information and key discussion points, and a tailored agenda in advance.

Host the Engagement Session

Roles and responsibilities for the sessions will be clearly defined during the planning stage in collaboration with BMS. This includes determining who will present specific content, respond to stakeholder questions, and manage logistics. While BMS will serve as the primary voice of the program, on request, Guidehouse team members will present material, facilitate the meeting, provide subject matter expertise, and technical support as needed. We will support BMS in delivering a clear, informative, and productive experience for participants, whether the session is structured as a collaborative meeting or an information presentation. Our team subject matter experts and project manager are effective facilitators in guiding the conversation, making sure all voices are heard and that key insights are captured.



Proven Stakeholder Engagement

For Maine, Guidehouse engaged long-term care stakeholders to gather feedback, performed a national scan of quality program practices, and developed new nursing facility and specialty care facility rate models to support program and payment modernization.

Consolidate Insights

We document the discussion, decisions, and action items to support follow-up and integration into the payment process. Following the session, our team will consolidate meeting notes and feedback gathered from providers. We will carefully review the notes, identify and prioritize key themes, and address critical areas promptly. These insights will be shared with BMS leadership to inform the ongoing work.

To extend the opportunity for feedback beyond the session, Guidehouse manages a centralized Q&A log to capture, track, and respond to provider inquiries throughout the program lifecycle. This log will serve as a transparent communication tool, helping to clarify policy, operational, and technical questions in real-time.

Manage Feedback

In addition to holding meetings, Guidehouse often uses a structured survey to gather feedback from participating stakeholders specific feedback is desired, and individuals need time to consider

their responses. Designed to capture both quantitative and qualitative input, the survey allows respondents to share insights, raise questions, and suggest improvements at their convenience. Survey results will be analyzed to identify key themes and shared with BMS leadership to support transparent decision making and refine implementation strategies.

HCBS-Specific Stakeholder Engagement

Given the unique data conditions of HCBS services, their far-ranging provider, advocacy, and participant communities, and more heavily politicized aspects of the rate setting process, Guidehouse often proposes to stand-up new or harness the resources of any existing committee or specially convened stakeholder “Advisory Groups” composed of key providers, tribal entities, recipients, and industry representatives. Stakeholders with detailed financial understanding of service delivery, are frequently able to identify many of the issues that might emerge during the survey and rate development process, without substantially lengthening project timelines. One lesson learned from our work with other states, has been to include members with lived experience, caregivers, key State Legislators, and members of the Governor’s office in our stakeholder outreach. There are several benefits of engaging with multiple groups of stakeholders during the rate development process, including, but not limited to the following:

- Soliciting technical feedback for rate development
- Boosting broader provider participation and awareness
- Securing buy-in from providers and Tribal Health Organizations for rate development and implementation processes
- Serving as liaison to circulating pertinent information to the broader membership of the represented communities
- Identifying provider informants and other stakeholders who could shed light on current service delivery challenges
- Demonstrating to CMS the State’s efforts to solicit and collect stakeholder feedback
- Aiding in promoting transparency with stakeholders
- Enhancing communication channels across state programs, as necessary
- Keeping all impacted parties informed about the study and its results

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

Guidehouse agrees to work with the Agency on changes to the applicable state plan. We have detailed our approach to SPA assistance and other implementation support in our methodologies in 4.2.1.5. Specifically, Guidehouse will support BMS through a disciplined, end-to-end methodology that translates policy or program changes into compliant State Plan actions. The team will assess current State Plan, waiver, contract, reimbursement, operational, and Federal requirements; develop decision-ready options and fiscal/program impact analyses; draft SPA or related CMS documentation; and support implementation through stakeholder coordination, system updates, monitoring, and post approval evaluation. This approach combines Guidehouse’s West Virginia experience with integrated policy, actuarial, financial, waiver, quality, and operational expertise.

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.

Guidehouse agrees to the requirement and affirms our capability to transmit final updated rates and payment parameters at least one month prior to the beginning of the effective rate year and to furnish each provider with its 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 noninstitutional & 447.321 outpatient hospital & clinic provisions.

Because CMS issued guidance in 2013 to state Medicaid Directors requiring annual obligations for filing Federal UPL submissions, our consultants have led the development of UPL demonstrations to CMS that maximize available funds within Federal guidelines. Beginning in SFY 2019, CMS further required states to submit these annual UPL demonstrations using the OMB-approved templates. Guidehouse adjusted our approach accordingly while maintaining favorable outcomes. We are also closely monitoring regulatory updates related to One Big Beautiful Bill Act and its impacts on UPL standards, supplemental payment and DPPs.

At present, states are required to submit UPL demonstrations for inpatient hospital services, outpatient hospital services, nursing facility services, clinics, physician services (for states that have physician supplemental payment programs), intermediate care facilities for the developmentally disabled (ICFs/developmental disabilities [DD]), psychiatric residential treatment facilities (PRTFs), and IMDs.

Guidehouse assists several other states with the development of UPL calculations in response to CMS' annual UPL demonstration requirements and with each SPA for a new payment methodology and/or evolving supplemental payment program. We have developed and created annual UPL demonstrations for inpatient hospital, outpatient hospital, nursing facility, professional services (qualified practitioner), PRTF and clinic services. However, Guidehouse does not apply a one-size-fits-all approach for all states, but tailor our specific approach to the unique programmatic features and needs of each state program, in compliance with Federal requirements. To complete these analyses for these provider types, we often employ the following approaches:

- **For inpatient and outpatient services**, Guidehouse has historically used a cost-based approach, which is a methodology approved by CMS. A cost-based approach uses Medicaid cost as an estimate of what Medicare would pay. We collect and analyze publicly available cost reports for all participating Medicaid providers. We then use these cost reports to develop per diems and cost-to-charge ratios based on reported all-payer costs, charges, and days. We apply the per diems and cost-to-charge ratios to the appropriate inpatient and outpatient Medicaid claims to calculate Medicaid cost. We aggregate Medicaid payments – the sum of claims payments supplemental payments – for each ownership category and compared the costs to the aggregated claim payments. An ownership category meets the UPL requirements for a cost-based approach if the total cost of services provided is greater than the aggregate Medicaid payments for the ownership category. The ownership categories include privately owned and operated hospitals, nonstate government owned or operated hospitals, and state government owned or operated hospitals. Guidehouse completes a separate demonstration for each ownership category as required by CMS.

- **For clinic services**, Guidehouse has historically used a payment-based approach, which is approved by CMS for these services. A payment-based approach uses Medicare fee schedules to approximate Medicare payments for clinic services. We collect and analyze five Medicare fee schedules to represent procedure codes that appear in four types of clinics. We also analyze and synthesize claims data for all clinic services included in the demonstration. Guidehouse completes a separate demonstration for each ownership category, with each ownership category meeting the CMS UPL requirements if Medicaid payments are less than the estimated Medicare payments for the same set of services.
- **For PRTF services**, Guidehouse has historically used a charge-based approach, which is recommended by CMS for these services. A charge-based approach uses billed charges as a reasonable estimate of Medicare payments. In compliance with CMS, Guidehouse completes a separate demonstration for each provider rather than at the ownership category level as for the other UPL demonstrations, with each provider meeting the CMS UPL requirements if Medicaid payments are less than routine charges for the same set of services.
- **For professional services**, which use a qualified practitioner services UPL, Guidehouse often a Medicare equivalent of the ACR (Commercial to Medicare Ratio Method), sometimes called a “Medicare Bridge” to relieve the burden of annual collection of commercial rate data. In states where we assist with Medicaid physician UPL supplemental programs, Guidehouse works with commercially contracted fee schedules and commercial payer claims data. In addition, Guidehouse reprices Medicare payments for professional service claims. We calculate the ACR for every procedure code experienced by each unique provider. Guidehouse ultimately creates a demonstration at the procedure code, provider, and provider ownership category level. Because the structures of physician supplemental payment programs vary substantially from state to state, Guidehouse’s approach to demonstrating the ACR reflects the particular contours of each state program.

For full compliance with the UPL demonstration requirements, we also perform a reconciliation of expenditures to the CMS-64 forms and complete the CMS demonstration form outlining the UPL approach.

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.

Guidehouse will provide BMS with responsive technical, financial, actuarial, and policy support for other fee schedule matters as they arise during the contract term. We understand that fee schedule issues may emerge from Federal or State regulatory changes, legislative direction, budget constraints, provider access concerns, litigation, CMS guidance, program design changes, stakeholder inquiries, and operational needs.

Our approach will help BMS evaluate these issues quickly, understand the fiscal and policy implications, and develop supportable recommendations that account for the Division's budget limitations.

Intake, Scoping, and Assignment of Expertise

For each fee schedule request, Guidehouse will first confirm the issue to be addressed, affected provider types or services, required timeframe, available data, budget limitations, applicable federal and State authorities, and intended audience for the work product.

We will then assign the appropriate subject matter experts, which may include reimbursement specialists, actuaries, data analysts, Medicaid policy experts, clinicians, financial analysts, or other professionals with relevant experience.

Fee Schedule Analysis and Advisory Services

Guidehouse's fee schedule support may include:

- Reviewing proposed or enacted federal and State regulatory changes and assessing their impact on existing fee schedules.
- Evaluating fee schedule adequacy, rate uniformity, provider access, utilization trends, and fiscal impacts.
- Comparing West Virginia reimbursement levels to Medicare, peer state Medicaid programs, available market benchmarks, or other relevant sources.
- Developing rate options, fiscal estimates, implementation considerations, and policy recommendations for BMS review.
- Preparing reports, briefing materials, technical memoranda, fiscal exhibits, presentations, and responses to questions from internal or external stakeholders.
- Supporting implementation activities, including fee schedule updates, provider communication materials, fiscal agent coordination, State Plan or waiver considerations, and postimplementation monitoring.

Budget-Conscious Options and Decision Support

Guidehouse will tailor each analysis to the Division's available budget approved by BMS. Where multiple options are available, we will identify the fiscal impact, operational complexity, Federal approval considerations, provider impact, access implications, and implementation risks associated with each option.

This approach will allow BMS to make informed decisions that balance reimbursement policy objectives with available resources.

Written Reports and Briefing Materials

Guidehouse will prepare written reports and related materials as deemed necessary by BMS. These work products may include fee schedule development reports, technical memoranda, fiscal impact summaries, methodology descriptions, provider impact analyses, presentation materials, and responses to questions from BMS leadership, CMS, legislative staff, providers, or other stakeholders.

Each report will document the purpose of the analysis, data sources, assumptions, methodology, findings, limitations, and recommended next steps so BMS has a clear and supportable record of the fee schedule issue and related decision points.

Support for Public, Legislative, Executive, and Judicial Appearances

Guidehouse understands that fee schedule matters may require explanation before judicial, legislative, executive, administrative, provider, employer, claimant, advocacy, or other groups. At BMS's request, our personnel will support appearances before these bodies by preparing talking points, presentations, technical exhibits, background memoranda, written responses, and other materials needed to explain the methodology, assumptions, fiscal impact, and policy rationale for fee schedule decisions.

When requested, Guidehouse staff will participate in meetings, hearings, briefings, or other proceedings to answer technical questions or present findings within the scope authorized by BMS.

Testimony and Hearing Support

If testimony is required before administrative hearings, tribunals, or State or Federal courts, Guidehouse will assist BMS by preparing testimony materials, reviewing supporting documentation, developing clear explanations of the relevant fee schedule methodology, and supporting the presentation of technical findings.

Our role will be to provide objective, well-documented technical analysis and subject matter support, while coordinating closely with BMS and counsel as appropriate.

Documentation, Defensibility, and Audit Trail

Guidehouse will maintain an organized record of source data, assumptions, calculations, methodologies, decision points, quality review steps, and final work products. This documentation will help make sure that fee schedule recommendations, written reports, public explanations, and testimony materials are traceable, defensible, and consistent with prior analyses.

This approach gives BMS access to a flexible advisory resource for emerging fee schedule issues while preserving transparency, fiscal discipline, regulatory alignment, and a clear record for future reference.

Mandatory Project Requirements (§4.2.2.)

Managed Care Program Administration (§4.2.2.1.)

4.2.2.2.1. 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.

Guidehouse agrees to be available within one business day for virtual meetings and within five business days for in person meetings with BMS, Managed Care entities, provider groups, and other parties as determined necessary by BMS. Guidehouse will attend in person meetings at a location determined by BMS based on space availability and will do so at no additional cost to the Agency.

4.2.2.2.1 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.

Proven Legislative Reporting Support for BMS

Guidehouse will provide BMS with proven, end-to-end legislative reporting support for all required reports, including reports mandated under WV Code §9-5-22, Medicaid managed care reporting, and the annual MHT and MHP reports submitted to the Legislature. Our team brings direct experience supporting BMS in this capacity, having previously served as a trusted advisor and extension of BMS in preparing timely, accurate, and decision-ready materials for legislative sessions, oversight discussions, and program leadership. This prior experience allows Guidehouse to begin work with a clear understanding of BMS' managed care programs, reporting expectations, data sources, review cycles, and the importance of producing defensible information that can withstand legislative and stakeholder scrutiny.

Guidehouse's prior support to BMS included preparing legislative and executive-facing materials that translated complex Medicaid, managed care, and actuarial information into clear, concise reports and briefing products. For example, during the 2021 legislative session, Guidehouse developed nine program fact sheets and issue briefings to support BMS leadership in conversations with legislators and in responding to questions raised during session. These materials included the SFY 2021 Budget Fact Sheet, Medicaid Fact Sheet, COVID-19 Issue Briefing, BMS Agency Fact Sheet, and specific program fact sheets on topics such as adult dental services and 1915(c) waiver services. Guidehouse also developed one-page fast fact summaries on the Intellectual Developmental Disabilities (IDD) waiver, key fee schedule increases, the launch of the 1915(c) waiver program for children with Serious Emotional Disturbances, and high-level Medicaid program data. These products helped BMS communicate with legislators more effectively and reduced the burden on State finance and program staff during time-sensitive legislative discussions.



Proven Legislative Reporting Support

BMS leveraged Guidehouse-developed briefing materials and analyses to support legislative discussions and policy decisions. Deliverables included **9 program fact sheets and issue briefings, executive-facing Medicaid reports, actuarial analyses, and managed care reporting materials** that reduced staff burden and supported timely responses during legislative sessions.

Guidehouse also supported BMS with the analytical foundation needed for legislative reporting and policy decision making. Our team prepared actuarial and financial analyses related to extending postpartum coverage from 60 days to 12 months, evaluated how public health emergency-related member mix changes affected anticipated program costs, and developed summaries and insights to inform legislative discussions. In addition, Guidehouse supported BMS' MHT and MHP programs by preparing 1915(b) waiver materials, quality strategy documentation, quarterly managed care dashboards, MCO performance monitoring materials, and analyses tied to managed care expansion, behavioral health integration, foster care, IMD services, and SUD waiver activities. This experience is directly relevant to the annual MHT and MHP legislative reports and other Medicaid managed care reporting required under this RFP.

Structured Approach to Report Development

For this engagement, Guidehouse will use a structured legislative reporting process that begins with confirming the applicable statutory, contractual, and agency-specific reporting requirements for each report. We will work with BMS to identify the reporting period, required content, data sources, responsible contributors, review milestones, and submission format.

Guidehouse will also support the preparation of any additional legislative reports or ad hoc legislative reporting requests identified by BMS during the contract period, including reports that arise from new statutory, regulatory, programmatic, or legislative priorities.

Data Validation, Quality Review, and Statutory Alignment

Guidehouse will then collect and validate source data; develop report outlines, narratives, tables, findings, and executive summaries; coordinate with BMS subject matter experts and leadership to confirm accuracy and messaging; and complete quality reviews for consistency, statutory alignment, readability, and defensibility before final submission. Where reports rely on MCO data, rate development information, waiver materials, quality measures, encounter data, financial information, or program monitoring results, Guidehouse will document sources, assumptions, and limitations so BMS has a clear record supporting each legislative submission.

Clear, Timely, Legislature-Ready Deliverables

Guidehouse's approach will exceed the minimum requirement by combining legislative report writing with programmatic, actuarial, financial, and Medicaid managed care expertise. Rather than simply compiling information, Guidehouse will help BMS develop reports that clearly explain program performance, identify key trends and policy considerations, and present information in a format appropriate for legislative review. Our prior BMS work demonstrates that we can produce high-quality legislative materials under tight timelines, using BMS-specific knowledge and national Medicaid expertise to deliver reports that are accurate, timely, and readily usable by State leadership.

Financial Services (§4.2.2.2.)

4.2.2.2.1. The vendor shall provide a fixed hourly rate for programmatic services and a fixed hourly rate for actuarial services.

Guidehouse acknowledges and agrees to provide a fixed hourly rate for programmatic services and a fixed hourly rate for actuarial services.

Ad Hoc Service (§4.2.2.3.)

4.2.2.3.1. 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.

Guidehouse acknowledges and agrees that BMS has the right to review and approve the hiring of key staff assigned to this engagement and may request replacement staff if BMS determines that staff qualifications and/or project needs are not being adequately met. Guidehouse will work collaboratively and promptly with BMS to identify qualified replacement personnel who meet or exceed the RFP requirements.

4.2.2.3.2. The vendor must ensure that all staff performing work under this contract adhere to their designated roles and responsibilities throughout the duration of the contract.

Guidehouse will make sure all staff performing work under this contract adhere to their designated roles and responsibilities throughout the duration of the engagement. We will manage staff assignments, expectations, and deliverable responsibilities through our project management structure, work plans, and regular coordination with BMS to promote accountability, continuity, and compliance with contract requirements.

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.

Guidehouse acknowledges and agrees to this requirement. Guidehouse has not held within the last 5 years prior to what may become the effective date of this contract with BMS, any contracts with any of the MCOs, provider, provider group, or provider association conducting business associated with this contract. Guidehouse will not perform work under this contract if doing so would create an unmitigated conflict with an MCO, provider, provider group, or provider association conducting business related to this contract in West Virginia, including applicable parent organizations. Prior to contract start and throughout the term of the engagement, Guidehouse will use its established conflict check procedures to identify any actual, potential, or perceived conflicts involving Guidehouse or any subcontractor. If any relevant relationship or interaction is identified, Guidehouse will promptly disclose the matter to BMS and submit a written mitigation plan for Agency review and written approval before implementation. Any approved mitigation plan will include appropriate safeguards, which may include ethical screens, restricted access to information, separated project teams, confidentiality controls, documented communication protocols, and ongoing monitoring to preserve objectivity and prevent inappropriate information sharing.

4.2.2.4. The vendor shall be bound to all service level agreements as defined within Exhibit B Service Level Agreements.

Guidehouse acknowledges and agrees to be bound by all service level agreements defined within Exhibit B, Service Level Agreements. Guidehouse will manage the engagement to meet or exceed the applicable service levels by incorporating SLA requirements into the project work plan, assigning responsible owners, monitoring performance against required timeframes and standards, and promptly escalating any risk to timely or complete performance. Guidehouse will maintain documentation of SLA-related activities and will work collaboratively with BMS to address any performance concerns, implement corrective actions when needed, and support continuous compliance throughout the contract term.

2.0 Qualifications and Experience (§4.3.)

Qualifications and Experience Information (§4.3.1)

Compliance Statement | Guidehouse meets and exceeds all requirements as set forth in Section 4.3 of this RFP.

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.

Guidehouse meets and exceeds the experience requirements of §4.3.1.1. Similar to our prior contract with BMS, and all of the work performed under that contract, BMS should and will experience a similar high level of satisfaction as was previously experienced when working with Guidehouse as a fully integrated single firm vendor, where we will be seamlessly providing all services within this RFP to BMS. As a fully integrated Medicaid consulting firm, Guidehouse combines a longstanding Medicaid actuarial practice with a managed care program administration and policy practice. Our actuarial practice brings nearly two decades of continuous experience developing capitation rates for Medicaid MCOs, while our managed care team brings more than two decades of experience developing, implementing, and overseeing Medicaid managed care contracts, policies, and programs.

Importantly, these capabilities are not separate areas of experience. Guidehouse has provided **both Medicaid managed care capitation rate development and Medicaid managed care contract and policy development or oversight in at least five states**, including West Virginia, Georgia, Kansas, Oklahoma, and Tennessee. Our integrated model allows our actuaries and managed care policy and operations professionals to work together so that capitation rates reflect program and contract requirements and policy decisions account for financial and actuarial implications.

Table 1. Guidehouse Meets and Exceeds §4.3.1.1 Experience Requirements

Mandatory Experience Requirement	RFP Minimum	Guidehouse Experience
Development of capitation rates for Medicaid MCOS	10+ years	Nearly 20 years of experience
Medicaid managed care contract and policy development and/or oversight	5+ years	20+ years of experience
States in which vendor has provided both services	5 states	5+ states including WV, GA, KS, OK, and TN

Documentation of 10+ Years of Medicaid Managed Care Capitation Rate Development Experience

Guidehouse's Medicaid actuarial practice has developed and certified Medicaid managed care capitation rates across programs and populations that include TANF, CHIP, ACA expansion, aged, blind, and disabled populations, foster care and adoption assistance, LTSS, 1915(c) waiver populations, dual-eligible populations, behavioral health, and dental services. Our work includes

development and validation of base data, trend and program change analyses, risk adjustment, rate ranges, directed payments, MLR and risk mitigation analyses, rate certifications, and support for State, MCO, and CMS review.

The following engagements document Guidehouse's experience developing Medicaid managed care capitation rates.

Table 2. Documentation of Medicaid Managed Care Capitation Rate Development Experience

State/Agency	Documentation of Representative Experience
West Virginia Bureau for Medical Services (BMS) 2018–2022 Contract #BMS1800000001	Developed and certified MHT and MHP capitation rates and provided risk adjustment, program change, directed payment, cost effectiveness, budget neutrality, MLR, IBNR, and other actuarial support.
Georgia Department of Community Health (DCH) 2009–2022 Contract #2009048	Served as Georgia's actuary of record and developed and certified Medicaid MCO capitation rates for programs including TANF/CHIP, foster care and adoption assistance, family planning, and Georgia Pathways.
Kansas Department of Health and Environment (KDHE) 2014–2017	Developed and certified managed care rates for KanCare populations including TANF, CHIP, ABD, former foster care children, medically needy/spenddown, dual-eligible, 1915(c) HCBS waiver, and LTSS populations.
Kentucky Department for Medicaid Services (DMS) 2014–2017 Contract #1400002401	Developed and certified managed care rates for TANF, CHIP, ABD, former foster care children, NEMT, dual-eligible, and behavioral health populations and performed related risk adjustment and waiver analyses.
Oklahoma Health Care Authority (OHCA) 2022–Present MSA Contract #8070001092	Serves as OHCA's Medicaid managed care capitation rate setting actuary for the SoonerSelect Medical, Children's Specialty, and Adult and Child Dental programs.
Tennessee Division of TennCare 2007–Present Continuous actuarial support documented through contracts including, but not limited to, #FA1131060 (2011–2015), #46433 (2016–2023), and #80990 (2024–Present)	Develops and certifies MCO capitation rates for TennCare's acute care and LTSS populations and provides related risk adjustment, financial, MLR, directed payment, CMS support, budget support, and waiver support.

Representative Actuarial Client References

The following client references are provided as additional documentation of Guidehouse's Medicaid managed care capitation rate development experience and can verify the nature, duration, and quality of the actuarial services described above.

State/Agency	Name	Title	Contact Information
Oklahoma Health Care Authority	Aaron Morris	Chief Executive Officer	aaron.morris@okhca.org

Tennessee Division of
TennCare

Zane Seals

Chief Financial Officer

Zane.seals@tn.gov

Documentation of 5+ Years' of Medicaid Managed Care Contract and Policy Development and/or Oversight

Guidehouse also brings more than two decades of experience helping state Medicaid agencies design, implement, monitor, and improve managed care programs. Our experience includes developing and amending MCO contracts; interpreting and implementing Federal managed care requirements; conducting readiness reviews; developing MCO reporting and monitoring processes; evaluating quality, access, network, financial, and operational performance; supporting waivers and quality strategies; and helping states address MCO compliance and performance concerns.

The following representative engagements document this experience.

Table 3. Documentation of Medicaid Managed Care Contract and Policy Development and Oversight Experience. Examples

State/Agency	Documentation of Representative Experience
West Virginia BMS 2018–2022 Contract #BMS1800000001	- Developed MHT and MHP MCO contracts and amendments; conducted a comprehensive Federal managed care compliance review. - Conducted desk and onsite readiness reviews. - Monitored MCO performance and managed care expansions. - Developed dashboards and reporting enhancements. - Prepared MHT and MHP 1915(b) waivers. - Refreshed the comprehensive managed care quality strategy.
Alabama Medicaid Agency 2013–2018; 2024–Present Contract #C4062192; #C260620217	- Supported managed care program and contract development, including compiling State and federal requirements, drafting contract sections, facilitating Agency review, and training staff on managed care requirements. - Additional work has included quality measures, waiver development, program design, implementation, and oversight.
Georgia DCH 2011–2015	- Supported Medicaid managed care program design, procurements and contract requirements. - Conducted readiness reviews for program expansions, including the expansion of managed care to include foster care. - Supported MCO, monitoring and oversight and staff training. - Implemented managed care programs serving multiple populations.
Kansas KDHE 2014–2019	- Supported KanCare policy development and alignment. - Assisted with response to CMS corrective action requirements. - Assisted with the development and approval of Section 1115 waivers. - Provided technical assistance for and managed care program operations, including MCO monitoring and oversight.
Mississippi Division of Medicaid 2010–2017	Supported implementation and operation of MississippiCAN, including readiness reviews and ongoing MCO monitoring.

State/Agency	Documentation of Representative Experience
Oklahoma OHCA <i>2022–Present</i> <i>MSA Contract #8070001092</i>	- Developed reporting templates and SOPs to support contract monitoring. - Conducted encounter validation and MCO performance analysis. - Supports design, implementation, and oversight of SoonerSelect, including MCO procurement and contract requirements and readiness reviews. - Assists with ongoing network monitoring and contract compliance. - Conducts staff training and provides ongoing technical assistance.
Tennessee Division of TennCare <i>2007–Present</i> <i>Contracts including, but not limited to, #FA1131060 (2011–2015), #46433 (2016–2023), and #80990 (2024–Present)</i>	- Provides longstanding support for Medicaid managed care policy and program design and Federal waiver requirements. - Serves as the independent evaluator for the Section 1115 waiver. - Provides additional strategic policy analysis as needed.

Representative Managed Care Program Administration Client References

The following client references are provided as additional documentation of Guidehouse's Medicaid managed care contract and policy development and oversight experience and can verify the nature, duration, and quality of the services described above.

State/Agency	Name	Title	Contact Information
Alabama Medicaid Agency	Barry Cambron	Deputy Commissioner, Health Systems	Barry.Cambron@medicaid.alabama.gov
Oklahoma Health Care Authority	Stephanie Mavredes	Chief Managed Care Officer	Stephanie.Mavredes@okhca.org

Guidehouse's experience also satisfies the requirement that the vendor have experience providing both Medicaid MCO capitation rate development and Medicaid managed care contract/policy development or oversight in at least five states. The following crosswalk identifies five states in which our teams have provided both services.

Table 4. Five-State Crosswalk of Required Experience

State	Medicaid MCO Capitation Rate Development	Managed Care Contract / Policy Development or Oversight	Representative Combined Experience
West Virginia	✓	✓	MHT/MHP capitation rates, MCO contracts and amendments, Federal compliance, readiness, MCO monitoring, waivers, and quality strategy

State	Medicaid MCO Capitation Rate Development	Managed Care Contract / Policy Development or Oversight	Representative Combined Experience
Georgia	✓	✓	Medicaid MCO capitation rates plus managed care program design, procurement, contract requirements, program expansion, and oversight
Kansas	✓	✓	KanCare capitation rates plus managed care policy, MCO oversight, CMS corrective action, quality, network, and waiver support
Oklahoma	✓	✓	SoonerSelect capitation rates plus contracts/procurement, implementation, readiness reviews, reporting, compliance, quality, and ongoing oversight
Tennessee	✓	✓	TennCare capitation rates plus longstanding managed care policy, program design, waiver, quality, implementation, and program support

Additional Documentation

Additional descriptions of Guidehouse's relevant state Medicaid engagements are provided in Section 4.3.1.3, Corporate Experience. Section 3, Staffing, provides the qualifications, credentials, and relevant Medicaid managed care and actuarial experience of the professionals proposed to perform this work for BMS.

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.*

Guidehouse meets this requirement, having two certifications to CMS on behalf of Tennessee, effective for CY25 and CY26 both of which were submitted to CMS more than the 90 days per CMS guidance, and one on behalf of Oklahoma for their managed care dental capitation rates effective SFY25 (which represents a lengthened 17 month covered period beginning February 1, 2024, because it was the first year of their managed care implementation). Because it was the first year and special circumstances, per direct conversations with CMS, it was requested that the certifications be submitted much earlier than the 90 days. Therefore, the rate certification was actually submitted more than 150 days prior to the managed care program's February 1, 2024, effective date. Please note that this represents a plan year that falls into the last two years, with that coverage period ending June 30, 2025, per our understanding of this RFP request. If this understanding does not meet this RFP item's intent, we ask for an exception on the extenuating circumstances surrounding this certification submission because of the extra-long contract year. We were in constant communication with CMS to support the State's compliance with meeting and exceeding CMS reporting requirements, while Oklahoma was in the process of implementing managed care. Although several years ago, WV has also previously experienced our impeccable

demonstration of our meeting and exceeding CMS reporting requirements and timely certification submissions throughout our prior 2018-2022 contract working with BMS.

We have provided examples demonstrating our capacity to meet reporting requirements in Appendix D of our proposal.

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 noninstitutional 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.

Guidehouse meets the requirements for ten (10) years of experience in the development of Medicaid provider rates for institutional and noninstitutional provider services. As illustrated in our recent and longstanding work with **Wyoming**, **Illinois**, and **Florida**, Guidehouse has a well-established track record of rate development across a wide range of Medicaid institutional and non-institutional programs. For example, Guidehouse consultants have been providing technical assistance services to the State of Wyoming Department of Health on a wide range of healthcare reform, Medicaid policy and financing issues for more than 25 years under six continuous competitive bid contracts. Guidehouse has also provided the State of Illinois with over a decade of provider rate setting services through a series of engagements with both the Department of Healthcare and Family Services and the Department of Human Services.

Wyoming Department of Health



Guidehouse has helped to grow Wyoming's Medicaid program into a mature and stable program that now allows the State to explore cutting edge approaches that focus on value, quality, care coordination, and innovation. Guidehouse has assisted the Wyoming Division of Health Care Financing with several updates to its APR-DRG based inpatient and EAPG outpatient prospective payment systems. Guidehouse developed multiple iterations of APR-DRG rate models to reach consensus on policy parameters, provider categories, and other payment decisions needed for updating the APR-DRG program. Guidehouse created individual hospital APR-DRG calculators and distributed the calculators to providers to provide insight into the APR payment methodology. In addition, Guidehouse priced provider's inpatient claims for six months prior to the APR-DRG system implementation to show providers how their current claim payments would change under the new system. Guidehouse monitors the APR-DRG program on a quarterly basis to identify instances where the MMIS incorrectly paid claims, requiring MMIS logic to be changed to comply with the approved APR-DRG state plan. We share quarterly monitoring summaries with the State to display how the APR-DRG payment system reflects current payment policies.

Guidehouse currently supports the Wyoming Division of Health Care Financing to calculate inpatient and outpatient supplemental payments for non-state government owned providers that qualify for intergovernmental transfer based supplemental payments and inpatient and outpatient supplemental payments for private hospitals paid for via a uniform provider assessment mechanism. Guidehouse collects information each year from Wyoming hospital providers to verify that the qualify for supplemental payment programs and drafts supplemental payments and supporting documents for the state to approve and send to providers.

We have successfully guided Wyoming through the hospital UPL process on an annual basis by creating inpatient and outpatient hospital UPL demonstrations accepted by CMS since SFY 2009. We have worked closely with the State to explore UPL demonstration options to maximize the UPL gap including a recent change in the UPL calculation that resulted in an additional \$10M in funds to providers.

We have assisted the Wyoming Division of Health Care Financing with the provision of Medicaid rate analysis and rate setting practices to establish rates for the various reimbursement methodologies employed by the Department. Guidehouse is responsible for carrying out reimbursement assistance services, including general research, policy analysis, analysis of State and Federal rules and regulations, and administrative support that is necessary to strategically analyze and update reimbursement methodologies. We perform tasks and activities in response to various State and Federal initiatives impacting Medicaid reimbursement strategies and rate setting practices.

Guidehouse assists with research and business analysis and performs rate studies at the request of the Department. We monitor Wyoming's reimbursement for NF and ICF/IDs through our regular tracking of WDH reimbursement in Guidehouse's annual benchmarking report along with the UPL supplemental payment and demonstration requirements we maintain for other programs. In the past, we also developed a percent of charges payment methodology to reimburse hospital-based nursing beds, including comparisons of cost per day and cost per discharge calculations to help set policy. We have also developed and implemented new payment policies or rebased current payment programs for a variety of services, including inpatient and outpatient hospitals, clinics, ground ambulances, physicians, **community mental health centers, FQHCs and Rural Health Clinics**, three **1915(c) HCBS waivers**, and **PRTFs**.

Documentation

Wyoming Department of Health, Division of Health Care Finance. Initial contract with WDH began in 1998. Contracts going back at least 10 years for purposes of this proposal's documentation include the following:

Contact Number	Contract Effective Date
210205	Effective date June 30, 2015 – March 31, 2022
220053	Effective April 1, 2022 – March 31, 2027, contract is current and ongoing

Illinois Department of Healthcare and Family Services



Guidehouse has assisted the **Illinois** Department of Healthcare and Family Services with rate development in varying capacities for 25 years. Beginning with helping the Department prepare to transition to Medicaid managed care, Guidehouse later worked closely with the Department to launch its Hospital Rate Reform Initiative to restructure and modernize the payment methodology for Medicaid FFS inpatient and outpatient hospital rates. The Department's hospital payment systems were frozen for several years by legislative mandate and were supplemented by significant static payments made outside of the claim-based system. As part of the Hospital Rate Reform Initiative, Guidehouse assisted the Department with transitioning its Medicaid inpatient prospective payment system to an APR-DRG payment model and its Medicaid outpatient prospective payment system to an Enhanced Ambulatory Patient Group (EAPG) payment model. These new payments models significantly improved the recognition of resource requirements by adding more patient classifications than the Department's historical system.

During the initial conceptual design process, we advised the Department on options for transitioning from the current system to a patient severity model. We then developed a significant number of analyses to calculate payment system components and simulate the fiscal impacts to the inpatient and outpatient systems using historical Medicaid-specific claims data. We also assisted the Department with the implementation process, including the development of revised administrative rules and assistance with MMIS business requirements and changes. Throughout the project we assisted the Department with the politically challenging stakeholder process, working with the provider community on sensitive issues such as updating the inpatient outlier payment method and moving a portion of its large static supplemental payment pool into its claim-based payment systems. Since initial implementation of APR-DRG and EAPG pricing, we have supported the Department with annual rate updates through 2020 and periodic rebasing using updated grouper versions.

Guidehouse also assisted Health and Family Services (HFS) in performing thorough analyses of the impacts of spread and passthrough pharmacy pricing, and all other pricing influences from its contracted MCOs and PBMs. Like many states, Illinois was concerned with the lack of pharmaceutical coverage for its senior citizens, implementing a Pharmacy Plus Waiver to extend pharmacy coverage to certain low-income elderly and disabled individuals who do not qualify for Medicaid. Our consultants assisted HFS with the development of its 1115 Research and Demonstration waiver application, which was the first-in-the-nation, under which HFS contracts with a Pharmacy Benefit Manager to implement pharmacy services through the waiver. In addition, HFS has gone a step further by implementing the Rx Buying Club in an effort to help seniors who do not qualify for the Pharmacy Plus waiver to save money on the cost of their prescription medications.

Our recent work with HFS in 2023-2024 involved assessing the impact of the State's 2022 Medicaid nursing home payment reforms, which were designed to align reimbursement more closely with resident needs and quality of care. Guidehouse reviewed the nursing home payment reforms by establishing a baseline for assessing the impact of the reform across various facets of nursing home operations, notably staffing, quality of care, financial performance, and the transition from resource utilization system to the patient driven payment model. The goal of the analysis and subsequent report was to identify areas in which changes to patterns of care signaled effective and

ineffective incentives to quality, as well as potential unintended consequences to the revised rate methodologies.

Beginning in 2019, Guidehouse assisted the DHS in conducting a rate study and develop recommendations for new rate methodologies and benchmark rates for Community Integrated Living Arrangements, the State’s residential waiver program for persons with intellectual and/or developmental disabilities (I/DD) and Intermediate Care Facilities for Persons with Intellectual / Developmental Disabilities (ICF/IDDs), the State’s privately-operated residential setting for persons with intellectual and/or developmental disabilities. In addition, Guidehouse studied and developed rate recommendations for all services that touch on an individual supported in a residential setting to include, but not be limited to, residential, supported living, personal supports, community day services, supported employment, therapy services, and supplemental services. While the initial rate development was finalized in 2021, Guidehouse has provided additional technical assistance on rate implementation in 2023 and 2024, and again in 2026.

Documentation

Illinois Department of Healthcare and Family Services (HFS) and Department of Human Services (DHS). Initial contract with HFS began in 1992. Contracts going back at least 10 years for purposes of this proposal’s documentation include the following:

Contact Number	Contract Effective Date and/or Reference
#2021-35-004-S / P-37413	Effective date August 1, 2022 – February 28, 2025)
B-9439	Effective August 1, 2019 – August 31, 2020, with subsequent contracts effective September 1, 2023 – June 30, 2024, and February 30, 2026 – June 30, 2026 DHS Contact: Meg Cooch, Chief of Staff, Meg.Cooch@Illinois.gov
Operational Support for Hospital Rate Setting	Effective date 1992-2020, with most recent contract effective date July 1, 2014 – June 30, 2020 HFS Contact: Dan Jenkins, Department Administrator for Rates & Finance, Dan.Jenkins@Illinois.gov

Florida Agency for Health Care Administration



Our current work in **Florida** is a testament to the wide array of our capabilities, building on a decade of hospital and nursing facility payment reform we began in 2012. Guidehouse, then operating as Navigant, began working with the Florida Agency for Health Care Administration (AHCA) in June of 2012. During this time, we led the design of new prospective payment methods using APR-DRGs and EAPGs to shift Florida Medicaid hospital reimbursement off cost-based rates. Design of the initial payment method conversions included rate modeling, leading discussions with an internal work group, leading discussions during public meetings with the hospital industry, and presenting to state legislative subcommittees. Since implementation of APR-DRGs in July of 2013 and EAPGs in July of 2017, Guidehouse calculated annual rate updates, including updates to the grouper versions each year through 2019.

Beginning in 2016, we also assisted AHCA conduct a transparent and collaborative nursing facility payment system rebasing. We worked with both AHCA and nursing facility stakeholders to receive input and develop ideas for the new payment method. During the payment methodology redesign, we held multiple meetings with AHCA leadership to review pricing models, consider industry input,

and discuss alternatives, resulting ultimately in the presentation of a new rate model that established new provider rates and payment methodologies for the first time since 2007. Since that time, we have continued to work with AHCA to transform nursing home reimbursement to incentivize quality and reward sustained improvement. Working through the quality incentive payment (QIP) framework Guidehouse helped design in 2016, we recently developed recommendations to innovate and evolve the QIP to drive better quality in long-term care, modeling the effects of our recommendations on providers. Our recommendations also included introducing innovative nursing home technologies and analyzed approaches for distributing payments optimally on a budget-neutral basis to incentivize key quality domains. In 2025, Guidehouse assisted AHCA with reviewing and revising the QIP framework, reassessing the incentive structure and performance domains, as well as incorporating consumer satisfaction data into the program.

Guidehouse also worked with the Florida Department of Elder Affairs from 2023-2025 on several initiatives to support improved oversight of long-term care providers as well as working with LTSS throughout the state to improve business practices and financial accounting, foster operational efficiencies, and make more effective use of multiple revenue streams.

Documentation

Florida Agency for Health Care Administration (AHCA) and Florida Department of Elder Affairs. Initial contract with AHCA began in 2012. Contracts going back at least 10 years for purposes of this proposal's documentation include the following:

Contact Number	Contract Effective Date and/or Reference
LTCOP-RFQ2045 PR666210	Effective date September 5, 2025 – June 30, 2026
C6260E	Effective date September 5, 2025 – June 30, 2026

Cost Reports, Cost Surveys, and Financial Review

Guidehouse is well-versed in developing effective cost reports and cost surveys, and we take care to design review procedures fit for purpose, performing reviews efficiently to validate the integrity and accuracy of data collected through these instruments. In our current work in Wyoming, for example, we have demonstrated a thorough understanding of cost reporting principles and processes, as well as the strong attention to detail and appreciation of the need for efficiency required for effective audit support. As the EQR organization and independent assessor for Wyoming's Care Management Entity Medicaid 1915 (b)/(c) combination waivers since 2016, Guidehouse has illustrated our careful approach both to financial and quality review, coordinating closely with the State and its providers/vendors to collect required documentation and build necessary transparency and structure into review processes. As a core component of our current rate setting work for WDH and the Wyoming Department of Education, we have also designed and regularly review cost reports for cost-based rate determinations for PRTFs, residential treatment centers, and Wyoming's Boards of Cooperative Educational Services, as well the underlying cost report data needed for rate adjustments to the State's FQHC and Rural Health Clinics.

Guidehouse's understanding of cost reporting, auditing, and financial review principles is not narrowly confined to traditional institutional reimbursement needs derived from hospital and nursing facility rate setting. The financial data collection tools we develop are aligned with Generally Accepted Accounting Principles and the review protocols we design and perform conform to the review procedures established under AICPA standards. Importantly, we have

applied our skills and expertise in recent years to emerging areas of cost report based rate methodologies for community-oriented services and programs. We are especially adept at understanding the business operations and reporting capabilities of small rural and frontier providers. For example, we recently assisted the states of **Alaska, Montana, and Vermont** in establishing prospective payment systems for their emerging networks of CCBHCs, requiring both intensive technical assistance to providers completing the relatively new and unfamiliar CMS CCBHC cost reports and substantial financial review to scrutinize reporting on existing and anticipated service costs. Additionally, as cost reporting has become more common for HCBS services, Guidehouse has helped other states such as **Montana and South Dakota** design or improve their cost reporting standards and requirements for HCBS providers, including assisted living facility and home health service providers. These cost reports are in addition to the provider cost surveys we regularly deploy as a part of HCBS rate studies. In the past 5 years, we have developed and administered cost surveys in at least ten states, including **Alaska, Illinois, Kentucky, Minnesota, Montana, North Carolina, Oklahoma, South Dakota, Virginia, and Wyoming.**

3.0 Mandatory Qualification/Experience Requirements (§4.3.2.)

Mandatory Key Staffing Qualifications (§4.3.2.1.)

Compliance Statement | Guidehouse meets and exceeds all requirements as set forth in Section 4.3.2 of this RFP.

Guidehouse has assembled a multidisciplinary team specifically designed to support the actuarial, financial, managed care oversight, program administration, and Medicaid policy functions required under this RFP. Our proposed staff bring deep experience supporting Medicaid managed care programs, including actuarial rate setting, managed care oversight, waiver implementation, financial analysis, program integrity, quality improvement, provider reimbursement, HCBS, behavioral health, and Federal Medicaid policy. This breadth of expertise allows BMS to access the specialized resources needed to support both routine contract requirements and emerging priorities throughout the contract term.

Guidehouse's staffing approach combines a dedicated core team that meets all mandatory staffing requirements with access to additional subject matter experts who can be engaged as needed. This structure provides continuity for day-to-day operations while allowing BMS to quickly access specialized expertise in areas such as actuarial services, waiver policy, quality improvement, behavioral health, program integrity, provider reimbursement, and financial analysis. Our project leadership team will actively monitor workload, upcoming deliverables, and emerging priorities to ensure appropriate staffing levels throughout the contract period.

The table below identifies the Guidehouse personnel proposed for each required key position. Collectively, these individuals meet or exceed the minimum education, credentialing, and experience requirements established by BMS and provide the leadership, technical expertise, and operational support necessary to fulfill the full scope of work described in this RFP.

Guidehouse Proposed Key Staff

Under the executive leadership of Russ Ackerman, Guidehouse's project leadership team will serve as BMS's primary point of contact and coordinate all actuarial, financial, managed care oversight, policy, reporting, and project management activities. This team will provide integrated oversight across contract functions while establishing accountability for deliverables, communication, issue resolution, and strategic support to BMS.

Proposed Key Staff Name / Title	Role	Mandatory Requirement	Summary of Qualifications
Russ Ackerman, ASA, MAAA, FCA Partner I Chief Actuary	Contract Manager (0.5 Full-Time Equivalent [FTE])	This position will have the ability and authority to commit the vendor and its resources. This position is required to have a minimum of a bachelor's degree, with five	✓ Meets and Exceeds Requirement As a Partner and Chief Actuary, Russ has the authority to bind Guidehouse and its resources to the terms of this contract.

Proposed Key Staff Name / Title	Role	Mandatory Requirement	Summary of Qualifications
		(5) 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. The Contract Manager must be available for quarterly onsite meetings with the Agency leadership and staff, and ad hoc meetings, as needed.	Professional Credentials / Education • Fellow of the Consulting Conference of Actuaries (FCA) • Associate of the Society of Actuaries (ASA) • Member of the American Academy of Actuaries (MAAA) • Bachelor of Science, Statistics, Brigham Young University Summary of Experience Russ has over 30 years of Medicaid health care experience including overall strategies, actuarial requirements, financial management practices, financial and eligibility data, analytics, and modeling. In his role as contract manager he will attend quarterly onsite meetings with Agency leadership and staff and be available for any ad hoc meetings or emerging issues as needed. He will also coordinate with the project teams as needed to facility the high standard of work his clients expect. Russ has previously served West Virginia under our prior 2018-2022 contract with BMS for these same services and has deep familiarity with the actuarial needs.
Elizabeth Barabas Associate Director	Project Management Lead (1 FTE)	The Project Management Lead will oversee that all contractual deliverables are fulfilled and provided within the required timeframes. Conducts oversight of the engagement, and ensure all deliverables and services are consistent with contract requirements, workplan tracking, and project tracking. The position is required to have a minimum of a bachelor's degree and five (5) years' experience, or eight (8) years' experience with Medicaid or Medicaid and CHIP managed care.	✓ Meets and Exceeds Requirement Liz has over 8 years of experience with Federal, state, and local government Medicaid and Medicaid CHIP Managed Care operations. Her experience includes working with West Virginia BMS. Professional Credentials / Education • Bachelor of Arts, Global Health, Washington University • Master of Public Health, Health Policy, Washington University in St. Louis Summary of Experience Liz brings extensive Medicaid project management experience leading complex reimbursement, rate setting, supplemental

Proposed Key			
Staff Name / Title	Role	Mandatory Requirement	Summary of Qualifications
Susan Harrison, MPP, PMP Associate Director	Managed Care Oversight Lead (1 FTE)	This position will be responsible for oversight of managed care operations and deliverables under the contract. As needed, the position would have responsibility for other projects assigned by the Deputy Commissioner, Division of Managed Care and Program Integrity. The Program Administration Lead will coordinate with the Finance Project Lead in the execution of deliverables defined in the contract. This position is required to have a minimum of a bachelor's degree and three (3) years' experience, or five (5) years in Medicaid or Medicaid and CHIP managed care operations, either with a State	payment, and Federal compliance engagements for state Medicaid programs. She currently manages client relationships, deliverables, budgets exceeding \$73 million, and multidisciplinary teams while coordinating multiple workstreams, meetings, and stakeholder communications. Her experience tracking deliverables, managing project budgets, facilitating stakeholder engagement, and overseeing day-to-day project operations directly aligns with the Project Management Lead responsibilities and exceeds the role's minimum experience requirements. In her role as Project Management Lead, Liz will oversee contractual deliverables, workplan execution, project tracking, stakeholder coordination, and day-to-day engagement management. She will also lead client communications, facilitate meetings, develop agendas, document decisions and action items, coordinate workstreams, and monitor progress to keep deliverables aligned with contract requirements and timelines.
			✓ Meets and Exceeds Requirement Susan has more than 20 years of Federal, state, and local government experience. With over 15 years focused on Medicaid, CHIP and/ Medicaid CHIP Managed Care. Professional Credentials / Education • Project Management Professional (PMP) • Master of Public Policy, University of Maryland • Bachelor of Science, Biology and Environmental Science, Dickinson College Summary of Experience Susan brings extensive Medicaid leadership experience from senior roles with MassHealth, Maryland Medicaid, CMS, and Guidehouse. She has directed large-scale Medicaid operations, managed program integrity and compliance

Proposed Key Staff Name / Title Role		Mandatory Requirement	Summary of Qualifications
		Agency, Federal Agency, or rendering services under contract to a State Agency. Program Administration Lead must be available for quarterly onsite meetings with the Agency leadership and staff, and ad hoc meetings, as needed. This position will develop meeting agendas and send out to all parties 24 hours prior to the meeting. This position will take meeting attendance, meeting notes, record action items and track action item completion. The meeting notes will be approved by the Agency then sent out to meeting participants.	functions, oversees major vendor contracts, led procurement and system modernization initiatives, and coordinated complex projects involving claims administration, behavioral health, pharmacy, provider services, and LTSS. She has directed large-scale Medicaid operations, managed program integrity and compliance functions, oversees major vendor contracts, led procurement and system modernization initiatives, and coordinated complex projects involving claims administration, behavioral health, pharmacy, provider services, Managed Care and LTSS. Her experience managing cross-functional teams, supporting executive leadership, monitoring program performance, and overseeing contract deliverables aligns directly with the responsibilities of the Managed Care Oversight Lead role and exceeds the position's minimum experience requirements. In her role as Managed Care Oversight Lead, Susan will provide oversight of managed care operations and contract deliverables, coordinate activities across functional teams, support Agency leadership on assigned projects, and facilitate ongoing program governance. She will lead stakeholder engagement, coordinate meetings, track action items, monitor contract performance, and provide operational oversight to support successful execution of managed care and program integrity initiatives.
Derek Knight, CPA Associate Director	Financial Oversight Lead (1 FTE)	This position will be liaison with the Deputy Commissioner of Finance and the Chief Financial Officer in the oversight of finance and budget initiatives and other projects within the scope of the contract. This position will coordinate the deliverables of the actuarial vendor with Agency Finance. The Finance Project Lead will coordinate with the Program	✓ Meets and Exceeds Requirement Derek has over 15 years of experience providing a unique blend of expertise in Medicaid policy, HCBS rate setting, and Medicaid cost and reimbursement analysis. Professional Credentials / Education • Certified Public Accountant (CPA) • Bachelor of Science, Accounting, Virginia Commonwealth University

Proposed Key Staff Name / Title	Role	Mandatory Requirement	Summary of Qualifications
		Administration Lead in the execution of deliverables in the contract. This position is required to have a minimum of a bachelor's degree in finance, accounting, business administration, or related field, must be a certified public accountant (CPA) with five (5) 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. Finance Project Lead must be available for quarterly onsite meetings with Agency leadership and staff, and ad hoc meetings, as needed.	Summary of Experience Derek brings extensive experience in Medicaid finance, reimbursement analysis, rate setting, financial accountability, and program integrity. As a CPA, he has led reviews of Medicaid financial submissions, evaluated cost neutrality and fiscal accountability requirements, managed analyses supporting HCBS reimbursement methodologies, conducted Medicaid audits and compliance reviews, and provided financial and policy guidance to state Medicaid agencies and CMS. His background in financial management, reimbursement analysis, budgeting-related reviews, rate development, program integrity, and Medicaid fiscal oversight directly aligns with the responsibilities of the Financial Oversight Lead role and exceeds the position's minimum qualification requirements. Derek will serve as the primary liaison for financial oversight activities, supporting budget and finance initiatives, coordinating financial deliverables, and providing analysis related to Medicaid reimbursement, rate setting, fiscal integrity, and program financial performance. In this role, he will work closely with Agency leadership and project teams to evaluate financial data, support oversight of Medicaid funding and reimbursement activities, and help manage financial components of contract deliverables.
Rick Henley, J.D. Associate Director	Contract Compliance/Research Analysts (0.5 FTE)	Research Analyst/Consultant positions will provide assistance in policy research and development, contract development and maintenance contract compliance and reporting and other MCO oversight activities as outlined within the procurement. The position is required to have a minimum of a Bachelor's Degree, with two (2) years' experience working with	✓ Meets and Exceeds Requirement Rick has over 13 years of state public service Medicaid in both a programmatic and legal capacity inclusive of managed care, contractual, and regulatory compliance and over 10 years of private sector experience working with state agencies under contractual arrangements. Professional Credentials / Education • Louisiana State Bar Association, Good Standing • Juris Doctorate, Louisiana State University Law School

Proposed Key Staff Name / Title	Role	Mandatory Requirement	Summary of Qualifications
		Medicaid or Medicaid and CHIP, either with a State Agency, Federal Agency, or rendering services under contract to a State Agency.	Bachelor of Science, History, Magna Cum Laude, Murray State University Summary of Experience Ricks brings proven experience in Medicaid policy, compliance, and program oversight experience from leadership roles in state government and consulting. He has led statewide engagements involving CMS reporting, managed care oversight, provider reimbursement, operational improvement, regulatory analysis, waiver compliance, and quality assurance activities. His experience includes developing and monitoring Medicaid policies and procedures, supporting procurement and contract management activities, leading corrective action planning, overseeing compliance initiatives, and advising state agencies on complex Medicaid operational and policy issues. This background aligns directly with the Contract Compliance / Research Analyst Lead responsibilities and exceeds the role's minimum experience requirements. In his role, Rick will provide leadership and support for policy research, contract compliance monitoring, reporting, program oversight activities, and regulatory analysis. In this role, he will evaluate program requirements, support contract development and compliance activities, monitor state and federal policy changes, develop reporting and documentation processes, and provide research and operational insights to support managed care and Medicaid program oversight.
Dustin Schmidt Director	Medicaid Policy Subject Matter Expert (0.5 FTE)	The Medicaid Policy Subject Matter Expert shall be leveraged for consultation services on Federal Medicaid regulation and policy and serve as a SME under both the program oversight contract development and actuarial services sections. This person must have experience crafting CMS managed care	✓ Meets and Exceeds Requirement Dustin brings more than 15 years of experience advising state Medicaid agencies on policy, program design, managed care oversight, operational improvement, and LTSS. Professional Credentials / Education Bachelor of Science, Finance, Arizona State University

Proposed Key Staff Name / Title	Role	Mandatory Requirement	Summary of Qualifications
		reports including 1915 (b) waiver applications/amendments, Medicaid and CHIP Program Annual Report (MACPAR) and Fraud, Waste, Abuse (FWA) compliance reports. The position is required to have a minimum of a Bachelor's Degree, with ten (10) years' experience in Medicaid or Medicaid and CHIP policy research and development, either with a State Agency, Federal Agency, or rendering services under contract to either Agency type.	Summary of Experience Dustin has led Medicaid transformation initiatives across multiple states, including West Virginia, with responsibility for developing waiver programs, policies and procedures, managed care oversight frameworks, performance improvement initiatives, stakeholder engagement strategies, and operational modernization efforts. His experience supporting state Medicaid agencies aligns directly with the responsibilities of the Medicaid Policy Subject Matter Expert role and exceeds the position's minimum experience requirements. In this role, Dustin will provide strategic guidance on Medicaid policy, program oversight, managed care operations, and LTSS. He will support policy research and development, advise on Federal and state Medicaid requirements, and assist with program implementation and waiver initiatives. Dustin will also contribute to CMS reporting and compliance activities, provide subject matter expertise to support managed care oversight, and help drive program improvement efforts across Medicaid and related service delivery programs. Dustin previously served West Virginia under our prior 2018-2022 contract with BMS for the same services and has deep familiarity with the State's managed care programs.
Sterling Felsted, FSA, MAAA Director	Lead Actuary (1 FTE)	The Lead Actuary will oversee that all deliverables within each approved Statement of Work (SOW), which includes actuarial services are fulfilled as defined within the SOW. This position is required to have a minimum of ten (10) years' experience with Medicaid or Medicaid and CHIP Managed Care rate setting and shall be either a Fellow of the Society of Actuaries	✓ Meets and Exceeds Requirement Sterling brings more than 16 years of actuarial consulting experience, including 14 years focused on Medicaid programs. Professional Credentials / Education • Fellow of the Society of Actuaries (FSA) • Member of the American Academy of Actuaries (MAAA) • Bachelor of Science, Mathematics, Brigham Young University

Proposed Key Staff Name / Title	Role	Mandatory Requirement	Summary of Qualifications
		(FSA) and/or Member of the American Academy of Actuaries.	Summary of Experience Sterling serves as the lead actuary for multiple state Medicaid clients and has directed capitation rate development, actuarial certifications, risk adjustment analyses, budget projections, waiver support, and managed care reimbursement strategies across numerous states. His experience includes overseeing Medicaid rate setting for acute care, long-term care, CHIP, and PACE populations, managing communications with CMS, signing actuarial opinions and certifications, and leading complex financial modeling and forecasting efforts. His FSA and MAAA qualifications align directly with the Lead Actuary requirements and exceed the position's minimum experience standards. As Lead Actuary, Sterling will oversee all actuarial work produced for West Virginia's program. He will lead the development, review, and delivery of all actuarial work products under approved statements of work. In this role, he will direct Medicaid rate setting activities, manage actuarial analyses and certifications, oversee project planning and quality review processes, support CMS-related actuarial requirements, and serve as the primary actuarial advisor for the Agency on managed care, reimbursement, and financial forecasting matters. Sterling previously served West Virginia under our prior 2018-2022 contract with BMS for these same services and has deep familiarity with the program and actuarial techniques needed to develop actuarial sound rates that stand up to CMS and MCO scrutiny.
Melanie Bell, ASA, MAAA Director	Staff Actuary (2 FTE)	The Staff Actuary will assist the Lead Actuary in providing the deliverables defined within each approved SOW. This position is required to have a minimum of five (5) years' experience with	✓ Meets and Exceeds Requirement Melanie Bell, ASA, MAAA Melanie brings 9 years of actuarial experience in Medicaid rate development and Medicaid CHIP managed care and leads rate

Proposed Key			
Staff Name / Title	Role	Mandatory Requirement	Summary of Qualifications
Debra Ruocco, FSA, MAAA Associate Director		Medicaid or Medicaid and CHIP managed care rate setting or other insurance pricing and shall be either a Fellow of the Society of Actuaries (FSA) and/or Member of the American Academy of Actuaries.	development the states of Oklahoma and Georgia Medicaid programs. Professional Credentials / Education • Associate of the Society of Actuaries (ASA) • Member American Academy of Actuaries (MAAA) • Master of Science, Actuarial Science, Georgia State University • Bachelor of Business Administration, Finance, University of West Georgia Summary of Experience Melanie brings significant Medicaid actuarial experience supporting and leading rate development efforts for multiple state Medicaid programs. She has led Medicaid capitation rate development for Oklahoma, supported rate development for Georgia, developed reimbursement models for West Virginia, and performed analyses involving IBNR reserves, risk adjustment, trend development, managed care savings, and financial forecasting. Her experience managing large Medicaid datasets, validating data, developing actuarial models, communicating results to state stakeholders, and preparing actuarial certifications directly aligns with the responsibilities of the Staff Actuary role and exceeds the position's minimum experience requirements. Debra Ruocco, FSA, MAAA Debra brings more than 20 years of actuarial experience, including significant experience supporting Medicaid managed care rate development and financial analysis including Medicaid CHIP managed care rate setting. Professional Credentials / Education • Fellow of Society of Actuaries (FSA) • Member of the American Academy of Actuaries (MAAA)

Proposed Key		Mandatory Requirement	Summary of Qualifications
Staff Name / Title	Role		
			Bachelor of Arts in Mathematics, Mount Holyoke College Summary of Experience Debra serves as a core member of the Oklahoma Medicaid rate setting team, where she develops capitation rates, manages directed payment analyses, supports budget development, evaluates risk adjustment methodologies, and oversees key actuarial deliverables. Her experience includes Medicaid reimbursement analysis, MLR development, financial forecasting, reserve calculations, provider payment modeling, regulatory compliance, and stakeholder communication. As an FSA and MAAA, her qualifications align directly with the responsibilities of the Staff Actuary role and exceed the position's minimum experience requirements. Our staff actuaries, Melanie and Debra, will support the Lead Actuary in the development and delivery of actuarial analyses, rate setting activities, financial projections, and other actuarial services required under approved statements of work. They will contribute to Medicaid rate development, data validation, financial modeling, trend analysis, reserve calculations, and actuarial reporting, while helping to develop and review deliverables that support Agency decision making and CMS requirements.

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

Detailed professional resumes can be found in Appendix B.

Appendix A Required Forms

Authorization to Bind and Designated Contact

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) Russell H. Ackerman, Partner and Chief Actuary

(Address) 1676 International Dr., Suite 800, McLean, Virginia 22102

(Phone Number) / (Fax Number) (480) 318-9390 / (703) 506-6740

(email address) russ.ackerman@guidehouse.com

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through wvOASIS, I certify that: I have reviewed this Solicitation/Contract in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation/Contract for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that this bid or offer was made without prior understanding, agreement, or connection with any entity submitting a bid or offer for the same material, supplies, equipment or services; that this bid or offer is in all respects fair and without collusion or fraud; that this Contract is accepted or entered into without any prior understanding, agreement, or connection to any other entity that could be considered a violation of law; that I am authorized by the Vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on Vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

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

Guidehouse Inc.

(Company)

Russell H. Ackerman

(Signature of Authorized Representative)

Russell H. Ackerman, Partner and Chief Actuary

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

(480) 318-9390 / (703) 506-6740

(Phone Number) (Fax Number)

russ.ackerman@guidehouse.com

(Email Address)

Addendum Acknowledgement

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)

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

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

Guidehouse Inc.

Company



Authorized Signature

September 9, 2026

Date

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

Certification and Signature Page

Certification and Signature Page

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.

Guidehouse Inc.
(Company)

Russell H. Ackerman, Partner, Chief Actuary
(Representative Name, Title)

(480) 318-9390 / (703) 506-6740
(Contact Phone/Fax Number)

September 9, 2026
(Date)

Appendix B Biographies of Proposed Guidehouse Team

Full resumes for our proposed project team are included on the following pages.

Engagement Leadership

- Russ Ackerman, Contract Manager | Engagement Partner

Project Team

- Susan Harrison, Managed Care Oversight Lead
- Elizabeth Barabas, Project Management Lead
- Derek Knight, Financial Oversight Lead
- Sterling Felsted, Lead Actuary
- Rick Henley, Contract Compliance | Research Lead

Actuarial Support Staff

- Melanie Bell, Staff Actuary
- Ben Maryland, Staff Actuary
- Debra Ruocco, Staff Actuary
- Ryan Butterfield, Staff Actuary
- Kory Wolf, Actuarial Data | Analytics Lead
- Laura Rapoport, Contract Compliance | Research Analyst

Managed Care Program Administration Support Staff

- Christina Koster, Managed Care Policy and Regulatory
- Drew Weiskopf, MCO Performance and Quality
- Chiara Alvisi, Readiness and Network Oversight
- Adam Goldman, Waiver and Federal Reporting
- Conor Ridlon, Reporting and Analytics
- Heather Kinigham, Compliance and Program Integrity

Subject Matter Experts

- Lance Robertson, Aging and Long-Term Care
- Coy Jones, Provider Rate Setting
- David Garbarino, Directed Payment Program
- Dustin Schmidt, Medicaid and CHIP Policy
- Charlie Smith, Behavioral Health and SUD
- Chad Mandala, Public Health

Russell H. Ackerman, ASA, MAAA, FCA

Partner and Chief Actuary



russ.ackerman@guidehouse.com
Phoenix, Arizona
Direct: (480) 318-9390

Professional Summary

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

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

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

Areas of Expertise

- Public systems / social insurance
- Regulatory
- Capital management
- Financial reporting

- Product pricing / development
- Risk management

Professional Experience

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

Work History

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

Certifications, Memberships, and Awards

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

Education

- Bachelor of Science, Statistics, Brigham Young University

Susan Harrison, MPP, PMP

Associate Director



sjharrison@guidehouse.com
Boston, Massachusetts
Direct: (410) 353-6800

Professional Summary

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

Areas of Expertise

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

Professional Experience

Project and Program Management

- Assisting clients with major program implementation, contract transitions, cost containment and organizational growth initiatives. Technical expertise in Medicaid including managed care implementation, program integrity and auditing, state and federal authorities, care/ utilization management and contact management. Leading large-scale

program implementations for managed care transformation and program integrity initiatives.

- Directed enterprise project management office (PMO) consulting within CWM, overseeing a large portfolio of strategic projects and managing \$3M in public and private vendor relationships including process improvements, systems integration, and compliance. Collaborated with public entities, private sector, and clinical systems to evaluate complex problems and implement meaningful solutions
 - Aligned project management and process improvement to support cross-solution set projects including the Executive Office of Health and Human Services (EOHHS) roadmap for behavioral health reform
 - Acting BTS Managing Director: Effectively managed BTS budget, resource allocation, strategic direction, and business development by doubling revenue and increasing margin-producing work by 20%
 - Collaborated with CWM senior leadership to implement effective value-driven organizational management and retention strategies including resource allocation, succession planning, clear career ladders, and targeted market analysis

Program Integrity

Directed all Medicaid program integrity (PI) and third party liability (TPL) efforts, and managed \$250M in annual vendor contracts. Oversaw all compliance activities for internal and external auditing entities including The Office of the State Auditor, the Medicaid Fraud Control Unit at the Attorney General's Office; The Centers for Medicare and Medicaid Services; and the U.S. Health and Human Services. Supervised 25 state staff and 130 vendor staff

- Generated over \$150M in annual PI member and provider cost savings and operational improvements for MassHealth
- Generated over \$400M in annual TPL and premium assistance program savings
- Decreased audit findings by \$300M from 2018 to 2019 reducing operational risk

Policy and Compliance

- Executive sponsor for \$90M in major IT (IT), pharmacy, and long term care projects including IT procurement, contract monitoring, PMO, and technical support. Monitored progress of projects and approved completed projects for technical accuracy and monitored adherence to established CMS and Maryland Department of IT (DoIT) policies, procedures, and standards. Implemented the electronic health record (EHR) incentive program, distributing \$10M in meaningful use payments to providers. Supervised 60 employees
 - Implemented Medicaid behavioral health program claims payment integration with an annual spend of \$1B, aligning and reducing authorization requirements
 - Developed and implemented an integrated care management system to support all in home Medicaid long-term supports and services with an annual savings of \$10M
 - Drove executive procurement team for Maryland Medicaid restructuring transition process and the proposal development and execution of a \$297M contract for a new Medicaid management information system (MMIS)

Health Policy Analysis

- Served as the key liaison between Medicaid programs and the Office of Systems, Operations, and Pharmacy (OSOP) on project implementation issues and lead analyst regarding budget and audit issues. Responded to requests from the Office of Governmental Affairs, other agencies or administrations, and director, deputy secretary, and secretary regarding Medicaid program, provider, and recipient questions or concerns. Led voice of customer and change management workgroups. Supervised six employees
 - Transitioned vendor utilization management for hospital and long-term supports and services, decreasing response time for authorizations
 - Implemented ICD-10 on time and under budget
 - Adopted innovative provider enrollment system resulting in shorter response time from Medicaid to providers with an annual savings of \$5M
- Analyzed and evaluated complex medical and scientific information. Developed and implemented technology assessments, procurements, and national coverage determinations (NCDs) related to Medicare coverage issues. Prepared internal technology assessments, issue papers, policy options papers, and press office roll-out documents including press releases, Q&As, and high-priority congressional correspondence. Represented the division and group at briefings and other meetings with senior CMS and departmental officials, congressional staff, special interest groups that represent health organizations, and other members of the public
 - Authored and published 15 NCDs related to Medicare coverage issues
 - Implemented Medicare's first coverage with an evidence-development policy
- Developed internal cost analysis for the Prescription Drug and Medicare Reform Act of 2003. Analyzed data collection and reporting complying with the Government Performance and Results Act (GPRA). Prepared the CMS annual performance plan. Conducted activity-based costing (ABC) analysis of contractors' spending

Work History

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

Certifications, Memberships, and Awards

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

Education

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

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Elizabeth Barabas, MPH

Associate Director



ebarabas@guidehouse.com
Philadelphia, Pennsylvania
Direct: (312) 583-5766

Professional Summary

Elizabeth is a skilled project manager with experience in several Medicaid reimbursement areas, focusing on rate setting, supplemental payments, and Federal compliance demonstrations. Elizabeth has also helped develop rates in several states, including hospital, clinic, and waiver services, and has conducted rate evaluations for many payment systems including DRG, per diem, home and community-based appendices, and more.

Areas of Expertise

- Project management
- Analysis of Medicaid claims data and relevant payment mechanisms
- Federal upper payment limit (UPL) demonstrations for institutional and professional services
- Healthcare cost estimation using detailed costing methodology, provider-reported data, and / or publicly available data
- Hospital supplemental payment programs
- Medicare healthcare cost report information system (HCRIS) hospital cost reports
- Programming in SAS, Stata, and SPSS Software
- Home and community-based services (HCBS) rate setting
- Rate determination for hospitals, clinics, and waiver programs
- Stakeholder facilitation and engagement
- Statistical analysis of health policy using advanced statistical methods
- Provider reimbursement rate setting
- Fiscal impact analyses
- Hospital supplemental payments
- Medicaid budget forecasts
- Waiver services

Professional Experience

Project Management

- Oversees project management, including spearheading client communication, creating deliverables, scheduling meetings, documenting meetings, tracking deliverables, organizing workstream leads, and disseminating client information to the internal team
- Manages day-to-day client contact, including internal preparation, deliverable management, and external management of multiple weekly meetings with agenda creation, time management, and call leadership
- Develops and delivers detailed invoices at regular intervals, including oversight of a budget of more than \$3M and tracks hours of more than 30 individual employees
- Develops data-focused deliverables and presentations and value messaging for client and stakeholder consumption
- Prepares and manages stakeholder communication, including verbal and written engagement such as FAQ documents, presentations and webinars, one-pagers, formal meeting minutes, individual email responses, and legislative documents

Government Payment Transformation

- Conducted physician and professional UPL demonstrations in compliance with CMS requirements using the ACR methodology and Medicare Equivalence Ratio methodology. Assisted states in developing supplemental payment programs based on these UPL demonstrations
- Conducted inpatient, outpatient, and clinic UPL demonstrations in compliance with CMS requirements to assist states with annual reporting using detailed estimated claim cost, claim payments, claim charges, and supplemental payment data to build cost-based inpatient and outpatient hospital UPL models. Assisted states in developing payment-based and charge-based clinic UPL demonstrations
 - Priced Medicare payments using claim line healthcare common procedure coding system codes and Medicare fee schedules
- Inpatient and outpatient hospital rate setting and reimbursement development and implementation
 - Detail costing of claims using cost-to-charge ratios and per diems developed from Centers for Medicare and Medicaid Services (CMS) HCRIS cost reports
 - Used Solventum (formally 3M) Core Grouping Software to group Medicaid claims for all patients refined diagnosis-related groups and improved ambulatory patient grouping payment simulations
 - Pulled from a variety of data sources to model hospital rates with the provider and rate-year-specific parameters, keeping in mind hospital type and the need for per diem payments when necessary
 - Calculated numerous types of supplemental payment programs, including implementation of some of these programs

- Calculated qualified rate adjustment supplemental payments for nonstate government owned hospitals:
 - Detail costing of claims using updated revenue codes and CMS HCRIS cost reports
 - Modeled claim cost using cost-to-charge ratios and per diems to determine supplemental payment amounts for qualifying hospitals
- Created and implemented a new professional services supplemental payment program for physicians and other professional services at hospitals:
 - Collected and analyzed commercial claims data and fee schedules
 - Modeled “ACRs” and estimated Medicare payments across all existing procedure codes to determine qualifying supplemental payments
- Calculated small and big disproportionate share hospital payments (Wisconsin Medicaid) using relevant eligibility criteria
- Calculated other UPL-based supplemental payment programs, including rural payments, critical care payments, and others
- HCBS waiver rate setting and reimbursement methodology, including:
 - Development of detailed provider cost surveys
 - Analysis of provider surveys and third party data sources
 - Works with stakeholders to get rate buy-in throughout the rate development process
 - Development of cost-based rates focused on parity across varying waiver populations where possible while also reflecting the complexities of the evolving COVID-19 emergency and economic landscape

Directed Payment Programs

- Helped transition from a delivery system reform incentive payment program to a directed payment program as well as helped develop and implement new directed payment programs, including ACR review, Medicare pricing methodology, cost report review, and general preprint support for multiple service types, including hospitals, community mental health centers, rural health clinics, local health departments, and outpatient clinics

Healthcare Reform

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

Behavioral Health

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

Other Relevant Experience

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

Work History

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

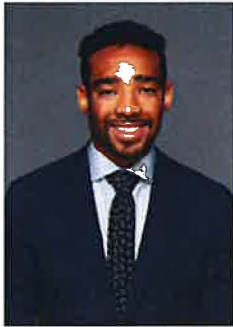
Education

- Master of Public Health, Health Policy, Washington University
- Bachelor of Arts, Global Health, Washington University

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Derek G. Knight, CPA

Associate Director



derek.knight@guidehouse.com
Richmond, Virginia
Direct: (202) 973-3133

Professional Summary

Derek is an experienced healthcare finance and policy consultant in Guidehouse's Healthcare Strategy practice. He is committed to improving access to Home and Community-Based Services (HCBS) and has worked alongside state and federal partners to evaluate reimbursement methodologies, service delivery policy, and state fiscal integrity measures to identify risks and vulnerabilities that contribute to Medicaid program inefficiencies.

He is also a Certified Public Accountant (CPA) and provides a unique blend of expertise in Medicaid policy, HCBS program analysis, HCBS rate setting, and Medicaid cost and reimbursement analysis. Derek has managed complex engagements with the Centers for Medicare and Medicaid Services (CMS), commercial and private provider groups, and State Medicaid Agencies.

Areas of Expertise

- Detection and Prevention of Fraud, Waste, and Abuse within Medicaid and HCBS Programs
- Conflict-Free Case Management Implementation
- Medicaid Program Integrity including the Design, Development, and Implementation of post payment Review
- HCBS Medicaid Rate Setting and Rate Review
- Medicaid Policy Analysis and Research

Professional Experience

Medicaid Performance Management

- Directed and managed the 1915(c) waiver application review of state cost neutrality and financial accountability appendices
- Reviewed financial submissions for state HCBS waiver programs to enable reasonable cost projections and state community-based programs were more cost-effective than institutional counterparts and demonstrated compliance with Federal requirements
- Developed training materials for HCBS rate setting methodology and HCBS waiver programs. These trainings highlighted multiple topics relating to HCBS rate setting, program integrity, and policy such as accounting for inflation and other cost pressures; implementing electronic visit verification, program and fiscal integrity, and other general policy considerations for administering HCBS programs

- Conducted data and policy analysis to evaluate HCBS programs at a national level and shared promising practices with other states and stakeholders. Managed the development of a dashboard containing financial and other data for all active 1915(c) HCBS waiver programs and routinely provided national HCBS data and policy insights to assist states with operating Medicaid HCBS programs as part of technical assistance requests, training materials, and other outreach
- Performed a cost report analysis and review to assist in developing payment rates for Wyoming Residential Treatment Centers, Psychiatric Residential Treatment Facilities, and Board of Cooperative Education Services providers. This analysis and review included assisting Wyoming providers with completing the cost survey, identifying cost outliers, and developing a rate methodology that produced payment rates based on the State's cost report submissions
- Conducted Medicaid reviews/audits for the State of Virginia to determine billing and reimbursement compliance for Medicaid HCBS providers. Prepared working papers to document scope and findings per Medicaid and government program regulations. Conducted all phases of the audit process including, but not limited to, planning and research, risk assessment, fieldwork, and reporting findings
- Conducted research to determine post payment compliance with Medicaid rules and regulations and current on the newest Medicaid rulings and memos

Long-Term Care

- Designed cost survey and performed data analysis to determine the overall revenue and expense impact for Colorado providers' transition to conflict-free case management. Provided technical assistance to providers completing cost surveys via webinars and teleconferences. Identified outlier provider data and performed telephone interviews and onsite visits to confirm the survey information submitted, then authored a report outlining the cost survey data analysis results
- Managed and developed review processes to evaluate cost reports, cost report methodology, and related rate methodologies for 1915(c) waiver programs for the elderly and intellectually / developmentally disabled population. These reviews were performed on an ad hoc basis and were requested based on new state cost methodology submissions. The reviews consisted of reviewing cost report categories and cost methodologies to confirm that costs were adequately captured to produce payment rates sufficient to attract an adequate and qualified provider base
- Managed the review process for HCBS 1915(C) waiver application quality improvement strategies and performance measures. These reviews assist states with their existing performance measures, quality improvement plans, and Federal compliance. Provided states with the information necessary to improve their data collection methods and performance measures to positively affect participant outcomes and improve quality measurement within the state

Grant Management

- Assisted a hospital system with navigating and requesting Federal and state grants in response to the COVID-19 public health emergency. This assistance included partnering with the Federal Emergency Management Agency, State Medicaid Agency, and other

stakeholders to submit supporting documentation and requests for additional funding to support hospital pandemic operations and safety measures

Work History

- Associate Director, Guidehouse (2014 – Present)
- Staff Accountant / Auditor, Myers and Stauffer (2013 – 2014)
- Payroll Accountant, Virginia Department of Accounts (2012 – 2013)

Certifications, Memberships, and Awards

- Certified Public Accountant

Education

- Bachelor of Science, Accounting, Virginia Commonwealth University

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Sterling Felsted, FSA, MAAA

Director



sterling.felsted@guidehouse.com
Atlanta, Georgia
Direct: (312) 805-0169

Professional Summary

Sterling is a Fellow of the Society of Actuaries and a Member of the MAAA. He has 16 years of actuarial consulting experience, with the most recent 14 focused on Medicaid work. In his current role, he provides project management and client interfacing for the firm's Medicaid clients. He orchestrates the development of the annual capitated rates as well as providing oversight on all ad hoc requests.

Professional Experience

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

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

Work History

- Director, Guidehouse (2023 – Present)
- Actuarial Consultant, Navigant / Guidehouse (2018 – 2023)
- Actuarial Consultant, Aon (2010 – 2018)
- Global Benefits Analyst, Aon (2009 – 2010)

Certifications, Memberships, and Awards

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

Education

- Bachelor of Science, Mathematics, Brigham Young University

Richard Lee Henley, J.D.

Associate Director



rhenley@guidehouse.com
Sanibel, Florida
Direct: (713) 646-5082

Professional Summary

Rick is a health and human services executive with extensive leadership experience advising state, local, and Federal agencies on Medicaid policy, home and community-based services, long-term services and supports, behavioral health, aging and disability programs, value-based care, actuarial regulatory strategy, and enterprise transformation. He brings a rare combination of executive-level state government leadership, legal and regulatory expertise, consulting advisory experience, and health IT growth leadership to help organizations navigate complex policy, operational, fiscal, rate setting, and technology challenges.

He is recognized for translating complex Federal and state requirements into practical strategies that improve program performance, strengthen compliance, modernize service delivery, and advance person-centered outcomes. He is experienced in leading and supporting high-impact initiatives involving waiver compliance, CMS reporting, provider reimbursement, managed care, value-based purchasing, quality and performance measurement, actuarial rate development, capitation rate review, regulatory analysis, stakeholder engagement, Advanced Planning Development, systems modernization, and implementation of large-scale health and human services programs. He is known as a trusted advisor to agency executives and stakeholders, with the ability to align policy vision, operational execution, technology strategy, and measurable results across complex health and human services environments.

Areas of Expertise

- Medicaid and health and human services policy
- Program strategy, design, and implementation
- Waiver compliance and corrective action planning
- Regulatory analysis, rulemaking, and policy development
- HCBS, LTSS, aging, and disability programs
- Value-based care, quality measurement, and actuarial regulatory strategy
- Managed care rate setting, capitation, and reimbursement policy
- Medicaid legal strategy, litigation, and settlement compliance
- Enterprise IT modernization, MITA alignment, and APD support
- Stakeholder engagement and interagency collaboration
- Federal reporting, CMS approvals, and operational oversight
- RFP development, evaluation, procurement, and contract management
- Federal funding strategy and enhanced FFP documentation
- Program integrity, utilization controls, and quality assurance
- Government relations, legislative analysis, and executive communications
- Enterprise sales, business development, and market growth

Relevant Experience

Policy, Regulation, Governance, and Compliance

- Leads statewide engagements supporting CMS federal reporting, provider reimbursement, managed care oversight, and operational improvement for Medicaid and health and human services programs.
- Supports actuarial and rate setting initiatives, including review of actuarial certification materials, risk adjustment considerations, and regulatory impacts.
- Led development of more than 14 standard operating procedures for recurring non-Medicaid administrative claiming reports, strengthening documentation, quality assurance, and reporting consistency.
- Spearheaded corrective action planning that brought a state Federal waiver program into compliance and supported CMS approval.
- Supported modernization of HCBS waiting lists, closed-loop referral systems, crisis continuum initiatives, Older Americans Act and Adult Protective Services systems, PACE expansion, ARPA-funded initiatives, executive dashboards, and self-direction strategies.
- Continuously monitors and analyzes state and federal legislative and regulatory issues and recommends advocacy and implementation strategies for health and human services programs.
- Developed, interpreted, monitored, and enforced Medicaid policies, procedures, rules, standards, court stipulations, and funding-related agreements across long-term care, HCBS, pharmacy, and state plan services.

Program Design, Implementation, and Operational Improvement

- Served in a staff augmentation role as Deputy Director for the Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services, supporting 1915(c) waiver improvement, Older Americans Act and Adult Protective Services modernization, development of Arkansas' State Plan on Aging, PACE expansion, ARPA oversight, executive dashboard implementation, and increased self-direction participation.
- Provides strategic advisory support to state managed care programs on Medicaid and healthcare topics including actuarial analysis, pharmacy policy, claims billing, program oversight, and operational improvement.
- Led efforts in two states to add more than 10 HCBS services and expand self-direction options, supporting broader access to community-based services.
- Oversaw a large municipality's efforts to create a strategic plan on aging for older adults and assisted community-based organizations in modernizing closed-loop referral systems and crisis care continuums.

Work History

- Associate Director, Guidehouse (2022 – Present)
- Business Development Executive, FEI Systems (2018 – 2022)

- Sales Executive, Government Healthcare Solutions, Conduent State Healthcare, LLC (2014 – 2017)
- Regional Director, Government and Community Relations, Senior Link, Inc (2014 – 2017)
- Division Director, Policy Development, Louisiana Department of Health and Hospitals (DHH) / Office of Aging and Adult Services (2006 – 2014)
- Attorney Supervisor, Bureau of Legal Services, Department of Health and Hospitals, Bureau of Legal Services, Baton Rouge, Louisiana (2002 – 2006)
- Attorney I, II, and III, Department of Health and Hospitals / Bureau of Legal Services, Baton Rouge, Louisiana (1998 – 2006)

Certifications, Memberships, and Awards

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

Education

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

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Melanie Bell, MS, ASA, MAAA

Director



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Professional Summary

Melanie is an Associate of the Society of Actuaries (ASA). She has a background in actuarial science and finance and actuarial work experience in the commercial and Medicaid space. She has worked on Medicaid Rate Development in multiple states and lead Rate Development for the states of Oklahoma and Georgia Medicaid programs. Melanie has experience working with a wide range of datasets performing actuarial, financial, and statistical analysis.

Professional Experience

Development of the Capitation Rates

- Lead the Rate Development for Oklahoma's Medicaid program (OHCA) for FY24 and FY25
 - Directed and delegated work for all aspects of rate development, including; calculation of the impact of program changes, trend development, Incurred But Not Reported (IBNR), managed care savings, and administrative assumption development
 - Managed the data books across two Oklahoma Medicaid programs
 - Communicated results to internal and external stakeholders
 - Developed presentation for OHCA CFO to present to Oklahoma Board on main drivers of the \$2.5B increase in Medicaid expenditures.
- Lead OHCA NEMT FY24 and FY25 Rate Development and FY22 and FY23 MLR calculations
 - Developed an NEMT rate development model to calculate accurate rates in a way that avoided the need for acuity adjustments
- Developed the model for West Virginia IDD rates
 - Conducted the data intake and data validation
 - Made improvements to the previous methodology and communicated findings to the client
 - Created regression model and data book to analyze data and develop individual budgets
- Assisted in the development of capitation rates for Georgia's Medicaid program for FY19 through FY23
 - Calculated the impact of program changes
 - Assisted in the development of trend

- Managed the data books across all three Georgia Medicaid programs (Georgia Families, Georgia Families 360, and Planning for Healthy Babies)
- Communicated results to internal and external stakeholders
- Provided statistical support for the validity study of the Minnesota Adult Protection Services intake tool
 - Analyzed the likelihood of an abuse report being screened in / out based on demographics like age, gender, race, disability type, and county
 - Used chi-square to test the statistical significance of the differences among demographic groups
- Estimated the FY20 and FY21 FFS IBNR for both Georgia and West Virginia Medicaid
- Estimated the HIF liability for the Georgia Medicaid program for the fee year 2020
- Calculated TennCare Risk Adjustment and Site of Service Adjustment for 2019
- Led the preparation of the CY23 Tennessee Comptroller Report
- Completed analysis of and draft certification for Oklahoma Alternative Benefits Plan
- Calculated monthly IBNR reserve and communicated financial impact to senior leadership within both actuarial and finance
- Evaluated Cigna's unit cost trend-setting processes and made recommendations for improvement
- Completed Quarterly Block Check to determine premium increases for renewing middle-market customers
- Developed assumptions and collaborated with the Finance team to deliver semiannual individual, small group, and large group forecasts and plan
- Performed other ad hoc projects as requested

Work History

- Director, Guidehouse (2026 – Present)
- Actuarial Director, Optum Advisory Services (2024 – 2026)
- Associate Director, Guidehouse (2019 – 2024)
- Actuarial Analyst, Aetna (2017 – 2019)

Certifications, Memberships, and Awards

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

Education

- Master of Science, Actuarial Science, Georgia State University
- Bachelor of Business Administration, Finance, University of West Georgia

Debra Ruocco, FSA, MAAA

Associate Director



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Professional Summary

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

Areas of Expertise

- Analytical skills
- Commercial pricing
- Medicaid rate setting
- Provider contracting
- Public policy
- Professional Experience

Professional Experience

Medicaid Actuarial Rate Development

- Develop annual and mid-year capitation rates for Oklahoma's Medicaid medical and dental programs, including projecting trend, quantifying impact of program changes, and evaluating managed care savings
- Serve as project manager for Oklahoma's Medicaid rate setting process, leading cross-team coordination, and deliverable tracking
- Manage analysis and reporting of state-directed payments within Oklahoma's Medicaid program, ensuring compliance with CMS regulations
- Lead the development of the Oklahoma Medicaid program budget, balancing program priorities, cost projections, and regulatory requirements to support stable funding
- Integrated a state-directed payment into Medicaid capitation rates, aligning with rate setting best practices

- Developed MLR template for medical and dental MCOs
- Completed and presented market research on Medicaid admin fees which led to redesigning the type and amount of Oklahoma's admin fees
- Led project to investigate existing risk adjustment anomalies among contracting entities; analysis included introduction of alternative risk adjustment methodology to highlight potential flaws in risk measurement of existing Tennessee methodology
- Performed national survey of Medicaid DPP (Directed Payment Programs) that pay providers up to 100% of commercial rates to quantify the prevalence of this type of payment model. Survey results informed state Medicaid client's response to hospitals that are pushing for payment up to 100% of commercial rates

Provider Shared Risk Contracts for Medicare Advantage

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

Large Group Commercial Pricing

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

Public Policy

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

Commercial Pricing

- Collaborated with local pricing teams on the peer review of rate developments and filings for various products, including Commercial (Legacy and ACA), Medicare Supplement, Medicare Part D Wrap, Federal Employee Plans, and Stop Loss
- Developed a tool to automate a large portion of the ACA annual review process. Streamlined several other team processes via automation, including quarterly reporting
- Assisted the Enterprise Pricing team during two annual ACA cycles by acting as a lead developer of ACA pricing tools and exhibits used to price businesses with more than \$10B in premiums
- Led the team that designed and now maintains the Actuarial Knowledge Library, which is an enterprise resource for all actuaries in the company

Healthcare Contracting

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

Healthcare Financial Reporting

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

Work History

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

Certifications, Memberships, and Awards

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

Education

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

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Ben Maryland, ASA, MAAA

Managing Consultant



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Professional Summary

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

Areas of Expertise

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

Professional Experience

Medicaid Plan Support

- Primary owner and leader of all actuarial work in support of health plans, including but not limited to: IBNR development, medical cost forecasting cycles, risk corridor analysis, rate adequacy research, audit compliance support, MLR template completion and validation, provider payment analysis, and more.
- Led IBNR Reserve setting during monthly close efforts. This included reviewing claim summaries and details across various categories of service and populations, completion factor development and review, deep dives into claims processing issues, collaborating with accounting partners to ensure results properly aligned to the ledger, and presenting and communicating results and implications of reserve changes to the Plan CFO and other Plan Finance and Corporate leaders.
- Led forecast modeling during periodic forecasting cycles including reviewing restated results from prior forecasting periods, data normalization for both program changes and managed care cost savings efforts, trend analysis, claims data validation, prospective adjustments for program changes and cost-saving efforts, and communication of results both in terms of total projected cost and comparison to prior budgeted forecast.

- After submitting updated projected claim cost, led the comparison of the medical forecast to the capitation rates for the period, along with any other risk-based financial arrangements such as a medical risk corridor, to assess needs for accruals.
- Developed risk corridor analysis to calculate necessary risk corridor accruals given financial input. The model would track monthly IBNR bookings and periodic forecast updates on the claim side, along with nonclaims inputs from Plan Finance partners, compared to the Medicaid Capitation rates from the state. The final calculation of the risk corridor remittance accrual would be based on managed care contract language and include sensitivity testing for variable claim results.
- Supported rate adequacy discovery and proposals. Lead in-depth research into claims data compared to capitation rate setting to find shortfalls in rate development. Suggest plan response to requests for response from Association of Health Plan requests for comment on capitation rate reception.
- Prepared actuarial entries for audit compliance efforts. Compiled, summarized, validated, and communicated audit data responses around claims data and actuarial accruals. This included MLR Report preparation, review of the final remittance calculation from the state, response to data requests from third party auditors, and supporting Medicaid responses in Medicare bid efforts that were part of a duals plan response.
- Supported RFP efforts in developing value-added benefit pricing, using internal and external sources, and providing feedback to respondent teams. Collaborated with Health Plan partners to price added benefits for the prospective new members and programs.
- Led the development of annual actuarial opinions and memorandums in accordance with NAIC instructions discussing actuarial accrual development across.

Value-Based Purchasing and Actuarial Support

- Supported the development of an actuarial service team with a focus in providing actuarial insight to value-based purchasing programs across numerous Medicaid markets.
- Developed stop loss pricing model used in value-based purchase contracts across several products and markets.
- Created benchmark targeting model, along with supporting models to forecast targets based on Medicaid rate changes and risk adjustment.
- Developed provider risk adjustment normalization module and managed proper application in provider benchmarking.

Work History

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

Certifications, Memberships, and Awards

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

Education

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

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Ryan Butterfield, ASA, MAAA

Managing Consultant



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Professional Summary

Ryan has six years of experience in healthcare and actuarial consulting with a primary emphasis on Medicaid managed care rate setting. His roles across multiple state Medicaid programs are generally focused on actuarial rates setting, including signing actuarially sound rates, with equal focus on both the development and consistency of the methodologies with CMS standards. Additionally, Ryan is regularly called upon by the client to perform recurring and ad hoc actuarial, legislative, and financial analyses based on state needs.

Areas of Expertise

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

Professional Experience

TennCare Actuarial Experience

- Managed the development and signed Medicaid capitation rates for the TennCare Dental program. Duties included overseeing and finalizing all actuarial decisions, presenting to the state, certifying rates to CMS, and responding to CMS questions regarding the rate setting process.
- Provided actuarial support in the development of actuarial sound managed care Capitation Rates for Calendar Years 2021 through 2026. Contributions include analysis of historical claims and membership data, development of trend models, fiscal analysis of legal, regulatory, and programmatic changes, risk adjustment, incorporating state-directed payments, and making sure appropriate certification of rates conforming to CMS standards
- Provided ad hoc actuarial support for state needs including time-sensitive legislative budget requests, TennCare historical performance compared to Medicare and Commercial healthcare, cost effectiveness analyses of a TennCare coverage tier that led to the expansion of that tier, fiscal projections of potential programmatic changes, introduced coverage for new services, change in payment structures for the ECF CHOICES populations and PCMH organizations, and the impacts of Tennessee Hospital Association rate variation
- Provided additional quality assurance of the rate setting process through the creation of a parallel rate setting process using an unrelated methodology for the accuracy of the capitated rates

Other Actuarial Experience

- Provided actuarial support for the rate development of Oklahoma's capitation rates from 2024 – 2026, which includes the implementation of managed care capitation rates from a Fee-For-Service arrangement
- Provided actuarial analysis and support for rate setting for West Virginia and Georgia from 2020 – 2022, including similar analysis to those performed for TennCare's rate setting process. Additionally, for West Virginia, Ryan helped develop appropriate completion and reporting of CMS-64 Payments
- Provided an independent analysis of risk adjustment methodologies comparing ACG and multiple CDPS methodologies
- Incorporation of additional rate setting quality assurance measures through the introduction of separately programmed independent analysis data

Work History

- Managing Consultant, Guidehouse (2020 – Present)

Certifications, Memberships, and Awards

- Associate, Society of Actuaries
- Members, American Academy of Actuaries

Education

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

Kory Wolf

Director



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Professional Summary

Kory is with the Value Transformation team and brings 26 years of healthcare experience. He has extensive background in data analytics; data management, SQL experience, IT business analysis; member, provider, and claim payment system configuration; and health plan daily operations. As one of the most effective and greatest-kept secrets for actuarial data development / analytics in the Medicaid consulting industry, he is at the forefront of all client data submissions between actuarial and technical consulting firms, such as Myers and Stauffer and DXC for seamless transitions into Guidehouse data systems and infrastructures. He has worked extensively with the Medicaid membership and claim data from Tennessee, Georgia, Kansas, Kentucky, and West Virginia; the membership and claim data of BCBS' PPO / POS; and HMO products in nearly all 50 states and the national commercial and Medicare claim data from Humana.

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

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

Areas of Expertise

- Managing and guiding healthcare analytics staff with the responsibility of providing output, data insights, and limitations to actuarial staff. Using expansive knowledge of industry-standard medical coding use for claims and encounter submissions and handling day-to-day interdepartmental operations of healthcare organizations
- Operating as a lead technical analyst and SQL programmer to health actuaries to develop and utilize actuarial models, analyze healthcare cost and utilization data, address data quality issues, support data reconciliation, and perform ad hoc data mining
- Maintaining client data warehouses in an SQL server environment and leading discussions on requirements for data transfer requirements, vendor software for projects, and security compliances
- Risk adjusting client data sets using various licensed products

- Performing business analyst work to evaluate user / system requirements to configure and integrate claims, provider, membership, and medical management subsystems of payment software to process claims and meet business-required adjudication rates
- Repricing client datasets using licensed tools as well as applying specific coding to work with items not covered under existing products

Professional Experience

Medicaid Managed Care

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

Other Relevant Experience

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

Work History

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

Education

- Bachelor of Arts, University of New Orleans

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Laura Rapoport, MPH

Managing Consultant



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Professional Summary

Laura is a member of the Strategy and Innovation team under the Healthcare Professional Services Practice with more than 10 years of experience driving strategic initiatives in the healthcare sector. Specializing in population health, Laura's experience span across user-led program design, research, health technology innovation, and quality improvement. Her comprehensive background has led to initiatives including developing technologies for tracking patient care, expanding access to telehealth services, and enhancing health literacy resources. Laura has also led research studies understanding health treatment utilization and spearheaded tailored quality improvement initiatives.

Her experience extends both domestically and internationally, successfully engaging diverse populations and clients ranging from Federal and state governments to healthcare providers and community organizations in countries such as Nigeria, India, Greece, Rwanda, Mozambique, and the U.S. Passionate about harnessing the power of data, user-centered design principals, and creative problem-solving, Laura is dedicated to improving health outcomes through rigorous evaluations, research-driven strategies, and transformative solutions that prioritize efficiency, equity, and impact.

Areas of Expertise

- User-led program design and design strategy
- Qualitative research
- Vulnerable population health and health equity
- Health technologies and innovation
- Quality improvement

Professional Experience

Virginia Department of Medical Assistance Services

- Led the quality workstream on implementing a new Medicaid Managed Care Directed Payment program (Item, 288 OO.9a9c) for private hospitals and health systems in compliance with state and federal regulations and laws.
- Collaborated with clinical and subject matter experts and engaged providers and hospital associations to select / develop quality measures for required CMS forms, applications, and attachments.

- Led internal and external meetings with clients and their partners providing progress updates, research findings, and consultative guidance for optimizing ongoing efforts.

Delaware, The Division of Services for Aging and Adults with Physical Disabilities

- Conducted in-depth quantitative and qualitative research and stakeholder engagement activities (e.g., desk review, interviews, focus groups, survey) to evaluate the existing respite services and caregiver needs for improving the delivery and quality of the State's respite services.
- Developed report with evaluation analyses and recommendations for the State to transform and unify respite services into an enhanced menu of supportive, flexible, and culturally appropriate services available to caregivers across age and disability spectrums in Delaware.
- Developed a program evaluation plan including strategic objectives, reporting outcomes, benchmarks, targets, qualitative and quantitative data collection measures, data sources, and reporting timelines to assess the effectiveness and impact of the Lifespan Respite Program and its associated initiatives, including pilot Volunteer, Congregate, and Emergency Respite Programs.
- Led numerous presentations to internal and external clients summarizing analytical and qualitative findings and providing consultative guidance for optimizing ongoing efforts.

New York State Podiatric Medical Association

- Developed a one-pager on the benefits of including podiatric services as part of an interdisciplinary approach to bariatric prevention and treatment approaches.

Arkansas Department of Human Services

- Developed a document outlining auto-assignment options, including benefits, challenges, and peer state examples, for the State to consider when designing a Medicaid auto-assignment process that meets the needs of all plans, current members, and eligible members.

Oklahoma Health Care Authority

- Developed CE and client-facing instructional guides and SOPs, internal tracking tools, and readiness review tools for the Dental, Medical, and Children's Specialty Programs to assesses the contracted entities (CEs) and their readiness to go-live in collaboration with subject matter experts within Guidehouse.
- Served as a Primary Reviewer / Team Lead for Administration, Enrollment, and Coverage Readiness Review Teams for Oklahoma's transition to Medicaid Managed Care. Reviewed over 400 documents for compliance with state contracts, federal and state regulations, and flagged risks or inconsistencies between workgroup discussions and submitted materials.
- Supported Oklahoma's Medicaid Managed Care implementation workgroups for Enrollment, Finance, and Quality. Developed meeting materials to share with health plans, suggested meeting topics, managed client communications, and co-facilitated debrief calls with various Oklahoma Health Care Authority clients.

- Key member of the team reviewing and preparing materials for submission to client which included managed internal team comments, conducted quality assurance checks, and facilitated discussions among various team members to resolve issues promptly and concisely.

Previous Work Experience

User-Led Program Design and Strategy

- Engaged user insights to design behavior change strategies for medication management and treatment adherence to reduce the high noncommunicable disease (NCD) burden for the Public Health Foundation of India.
- Devised policy solutions for targeting root causes of adverse mental health conditions affecting asylum-seeking children in Greece using an empathetic, iterative design approach involving key-informant interviews, experience and journey mapping, context assessments, and refugee camp site observations with Save the Children, Greece.

Qualitative Research

- Designed and implemented a retrospective study evaluating indirect costs of diarrheal disease in children and its impact on food insecurity for women and children on 1000+ participants in Peru with the Johns Hopkins Center for Global Health.
- Researched HIV status disclosure of 20+ pregnant women and trained 100+ women on community-driven HIV response to reduce mother-to-child-transmission of HIV with the Institute of Human Virology, Nigeria.
- Managed, cleaned, and analyzed a large prospective longitudinal dataset for an intergenerational study on behavioral interventions for war-afflicted youth in Sierra Leone for Harvard's T. H. Chan School of Public Health.

Vulnerable Population Health and Health Equity

- Piloted an integrated care model combining HIV care and treatment programs with NCD prevention at outpatient facilities across Rwanda through training 1200 healthcare workers in collaboration with the Ministry of Health, Rwanda.
- Developed a conceptualized model for intersectional stigma effecting fear of deportation for HIV-positive Latinx sexual and gender minorities based on distribution of health disparities and social determinants of health for the American University School of International Service.

Health Technologies and Innovation

- User-tested and deployed more than 15 digital health products including real-time data tracking and visualization tools, synthesizing more than 400k patient samples from 500 users with the University of Maryland School of Medicine.
- Operationalized a health informatics consulting unit by creating a cost center, scaling team 33%, implementing a tool measuring progress tracked by 200% and completed by 1200%, and developing long-term growth strategies with the University of Maryland School of Medicine.

Quality Improvement

- Implemented continuous quality improvement (CQI) including the development and deployment of a CQI digital platform for tracking 50 projects in 111 health facilities to strengthen the capacity and quality of Rwanda's laboratory network with the University of Maryland School of Medicine.
- Improved contact tracing, information-flow, and access to homecare for Maryland's 600K senior population through development of Maryland's COVID-19 Incident Action Plan and program guides for the Caregiver Service Corps Team in collaboration with state and local government.
- Work History
- Managing Consultant, Guidehouse (2022 – Present)
- Global Health Program Specialist, Institute of Human Virology, University of Maryland School of Medicine (2020 – 2022)
- Research Consultant, American University School of International Service (2018 – 2019)
- Graduate Reacher, Harvard T. H. Chan School of Public Health (2016 – 2018)
- HR Consultant, Mount Sinai Beth Israel Hospital (2015 – 2016)
- Research Assistant, Johns Hopkins Center for Global Health, Peru (2014)
- Research Assistant, Institute of Human Virology, Nigeria (2013)

Certifications, Memberships, and Awards

- American Public Health Association, Member

Education

- Master of Public Health, Harvard T. H. Chan School of Public Health School (2018)
- Bachelor of Arts, Cultural Anthropology, University of Michigan- Ann Arbor (2013)
- Bachelor of Arts, Art and Design, University of Michigan- Ann Arbor (2013)

Thought Leadership

- Collaborated with Digital Health and Marketing Teams and to collect an HFMA survey and publish the 2024 Health System Digital & IT Investment Trends Report
- Marie-Claude C. Lavoie... **Laura Rapoport** et al; Effect of Test and Treat on clinical outcomes in Nigeria: a national retrospective study (Submitted for publication, May 2022).
- Yamanis T, del Rio-Gonzalez, A.M, **Rapoport, L** et al; Understanding fear of Deportation and its Impact on Healthcare Access among Immigrant Latinx Men Who Have Sex with Men. Sexual and Gender Minority Health. Advances in Medical Sociology. 2021. Vol 21. Emerald Publishing Limited, Bingley, pp. 103-131. <https://doi.org/10.1108/S1057-629020210000021010>.

Christina Koster, MHSA

Director



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Professional Summary

Christina is a Medicaid transformation and managed care leader with more than 18 years of experience advising state Medicaid agencies, Medicaid managed care organizations, and providers on policy, program design, Federal compliance, procurement, operational performance, organizational effectiveness, and delivery system reform. She has led complex, multi-year engagements supporting states with managed care strategy, Section 1115 demonstrations, value-based purchasing, program evaluation, business process improvement, reporting, and stakeholder engagement. Christina serves as a senior advisor to Medicaid leadership teams and brings deep experience translating policy and regulatory requirements into actionable program, operational, and procurement strategies.

Areas of Expertise

- Advises state Medicaid agencies on policy, program, and operational strategy, including managed care, delivery system reform, value-based purchasing, organizational effectiveness, and regulatory compliance
- Leads development of Federal approval strategies and submissions, including Section 1115 demonstrations, State Plan Amendments, waiver amendments, and provider funding initiatives, and supports negotiations with CMS
- Directs program evaluations, feasibility studies, and financial sustainability assessments, including analysis of policies, procedures, workflows, operating models, cost impacts, implementation considerations, and performance improvement opportunities
- Provides executive-level advisory support on procurement and contract strategy, including scope development, RFP support, readiness tools, and compliance review
- Leads large, multi-year, multi-million-dollar Medicaid engagements, managing cross-functional teams, stakeholder relationships, deliverables, and project execution from strategy through implementation
- Designs and delivers training, technical assistance, and knowledge transfer activities that strengthen client capabilities, support change management, and improve long-term program operations

Professional Experience

Medicaid and Medicaid Managed Care

- Leading an assessment for the Alabama Medicaid Agency to evaluate the performance of two primary care case management entity programs, including review of policies, procedures, workflows, governance, role clarity, and operating model efficiencies;

conducted stakeholder interviews and vendor focus groups and developed short- and long-term recommendations to strengthen program performance, streamline operations, and improve administrative effectiveness.

- Advising the Alabama Department of Mental Health to develop a Section 1115 demonstration to improve the delivery of SUD services and to gain approval for a limited Medicaid eligibility expansion for individuals with a qualifying SUD in select Alabama counties
- Providing strategic advisory support to the Oklahoma Health Care Authority for the SoonerSelect managed care program, with a focus on Federal regulatory guidance, compliance oversight, reporting strategy, and re-procurement readiness
- Guiding the Wyoming Department of Health in redesigning its Care Management Entity program by leading key transition activities from managed care to fee-for-service, advising on Federal authority modifications, revising waiver language, and developing the scope of work to procure an administrative services organization
- Designed an interim evaluation report for TennCare's Section 1115 demonstration, as required by CMS, and created the evaluation design for its Section 1115 demonstration; continue to lead the independent evaluation of TennCare's Section 1115 demonstration
- Advised the Arkansas Department of Human Services on redesigning its review and approval process for Medicaid alternative payment models, developing a governance framework, decision trees, workflows, and standard operating procedures to improve consistency, streamline decision making, and strengthen program oversight
- Advised the Arkansas Department of Human Services on strategic options to strengthen the long-term financial sustainability of Medicaid programs, including managed care, payment reform, value-based purchasing, and long-term services and supports; developed leadership briefings for legislative engagement and authored a public-facing report outlining strategic alternatives, savings opportunities, implementation considerations, stakeholder impacts, and leading practices
- Directed technical assistance and training for TennCare's Patient Centered Medical Home and Health Link (behavioral health home) programs, to support Tennessee in achieving primary care transformation goals, including reducing total cost of care, improving quality measure performance, and integrating physical health and behavioral health services. Provided technical assistance and training to more than 350 TennCare Medicaid practices to support them in achieving Patient Centered Medical Home recognition from the National Committee for Quality Assurance. Practices also improved performance for 16 out of 18 core quality measures and reduced the total cost of care by three percent
- Guided the Kansas Department of Health and Environment in the development of an extension for the KanCare Section 1115 demonstration. Drafted the extension application to meet the Federal transparency and public notice requirements, compiled documentation of compliance with the KanCare Special Terms and Conditions, supported meetings with CMS, and guided public notice and public hearing requirements

- Facilitated the development and submission of the Alabama Medicaid Agency's Section 1115 demonstration proposal to implement a provider-led managed delivery model. Drafted content, managed the Federally required public comment process, negotiated with CMS, and assisted the State in reviewing and operationalizing the demonstration's Special Terms and Conditions as required by CMS. The approved demonstration includes Designated State Health Program (DSHP) funding and more than \$300M in Transition Pool funding to assist in the State's Medicaid transformation
- Advised the Illinois Governor's Office with its State Innovation Model design process, which was focused on strategies to improve the delivery of behavioral health services provided through the Department of Healthcare and Family Services, the Division of Mental Health, and the Division of Alcoholism and Substance Abuse. Assisted with the evaluation of health transformation strategies, stakeholder engagement, and workgroup facilitation and development of a State Health Innovation Plan (SHIP)
- Assisted the Minnesota Department of Human Services with the redesign of its case management program, including the development of a revised case management rate methodology, stakeholder engagement activities with county representatives, and support to the Department related to State Plan Amendment development
- For the Wisconsin Department of Health Services, conducted a feasibility study for implementing state-directed payment options to expand the State's fee-for-service physician UPL program to its managed care program. Identified the steps for designing, implementing, and obtaining CMS approval for a state-directed payment program
- Supported the Alabama Medicaid Agency to design and implement a managed care under which Alabama Medicaid would pay risk-bearing, provider-based regional care organizations (RCOs) on a capitated basis to provide the full scope of Medicaid benefits
 - Assisted the State in developing the protocols for providers to receive Transition Pool funding, educate stakeholders, develop application materials and instructions, and comply with Federal requirements
 - Assisted with the development and implementation of the statewide Health Home program, authorized under Section 2703 of the Affordable Care Act, to provide case management and care coordination services to approximately 300,000 individuals with chronic conditions in Alabama. Developed and refined Health Home procurement materials and readiness assessment materials
 - Developed managed care contract requirements following State laws, administrative rules, and Federal regulations
 - Led the development of a Federally required managed care quality strategy, including quality goals and objectives, program effectiveness and quality measures, monitoring approach, and major quality initiatives

- Led a project to assist the Nevada Division of Health Care Financing and Policy to evaluate options for modifying its Medicaid managed care delivery system. Considered options such as expanding the current managed care program to new geographic areas and populations. Evaluation considered the impact of managed care models on the State's supplemental payment programs and the impact of managed care on special populations including those with behavioral health issues, children receiving foster care, and children involved in the juvenile justice system. Conducted more than 30 focus groups and town hall meetings regarding the proposed delivery system recommendations
- Assisted Georgia's Department of Community Health with the design, implementation, and ongoing operations of Medicaid managed care programs. Led the development of monitoring materials and readiness review tools for the implementation of managed care for children in foster care and adoption assistance and youth in juvenile justice. Co-led the development of the operational design of a value-based purchasing program and the development of a value-based purchasing manual to guide State and managed care organization (MCO) operations
- Supported the Pennsylvania Department of Public Welfare with various activities to support its Medicaid managed care program. Developed a learning institute for the Department to train approximately 400 staff and contractors on Medicaid, health reform topics, leadership, and operations. Assisted with the development of a value-based purchasing program to encourage performance improvement on program goals
- Served as the key point of contact for a multi-year project with West Virginia's Bureau for Medical Services for the design and administration of a mandatory managed care program. Managed daily contact with the client, contracted MCOs, and other vendors, conducted an ongoing evaluation of MCO performance, developed provider network standards, evaluated provider networks, prepared annual MCO contract updates, created 1915(b) waiver renewal applications, and coordinated with CMS to obtain approval of the applications
- Assisted the Texas Health and Human Services Commission in evaluating the readiness of 17 health plans to participate in Texas' Medicaid and Children's Health Insurance Program managed care programs. Reviewed provider and member materials and internal policies and procedures to identify the operational and provider network readiness for each MCO. Conducted site visits and interviews with MCO staff

Behavioral Health

- Led a training initiative for SUD prevention providers on behalf of the Alabama Department of Mental Health Office of Prevention. Developed a Training and Technical Assistance Plan to deliver quarterly training on health equity and health disparities for more than 20 prevention organizations across Alabama
- Led the development of a SUD needs assessment for the Alabama Department of Mental Health. Used a mixed methods approach to gather information on the current state of SUD treatment services in Alabama. Compared current state to national industry leading practices and developed recommendations in the priority areas of access to care and capacity, workforce, regulatory barriers, monitoring and reporting mechanisms, and awareness and stigma associated with SUD resources and treatment
- Assisted Illinois in developing strategies to improve physical health and behavioral health integration, including behavioral health homes, data-sharing options for behavioral health providers, behavioral health self-management programs, and supportive housing services

for individuals with behavioral health needs. Prepared for and facilitated dozens of stakeholder workgroups to develop recommendations for improvements to the behavioral health delivery system

Long-Term Care

- Assisted the Wyoming Department of Health to conduct a feasibility study of adding assistive technology to the State's home and community-based waiver benefits. Conducted stakeholder interviews, issued a beneficiary survey, and conducted a landscape review of approved 1915(c) waivers to develop a report for the State with findings and recommended implementation steps.
- Assisted Alabama Medicaid with the design and implementation of an Integrated Care Network program, authorized by State legislation, to cover individuals in need of long-term care services in a nursing facility or home- and community-based setting. Provided guidance to leadership regarding Medicaid long-term care program design options and supported stakeholder meetings. Developed a concept paper to summarize program design decisions and seek input from stakeholders. Created an administrative rule on network adequacy standards for the program
- Assisted Georgia's Department of Community Health with the development of a Request for Proposals for a Medical Coordination Program to provide medical coordination services to Medicaid members who are aged, blind, or disabled
- Worked with the Illinois' Bureau of Managed Care to develop and implement a new monitoring approach for the Integrated Care Program, a Medicaid-managed care program for seniors and persons with disabilities. Led the development of business processes, databases, and standard operating procedures to support contract monitoring. Trained staff on managed care and use of monitoring tools

Work History

- Director, Guidehouse (2013 – Present)
- Project Manager, University Health System Consortium (now Vizient) (2011 – 2013)
- Consultant, The Lewin Group (2005 – 2009)

Education

- Master of Health Services Administration, Health Management and Policy, University of Michigan
- Bachelor of Science in Public Health, Health Policy and Administration, University of North Carolina

Thought Leadership

- Brinda Gupta, Baxter DeBruyn, **Christina Koster**, and Nicholas Lincoln. "States are Cultivating a Medicaid Marketplace Where MCOs Must Prove Their Worth." Guidehouse Health Insights. September 22, 2022.
- Jeffrey Meyers, **Christina Koster**, and Jason Duhon. "\$5 Billion Can Breathe New Life into Long-Term Behavioral Health Efforts." Guidehouse Health Insights. May 10, 2021.

Drew Weiskopf, MBA

Associate Director



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Professional Summary

Drew is a seasoned consultant and strategist with more than 14 years of experience in management and policy consulting within the public sector, specifically focusing on health and human services. His expertise lies in leading complex, multi-million-dollar initiatives across state and federal governments, successfully driving transformative solutions in Medicaid,

health insurance exchanges, and public health systems.

As a trusted advisor, Drew excels in designing and executing strategies that align with clients operational goals, while fostering strong relationships with state agencies and legislative bodies across multiple states and Washington D.C. His proven track record includes overseeing cross-functional teams, successfully navigating State / Federal partnership programs and delivering impactful outcomes that improve healthcare access and quality for underserved populations.

Areas of Expertise

- Project and program management
- Medicaid program and policy
- Strategic planning and execution
- Federal and State policy research
- Integrated disease surveillance
- Affordable care act
- Public healthcare delivery reform
- Child Care Subsidy and Payment Programs
- Medicaid managed care procurement and oversight
- Business process redesign
- Stakeholder engagement
- Medicaid waiver design
- Federal funding partner standards
- Waiver design and implementation

Professional Experience

Medicaid Managed Care

- Led the planning and implementation of Medicaid managed care procurements in Mississippi and Louisiana from the drafting of the procurement and draft contract to the implementation of contracts and readiness review
- Advised on care management models and social determinants of health integration into managed care contracts, identifying national trends and leading practices
- Developed and oversaw the process for the managed care compliance reporting manual for the Mississippi Division of Medicaid
- Prepared and delivered training to state procurement reviewers on processes and leading practices
- Served as state procurement subject matter expert and advised on applicable rules

Affordable Care Act

- Assisted in the establishment of the Arkansas Health Insurance Exchange and led workstreams related to plan management, consumer assistance, and CMS reporting
- Managed and led stakeholder groups to gather input and educate on the State's initiatives
- Managed the review of qualified health plans and confirmed compliance with applicable state and federal regulations
- Drafted public comment responses and supported clients through the implementation and compliance phases of complex regulatory frameworks

Medicaid Program and Policy

- Led a project for the Georgia Department of Human Services to explore opportunities to improve provider reimbursement models and improve healthcare access for low-income and uninsured populations; advanced cross-agency service coordination
- Oversaw the Mississippi Medicaid Enterprise Project Management Office (ePMO), managing over half of the State's Medicaid project portfolio and making sure alignment with enterprise goals
- Assisted the Mississippi Division of Medicaid in developing the process for Medicaid Unwind at the conclusion of the Public Health Emergency and confirmed compliance with Federal regulations
- Assisted with the implementation of new Dual Special Needs Program contracts and led the effort for real-time eligibility confirmation
- Assisted with the implementation of a new provider enrollment system with the Louisiana Department of Health

Integrated Disease Surveillance Systems

- Led project to develop business and technical requirements for an integrated disease surveillance system for the Mississippi State Department of Health
- Conducted a review of current processes and desired future state to understand the gaps and identify a comprehensive set of requirements for future technology
- Conducted research and questionnaires to understand national disease surveillance industry leading practices
- Developed a comprehensive solicitation for the state to procure a vendor for a modernized disease surveillance system

Child Care Subsidy and Payment Programs

- Served as subject matter expert on engagement with a state regarding child care subsidy rate study to determine peer states subsidy amounts and compare with cost of living rates.
- Developed thought leadership piece on initiatives governments are adopting to address affordability, availability and quality of child care
- Knowledge of the Child Care Development Fund (CCDF) and partnership between states and the Administration for Children and Families (ACF)

Other Initiatives

- Led a statewide business process redesign assessment for the Texas Health and Human Services Commission to identify operational efficiencies, process automation, and modernization opportunities
- Served as subject matter expert on childcare subsidies for Oklahoma Human Services to conduct a cost-of-living analysis and provided recommendations on subsidies

Work History

- Associate Director, Guidehouse (2025 – Present)
- Senior Manager, Ernst and Young (2022 – 2025)
- Senior Manager, Cambria Solutions (2019 – 2022)
- Senior Consultant, Public Consulting Group (2014 – 2019)
- Associate, CF Health Advisors (2013 – 2014)
- Special Project Officer, Mississippi Insurance Department (2011 – 2013)

Education

- Master of Business Administration, Clark University (2015 – 2017)
- Bachelor of Business Administration, Mississippi State University (2007 – 2011)

Chiara Alvisi

Managing Consultant



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Professional Summary

Chiara has experience supporting government agencies with managed care implementation, systems of care reviews, stakeholder engagement activities, and HCBS policy and waiver reviews. For the projects Chiara is engaged in, she provides extensive expertise in the analysis of large and complex data sets including tool development, review of policy language, report writing, and program management activities. Before Guidehouse, Chiara received her bachelor's from Cornell University, where she studied how hard sciences and the United States healthcare system intersect and interact with society and policy decisions.

Areas of Expertise

- Network Adequacy Review and Analysis
- Data Analysis and Analytic Tool Design
- Project Management and Organization
- Microsoft Office Suite (Excel, PowerPoint, SharePoint, Word)

Professional Experience

- Served as Program Manager for Oklahoma's Medicaid Managed Care implementation for Dental, Medical, and Children's Specialty Program populations. Supported in oversight of numerous facets of the project and regularly met with Oklahoma Health Care Authority leadership to review ongoing activities and future work
- Led network adequacy efforts in preparation for Oklahoma's Medicaid Managed Care implementation for Dental, Medical, and Children's Specialty Program populations. Created extensive and largely automatic analysis tools to analyze network changes overtime and compare contracted entity reported networks to the existing fee-for-service Medicaid network and each other. Regularly assisted the State with identifying points of interest within the data and communicating questions with Contracted Entities
- Served as a Team Lead for the Member Enrollment Readiness Review Team for Oklahoma's transition to Medicaid Managed Care. Developed project trackers, managed timelines, conducted a thorough review of materials submitted by health plans, and communicated key findings to the clients
- Served as the Workgroup Lead for Oklahoma's Medicaid Managed Care implementation workgroups for Technical, Provider, Legal, and Medical, Behavior Health, and Pharmacy.
- Developed meeting materials to share with health plans, suggested meeting topics, managed client communications, co-facilitated debrief calls with various Oklahoma Health

Care Authority clients, and oversaw similar activities for the additional Guidehouse team supporting eight other workgroups

- Reviewed current activities in Arkansas' Medicaid Program, particularly relating to noninstitutional services and maternal and childcare. Conducted stakeholder engagement and research of different state programs to analyze possible changes to the State's current program to maximize cost savings, quality care, and program efficiency.
- Conducted stakeholder engagement activities for Florida's Long Term Care State Ombudsman Program and supported analysis of the Program's current practices to develop recommendations to increase the efficiency and visibility of the Program throughout the state.
- Led data management workstream related to rate and fiscal integrity of state Home and Community-Based Services (HCBS) programs. Developed data collection tools, determined data analysis methods, developed detailed analysis plans and coordinated with multiple teams and contractors
- Analyzed 20 policy points of comparison between the State of Maine and six identified comparison states on programmatic activities of Assisted Living Facilities from language within state regulations and 1915(c) waivers. This analysis was delivered in an Excel-based crosswalk which provided insights into industry leading practice examples seen in comparable state policies and recommendations based on the research conducted
- Conducted numerous rate studies across a range of Medicaid-funded behavioral health services, developmental disability services, and senior and long-term care services for the State of Montana, including a cost and wage survey for service providers to capture the providers' cost of delivering services
- Supported an in-depth analysis of wages, benefits, and direct and indirect costs, rate development, a report of all findings, and the development of recommendations for the Department of Public Health and Human Services
- Facilitated extensive stakeholder engagement with providers, state staff, legislators, and other advocacy groups to guide the rate development process

Work History

- Managing Consultant, Guidehouse (2019 – Present)
- National Science Foundation, Pathways Student Summer Intern (2019)
- Cornell University, Department of Psychology, Research Assistant (2017 – 2020)

Education

- Bachelor of Arts, Biology and Society, Cornell University

Adam Goldman, MSc

Managing Consultant



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Professional Summary

Adam is a former Centers for Medicare and Medicaid Services (CMS) Technical Director and, on behalf of the Federal government, headed many of the nation's largest and most innovative Medicaid programs, such as New York's and Florida's. With more than 30 years of combined experience, he has led innovative healthcare reformations and many first-in-the-nation programs related to value-based care (VBC), delivery system reform, serious mental illness (SMI)/serious emotional disturbance (SED), and social determinants of health (SDOH). Adam also authored and co-authored numerous Federal guidance documents, such as a state Medicaid director letters (SMDL) on budget neutrality policies for section 1115(a) demonstrations, and strategies to address the opioid epidemic. He has presented national trainings on Medicaid policies related to Health IT, prescription drug monitoring programs (PDMP), modeling for expenditures related to institutions for mental disease (IMD), as well as general Medicaid statutes, rules, and requirements.

Adam has also worked for state Medicaid agencies (SMA) such as Virginia's Department of Medical Assistant Services (DMAS), run his own consultancy, and is a proud U.S. Army veteran.

Areas of Expertise

Medicaid Expertise

- Has led development and implementation of Medicaid section 1115(a) demonstration policies, on behalf of the Center for Medicaid and CHIP Services (CMCS), for numerous innovations in service delivery and financing
- Oversaw nearly a dozen state Medicaid programs which included managed care/managed care organizations (MCO), fee-for-service (FFS), home and community-based services (HCBS) and other long-term services and supports (LTSS), and designed and crafted innovative health policies
- Directed complex activities related to the policy development and design for state "delivery system reform incentive payment" (DSRIP) programs including VBC metrics / attainment goals and negotiated with SMA and other Federal / nonfederal agencies on behalf of CMS / HHS leadership
- Led approvals for several first-in-the-nation programs related to SDOH, SUD, SMI, SED, LTSS, HCBS, and uncompensated care (UC) pools
- Spearheaded many of CMS's nationwide econometric modeling efforts and designed the template and other policy documents used for states to project their SUD, SMI, and SED spending in IMD (see 'Thought Leadership' below)
- Coached state and junior staff on Medicaid financial modeling and trained them how to leverage the tools necessary to do their own cost projections

Federal Guidance and Trainings

- Co-designed, among others, CMS's nationwide guidance related to certain Health IT strategies and presented, on behalf of CMS / HHS leadership, at several national conferences
- Lead CMS drafter of national guidance to state Medicaid directors, outlining complex section 1115(a) policies for SUD, SMI, and Medicaid financing (see 'Thought Leadership' below)
- Revised CMS's T-MSIS Large System Enhancement (LSE) Standard Operating Procedures (SOP) which outline the roles and responsibilities of CMS, Mathematica, and eSimplicity SMEs, related to when states submit "test" data to CMS as part of their requisite parallel testing of large new health data systems
- Created technical written / policy documents, including, targeted special terms and conditions (STC), to confirm accurate Federal program and finance policy design, implementation, compliance, monitoring, and evaluation
- Provided general Medicaid finance and budget/cost neutrality thought leadership and was the principal CMS analyst and expert responsible for nationwide webinars and in person presentations
- Developed trend rates based on, and with the support of, HHS's Office of the Actuary (OACT), for use in determining budget/cost neutrality ceilings, known as section 1115(a) "Without Waiver" baselines
- Designed and delivered virtual training sessions for CMS and their contractors that covered, among others: Medicaid eligibility, Federal Medicaid authorities, and Federal claiming of Medicaid expenditures

Professional Experience

Arkansas Hospital to Home 1915(c)

- Currently leading development of a brand new 1915(c) "Hospital to Home" (H2H) Waiver for Arkansas that has the goal of reducing unnecessary use of hospitals and emergency departments for some of the state's most challenging target populations (aging, physically disabled and intellectually/developmentally disabled)
- Responsible for collaborating with state/contractor SMEs, to create a sustainable continuum of care for Arkansans, as the H2H Waiver's goal is for its beneficiaries to ultimately receive their HCBS in one of Arkansas' other 1915(c) LTSS programs
- Works with fellow Guidehouse team members and Arkansas Medicaid partner organizations to develop H2H training materials, policy documents, stakeholder engagement briefings, SOP, and evaluation plans
- Coaches junior staff, leads briefings to the client on a weekly basis, and presents to stakeholders as part of a panel of H2H SMEs

CMS Transformed Medicaid Statistical Information System Project

- Served as Guidehouse's Medicaid Policy SME for its subcontract under eSimplicity's Transformed Medicaid Statistical Information System (T-MSIS) project supporting CMCS's data reporting efforts
- Team policy expert and single point of contact with states/territories and CMS for nationwide implementation of health data systems changes that affected T-MSIS reporting to make sure that there was minimal degradation in the level of accuracy, completeness, or timeliness of T-MSIS data submissions
- Collaborated with a cross-functional team of Guidehouse and eSimplicity experts, advisors, consultants, and IT professionals and leveraged knowledge of Medicaid policy to identify data quality issues, find root causes and identify solutions, for LSEs
- Applied extensive knowledge of Medicaid policy to develop models and algorithms to determine causes/failures in data quality and was solely responsible for coaching stakeholders on data compliance, with regards to the operations and maintenance (O&M) portion of LSE testing
- Brought knowledge and insights from years of experience working with, and for, SMAs and CMS to develop training material customized for our client and project team members

Technical Direction

- Was the SME and Medicaid state demonstration lead for nearly a dozen section 1115(a) demonstrations focusing on: Managed Care, DSRIP, SUD, SMI / SED, UC, VBC, SDOH, HCBS/LTSS and numerous other Medicaid innovations related to Health IT
- Has particular expertise in Medicaid program financing, allowable nonfederal share sources, Federal matching rates/percentages, expenditure modeling, and development of per member per month (PMPM) caps and costs not otherwise matchable (CNOMs)
- Worked independently and solved complex policy and operational issues in collaboration with experts across CMCS, Office of General Counsel (OGC), Office of the Assistant Secretary for Financial Resources (ASFR), Office of the National Coordinator (ONC), Office of Management and Budget (OMB), Executive Office of the President (EOP), and the U.S. Congress
- Worked in close collaboration with states and other nonfederal stakeholders while overseeing the work products of several Project Officers under his supervision

Policy Analysis

- Was responsible for researching ongoing legislation, regulation, and industry changes that had the potential to affect Virginia's Medicaid program to provide Virginia DMAS leadership with clear and actionable recommendations
- Was both a general Medicaid SME and specialist in section 1115(a) demonstrations which allow states, like Virginia, to break "normal" Medicaid rules through waivers and expenditure authorities

- Due to many years working as a CMCS Technical Director, was DMAS's "go to" liaison with CMS, contractors and state leadership based on relationships developed over many years in those roles
- Contributor of original research, editing, and analysis for numerous U.S. Department of Commerce academic reports focusing on shifting U.S. demographics, minority business enterprise metrics, global market entry strategies, and alternate financing solutions

Program Management

- Lead project manager for a new 1915(c) program in Arkansas, to make sustainable care coordination pathways, intended to divert costly / high users of emergency departments and hospitals, back to their homes and communities for service delivery
- Lead project manager and CMS SME responsible for numerous multi-billion-dollar state Medicaid programs—including the development, submission, review, maintenance / monitoring, evaluation, and course corrections / corrective actions
- Guidehouse's single point of contact with states / territories, the prime contractor (eSimplicity) and CMS, for nationwide implementation of data systems changes that affected health data reporting
- Acted as Demographer-in-Residence for the Minority Business Development Agency (MBDA) and developed demographic and business analyses / comparisons between minority and nonminority business enterprises
- Oversaw the work products of numerous junior staff—including Senior Consultants, Project Officers, and Interns—and worked with leadership to conduct yearly reviews, awards, counseling, corrective actions, and performance improvement plans
- Developed SOPs, memorandums of understanding / agreement (MOU / MOA), statements of work (SOW), interagency agreements (IAA) and implemented project plans, operational plans, and budgets

Work History

- Managing Consultant, Guidehouse (2023 – Present)
- Chief Executive Officer, Constellation Analytics LLC (2021 – 2023)
- Senior Policy Analyst, Virginia Department of Medical Assistant Services (2022 – 2023)
- Technical Director, U.S. Department of Health and Human Services (2018 – 2021)
- Project Officer, U.S. Department of Health and Human Services (2015 – 2018)
- Senior Program Manager (Acting), U.S. Department of Commerce (2014 – 2015)
- Research Analyst, U.S. Department of Commerce (2014)

Certifications, Memberships, and Awards

- FAC P/PM Level I and II, U.S. Department of Health and Human Services
- Federal Appropriations Law, U.S. Department of Health and Human Services
- CRM System, U.S. Department of Commerce
- ANOVA and Regression, SAS
- ArcGIS and ArcMap Certification, Esri
- Economist Intelligence Unit, U.S. Department of Commerce
- Team Leadership and Staffing, U.S. Army
- Designated Federal Officer, U.S. Department of Commerce
- Public Speaking, U.S. Department of Commerce
- Cultural / Gender Sensitivity Training, U.S. Army
- International Migration, Georgetown University

Education

- Master of Science, American Government and Politics, Birkbeck College, University of London
- Bachelor of Arts, Political Science, California State University

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Conor Ridlon, MPP

Managing Consultant



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Professional Summary

Conor studied Political Science and Finance at Washington and Lee University and received a Master's Degree in Public Policy from Northeastern University with a concentration in Healthcare Policy. In school and previous work experience, Conor has worked with states, associations, and the Federal government in all aspects of Medicaid and HCBS policy, including Medicaid finance, program innovation and development, waivers and demonstrations, and program evaluation. At Guidehouse, Conor works in state engagement within the Payer Provider Health team.

Areas of Expertise

- Legislative analysis
- Medicaid waivers and demonstration
- Healthcare policy

Professional Experience

State Health Consulting

- Collaborated with state Medicaid agencies to enhance and optimize their Medicaid programs
- Worked on the implementation of Medicaid managed care and assisted in writing the request for proposal (RFP), development of readiness review tools for selected MCOs, analysis of MCO readiness review, communications work internally, with external entities, and the general public, and coordinated training programs for staff on managed care
- Experience with state home and community-based services programs, and the implementation of a Certified Community Behavioral Health Center program

Health Policy

- Supported state partners by analyzing legislation, 1915(c), 1332, and 1135 waivers, or 1115 demonstrations on all topics and issue areas that may impact their state Medicaid programs, dually-eligible individuals, or state-based exchanges. Developed internal positioning, documents, and strategy when these issues arise, along with briefing key internal and external figures
- Analyzed and influenced Federal policy from the Administration and the Centers for Medicare and Medicaid Services (CMS), as well as any Federal legislation that may impact the Exchanges or Medicaid, including drafting legislative language, comment letters, RFIs, and summaries to support our lines of business and the industry

Public Policy and Government Affairs

- Worked in a policy and government affairs role to assist our external and internal clients with creating company positions, white papers, talking points, and other projects and documents for our external and internal clients on all topics relating to Medicaid, Medicare, Pharmacy Benefits Manager, and other healthcare issues
- Analyzed and developed positioning and strategy on legislation from all fifty states on many healthcare issues. Responsible for managing association relations, legislative market calls, lobbying efforts, and assisting external and internal lobbyists with policy and legislative issues
- Assisted our Political Compliance and Political Action Committee teams to aid in PAC fundraising, PAC finance, and FEC compliance and filing

Work History

- Managing Consultant, Guidehouse (2022 – Present)
- Senior Health Policy Analyst, Centene Corporation (2020 – 2022)
- Public Policy and Government Affairs Analyst, WellCare Health Plans (2018 – 2020)

Education

- Master of Public Policy, Northeastern University
- Bachelor of Science, Washington and Lee University

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Heather Kiningham, MPP, MSW

Senior Consultant



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Professional Summary

Heather has expertise and experience in health program implementation and improvement, with a focus on Medicaid. She has experience working both with states and CMS to promote program compliance with state and federal requirements and leading practices. Her work has been in topical such as 1115 waivers, Medicaid managed care, and school-based services. Heather also has additional experience working to improve behavioral health and community-based services through supporting a state Medicaid 1915(c) waiver program and multiple state school-based Medicaid programs. Throughout her career, Heather has engaged in successful stakeholder engagement and feedback efforts, including leading webinars, developing and deploying surveys, and conducting interviews to inform program improvements, recommendations, and leading practices.

Broadly, Heather has technical expertise in quality improvement, program implementation, and oversight and monitoring practices for Medicaid programs. Before her work in Medicaid, Heather worked in research, studying the effects of social and health policies on individuals and communities, and has published two papers.

Areas of Expertise

- Medicaid managed care
- Medicaid waivers
- School-based Medicaid services
- Stakeholder engagement
- Oversight and monitoring
- Technical assistance and learning
- Quality and program improvement

Professional Experience

- Provides targeted support and technical expertise to the California Local Educational Agency Billing Option Program (LEA BOP) on program implementation, oversight, and improvements in topical areas such as cost reports, cost settlement, random moment time survey (RMTS), provider rate setting, and interim claiming.
- Supports student access to behavioral health services in schools through assisting the LEA BOP navigate changes and integration of reimbursement for behavioral health services in schools with the implementation of the Children and Youth Behavioral Health Initiative (CYBHI).

- Leads school-based Medicaid work with the Alabama Medicaid Agency on their school-based Medicaid program. Acts as subject matter and technical expertise on oversight and monitoring to identify areas for improved State oversight and recommend solutions to comply with CMS guidance and improve school-based Medicaid services.

Mathematica

- Created and designed 1115 HRSN monitoring tools, assisting with the creation of quality measures for CMS oversight. Conducted cross-tool coordination to align monitoring tools with other 1115 demonstration components.
- Supported Iowa Medicaid's HCBS 1915(c) redesign, specifically working to improve system navigation for state employees, care coordinators, and beneficiaries to better access and understand available resources, programs, and community-based services.
- Co-wrote a beneficiary support system (BSS) toolkit to promote technical assistance and learning to states to adhere to Federal regulations surrounding managed long-term services and supports (MLTSS). Lead interviews with state Medicaid programs and advocacy organizations to inform toolkits.
- Organized and coordinated bimonthly webinar presentations with more than 100 participants on behalf of CMS on managed care regulation updates and data collection / tool requirements. Provided regular technical support and expertise to states on managed care reporting, including the Managed Care Program Annual Report (MCPAR).

University of Michigan

- Co-author of a paper on noncontractual relations between private mutual aid and government during the COVID-19 pandemic.
- Designed a mutual aid network survey to gauge community needs and grassroots assistance / organizing during the COVID-19 pandemic, connecting with nearly 200 mutual aid advocates across the United States.

Poverty Solutions

- Conducted over a dozen interviews and performed a qualitative analysis of responses of Parkside Resident Resource Connections.
- Created nearly a dozen policy and program recommendations to connect Detroit communities with mental health services through community center programming to inform policies of the City of Detroit's Park's Department.

Oregon Health Authority

- Researched leading practices of social determinants of health (SDOH) screening measures, including the design of SDOH quality metrics and unintended consequences of screening to inform the creation of a standardized SDOH screening quality measure for the Oregon Health Plan.
- Surveyed and interviewed more than 20 Transformation Center imitative leads to improve the Center's collective efficiency and effectiveness of goals, values, and mission. Presented the research results and recommendations to the Director of the Transformation Center and initiative leads to inform initiative alignment and collaboration.

Work History

- Senior Consultant, Guidehouse (2023 – Present)
- Health Analyst, Mathematica Policy Research (2021 – 2023)
- Research Assistant, University of Michigan School of Social Work (2019 – 2021)
- Independent Student Consultant, Poverty Solutions (2020 – 2021)
- Summer Fellow, Transformation Center, Oregon Health Authority (2019)

Education

- Master of Public Policy, University of Michigan Ford School of Public Policy
- Master of Social Work, University of Michigan School of Social Work
- Bachelor of Arts, Political Science, American University

Thought Leadership

Publication

- Zullo, Roland, and **H. Kinningham**. “Noncontractual Relations Between Private Mutual Aid and Government During a Crisis.” *Journal of Sociology & Social Welfare*, vol. 49, no. 2, June 2022, pp. 93-113
- **Kinningham, Heather**. “Health as a Planning Problem: Combatting Diseases of Poverty.” *Agora Journal of Urban Planning and Design*, 2020, pp. 54-63.
<http://hdl.handle.net/2027.42/154843>

Hon. Lance Robertson, MPA

Partner



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Professional Summary

Lance has extensive experience working with programs and services that support the nation's most vulnerable and marginalized populations as the former U.S. Assistant Secretary for Aging and Administrator, U.S. Department of Health and Human Services, Administration for Community Living (ACL) from 2017 to 2021. His unmatched experience in the development and execution of large public sector agencies, both at the state and federal level, brings a unique point of view to any engagement. Lance also has the practical experience of creating partnerships and successful collaborations across disparate agencies and partners, increasing the potential for impactful solutions with lasting effects.

He has performed critical work for providers, payers, state, and Federal agencies, community-based organizations, hospitals, and various other public and private sector clients. His focus within the public sector includes social determinants of health, long term care, and health equity for older adults and people with disabilities. Client work examples include:

- Managing a project with Arizona Medicaid to evaluate the impact of opioids / substance abuse on tribal communities
- Guiding the State of Florida's development of a Community Integrated Health Network (CIHN) and standing up a Network Lead Entity (NLE)
- Assisting community-based organizations in contracting with healthcare plans
- Leading the development of Oklahoma's Multisector Plan on Aging (MPA)
- Working with Lt. Governors across two dozen states in operationalizing Federal relief funds and coordinating statewide Home and Community-Based Services (HCBS) service efforts
- Assisting states (Arkansas, Oklahoma, Georgia, South Dakota, etc.) with ARPA Section 9817 Federal relief funds for expanding, improving, and strengthening HCBS services
- Counseling the Veteran's Administration on rebalancing to community-focused care
- Working with New York on an innovative falls prevention model
- Engaging the nursing home industry on pivoting unused capacity to serve older adults as a home and community-based provider
- Supporting hospital data and collection analysis in Oklahoma
- Reviewing effectiveness of Adult Protective Services program in Minnesota
- Evaluating impact of public health emergencies on people with disabilities in partnership with the Association of State and Territorial Health Officials

Areas of Expertise

- HCBS and Long Term Care (LTC) with a focus on aging / disability
- Medicaid, Older Americans Act, and safety net services
- Value-Based and accountable care solutions
- Service program development and execution
- Interagency collaboration
- Community-based organization network development
- Effective stakeholder engagement
- Social determinants of health
- Telehealth
- Legislative engagement and advocacy
- Hospital discharge and diversion programs

Professional Experience

U.S. Department of Health and Human Services, Administration for Community Living (ACL)

- Nominated by President Donald Trump and unanimously confirmed by the U.S. Senate; served as the nation's gerontologist as well as lead on national aging and disability issues and Federal programs.
- As Administrator, oversaw the programmatic bandwidth of ACL services (36 programs) focusing on helping older adults and people with disabilities live independently in the community. The population targets represented more than 160 million Americans. Oversaw the agency's \$3.6B budget and staff resources in D.C. and across nation in regional offices.
- Programs fell into several service categories, namely through the Administration on Aging, the Administration on Disabilities, the Center for Innovations and Partnerships, and the National Institute on Disability, Independent Living and Rehabilitation Research. The agency also included operational offices assisting with budgeting, policy development, grants, media relations, Congressional affairs, evaluation, etc.
- Served on workgroups, committees, and task forces within Health and Human Services (HHS) and the Federal government to represent the interests of HHS and ACL (opioids, hurricane response, COVID-19, etc.). Responded boldly to the COVID-19 pandemic by bolstering programmatic support in an unprecedented way to safely meet the needs of two highly impacted populations.
- Led significant work with the White House, primarily the Domestic Policy Council, in the areas of disability employment, elder abuse, healthcare, suicidality for people with disabilities, serious mental illness, guardianships, homelessness, etc.
 - Secretarial designee for global health affairs and abuse prevention.
 - National Chairman for multiple councils / boards on healthcare, aging, and disability.
 - Selected as chair of the U.S. Access Board (twice – 2018, 2020).

- Chair, Executive Review Board, U.S. Access Board.
- Established global leadership in aging, served in multiple events as the Secretary's proxy in representing the U.S., including an Asia-Pacific Economic Cooperative (APEC) summit in Chile. Also, served on the global oversight council for the National Academies of Medicine.
- International work: Australia, China, Canada, Japan, and India.
- Designated Chair of the 16 agency Federal U.S. Elder Justice Coordinating Council.
- Co-led multiple diversion and discharge initiatives with HRSA and CMS to reduce the number of unnecessary hospital admissions, shorten hospital stays, and support successful discharge planning.
- Worked with Surgeon General on Opioid public awareness campaign.
- Created and co-led the agency wide Committee to Address Abuse for Children with Intellectual and Developmental Disabilities.
- Launched and co-chaired the agency wide Disability Collaborative.
- Oversaw ACL's work with Congress for the reauthorization of the Older Americans Act.
- Led agency's role in emergency preparedness / response following three 2017 hurricanes.
- Created key partnerships with other Federal agencies including the Department of Labor, Department of Justice, Veteran's Administration, Department of Education, and others.
- Launched the National Center for Person-Centered Thinking, Planning, and Practice in partnership with Centers for Medicare and Medicaid (CMS).
- Pushed for strengthening relationship and discovering more commonalities between the aging and disability networks.
- Launched the Multi-Agency Task Force on Increased Employment, a voluntary Federal committee of a dozen Federal agencies doing program work in this space.
- Created a stronger support structure for the work done by the agency with tribes.
- Celebrated annual Disabilities Awareness Month with 2017 joint event co-sponsored by the Department of Labor and Major League Baseball.
- Oversaw all critical administrative functions of agency including budget development, policy proposal, Congressional responses, key report generation, supporting HHS Reimagine campaign, serving on HHS Secretary's Opioid Task Force, etc.
- Provided leadership for 30th anniversary celebration of Americans with Disabilities Act.
- Worked with Veterans Administration to expand home and community-based services.
- Enacted the Congressional RAISE Act and SGRG Act in launching Federal committees focused on better services to family caregivers and grandparents raising grandchildren.
- Worked with the Administration for Children and Families on the Administration's Welfare Reform priority and an initiative on addressing homelessness for older adults.
- Launched an HHS wide home and community-based services council.

- Managed Memorandum of Agreement with the National Aeronautics and Space Administration (NASA).
- Spearheaded significant work for ACL and HHS in linking health with human services to better appreciate value-based care through social determinants services.
- HHS Secretarial proxy: National Association of Attorneys General (2018), APEC in Chile (2019), Department of Justice Surge (2019), Department of Justice Elder Abuse Summit (2020). Placed on HHS leadership roster (6th) for devolution event.

Oklahoma Department of Human Services (OKDHS), Aging Services

- Served as the chief advocate for seniors and adults with physical disabilities for the State of Oklahoma. Directed Aging Services (AS), designated by both the Governor and Federal government, in programmatic offerings and service delivery. Responsible for approximately \$325M program and administrative dollars (State / Medicaid) and employed a team of 250. AS offers 15 major programs, which includes (select): Adult Day Health, Respite, Transportation, Legal Services, Ombudsman, Senior Employment, and the ADvantage Medicaid waiver. Additionally, AS is the federally designated oversight agency for the Older Americans Act, which provides funding for a variety of localized services, notably senior meals. AS touches 400,000 Oklahomans annually.
- Successfully broadened network and developed a robust array of partners, including multiple state agencies, internal (OKDHS) partners, tribes, higher education, corporations, faith based organizations, mental health association, and many others.
- Strengthened the agency's relationship and communication with the 11 Area Agencies on Aging, the Oklahoma Association of Regional Councils, and five Centers for Independent Living.
- Led division thru budget reduction cycles (2009, 2010, 2014, 2015, 2016, and 2017).
- Successfully transitioned the Senior Community Service Employment Program to the division from the Oklahoma Securities Exchange Commission.
- Supported Oklahoma's decision to be the first state to pass the CARE Act which supports better coordination with family caregivers when someone is released from a hospital setting.
- Provided accurate and thorough contract management / oversight to more than 800 partners.
- Successfully launched key initiatives like the Aging and Disability Resource Consortium, ELDERS program, the No Wrong Door initiative, and National Core Indicators (Aging and Disability).

Oklahoma State University Gerontology Institute (academic unit)

- Housed in the College of Human Environmental Sciences (CHES), the Institute ran the multidisciplinary gerontology program for the University. In this position, was responsible for all noncredit programming, conference management, contracts, grants, special projects, distance education, and training offerings for business and industry contacts.

Oklahoma State University CHES University Extension (administrative unit)

- Provided leadership for the CHES division (18 FTE, annual budget of \$3.4M), managing 325 annual noncredit programs, credit courses, special events, marketing campaigns, distance education, and service learning contracts. Served on college and university executive committees and strategic planning groups. Provided overall leadership in international, distance education, and extramural funding efforts. Managed contractual responsibilities, including the nationally recognized Replenishing the Caregiver program and the administrative management of Partnerships for Aging. Provided concurrent leadership for the Gerontology Institute.

Partnerships for Aging, Oklahoma State University

- Served as the chief administrative officer for the then largest regional gerontology association in the U.S. Oversight for all organizational activities, including a large annual conference, multiple statewide forums throughout the region, membership drives, webpage development, the production of two peer reviewed journals annually and much more. Made sure the organization had a strong presence and met membership needs in the 18 state region. Managed budget, fundraising, recruiting and supervising 50 volunteers annually, interacting daily with board members, providing long range planning, negotiating contracts, using available technology, etc. Provided oversight for the merger of the Southwest Society on Aging and the Mid-America Congress on Aging.

Staff Sergeant (E6), U.S. Army and U.S. Army Reserves

- Extensive and successful career. Throughout eight years of service, held a variety of positions and received specialized training in the following areas: Adjutant General Corps, Infantry, and Security. Numerous awards and honors. Honorably discharged.

Work History

- U.S. Assistant Secretary for Aging at Health and Human Services Administration on Community Living (2017 – 2021)
- State Director, Aging Services, Oklahoma Department of Human Services (2007 – 2017)
- Director, Oklahoma State University (1994 – 2005)
- Staff Sergeant, U.S. Army and U.S. Army Reserves (1989 – 1997)

Certifications, Memberships, and Awards

- Awardee, The Caring Award (Advocate), The Caregiving Years Training Academy (2022)
- Member, University of Central Oklahoma (UCO) President's Council of Advisors (2021 – Present)
- Technical Expert Panel, HHS Substance Abuse and Mental Health Services Administration (SAMHSA), "Older Adults and Serious Mental Illness" (2020 – 2021)
- Villages OKC Board, Oklahoma City, Oklahoma (2021 – Present)

- Sleep Smartz Board, Edmond, Oklahoma (2021 – Present)
- In Federal role, served on numerous committees including:
 - COVID-19 HHS and FEMA leadership team (various committees). Multi-agency
 - HHS COVID-19 Operation Warp Speed
 - Elder Justice Coordinating Council (Chair). Multi-agency
 - U.S. Access Board (Chair, Vice Chair). Multi-agency
 - Multi-Agency (11 Federal agencies) Task Force on Improving Employment for People with Disabilities (Chair)
 - White House National Council on the American Worker. Multi-agency
 - HHS Secretary's Tribal Advisory Council
 - Coordinating Council on Access and Mobility. Multi-agency
 - HHS Disability Collaborative (Co-Chair)
 - HHS Patient Centered Outcomes Research Trust Fund Leadership Council
 - National Academies of Medicine Global Oversight Board for Health Longevity
 - HHS Council on Economic Mobility
 - HHS SUPPORT Act Opioid Task Force
 - National Action Alliance for Suicide Prevention. Multi-agency
 - Family Caregiving Advisory Council, RAISE Act. Multi-agency
 - Supporting Grandparents Raising Grandchildren. Multi-agency
 - HHS Home and Community-Based Services Council (Chair)
 - White House Workforce Grand Challenge. Multi-agency
 - HHS Health Disparities Council
 - HHS President's Council on Sports, Fitness, and Nutrition
- Past President, National Association of States United for Aging and Disabilities (NASUAD), Washington, D.C., 2007 to 2017. NASUAD is the nation's most influential aging professional organization. Various roles and responsibilities include (select):
 - Member, Oklahoma Public Employees Association Political Action Committee Board of Directors, Oklahoma City, Oklahoma (2015 – 2017)
 - Co-Leader, Alzheimer's State Plan Task Force, Oklahoma City, Oklahoma (2015 – 2017)
 - Senior Advisory Board Member, Oklahoma Healthy Aging Initiative, OU Health Sciences Center, Oklahoma City, Oklahoma (2009 – 2017)
 - Appointee, Catastrophic Health Emergency Task Force, Oklahoma State Department of Health, Oklahoma City, Oklahoma (2008 – 2017)
 - Appointee, Senior Advisory Committee on Statewide Emergency Response, Oklahoma State Department of Health, Oklahoma City, Oklahoma (2008 – 2017)

- Delegate, Centers for Medicare and Medicare Services Agency Advisory Body, representing the National Association of States United for Aging and Disabilities, Washington, D.C. (2011 – 2013)
- Appointee, Oklahoma Attorney General's Task Force to Improve End-of-Life Care, Oklahoma City, Oklahoma (2004 – 2005)
- Distinguished Alumni Award, University of Central Oklahoma, Edmond, Oklahoma (2019)
- Pi Alpha Alpha Honorary Initiation, University of Central Oklahoma, Edmond, Oklahoma (2019)
- U.S. Access Board Chair Recognition, Washington, D.C. (2018)
- Leadership Recognition Award, State of Ohio, Toledo, Ohio (2018)

Education

- Master of Public Administration, University of Central Oklahoma (2013)
- Bachelor of Science, Business, Oklahoma State University (1993)
- Graduate, The Governor's Executive Development Program for State Officials, State of Oklahoma, Office of Personnel Management (2010)
- Graduate, Oklahoma Aging Advocacy Leadership Academy, Oklahoma Department of Human Services, Aging Services (1998)
- Graduate, University of Oklahoma and Oklahoma State University Management Development Program (1997)
- Graduate, Leadership Program, Oklahoma State University (1996)

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Coy Jones, PhD

Director



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Professional Summary

Coy has extensive experience in Medicaid policy and finance, with a specific expertise in home and community-based services rate setting, waiver design, supplemental payments, and delivery system performance evaluation. He has an excellent track record in supporting state healthcare delivery system and payment reform efforts to transform services for behavioral health and developmental disabilities clients. His recent experience includes conducting rate studies for community mental health clinics, Intermediate Care Facility (ICF/DD), Medicaid 1915(c) waiver services, and physician services in Montana, South Dakota, Wyoming, Illinois, Kentucky, West Virginia, and New Hampshire.

Areas of Expertise

- Institutional and community rate setting
- Behavioral health and developmental disabilities systems Medicaid waivers design and home and community-based services
- Medicaid supplemental payment programs

Professional Experience

Rate Setting

- Directs the multi-year contract with the State of Wyoming to perform ongoing maintenance and analysis of the State's Medicaid reimbursement programs. Oversees Physician UPL and Hospital UPL supplemental payment programs, as well as annual UPL demonstration deliverables. Annually prepares work plans and budgets to outline the planned tasks for the contract year. Responsible for the day-to-day correspondence with Wyoming State staff and the timely response to all requests.
- Oversees rate development for home and community services and NF for Montana's Department of Public Health and Human Services (DPHHS). Led a reimbursement review of physician and professional services, as well as a major rate study of the community service array, including adult behavioral health, children's mental health, developmental disabilities, and senior and long-term care services. Developed a cost reporting plan covering community service providers and is currently assisting in development of a prospective payment system for CCBHC services.
- Served as a project manager for a detailed rate study of South Dakota's 1915(c) CHOICES waiver for individuals with intellectual and developmental disabilities. Led monthly

stakeholder meetings with providers and state staff, conducted a provider cost and wage survey, developed a new rate methodology, recommended benchmark rates, assisted with expanding the existing service array, and reviewed the fiscal impact of implementing recommended rates over the engagement. The results of the rate study led to ongoing implementation work including the development of service definitions for the waiver application and a budget estimation tool.

- Conducted a detailed RBRVS-based rate update for professional services reimbursed through the State of Wyoming's Medicaid fee schedule. The analysis included recommendations to align Medicaid reimbursement rules with current Medicare ground rules and included recommendations for developing dental and select behavioral health therapy rates under an RVU-based fee schedule. Served as team lead for the project.
- Served as project manager for a rate study for intermediate care facility (ICF) and HCBS residential services for the State of Illinois. The rate study includes the development of rate methodologies across a wide array of settings, Medicaid authorities, and residential models, as well as facilitating an intensive stakeholder feedback and approval process, developing and administering cost and wage surveys, and estimating fiscal impacts under a variety of scenarios.
- Directed a rate study of costs and wages for home and community-based waiver services for the Commonwealth of Kentucky. The rate study included facilitating an intensive stakeholder feedback and approval process, developing, and administering cost and wage surveys, and developing rate components, rate recommendations, and related fiscal impacts.
- Conducted numerous rate studies across a range of Medicaid-funded behavioral health services for the District of Columbia, including a cost survey for Medicaid behavioral health providers and community-based waiver programs, as well as a cost survey for a sample of the District's group home providers. These studies involved in-depth analysis, a report of all findings, and the development of recommendations for the Department of Behavioral Health.
- Developed an improved reimbursement methodology for Ohio's intermediate care facility providers that adjusts payments for acuity more robustly, encouraging ICF providers to take high-need consumers while incentivizing community services for consumers with lower-intensity needs. Served as project manager and oversaw all aspects of the project, including developing a new acuity instrument, analyzing cost reports, establishing rate setting and fiscal impact models, and drafting recommendations for implementing a quality incentive program to accompany the reimbursement methodology.
- Tasked with a comprehensive rate study of all medical fees regulated by the Commonwealth of Massachusetts' workers' compensation fee schedule, including hospital inpatient and outpatient services, ambulatory surgical centers, and physician and professional services. Worked to transition the Commonwealth to a Resource-Based Relative Value Scale (RBRVS)-based fee schedule, which includes a) the development of a state-appropriate RBRVS fee schedule and conversion factors specific to the needs and requirements of the industry; b) an analysis of potential economic indicators to be used as the basis for advancing conversion factors overtime; and c) detailed guidelines for implementation and transition, with Massachusetts-specific reimbursement ground rules.

- Assisted the Industrial Commission of Arizona in transitioning to an RBRVS fee schedule from the current Arizona Physician and Pharmaceutical Fee Schedule, which is calculated using an algorithm that synthesizes fee schedules used in several peer states. Completed implementation includes a) the development of a cost-neutral RBRVS fee schedule and conversion factors specific to the needs and requirements of the ICA; b) an analysis of potential economic indicators to be used as the basis for advancing conversion factors overtime; and, c) detailed guidelines for implementation and transition, with Arizona-specific reimbursement ground rules.

Medicaid Supplemental Payment Programs

- Currently assisting the State of Wyoming with a review of the State's Supplemental Payment Programs to propose and develop alternative UPL-based supplemental payments to meet WDH and Wyoming provider needs. This work involves assessing the feasibility of different potential funding sources, including intergovernmental transfers and provider assessments, as well as identifying strategies for including nontraditional provider types in supplemental payment programs. Serving as the project lead for the review.
- Manages the State of Wisconsin's Physician UPL program, which provides revenue increase to the Medicaid upper payment limit for the University of Wisconsin Medical Foundation's physician practice plans. Over sees annual Average Commercial Rate calculations, processes supplemental payments and annual reconciliations, and provides necessary audit support. Served as the primary client contact, managed project operations, maintained database functionality, performed calculations, produced project documentation, and established uniform processes for ACR, supplemental payments, and annual reconciliations.
- Serving as fiscal administrator for the State of Texas' Medicaid 1115 waiver Delivery System Reform Incentive Payment (DSRIP) supplemental payment program. Responsible for managing templates used by providers to report health measure achievements, aggregating provider data, assessing provider performance, and calculating provider financial requirements and payments for meeting performance benchmarks.
- Administered the Physician UPL supplemental payment program for the State of Colorado, including revenue increase to the Medicaid upper payment limit for the University of Colorado's physician practice plans.
- As project manager, oversaw annual Average Commercial Rate calculations, processing of supplemental payments and annual reconciliations, and provided necessary audit support.
- Served as administrator for the Medicaid UPL for the University of North Carolina and East Carolina University's physician practice plans. Performed annual Average Commercial Rate calculations, processed supplemental payments and annual reconciliations, and provided necessary audit support. He served as the primary client contact, managed project operations, maintained database functionality, performed calculations, produced project documentation, and established uniform processes for ACR, supplemental payments, and annual reconciliations.

Performance Evaluation and Medicaid Waiver Reform

- Assisted Alaska's Department of Health and Social Services determine whether privatization of Alaska's only state mental hospital is feasible and can generate cost savings without diminishing quality of care. Responsible for managing all aspects of the project and delivering the final report and recommendations.
- Led a performance review of the Alaska's behavioral health and long-term care systems on behalf of the Division of Legislative Audit in order to evaluate the efficiency and effectiveness of services administered by Alaska's DHSS. The review included all aspects of these system, including opportunities for cost collaboration with Federal agencies such as Veterans Affairs and the Indian Health Service. Responsible for overseeing the project, identifying key stakeholders, conducting onsite visits and interviews, and delivering the final recommendations and report.
- Conducted an independent assessment of the State of Texas Nonemergency Medical Transportation waiver program, evaluating the cost effectiveness, accessibility, and quality of State services. Responsible for managing all aspects of the project and delivering the final report and recommendations.
- Performed an independent evaluation of Phoenix Children's Hospital's use of Safety Net Care Pool funds, in alignment with Federal requirements stipulated in Arizona's Medicaid 1115 waiver establishing the fund. Responsible for reviewing the expenditures involved in SNCP financing and determining the continuing necessity of SNCP funding for the hospital in the post-ACA environment.

Work History

- Director, Guidehouse (2018 – Present)
- Senior Consultant, Public Consulting Group (2016 – 2018)
- Consultant, Public Consulting Group (2012 – 2016)
- Education Management Analyst, Teach Newark Public Schools (2012 – 2013)
- Program Coordinator, Holy Cross College (2002 – 2011)
- Adjunct Professor of Philosophy, Holy Cross College (2002 – 2011)

Education

- Program in Analytics and Statistical Studies, Analytics Certificate (in progress), Institute for Statistics Education
- Doctor of Philosophy, Candidate in Religion, University of Chicago
- Master of Arts, Theological Studies, Claremont School of Theology
- Bachelor of Arts, Philosophy, University of Georgia

David Garbarino, MPA

Director



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Professional Summary

David has more than 30 years of experience in both private and public sector leadership positions in healthcare finance, management, and policy. He has extensive knowledge of the healthcare market, strategic planning, analytic development and data analysis, and reimbursement with a focus on public payer and state Medicaid programs. David has worked in hospital, health plan, state government and now consulting settings giving him broad exposure and understanding of the healthcare industry.

Areas of Expertise

- Strategic planning risk adjustment
- Medicaid rate setting and reimbursement
- Upper payment limit
- Public policy analysis Federal finance
- Data assessment / analytics
- MCO / ACO strategy

Professional Experience

Guidehouse

- Provide rate setting consulting leadership to states and hospitals with a focus on innovative methodologies for institutional care
- Lead numerous engagements with a recent focus on innovative nursing facility reimbursement
- Worked with hospitals to assess their Medicaid book of business with a focus on contract revenue compliance and growth
- Developed supplemental payment programs for states to fund quality improvement

Massachusetts Executive Office of Health and Human Services (EOHHS)

- Oversaw provider reimbursement strategy and rate development for MassHealth statewide institutional and ambulatory providers and health plans
- Directed MCO / ACO capitation rate development
- Headed risk adjustment application and development of Social Determinants of Health (SDOH) model

- Led development of new acute hospital reimbursement systems based on 3M tools
- Built agency wide analytic support unit

Celticare Health plan

- Responsible for the oversight, development, and ongoing financial planning and budgeting of revenues and expenses for startup public payer MCO
- Oversaw managed care reimbursement modeling, reporting, and analysis and financial improvement projects
- Analyzed regulatory and payment legislative changes that impacted health plans and providers

Boston Children's Hospital

- Led strategic reimbursement and revenue planning for state government payers
- Directed all aspects of annual re-procurement state Medicaid contract focusing on revenue growth
- Evaluated the financial impact of public policy changes and presented findings to senior leadership
- Negotiated out of State Medicaid reimbursement agreements with state governments
- Led a multidisciplinary team to revise front-end operations for government payers and a team for Federal 340B drug discount program

Cambridge Health Alliance

- Directed managed care contract negotiation, implementation, and analytic modeling for 400-bed safety net acute care academic community hospital
- Negotiated, operationalized, and administered all third party contracts
- Managed disproportionate share / safety net reimbursement
- Conducted financial planning, budget, and reimbursement for captive Medicaid MCO

Work History

- Director, Guidehouse (2021 – Present)
- Principal, Highland Health Strategies (2020 – 2021)
- Director of Purchasing Strategy and Analytics, MassHealth, Commonwealth of Massachusetts - EOHHS (2012 – 2020)
- Director of Finance (CFO), Celticare Health plan (2009 – 2012)
- Director, Government Finance Programs, Boston Children's Hospital (2005 – 2008)
- Director of Managed Care Finance, Cambridge Health Alliance (1998 – 2005)

Education

- Master of Public Administration, Maxwell School of Citizenship, Syracuse University
- Bachelor of Arts, Economics and Political Science, Syracuse University

Dustin T. Schmidt

Director



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Professional Summary

Dustin has more than 15 years of consulting experience working with government healthcare agencies to transform their organizations and operations, build policies and procedures, and implement strategies and recommendations to fulfill their missions. Dustin brings deep Medicaid and long-term services and supports subject matter expertise, combined with proven strategies, tools, and approaches that help clients thoughtfully and efficiently execute tasks. He has worked with State health clients in fifteen states including Alabama, Arkansas, Georgia, Kansas, Kentucky, Louisiana, Minnesota, Mississippi, North Carolina, New Hampshire, Oklahoma, Rhode Island, South Dakota, Utah, and West Virginia.

Areas of Expertise

- **Program Design and Implementation:** Designs and implements state healthcare reform initiatives – which involves performing a variety of activities, including contract development, creating / updating waiver applications, crafting new policies and procedures, and leading strategy design sessions.
- **Performance Improvement and Assessments:** Works closely with state agency leadership to assess program operations and quickly identify opportunities for improvement that lead to efficiencies across people, technology, and processes.
- **Stakeholder Engagement and Workgroup Facilitation:** Expert at facilitating challenging conversations and developing communication materials for a variety of purposes and audiences, including public stakeholder engagement sessions, town halls, and regulatory agencies (e.g., CMS).
- **Analytics, Evaluation, and Research:** Supports clients on all projects to use data and industry leading research to drive their decision making.

Professional Experience

Program Design and Implementation

- **Rhode Island's Executive Office of Health and Human Services:** Supported the State to design and implement two new services:
 - *Person-Centered Options Counseling (PCOC):* Designed and implemented a new PCOC program and network to assist consumers who are entering into or inquiring about the State's system of publicly and privately financed LTSS. Successfully supported EOHHS to launch a PCOC pilot in March 2021 and a full system launch in August 2021. Prepared more than 100 deliverables to support PCOC implementation including various pros / cons listings to support EOHHS decision making, a no wrong door strategic plan, PCOC operational manual, PCOC fact sheets, and PCOC policy and procedures.

- *Conflict-Free Case Management:* Advised EOHHS to design and implement a statewide system for providing case management for all Medicaid HCBS participants. Developed a Strategic Plan and an Operational Program Manual to support case managers.
- **Arkansas Medicaid:** Led a team to create a new state agency division to streamline its provider licensure, certification, and monitoring functions across five existing state agencies. Eliminated duplicate activities by successfully streamlining the provider certification process.
- **Alabama Medicaid:** Led a more than 500 employee organization through a reorganization as it moved from a fee-for-service to a managed care delivery system. Developed and implemented a new agency wide organizational structure that streamlined operations and removed duplication. Developed new business processes to support new staff roles and functions.

Performance Improvement and Assessments

- **Utah Adult Protective Services:** Led a team to identify opportunities for improvement and create a strategic vision that supported the agency's future direction. Provided regular project management that included tracking decisions, action items, and risks. Regularly adjusted the team's focus to best address the client's key priorities and immediate challenges.
- **Mississippi Medicaid:** Led an assessment of Mississippi Medicaid's managed care program and its hospital access payment program to identify opportunities for improvement. Successfully developed a report, within a tight legislative timeframe, that identified 29 findings and provided 31 recommendations for operational improvement.
- **South Dakota LTSS:** Conducted an assessment to improve South Dakota's LTSS operations and approach. Guidehouse produced a final report that identified 23 findings and 43 recommendations for improvement. Provided recommendations to improve ADRC intake processes, which were found to be inefficient and burdensome to specialists, and to update the ADRC resource directory to enhance its utility and accuracy.
- **Kansas Medicaid:** Conducted an operational assessment across multiple state agencies that administer Medicaid long-term care, behavioral health, and physical health services. Interviewed more than 50 department leaders and program area managers to identify areas of deficiency, duplication, and/or uncoordinated processes as part of day-to-day operations. Successfully provided a report that identified more than 75 opportunities for improvement.
- **North Carolina Medicaid:** Assessed the operational structure, processes, and staffing needs for the budget, finance, cash management, and program integrity departments. The evaluation and recommendations resulted in changes to the organization structure, staffing, and skillsets and improved reporting and business processes.

Stakeholder Engagement and Workgroup Facilitation

- **Alabama Medicaid:** Led a twenty-member Quality Assurance Committee to identify quality measures for a \$1B Medicaid long-term care program.
 - Presented to the Committee on Federal and state requirements, leading practices, and benchmark data to assist the Committee in selecting 35 quality measures.

- **Rhode Island's Executive Office of Health and Human Services:** Developed the State's stakeholder engagement strategy and regularly participated in and developed materials to support stakeholder webinars.
- **New Hampshire Department of Health and Human Services:** Conducted 11 different stakeholder engagement sessions and developed a web-based survey to identify opportunities to improve a state's LTSS delivery system.

Analytics, Evaluation, and Research

- **New Hampshire Department of Health and Human Services:** Led a team to research and evaluate opportunities to improve the State's LTSS service delivery model.
 - Conducted a market-based rate study and set rates for the State's HCBS waiver.
 - Analyzed capacity for nursing facilities and HCBS to determine service gaps.
 - Analyzed Medicaid eligibility determination timeframes and implemented new processes to improve staff eligibility determination reviews.
- **West Virginia Medicaid:** Supported the State to oversee, manage, and enhance the State's managed care programs. Designed an approach and process to oversee the MCOs' performance and compliance. Led a team to create a web-based dashboard that: 1) enabled visualization of key performance indicators to improve quality and performance and inform decision making and 2) Provided real-time view of cost, access, utilization, and quality performance data across MCOs and populations.
- **Kentucky Medicaid:** Analyzed the State's critical incident data and researched industry leading practice to redesign the State's approach to critical incident reporting, provider licensure and certification, and corrective action plans.

Work History

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

Education

- Bachelor of Science, Finance, Arizona State University

Thought Leadership

- "It's Time for States to Reshape Medicaid" Article on Guidehouse's website (Jan. 2021)
- "Core Elements of a Critical Incident Management System" Webinar for Advancing States (Feb. 2020)

Charles Smith, PhD, MA

Director, Behavioral Health Lead



Charlsmith@guidehouse.com
Denver, Colorado
Direct: (720) 520-0922

Professional Summary

Charlie is a national behavioral health leader who aims to harness the knowledge, expertise, and innovation to advance the country's behavioral health care system. He is a licensed Psychologist with more than 30 years of clinical, research, and leadership experience in forensic psychology, addiction, rehabilitation, emergency / crisis intervention, integrative / collaborative systems of care, and Federal and State government administration. Charlie has deep experience developing statewide behavioral health policy and programs that promote prevention, treatment, recovery, and workforce system infrastructure, advancing strategic relationships and leveraging Federal, state, and local resources to address complex public behavioral health challenges.

Before joining Guidehouse, Charlie served as the Regional Director for the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) serving as the lead Federal authority for mental health and substance abuse for the states of Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming and 33 Federally recognized Tribal Nations. He also served as a Senior Policy Advisor for the 988 Behavioral Health Crisis Coordinating Office and Senior Leadership Consultant for SAMHSA's Center for Mental Health Services. Charlie's distinguished career includes serving as the Director / Commissioner for the Colorado Office of Behavioral Health, Director of Community Mental Health Programs and Mental Health Services for the Colorado Department of Corrections, and practicing psychologist in many forensic, hospital, community, and college settings.

Areas of Expertise

- State and Federal behavioral health leadership, policy, and program development and implementation
- Licensed Psychologist with subspecialties in forensic, rehabilitation, and addiction psychology
- Advising state, tribal, and local mental health and substance abuse authorities, governors, legislators, tribal leaders, healthcare providers, academic institutions, advocacy organizations, and community members
- Building strategic relationships and multisector leadership coalitions across Federal, state, tribal, and local governments, and agencies
- Using Federal, state, and foundation assets to national, regional, and local stakeholders to advance behavioral health prevention, treatment, and recovery services
- Developing thorough behavioral health systems of care, infrastructure, and models that equitably support the evidence-based and culturally responsive, behavioral health

prevention, treatment (outpatient and inpatient), crisis services, recovery support services, and workforce practices

- Analyzing behavioral health trends, gaps, and strategic opportunities across urban, suburban, rural, and remote communities and critical populations
- Developing critical statewide behavioral health crisis response protocols and post disaster recovery plans across FEMA, HHS, state, tribal, and local governments
- Advising states regarding the development, management, and implementation of Federal block grant requirements and leveraging multiple government resources to support population health and social determinants of health initiatives
- Conducting strategic planning with criminal and juvenile justice systems to improve community intervention, diversion, correctional management, behavioral health care, and reentry programming for persons with mental and substance use disorders who intersect with the justice system

Professional Experience

Guidehouse

- Director and Behavioral Health Lead for the Guidehouse's State Health and Human Services practice
- Leads multiple state and local projects focused on strategy and system transformation, crisis services / 988 implementation and program evaluation, 1115 IMD SMI / SUD, integrated care / CCBHC, substance use prevention and treatment, supportive housing and recovery housing models, criminal justice, and workforce development and training
- Leads national business development and go-to-market strategies focused on behavioral health
- Provides subject matter expertise, thought leadership, and advisory consultation related to behavioral health policy, program design, standards of care, leveraging Federal and state resources, and quality assurance and compliance programs, across multiple business practices and service lines

Federal Government

- Led Federal Behavioral Health Authority for U.S. DHHS-Region VIII States and Tribal Nations (CO, MT, ND, SD, UT, WY, and 33 Tribal Nations)
- Senior Policy Advisor for the SAMHSA 988 Behavioral Health Crisis Coordinating Office and Senior Leadership Consultant to the SAMHSA Center for Mental Health Services
- Served as national subject matter expert in behavioral health administration, rural behavioral health, system design, workforce, supported employment, criminal and juvenile justice, suicide prevention and crisis response, prevention / harm reduction, and addiction treatment and recovery
- Consulted with State Mental Health and Substance Abuse authorities, Governors, Legislators, Tribal Leaders, Health Care Providers, Academic Institutions, Private Industry, and individuals and families. Leverage and link Federal resources and assets to national, regional, and local stakeholders to advance behavioral health prevention, treatment, and

recovery services. Worked with states, tribes, and communities to develop targeted responses to local opioid, stimulant, overdose, and suicide epidemics

- Collaborated with multiple Federal agencies (e.g., CMS, HRSA, OASH, OCR, ACF, ACL, USDA, DEA, DOL, DOE, BIA, HUD, CDC, etc.) to advance national and regional behavioral initiatives. Coordinated with FEMA and HHS-ASPR regional, state, tribal, and local emergency management and disaster/crisis response. Led the joint FEMA / SAMHSA analysis of technology advancements to address behavioral health during COVID-19
- Developed Federal CMS policy revisions to expand behavioral health professionals working in rural health clinics and critical access hospitals
- Initiated SAMHSA's application to the American Academy for Continuing Medical Education (AACME) Joint Accreditation Board to align and standardize all internal and external behavioral health training / continuing education requirements for all designated behavioral health professions across the country
- Designed expanded policies and contract language of HRSA's National Health Service Corp (Loan Forgiveness Program) for behavioral health professionals
- Advised Federal agencies (SAMHSA, NH-NIDA, FDA, CDC) regarding the expansion of telehealth and digital behavioral health therapies and represented HHS / SAMHSA at the Electronic Mental Health International Congress (emic)
- Conducted environmental scans identifying behavioral health trends and service gaps across urban, rural, and remote communities
- Facilitated national listening sessions regarding SAMHSA's Data Strategy and cross-agency redesign of the National Outcome Measures, Treatment Episode Data Set, and Unified Reporting System
- Oversaw SAMHSA's Policy Brief on "Behavioral Health Treatment Indications for Individuals with Traumatic Brain Injury" and coordinated regional training on TBI for behavioral health professionals
- Developed and implemented specialized regional Policy Academies on Aging and Behavioral Health, Behavioral Health Technology, Workforce Development, Syringe Service Programs for Rural Communities, Community-based Behavioral Health Organizations, and Collegiate Behavioral Health
- Established Public Behavioral Health Policy Fellowship Program for advanced pre / postgraduate students
- Developed a collaborative relationship between SAMHSA and the National Health Occupations Student Association (HOSA) to expand opportunities for high school students to be exposed to behavioral health professions in 49 states
- Developed a national model for state, territory, tribal, and local public health consultation. Established cross-agency consultation teams to address key state / local behavioral health issues such as overdose, suicide, LGBTQ+ behavioral health, ADA / Olmstead compliance, social determinants of health, housing, etc.

- Developed and implemented multi-agency regional consultation teams and collabs: Region 8 National Prevention Collaborative, Opioid / SUD Misuse Consultation Team; Olmstead Consultation Team, Serious Mental Illness Consultation Team, Suicide Prevention Learning Community; Harm Reduction Collaborative; Disaster Behavioral Health Consultation Team; LGBTQ+ Consultation Team; Adolescent Health Consultation Team

State Government

- Served as the State Director (Commissioner) of the Colorado Office of Behavioral Health, Mental Health and Substance Abuse and statewide leader of the public behavioral health system (prevention, treatment, and recovery)
- Led reorganization and merger of the Division of Mental Health and Alcohol and Drug Abuse Division to form the Office of Behavioral Health (formerly, Division of Behavioral Health)
- Responsible for the administration and management of Colorado's public mental health and substance use prevention, treatment, and recovery systems (17 community mental health centers, four managed service organizations, 357 SUD treatment organizations, 27 prevention agencies, nine withdrawal management programs, 12 methadone maintenance programs, 27 – 65 designated mental health facilities, and state psychiatric hospitals). Annual budget of \$150M, Federal Block Grants, general fund, and multiple Federal, state, foundation grants
- Managed 85 FTE (including Federal Prevention Fellowship and CU Postdoctoral Psychology Fellowship). Directed public funding, community programs (prevention, treatment, and recovery programs), workforce development, research / program evaluation, and quality assurance and standards sections
- Developed statewide policies and financing that shows improved services for juvenile and adult offenders, recovery support services, supported employment, loan forgiveness and scholarship programs for behavioral health professionals, traumatic brain injury, integrated care, evidenced-based clinical practices, and peer support services. Established competencies for peer specialists from which national standards are based
- Consulted and collaborated with Federal, State, and local agencies, community / providers, primary care clinics, hospitals, universities as well as patients, families, and stakeholders
- Oversaw the development and management of legislative reports, budget analyses and contract management, public policy initiatives, Federal formulary and discretionary grants
- Appointed Member of the Colorado Legislative Mental Health Task Force on the Examination of Persons with Mental Illness in the Criminal Justice System; Governor's Justice Assistance Grant Board; Vice Chair, State Methamphetamine Task Force; Vice Chair, School Safety Resource Board; Interagency Advisory Committee for Juvenile & Adult Correctional Treatment; Chair, Interagency Task Force on Treatment; Vice Chair, Behavioral Health Transformation Council; Governor's Justice Assistance Grant Board; Governing Body, Colorado Mental Health Institute at Pueblo and Fort Logan
- As Director of Community Mental Health Programs for the Colorado Department of Corrections, Responsible for statewide, community mental health, substance use, anger management, and sex offender services for offenders in parole, community corrections and youth offender services. Collaborated with community treatment providers to advance offenders' access to health care services post prison release

- Managed \$80M, supervised four FTE and contract staff. Responsible for the Division of Quality Assurance, Research and Analysis and oversaw the DOC Approved Community Treatment Provider Board
- Conducted regular training and case conferences with parole officer: managing offender medical / mental illnesses, substance abuse screening and treatment, and sex offender services.
- Co-developed and implemented statewide Crisis Intervention Training for Parole Officers and established statewide Crisis Response and Review Team.
- Coordinated prison community transition/reentry initiatives for SMI offenders. Conducted regular case conferences pertaining to special needs offenders leaving prison and involuntary commitments to the State Psychiatric Hospital system from prison
- Co-developed and implemented John Eachon Reentry Program (Jefferson County) and Independence House-Fillmore Modified Therapeutic Community Program
- Appointed - Governor's Interagency Coalition for Homelessness; Mental Health Planning and Advocacy Council; Denver Crime Commission; Interagency Council on Health Disparities
- Led state policy / legislative action items (e.g., suspended Medicaid benefits, early Medicaid applications for offenders in jails and prisons). Successfully negotiated with Social Security Administration for the inclusion of community corrections offenders as eligible recipients of SSI
- Created working relationships between Division and numerous State agencies (i.e., Division of Mental Health, Alcohol and Drug Abuse Division, Division of Criminal Justice, Division of Vocational Rehabilitation, County Community Corrections Boards, FQHCs, hospitals, and advocacy organizations)
- As Director of Mental Health Services for the Colorado Department of Corrections-Denver Complex, oversaw mental health, substance abuse and sex offender services at three state prisons managing more than 50,000 offenders per year
- Supervised 33 professional clinicians, administrative and 15 contract staff. Developed clinical forensic training rotation for psychiatry residents and psychology interns in the University of Colorado, Departments of Psychiatry and Psychology
- Responsible for Federal and state licensure / accreditation reviews and compliance. Co-wrote and managed NIDA grant examining the effectiveness of prison-based, intensive substance abuse treatment for female offenders
- Awarded Federal National Health Service Corp loan repayment grant for mental health professionals
- Developed and implemented correctional health policies: intake behavioral health screening and assessment, mental health isolation / restraint protocols, suicide prevention / intervention procedures, offender reentry, OBGYN / delivery / postpartum maternal mental health care, involuntary medication procedures, parole board review procedures, transgender behavioral healthcare, and HIV / AIDS mental health services

- Developed and implemented specialized mental health programs: a 48-bed inpatient psychiatric unit for female offenders, a 72-bed therapeutic community for female offenders with substance use disorders, an emergency psychiatric hospitalization program for male and female offenders, and a dialectical behavioral therapy program for female offenders
- Developed clinical forensic training rotation for psychiatry residents and psychology interns in the University of Colorado, Departments of Psychiatry and Psychology

Clinical

- Licensed Psychologist with subspecialties in forensic, addiction, and rehabilitation psychology
- Provided psychiatric crisis assessment, intervention, and management in community and forensic settings. Conducted competency evaluations for adult and juvenile detainees / inmates at the Denver County Jail, Denver Pre-arraignment Detention Facility, and the Denver Forensic Medical Center
- Provide clinical psychotherapy (individual and group) in college / university, hospital, community, and forensic settings. and individual and group psychotherapy. Developed patient and family support groups for cancer, dialysis, Parkinson's disease, and traumatic brain injury
- Conducted psychological and neuropsychological assessments and on-call emergency services. Provided specialized mental health services for offenders with chronic medical illnesses
- Clinical Consultant / liaison for hospital inpatient psychiatric, emergency department, EMS, and drug withdrawal treatment units
- Coordinated prison community transition / reentry initiatives for SMI offenders. Conducted regular case conferences about special needs offenders leaving prison and involuntary commitments to the State Psychiatric Hospital system from prison

Work History

- Director, Guidehouse (2023 – Present)
- Regional Director / Senior Policy Advisor, Substance Abuse and Mental Health Services Administration (SAMHSA), United States Department of Health and Human Services (2012 – 2023)
- Director, Office of Behavioral Health, Colorado Department of Human Services (2010 – 2012)
- Deputy Director, Office of Behavioral Health, Colorado Department of Human Services (2007 – 2010)
- Director, Community Mental Health Services, Division of Parole, Community Corrections, Youth Offender Services, Colorado Department of Corrections (2005 – 2007)
- Director, Mental Health Services, Denver Reception and Diagnostic Center / Denver Women's Correctional Center, Colorado Correctional Center, Colorado Department of Corrections (2000 – 2005)

- Psychologist, Addiction Recovery Programs, Colorado Department of Corrections (1998 – 2000)
- Forensic Psychology Intern, Denver Health Medical Center (1997 – 1998)
- Psychology Practicum Student, Office of Behavioral Health Services, Denver Health Medical Center (1996 – 1997)
- Graduate Clinical Assistant, Counseling and Consultation Center, University of Denver (1994 – 1996)
- Senior Rehabilitation Counselor, Department of Rehabilitation Medicine, Mount Sinai Medical Center (1991 – 1994)
- Substance Abuse Counselor, Opioid Treatment Program, St. Joseph's Medical Center (1989 – 1991)

Certifications, Memberships, and Awards

License/Certifications

- License Psychologist, Colorado License # 2476 (2000 – Present)
- Advanced Certification, Treatment of Alcohol and Other Psychoactive Substance Use Disorders, American Psychological Association (2002)
- Certified Rehabilitation Counselor (1991 – 2000)

Academic Lecturer

- University of Denver, School of Professional Psychology (2004 – Present)
- University of Denver, Department of Counseling Psychology (2000 – Present)
- University of Denver, Department of Social Work (2014 – Present)
- Clinical Instructor, University of Colorado, Department of Psychiatry (2014 – 2023)
- Metropolitan State University, Department of Social Work (2014 – 2023)
- University of Colorado, Denver, Department of Sociology (2001 – 2006)
- Metropolitan State University, Department of Human Services (2000 – 2023)
- Columbia University, Department of Occupational Therapy (1991 – 1994)
- New York University, Department of Rehabilitation Counseling (1991 – 1999)

Boards and Commissions

- Executive Board Member, National Dialogues of Behavioral Health (2026 – Present)
- Board Member/Treasurer, Advocates for Recovery Colorado (2025 – Present)
- Board Member, National Association for Rural Mental Health (2021 – 2023)
- Advisory Board, Mountain Plains Mental Health Technology Transfer Center (2018 – 2023)
- Advisory Board, Mountain Plains Addiction Technology Transfer Center (2018 – 2023)
- Advisory Board, Mountain Plains Prevention Technology Transfer Center (2018 – 2023)

- Board Member, Montana Health Occupations Student Association (2018 – 2022)
- Member, Colorado Psychological Association (Presidential Advisor) (2014 – 2016)
- Member, Colorado Criminal and Juvenile Justice Council (2010 – 2016)
- Member, National Association of State Mental Health Program Administrators (2007 – 2012)
- Member, National Association of State Alcohol and Drug Abuse Directors (2007 – 2012)
- Vice Chair, Behavioral Health Transformation Council (2010 – 2012)
- Vice Chair, State Methamphetamine Task Force (2009 – 2012)
- Chair, Interagency Advisory Committee for Juvenile and Adult Correctional Treatment (2008 – 2012)
- Governor's Justice Assistance Grant Board (2008 – 2012)
- Member, Governing Body, Colorado Mental Health Institute at Pueblo (2007 – 2012)
- Member, Governing Body, Colorado Mental Health Institute at Fort Logan (2007 – 2012)
- Colorado Legislative Mental Health Task Force on the Examination of Persons with Mental Illness in the Criminal Justice System (2007 – 2012)
- Vice Chair, School Safety Resource Board (2007 – 2012)

Awards and Recognitions

- Legacy Award, U.S. Department of Health and Human Services (2023)
- HHS Secretary's Award, 988 National Suicide and Crisis Lifeline, U.S. Department of Health and Human Services (2023)
- Trailblazer Team Award, HHS Region 8 SUD Consultation Team, U.S. Department of Health and Human Services (2023)
- Partnering for Excellence Team Award, HHS Region 8 Workgroup Advancing Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and Two Spirit Efforts, U.S. Department of Health and Human Services (2023)
- Going to Bat Award, National Association of Rural Mental Health (2022)
- Policy Advocate Award, National Association of State Head Injury Administrators (2020)
- HHS Ignite Award, Regional Consultation Model to Address the Opioid Epidemic, U.S. Department of Health and Human Services (2016)
- Colorado Health Occupation Student Association Lifetime Member Award (2019)
- Colorado Association of Addiction Professions Leadership Award (2017)
- Colorado Behavioral Health Integration Leadership Award (2011)

Education

- Doctor of Philosophy, Counseling Psychology, University of Denver (1994 – 1999)
- Master of Arts, Rehabilitation Counseling, New York University (1989 – 1991)
- Bachelor of Science, Psychology, Allegheny College (1984 – 1988)

Thought Leadership

- Senior Policy Advisor for the SAMHSA 988 / Behavioral Health Crisis Coordinating Office. Assisted with the system architecture, roll-out, and launch of the 988 National Suicide and Crisis Lifeline (2021 – 2023).
- Senior Leadership Consultant to the SAMHSA, Center for Mental Health Services (2021 – 2023).
- Developed comprehensive resource guides on Suicide Prevention, Trauma, Recovery, Supportive Housing, Older Adult Behavioral Health, Collegiate Behavioral Health, Veterans Behavioral Health, LGBTQ+ Behavioral, Maternal Behavioral Health, Workforce Development, Asian Americans and Pacific Islander Behavioral Health, and Criminal / Juvenile Justice Behavioral Health (2012 – 2023)
- “Youth Mental Health: Advancing National, Regional, and Local Collaboration”, Department of Labor Annual Conference (November 2023)
- Advised the Council of State Governments national brief on the management of individuals with traumatic brain injury who are involved in the criminal justice system (2023)
- “Substance Use Prevention, Treatment, and Recovery: National Trends and Opportunities.” Utah Substance Use Annual Conference (September 2023)
- “Leveraging 988 and the National Suicide and Crisis Lifeline: Strategies and Opportunities”, South Dakota Suicide Prevention Annual Conference (August 2023).
- “New Mental Health Commissioner Orientation – SAMHSA 101”, National Association of Mental Health Program Directors (NASMHPD) Annual Conference (July 2023)
- “Collaboration and Partnership in Digital Mental Health Environments,” International Electronic Mental Health Congress (May 2023)

Publications

- Special Issue Editor, Journal of Professional Psychology: Research and Practice Special Issue – Substance Use Disorders and Addictions. American Psychological Association, volume 51 (1)
- **Smith, C & Borden, K.A.** (2020). Introduction to the Special Issue on Substance Use Disorders and Addictions. Journal of Professional Psychology Research and Practice, 51(1), 1-4

Chad R. Mandala, PhD, MS

Managing Consultant



cmandala@guidehouse.com
Atlanta, Georgia
Direct: (404) 575-3802

Professional Summary

Dr. Chad R. Mandala is an administrator with more than 13 years of experience in the public sector. His research focuses on the emotional labor experiences of individuals holding minoritized identities and how they navigate the structural barriers of their environments. He served as an administrator for over a decade at Virginia Tech, Texas A&M University, and the University of Georgia and was responsible for helping to implement the DEI recruiting strategy for a technology firm.

Areas of Expertise

- Ryan White Policy
- 340B Compliance
- Higher education
- Organizational culture
- Qualitative research
- Sexual and gender minorities

Professional Experience

Mississippi Department of Public Health

- ADAP Optimization
 - Lead workstream to improve revenue capture, enhance compliance, and develop strategic plan for ADAP
 - Support ADAP Director for all initiatives related to program income tracking, eligibility compliance, and data reporting
- Training and Curriculum
 - Lead project workstream for developing ongoing trainings and workshops tied to gap analysis data
 - Develop training curricula for in person and virtual delivery for audiences of more than 60 people
- Fiscal
 - Support data analysis for budget development and tracking
 - Develop tools for fiscal monitoring and reporting of subrecipient budgets

- Identify recommendations for strategic improvement and optimization

Alabama Medicaid

- Draft narrative for grant proposal to CMS
- Identify data needs for proposal and collaborate with department to gather data
- Develop logic model and workplan for overall grant submission

Georgia Department for Behavioral Health and Developmental Disabilities

- Support project management for all aspects of workstream
- Develop stakeholder engagement strategies and interview guides for multi-format strategy
- Lead project research team to identify leading practices and current scholarship

Tennessee Division of Vocational Rehabilitation

- Support project management for all aspects of workstream
- Develop logic model for project implementation
- Draft narrative for grant submission to Department of Education

Kentucky Department for Public Health

- Pharmacy Optimization
- Lead workstream to improve revenue capture, enhance compliance, and develop strategic plan for ADAP
- Provide contract pharmacy oversight support to program leadership, including cabinet secretary
- Support strategic initiatives to improve insurance enrollment
- Training and Curriculum
 - Lead project workstream for developing ongoing trainings and workshops tied to gap analysis data
 - Develop training curricula for in person and virtual delivery for audiences of more than 60 people
- Linkage Navigation
 - Lead project workstream for strategic transformation of program to better align with agency needs
 - Conduct research on national standards and leading practices along with stakeholder engagements
- Program Income Investment Analysis
 - Serve as a subject matter expert for qualitative research with a focus on stakeholder strategy
 - Conduct statewide stakeholder engagement including Cabinet member interviews

- Fair Market Value
 - Support project research and data analysis for pharmaceutical contract pricing model
 - Support development of project reports and meeting materials to convey complex concepts to clients in easy to digest format

California Health and Human Services

- Supported the data analysis, qualitative data collection, and affiliated research
- Helped develop the equity framework for an agency of more than 34,000 employees across 17 departments, offices, and centers

New York Vital Access Program

- Supported the review of provider applications for state funding to support the expansion of services at rural hospitals in the State of New York

North Carolina Department of Health and Human Services (NCDHHS) – Division of Child and Family Well-Being

- Supported the quality control for policies, job aids, and other procedural documents for a newly created division within NCDHHS

Other Select Professional Experience

- Provided consulting to 15 global senior leaders to help create strategic hiring plans for increasing racial and gender diversity
- Developed long-term Minority Serving Institution strategy rooted in data
- Led the development of enterprise-level education initiatives focused on LGBTQ+ populations
- Create a unified unit learning curriculum and learning imperative to ground all offerings in theory and leading practice
- Collaborate with University Health Centers, Colleges of Pharmacy, and university medical partnerships to provide health equity workshops

Work History

- Managing Consultant, Guidehouse (2023 – Present)
- Micron Technology, University Recruiter (2022 – 2023)
- University of Georgia, Director (2018 – 2022)
- Texas A&M University, Director (2016 – 2018)
- Virginia Tech, Residential Learning Coordinator (2012 – 2016)

Certifications, Memberships, and Awards

- Social Justice Training Institute (2013)

Education

- Doctor of Philosophy in Higher Education, University of Georgia
- Master of Science in Higher Education, Florida State University
- Bachelor of Arts in English and Dramatic Art, University of California, Santa Barbara

Thought Leadership

Dissertation

- Or students will suffer: Feeling rules in identity advocacy centers at institutions of higher education in the United States - University of Georgia (uga.edu)

Published Articles

- Eppley, J. & **Mandala, C.R.** (2022). More than rainbows: Creating and reframing queer spaces on college campuses. In Mahn, C., Brim, M., & Taylor, Y. (Eds.). (2022). *Queer Sharing in the Marketized University*. Routledge.
- **Mandala, C. R.** & Ortiz, S. M. (2021). Queerness is a particular liability: Feeling rules in university LGBTQ Resource Centers. *Journal of Homosexuality*.
- Media appearance: Nathoo, Z. (Nov. 1, 2021) The people penalized for expressing feelings at work. *BBC Equality Matters*
- Ortiz, S.M., & **Mandala, C.R.** (2021). "There is queer inequity, but I pick to be happy": Racialized feeling rules and diversity regimes in university LGBTQ resource centers. *Du Bois Review*, 1-18
- Suárez, M.I, Asadi, L.; Scaramuzzo, P.; Slattery, P. & **Mandala, C. R.** (2020). Using photovoice as an arts-based method for grieving: LGBTQ + students & the pulse nightclub shooting, *International Journal of Qualitative Studies in Education*

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Appendix C Actuarial Certifications

Russell H. Ackerman | Partner and Chief Actuary | Contract Manager

The Actuarial Directory	
Russell H Ackerman ASA MAAA FCA	
Email russ.ackerman@guidehouse.com Tel +1(480)318-9390	
Designations ASA 2007 MAAA 2007 FCA 2015	SOA CPD attestation status Compliant(2023-2024) Compliant(2024-2025)
Primary area of practice Health	Specializations Capital Management Financial Reporting Product Pricing/Development Public Systems/Social Insurance Regulatory Risk Management

Sterling Felsted | Director | Lead Actuary

The Actuarial Directory

Sterling Arthur Felsted

FSA MAAA

163 George Wynn Rd
Palmetto
Georgia 30268-8581
United States

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



Designations

MAAA 2014
FSA 2021

SOA CPD attestation status

Compliant(2023-2024)
Compliant(2024-2025)

Primary area of practice

Health

Specializations

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

Biography

Sterling has 15 years of actuarial consulting experience, focused primarily on Medicaid work. He provides project management and client interfacing for Guidehouse's Medicaid clients. In this capacity, he assists States in addressing ongoing legislative and regulatory changes as well as pioneering innovative methods to assess program solvency and address areas of uncertainty. Over the last several years, he has led his team to develop and share techniques to account for fluctuating reversion efforts amongst Medicaid populations. He leads many of the projects and actuarial models for State's managed care rate development (including MLTSS, CHIP, and PACE), risk adjustment, budget projections and other financial analyses. Sterling's experience also includes IBNR modeling, risk mitigation strategies, program monitoring, Medicare pricing, fee schedule development,

Melanie Bell | Associate Director | Staff Actuary

The Actuarial Directory

Melanie Neal Bell

ASA MAAA



Designations

MAAA 2022
ASA 2022

SOA CPD attestation status

Compliant(2024-2025)
Compliant(2023-2024)

Academic degrees

M.Act.Sc

Primary area of practice

Health

Debra Ruocco | Associate Director | Staff Actuary

The Actuarial Directory

Debra Marie Ruocco

FSA MAAA

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



Designations

FSA 1999
MAAA 2000

SOA CPD attestation status

Compliant(2023-2024)
Compliant(2024-2025)

Primary area of practice

Health

Ben Maryland | Associate Director | Staff Actuary

The Actuarial Directory

Benjamin Maryland
ASA MAAA

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



Designations

ASA 2022
MAAA 2023

SOA CPD attestation status

Compliant(2024-2025)
Compliant(2023-2024)

Academic degrees

B.S.

Primary area of practice

Health

Specializations

Health Insurance - Commercial

Ryan Butterfield | Managing Consultant | Staff Actuary

The Actuarial Directory

Ryan Butterfield

ASA MAAA

Email rwbutterfield4@gmail.com
Tel +1(678)634-3576



Designations

ASA 2024
MAAA 2024

SOA CPD attestation status

Compliant(2023-2024)
Compliant(2024-2025)

Derek Knight | Associate Director | Financial Oversight Lead

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Name
Name: Derek Gregory Knight
Address: 110 West Marshall Street
Apt 41
Richmond, VA 23220

Licenses

Name
Name: Derek Gregory Knight
Address: 110 West Marshall Street
Apt 41
Richmond, VA 23220

Licenses

Exam Candidate

DOCUMENTS

Profession: Accountancy **License Number:** VA2012129908 **License Status:** Null and Void
Issue Date: 8/4/2016 **Expiration Date:**

Certified Public Accountant

DOCUMENTS

Profession: Accountancy **License Number:** 45059 **License Status:** Active
Issue Date: 8/12/2016 **Expiration Date:** 6/30/2027

Appendix D CMS Reporting Requirement Samples

Exhibit 1 – State of Tennessee, Medicaid Capitation Rates for TennCare (January 1, 2026 – December 31, 2026)

CLIENT PROPRIETARY \ PROTECTED



State of Tennessee

Department of Finance and Administration Division of TennCare

Medical Capitation Rates for TennCare's
Non-CHOICES, CHOICES, and CoverKids Programs for the Contract
Period
January 1, 2026 through December 31, 2026

CLIENT PROPRIETARY \ PROTECTED



September 30, 2025

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

Subject: Actuarially Sound Medical Managed Care Capitation Rates for Tennessee Managed Care Organizations for the period January 1, 2026, through December 31, 2026 (Non-CHOICES, CHOICES, and CoverKids programs)

Dear Mr. Seals:

We have calculated and are certifying the actuarially sound rates for the Managed Care Organizations (MCOs) participating in the State's Medical Managed Care Program for Non-CHOICES, CHOICES and CoverKids members for the contract period January 1, 2026, through December 31, 2026.

For the purposes of this report, the actuaries find it helpful to distinguish between the capitation rates that are developed without MCO-specific components, and those that reflect the 'fully loaded' amounts that will be paid to the MCOs:

1. **Core capitation rates** refer to the capitation rates prior to the addition of MCO-specific elements, namely the FIDE crossover amounts and 'add-on' directed payments.
2. **Certified capitation rates** refer to the fully loaded capitation payments that will be paid out to the MCOs and include the core capitation rates along with FIDE crossover claims and any 'add-on' directed payments. For transparency, this report shows the regional impacts by rate cell from adding these MCO-specific elements but avoids showing the MCO-specific components or final certified capitation rates themselves.

Appropriate documentation for all directed payments applicable and approved during the CY26 rating period are contained herein. For the purposes of this report, TennCare's State-directed payments have been categorized as follows:

1. **'Built-in' directed payment** arrangements refer to fee schedule or rate increases that can't be divorced from the base data. These increases are included in the traditional rate development process as part of the 'core' capitation rates.
2. **'Add-on' directed payment** arrangements refer to budgeted increases that are applied after the development of the 'core' capitation rates. As these often demonstrate differences between MCO, these are MCO-specific based on projected MCO expenditures.
3. **'Separate payment term' directed payment** arrangements refer to increases paid outside of the capitation rates as defined and approved by CMS.

Please note that no directed payment arrangements or FIDE SNP costs pertain to the CoverKids program, so the core and certified capitation rates will be the same for the CoverKids program.

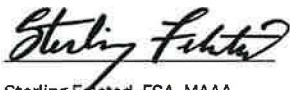
CLIENT PROPRIETARY \ PROTECTED



For comparison against capitation rates from prior rate setting periods, we include comparisons not only to the certified capitation rates but also comparisons between the core capitation rates.

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

Sincerely,



Sterling Fritsted, FSA, MAAA
September 30, 2025



Alysia Overdorf, FSA, MAAA
September 30, 2025



Will Lu, FSA, MAAA
September 30, 2025

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

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State of Tennessee

Department of Finance and Administration Bureau of TennCare

Medicaid Capitation Rates for TennCare's
Non-CHOICES and CHOICES Programs for the Contract Period
January 1, 2025 through December 31, 2025

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September 30, 2024

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

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

Dear Mr. Seals:

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

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

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

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

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

Sincerely,



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



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

**Exhibit 3 – Oklahoma Health Care Authority Medicaid Managed Care Capitation Rates for
SoonerSelect Medical Program (April 1, 2024 – June 30, 2025)**



State of Oklahoma

Department of Finance and Administration

Oklahoma Health Care Authority

Medicaid Managed Care Capitation Rates for Oklahoma's
SoonerSelect Dental Program for the Contract Period
February 1, 2024, through June 30, 2025



August 11, 2023

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

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

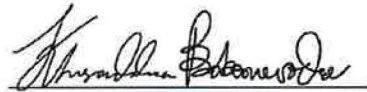
Dear Mr. Morris:

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

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

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

Sincerely,



Khisamiddin Bobomurodov, FSA, MAAA
August 11, 2023



Alysia Overdorf, FSA, MAAA
August 11, 2023

Appendix E Reservation of Rights



Submission of this proposal by **GUIDEHOUSE INC.**, a Delaware corporation, or any of its affiliates (the "Vendor"), is not an indication of Vendor's willingness to be bound by all of the terms presented in the **West Virginia Department of Human Services (DoHS), Bureau for Medical Services (BMS)**, which includes both the **West Virginia Medicaid Program** and the **West Virginia Children's Health Insurance Program (WVCHIP)**, along with other **DoHS Bureaus**, (the "Agency") Request for Proposals, pertaining to Medicaid Managed Care Rate Setting: CRFP BMS2700000001 (the "RFP"). This proposal in response to the Agency's RFP does not constitute a contract to perform services and cannot be used to award a unilateral agreement. Final acceptance of this engagement by the Vendor is contingent upon successful completion of Vendor's acceptance procedures. Any engagement arising out of this proposal will be subject to negotiation of a mutually satisfactory vendor contract including (i) modifications to certain RFP terms and conditions and (ii) our standard terms and conditions and fees and billing rates established therein.

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

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

1. Section 8 – Insurance

Vendor must maintain:

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

2. Section 13 – Pricing

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

3. Section 20 – Time

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

4. Section 36 – Indemnification

36. **INDEMNIFICATION:** The Vendor agrees to indemnify, and defend, and hold harmless the State and the Agency, their officers, and employees from and against (1) Any third party claims or losses resulting solely and directly from for services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with Vendor in the performance of this Contract. Such indemnification shall be conditioned upon the State promptly notifying the Vendor, in writing, of any such claim, permitting the Vendor the authority to settle or defend the claim (including selection of defense counsel) and reasonably cooperating with the Vendor in the defense and settlement thereof. Notwithstanding the foregoing, the Vendor shall not enter into any stipulated judgment or settlement that purports to bind the State without the State's express written authorization, which shall not be unreasonably withheld or delayed; (2) Any claims or losses resulting to any person or entity injured or damaged by the Vendor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under the Contract in a manner not



~~authorized by the Contract, or by Federal or State statutes or regulations; and (3) Any failure of the Vendor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws.~~

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

1. **Limitation on Liability:** Notwithstanding the terms of any other provision, the total liability of Vendor and its affiliates, directors, officers, employees, subcontractors, agents and representatives for all claims of any kind arising out of the Agreement, whether in contract, tort or otherwise, shall be limited to the total fees paid to Vendor under the applicable statement of work in the preceding twelve (12) months. Neither Vendor nor Agency shall in any event be liable for any indirect, consequential or punitive damages, even if Agency or Vendor have been advised of the possibility of such damages.
2. **Consulting Services Disclaimer:** Vendor will not audit any financial statements or perform any attest procedures in the course of performing the services under the Agreement. Vendor's services are not designed, nor should they be relied upon, to disclose internal weaknesses in internal controls, financial statement errors, irregularities, illegal acts or disclosure deficiencies. Vendor is not a professional accounting firm and does not practice accounting. Vendor's services will not include legal, engineering or architectural advice or services.
3. **Standard of Care and Performance:** Vendor agrees that the services provided for under the Agreement will be performed in a professional manner in accordance with recognized professional consulting standards for similar services and that qualified personnel will be assigned for that purpose. In providing the services, Vendor and its personnel shall exercise reasonable care. Vendor cannot guarantee or assure the achievement of any particular performance objective, nor can Vendor guarantee or assure any particular outcome for the Agency or any other person as a result of the Agreement or the performance of the services contemplated thereunder.

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

4. **Intellectual Property:** Upon full payment of all amounts due Vendor in connection with the Agreement, all rights, title and interest in any information and items, including summaries, documents, reports and portions thereof Vendor provides to the Agency (collectively, the "Vendor Deliverables") will become the Agency's sole and exclusive property for its internal business purposes and uses pursuant to the scope set forth in the applicable statement of work, subject to the exceptions set forth hereafter. Vendor shall retain sole and exclusive ownership of all rights, title and interest in its work papers, proprietary information, processes, methodologies, know-how and software, including such information as existed prior to the delivery of the services and, to the extent such information is of general application, anything that it may discover, create or develop during provision of the services (collectively, the "Vendor Property"). To the extent the Vendor Deliverables contain any Vendor Property, the Agency shall be granted a non-exclusive, non-assignable, royalty-free license to use such Vendor Property solely in connection with the subject of the Agreement.
5. **Acceptance:** Receipt of a deliverable occurs when the deliverable is provided to the Agency. Receipt of services is deemed to occur when the Agency receives an invoice from Vendor for those services. Absent written notification of non-acceptance from the Agency within five (5) business days of receipt, deliverables and services will be construed as accepted. Any such notice shall specify in reasonable detail the reasons such deliverable or service has been deemed unacceptable. If the notice of non-acceptance is not sufficiently detailed to allow Vendor to determine why such deliverable or service is unacceptable, Vendor may request in writing that the Agency provide additional information. The passage of ten (10) business days from the date of such request without the provision of such



additional information shall constitute final acceptance of such deliverable or service by the Agency. Within fifteen (15) days of receipt of the Agency notice, Vendor shall, at its option, either correct the problems in such deliverable or service or present the Agency with a plan to fix such problems within a reasonable period of time under the circumstances. The deliverable or service shall be deemed accepted by the Agency after comments have been incorporated and the deliverable or service re-submitted. Acceptance by the Agency shall not be unreasonably withheld or delayed.

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

1. Section 3(l) – Notification of Breach

Notification of Breach. During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology within fifteen (15) business days ~~immediately~~ by 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 violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and, unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or <https://apps.wv.gov/ot/ir/Dcfault.aspx>.

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

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

1. **Unsuccessful Attempts.** Both the Agency and Associate agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur would swamp any potential benefit gained from reporting them. Consequently, both Agency and Associate agree that this Agreement shall constitute the documentation, notice and written report of such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the parties consider the following to be illustrative (but not exhaustive) of Unsuccessful Security Incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of EPHI or interference with an information system:

- a. Pings on a party's firewall;
- b. Port scans;
- c. Lost or stolen encrypted hardware, such as laptops;
- d. Attempts to log on to a system or enter a database with an invalid password or username;
- e. Denial-of-service attacks that do not result in a server being taken off-line; and
- f. Malware (e.g., worms, viruses).

